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Public Health Liberation – An Emerging Transdiscipline to Elucidate and Transform the Public Health Economy

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Public Health Liberation – An Emerging Transdiscipline to Elucidate and Transform the Public Health Economy

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Abstract

Public Health Liberation (PHL) is an innovative general theory of public health aimed at accelerating health equity. This paper provides a rich synthesis of philosophical traditions, novel theories, and approaches to establish the basis for a new public health transdiscipline. The authors argue that the "public health economy" as a single analytic lens elucidates the contradictions and tensions that reproduce vast health inequity. Authored by a majority of Black women, community experiences and perspectives are a major strength of this paper because they draw upon leadership experiences with contemporary issues.

The authors begin by describing their background in public health advocacy and by demonstrating the need for PHL using lead-contaminated water crises from Flint, Michigan and Washington, DC. They discuss the benefits of horizontal and vertical integration that broaden public health discourse to include affected populations and that seek opportunities throughout the public health economy. Their philosophical and theoretical reasoning reinterprets and adopts disciplinary concepts in political theory, sociology, women's studies, African American emancipatory writing, anti-racism, and community psychology to form a culturally relevant worldview and cogent thesis. Several new constructs emerge that do not appear elsewhere in the literature - Gaze of the Enslaved, Morality Principle, liberation, illiberation, liberation safe spaces, public health realism, and hegemony. The authors use their ethical and theoretical assumptions to guide practice and community self-help. Public Health Liberation presents a major challenge to assumptions about public health effectiveness in addressing vast health inequity.

Conflict of Interest Statement

The authors have no conflict of interest other than that they are all members of Public Health Liberation - a non-profit.

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WHITE PAPER

Public Health Liberation – An Emerging Transdiscipline to Elucidate and Transform the Public Health Economy

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Abstract

Public Health Liberation (PHL) is an innovative general theory of public health aimed at accelerating health equity. This paper provides a rich synthesis of philosophical traditions, novel theories, and approaches to establish the basis for a new public health transdiscipline. The authors argue that the “public health economy” as a single analytic lens elucidates the contradictions and tensions that reproduce vast health inequity. Authored by a majority of Black women, community experiences and perspectives are a major strength of this paper because they draw upon leadership experiences with contemporary issues.

The authors begin by describing their background in public health advocacy and by demonstrating the need for PHL using lead-contaminated water crises from Flint, Michigan and Washington, DC. They discuss the benefits of horizontal and vertical integration that broaden public health discourse to include affected populations and that seek opportunities throughout the public health economy. Their philosophical and theoretical reasoning reinterprets and adopts disciplinary concepts in political theory, sociology, women's studies, African American emancipatory writing, anti-racism, and community psychology to form a culturally relevant worldview and cogent thesis. Several new constructs emerge that do not appear elsewhere in the literature - Gaze of the Enslaved, Morality Principle, liberation, illiberation, liberation safe spaces, public health realism, and hegemony. The authors use their ethical and theoretical assumptions to guide practice and community self-help. Public Health Liberation presents a major challenge to assumptions about public health effectiveness in addressing vast health inequity.”

Public Health Liberation (PHL) is an innovative, multi-faceted approach to public health discourse and practice aimed at radical transformation to ensure health equity. The objective of this paper is to present the arguments for a public health transdiscipline on a scale and scope to achieve this aim. This sweeping framework synthesizes rich philosophical and theoretical traditions to argue for a reconceptualization of determinants of health through a single analytic lens, defined as the public health economy. PHL unifies worldviews, theories, practice, training, and research for a cogent approach to elucidate motivations and operations

within the public health economy. Although it is primarily contextualized within the US, PHL is universally applicable. Its significant contribution of liberation and African American philosophy to public health theory is highly innovative. This strength derives from the authors' strong cultural identity and collective advocacy on behalf of communities burdened by structural violence and historical trauma. The narrative on current events and inclusion of community voices makes this discussion relatable to non-academics and bridges academic and popular discourse. Notably, Black women constitute a majority of the paper's authors.

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In this paper, we begin by describing the background for PHL theory and practice by drawing upon the authors' community leadership experiences. We then present the need for PHL based on two case studies of lead-contaminated water crises - Flint, Michigan and Washington, DC. A full discussion of relatedness among each of the five PHL components follows a broad overview of horizontal and vertical integration that calls for expanding coalitions. The authors synthesize wide-ranging theories and establish the centrality of liberation as both a state of consciousness and means to achieve health equity. They posit a principled and practical course of action for communities. African American heritage figures centrally in their philosophical and methodological framing, offering several new constructs for evaluating research ethics ("Gaze of the Enslaved"), identifying psychosocial barriers ("illiberation"), dictating when to act ("Morality Principle"), and contrasting PHL with anti-racism. Many terms appear in our previously published abbreviated dictionary on "Health Equity and Liberation Terms for Praxis."¹

The public health economy is explained in rich theoretical detail using novel theory-building - Theory of Health Inequity Reproduction, public health realism, and hegemony - that elucidates public health contradictions and tensions. The theories provide a blueprint to communities for effective self-advocacy. The final sections on PHL praxis, research, and training further support the need for a new transdiscipline and showcase the authors' work in applied PHL theory.

1. Background

PHL theory and practice formed unintentionally from what we were already doing in our communities of practice. Our collective experience in public health practice as advocates, clinicians, researchers, and administrators varied considerably - community health in rural Africa, minority urban health, academic research, environmental science, and political leadership. In these roles, we have gained insight into the social, political, and economic mechanisms that drive structural inequity. These efforts have been invaluable because we have accumulated specialized knowledge in various fields ranging from environmental regulation to housing financing. Our analytic skills have evolved as we have immersed ourselves in this work, focusing attention and resources on the root causes.

Just within the last five years, the authors have worked to combat environmental racism, food and water insecurity, the devastation of the fentanyl

crisis, poor housing quality, wholesale neighborhood displacement, and economic marginalization. We have challenged permits issued to industrial polluters in our neighborhoods, editorialized about poor economic planning, established our own newspaper for self-advocacy, published peer-reviewed citizen research studies, and protested against deteriorating public housing conditions and displacement policies.

Many authors reside and maintain public health practice in Washington, DC where there exist major structural influences that concurrently promote and hinder public health. At a time of rapid economic growth, the nation's capital is the most intensely gentrified city in the US in the 21st century, resulting in at least 20,000 displaced Black Americans.^{2,3} Among males, the black-white life expectancy gap of 17.23 years was 399% larger than U.S. black-white males.⁴ Similarly, a black-white gap of 12.06 years was observed for females - 482% larger than U.S. black-white females.⁴ The now iconic street mural bearing the words, "Black Lives Matter," in the city does not reflect our lived experiences.

Our advocacy efforts in certain domains are effective but are limited in other areas such as environmental racism, government-driven displacement, racial health disparities, eroding affordability, and economic parity. The city only recently decided on a policy shift to undo environmental racism by de-industrializing because of an "influx of white residents".⁵ Burdened by poverty and poor health outcomes, minority residents for years protested the industrial activity in their backyard, even published editorials, to no avail until a demographic shift.⁶ The housing authority presents another host of challenges for families — poor building maintenance, declining federal support, wholesale neighborhood displacement, investigations of corruption, and intensified oversight by the US Department of Housing and Urban Development (HUD).

The eponymous PHL framework presented here is the result of deliberations within Public Health Liberation, a non-profit that was founded in November 2021. We have held biweekly meetings to discuss challenges within our communities of practice and to develop PHL principles while simultaneously engaging in applied Public Health Liberation. This manuscript is the culmination of eight months of dialogue to define the central tenets of PHL. It is introductory rather than conclusive. Although much of this content appears in The Hub, our online publication platform, we have decided to publish a separate manuscript to present a unified framework.⁷ Before describing our theoretical

framework, we seek to demonstrate the need for PHL with two case studies from Flint, Michigan and Washington, DC.

We use the term “health equity” frequently in this document. We build upon previous definitions that include, “fair and just opportunity to be as healthy as possible” and “reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups,” while recognizing the lack of conceptual clarity.⁸ Our definition of health equity moves beyond “opportunity” because we recognize the powerful force of liberation, illiberation, public health realism, and hegemony, as discussed later. Rather, health equity as the elimination of health disparities by race, income, and social determinants, requires a reconciliation with the public health economy. We are less interested in the debate over theoretical boundaries, usually a distinction without a difference from our point of view. The greater importance is to understand what has health equity “stuck” in the first place. In other words, context matters. The cumulative effects of less noticeable health inequity reproduction are the topics of this paper. Only through changing conditions based on a general theory of the public health economy can health equity be achieved.

2. The need for PHL: the lessons of Flint, Michigan and Washington, DC

The lead crisis in Flint, Michigan demonstrates the need for Public Health Liberation. To our understanding, an injunction to prevent a switch to the Flint River was not requested. If granted, a request to enjoin the switch could have prevented the public health crisis that disproportionately affected Black Americans while demanding that the Flint government and state of Michigan disclose more information, including its plan to not adequately treat water from the Flint River, through a process of discovery. It would have involved Flint government paying to extend its contract with another water authority until an adequate plan could be put into place. This legal insight is precisely the proactive public health transformation that PHL envisions. In fact, there are almost 3000 U.S. neighborhoods with lead poisoning rates at least twice as high as during the peak of Flint's lead crisis that should now be the focus for a public health transformation.⁹

The Flint Water crisis was not the only major case of environmental racism due to abject failure in water authority policy. Black communities in Washington, DC also suffered a lead crisis in the early 2000s that was “20 to 30 times larger” than

Flint's.¹⁰ It crystallized interlocking injustices implicating Washington's Water and Sewer Authority and the U.S. Centers for Disease Control (CDC). “The U.S. Centers for Disease Control came into town and wrote a falsified report that literally claimed that not a single man, woman or child in D.C. had any evidence any of them had their blood lead elevated above CDC's level of concern,” according to Virginia Tech environmental engineer Marc Edwards.¹⁰ An investigation by the US House of Representatives found that the CDC made “scientifically indefensible claims.”¹¹ PHL calls attention to the public health economy for this reason. These crises illustrate the need for a single discipline to reflect this milieu and to fulfill the vision of PHL. Contaminated water crises are among a whole host of economic, political, and social challenges that warrant public health attention and intervention.

3. Public Health Liberation theory and practice: an introduction

3.1. Defining public health economy

Public Health Liberation is consistent with a transdisciplinary approach because it seeks a “homogenized theory” or general theory with “mutual interpenetration of disciplinary epistemologies,” as opposed to an interdisciplinary method that stops short of a general theory.¹² These interdependencies of theories and praxis will become apparent as our discussion unfolds. We begin by introducing a fundamental concept in PHL theory and practice - the public health economy.

Public health economy can be understood as the interactions and totality of economic, political, and social drivers that impact our communities' health and well-being. It is concerned with the relationship and interaction among all agents or classes of agents in the operationalization and reproduction of health inequity. It assumes a perpetual state of competition for resources and power in which moralities and self-interest collide. The aim in defining this concept is to illuminate public health economic dynamism, which requires merging all aspects of the public health economy conceptually and methodologically into a coherent discipline. We posit that this approach is likely a more effective “backdoor pathway” beyond traditional public health since it involves concurrent interventions at multiple levels in different fields. We discuss many examples throughout this paper. Through ongoing surveillance of the public health economy, it enables PHL practitioners to identify opportunities to interrupt

harm and to quickly marshal resources for legal, social, and political intervention. As discussed later, the public health economy is situated within our liberation philosophy. Pathways to accelerate health equity are quite limited absent a shift à la PHL because it is the current state, characterized by anarchy and fragmentation, that is reproductive of health inequity.

We immediately recognized that the public health economy lacked order. Indeed, it is the anarchy within the public health economy that elucidates the tensions and contradictions that we encounter. Anarchy refers to the apparent or demonstrable absence of a governing authority or central principles from which actions in the public health economy stem. This explains the conundrums that we see in our own communities of practice. As we discussed with our experiences in Washington, DC, vast and deep racial health and economic disparities persist amidst abundant resources.

We borrowed from the concept of political economy, which is the study of relationships between individuals and society and the linkages between economic and political systems. We acknowledge the work of Soheir Morsy, who first called for political economic perspectives in medical anthropology more than 40 years ago, “(It) undermines the idealist, reductionist, and dualist approaches to the study of health and illness ... Alternatively, it suggests that analysis of health systems requires their placement in their broader political-economic environment.”¹³

We do not purport that public health economy is a novel construct broadly, only that we are the first to give it this name, based on a survey of articles written in English. Indeed, there exists a constellation of constructs that are more or less conceptually connected: structural vulnerability, social, political, and economic determinants, structural violence, embodiment, social murder, policy murder, etc. In his 1845 work, *The Condition of the Working-Class*, Friedrich Engels coined the term “social murder” to describe society’s role in “plac (ing) hundreds of proletarians in such a position that they inevitably meet a too early and an unnatural death.”¹⁴

However, these terms have several drawbacks. First, they are not unified under one disciplinary umbrella. Some terms are more common in certain specialties such as “structural violence” in anthropology. The area of emphasis also differs. Hard sciences such as public health tend to focus on theory operationalization, psychometric testing, and causal inference. Second, discourse and research on determinants of health describe sources of inequity ad nauseum and largely reflect what we and our communities already know. Income predicts health.

Residential segregation exacerbates lack of access to resources. Race and racism play a role in explaining health disparities.

A third major disadvantage is that our research strongly suggests a bias in the literature toward a deracialized and de-historicized understanding for many of these terms. For example, structural vulnerability and violence have failed to examine the historical roots of health inequity. Despite clear precedents in the nearly 250 years of US history (e.g., slavery, violence against American Indians, violence against women), structural vulnerability only appeared widely in the academic vernacular recently. 189 out of 215 (88%) studies on “structural vulnerability” are within the last ten years based on a PubMed search in May 2022. An Online Computer Library Center (OCLC) search yielded similar results, 1593/2355 or 68%.

A PubMed search of “structural violence” and “slavery” conducted on May 1, 2022, resulted in two articles, only one discussed US slavery. A search for “structural vulnerability” and “slavery” yielded no search results. Similar findings using “structural vulnerability ” or “structural violence” and “US slavery” were found in OCLC searches, 8 and 0 results respectively. A PubMed search of “structural violence” and “racism” conducted on May 1, 2022, resulted in 41 articles based on abstract text, 11% of all articles on structural violence ever. A search for “structural vulnerability” and “racism” yielded 9 results, all within the last 7 years and 4% of all articles overall. Although we were not exhaustive in our search and did not conduct confirmatory article content analysis, the preliminary results are not favorable to PHL philosophy.

Based on the assumption of non-neutrality, we cannot assume that writers about structural vulnerability, structural violence, and other constructs are devoid of values, beliefs, and worldviews that manifest in public health research and practice.¹⁵ PHL uses public health economy to establish ourselves as arising from different motivations, histories, and perspectives — and toward a more inclusive public health agenda. Future research will delineate the theoretical and practical boundaries of the public health economy.

3.2. PHL as a horizontal and vertical integration

To better understand the nature of changes to the public health economy that is needed, we examine both horizontal and vertical integration. Horizontal integration seeks to create effective representation and influence of affected and marginalized populations in public health agenda-setting and

practice. It recognizes that high membership and conference costs for public health organizations have, in effect, erected barriers to the full engagement of vulnerable communities. We find that those whose health and social conditions are purportedly of immense research and policy concern have been consistently shut out of public discourse and full participation, especially among major health institutions and academic public health. These communities are often only engaged at the time of research.^{16,17} We should note that public housing resident leaders helped author and review this manuscript and play a central role in our non-profit. PHL implores organizations to allow for community influence and perspective-sharing within internal deliberations on a proposed course of action. Horizontal integration in this regard is needed because sources of anarchy in the public health economy derive from illiberation, fierce competition, and a pursuit of hyper self-interest.

Another key aspect is that communities need not rely on placating these organizations to integrate them as independent and influential voices. As we discuss later on liberation, effective representation can and should arise from within. This is the focus of the PHL non-profit. We discuss several theories that question whether the first approach can work at all in the interest of vulnerable communities. Our theory on liberation philosophy explains the benefits when communities of practice form out of kinship and mutual trust. In fact, social embeddedness is preferred such that members of a community of practice share a common physical and social space. It is only when PHL practitioners can rely on experiential knowledge and community exchange, that they can accurately describe the public health economy and apply praxis techniques. PHL eschews estranged public health, which can occur through alienation of the “objective” researcher from a community of practice rather than engaging non-instrumentally in promotion of an inclusive public health agenda. Spatial integration uniting similarly situated communities across geographic areas is a component of horizontal integration, although PHL emphasizes much of the applied work to occur among local populations because that is where health inequity reproduction can be more easily interrupted — within the locus of control for communities.

Vertical integration expands the scale and scope of the public health agenda. It first proposes that the entire public health economy becomes the scientific, social, and political basis for inquiry and intervention. It becomes heightened monitoring of and responsiveness to activity across the public health economy and necessarily requires subject-matter expertise,

cognitive demand, community involvement, and strong social bonds to act across disparate fields. It is proactive, anticipatory of harm, and looks for opportunities to attenuate or eliminate health inequity through incremental, moderate, or seismic changes.

We wish to provide an example of vertical integration in practice. PHL founder (CW), a trained public health researcher, and colleagues critiqued economic and housing policies in Washington, DC as part of a broader campaign to mobilize communities against unjust economic and neighborhood planning. They editorialized in the Washington Post, “The principal failed policy is that building more market-rate residential density will result in adequate affordable replacement units ... Our city’s feeble inclusionary zoning program has produced only 1000 units in the past decade because typically only 8 to 20 percent of new units are set aside as “affordable.” Also, officials have pegged affordability as mid-area incomes, approximately \$1500 a month for a studio, rates out of reach for most working people, let alone the poor.”¹⁸ Despite having no formal training in economics, they had built a robust fund of knowledge through coalition work.

Broadly, integration would increase order in an otherwise anarchical public health economy. PB, a manuscript author, noted that vertical integration translates as telling people how to do the job they are getting paid to do. So much of vertical integration is interfacing with elected and public officials who struggle to make ethical choices affecting our communities of practice.

3.3. Weakness in public health paradigm and benefits of integration

To accelerate health equity, it is vital to shift toward horizontal and vertical public health integration because of drawbacks in the current public health paradigm. Public health has yet to evolve a transdiscipline capable of 1) creating a theory that explains persistent health disparities, 2) establishing consistent techniques to respond to the complexity of economic, political, and social influences in the public health economy, 3) centrally situating liberation in which affected populations have an effective voice in shaping the public health agenda, 4) supporting a research enterprise that is agile and responsive to community needs, and 5) recognizing the drawbacks of the basic research paradigm over a multi-pronged or structural approach that deploys resources quickly and efficiently to achieve gains in health equity.

Further, the public health economy is anarchical, meaning highly fragmented and discordant where

priorities and conduct in one area are most often independent of or incompatible with another. The legal and regulatory frameworks in this or that industry are not sufficient to establish that order exists broadly across the public health economy. It does not. The politicization and mainstream denialism of the Covid-19 pandemic at the highest levels of government are sufficient proof. Anti-vaccine and anti-science campaigns, backed by political and economic activities (e.g., forbidding local mask mandates, peddling false cures), are illustrative of anarchy in the public health economy.

Even within the same organization, it can be difficult to find internal consistency throughout all internal affairs on issues of health equity. For instance, health disparities may be a strategic priority for which organizations receive funding to study, but those organizations may lack any linkages to or demonstrable intent for political and community engagement. Governments are another concern. Earlier we described our struggle to contend with conflicting policies in Washington, DC. We even struggle to make sense of the lack of coordination within government public health agencies and among nonprofits, industry, researchers, and government. As the whole, the public health economy is anarchical, inefficient, fragmented, and reproductive of the status quo wherein vast inequity, particularly by income and race, is normalized. PHL is proposing a more efficient public health specialty that we believe will have cost savings and produce greater gains in health equity. Future research on economies of scale should evaluate the advantages of this model.

The benefits of horizontal and vertical integration impact all facets of the public health agenda on research, innovation, and accountability. Changes in contextual factors within the public health economy have major implications for the generalizability and reproducibility of research. Health equity research is valuable insofar as studies can be reproduced and can assume that unmeasured variables, including external influences, do not confound the study.¹⁹

Redundancy in research, estrangement from communities and policymaking, and the lack of robust analytic methods to evaluate multilevel interventions are common.^{20,21} Second, it is our hope that the study of the public health economy catalyzes transformative innovation in theory-building, training and skills development, methodologies, and public health practice. Leveraging the vast trove of public and proprietary data to visualize and forecast trends in the public health economy is a worthwhile goal. Third, the benefit of broadening the scope of public health to include the public

health economy would improve collaboration and accountability while reducing redundancy in public health. Finally, horizontal and vertical integration in terms of a disciplinary shift would force greater convergence around a common language and democratize knowledge and skills because specialists would need to communicate effectively with non-experts.

4. Five components of Public Health Liberation

Even if we achieved horizontal and vertical integration alone, there is no guarantee that a reorganization of agents within the public health economy will produce different results. Given the imbalance of technical expertise, resources, and influence among agents, several risks are apparent. First, agents' speech and actions can mislead communities to believe that they have effective representation and voice and have an ally willing to pursue full horizontal and vertical integration. Only belatedly might a community realize that they are no better off than before a coalition formed. Second, agents may not see communities as equals. They may exploit differences in knowledge and resources to frame discussion to the agents' advantage and self-interest that we attribute to public health realism and hegemonic theory. Further, liberation is not a common focus in public health - wherein benefits of knowledge gains, research, social capital building, and resource allocation primarily flow to the community.

Vertical and horizontal integration requires many more guardrails to work effectively to accelerate health equity. An alignment of philosophy, theory, training, practice, and research along a central axis forms an internally consistent, efficient, and agile approach. Further, we need a general theory to explain motivations and conduct of all agents. The five PHL components (philosophy, theories, praxis, research, and training) address what is needed most in the public health economy — order. While disorder is likely to remain the overall dynamic of the public health economy, its fullest realization within communities of practice will mean activism and accountability in many more spaces and at all levels of the economy.

To achieve health equity, PHL posits that shared values and beliefs (philosophy) should broaden our understanding of causal factors (theories) and maximize the variety of tools and solutions (praxis), to include data-gathering (research) and community and student development (training). PHL resembles a “pluripotent” discipline - theoretically-rich,

technically adaptive, and socially immersed. Practitioners are conversant in wide-ranging theories and worldviews needed to explain and affect the context that reproduces health inequity. In practice, PHL practitioners can apply skills in law, regulatory appeals, lobbying, policy analysis, legislative writing, community organizing, training, research within real-world constraints, media and performative arts, community history-taking, cultural preservation and regeneration, religion/faith, community relations, clinical work, journalism, and identifying ad hoc opportunities for community engagement and intervention. We now discuss each of the central tenets of PHL.

4.1. Central tenet I: Public Health Liberation philosophy

PHL philosophy represents a value-laden construct, heightened state of consciousness, social orientation, and a way of life that guide critical assessment and judgment. It derives values and worldviews from diverse philosophical, emancipatory, and religious traditions that provide conceptual clarity and ethical guidance to realize idealized human development and health. It also innovates, even defines new words in the English language, to gain insight into the problems that beset our communities of practice and to act in accordance with moral judgment and principles. Due to space limitations, we cannot fully explain all traditions and their influence on our philosophy. Suffice to say, our members bring diverse perspectives and rich experiences that draw from biblical and religious teachings, constitutional liberties and rights, political theory, philosophy, human rights, non-hegemonic philosophy (e.g., historical trauma, critical race theory, feminist theory, queer theory), social and medical sciences, communication theory, and historical writings and speeches from social justice movements that include antislavery, American Indian critical thought, civil rights, women's rights, gay liberation, labor rights, and other social activism, both national and local. We will briefly discuss several traditions.

4.1.1. Madisonian factions

To illustrate the influence of political theory, James Madison cautioned in Federalist No. 10 in 1787 about factionalism as an inherent threat to society, “The latent causes of faction are thus sown in the nature of man (kind); and we see them everywhere brought into different degrees of activity, according to the different circumstances of civil society ... inflamed them with mutual animosity,

and rendered them much more disposed to vex and oppress each other than to co-operate for their common good.”²² Madison enslaved African Americans throughout his lifetime, which colors our view of his judgment and morality. However, his theory on factions is not only a moral argument against slavery itself, but also is proven by political and social events that have transpired in US history. The January 6th insurrection is precisely the sort of violence in Madison's presage. We have theorized that the public health economy has not garnered a critical Madisonian appraisal and can be understood as a competition of public health “factions”. **Table 1** provides a non-exhaustive list of factions in the public health economy. We apply his theory on factionalism, in conjunction with an original interpretation of a theory on order, to posit public health realism, which appears later in our discussion.

4.1.2. Social functioning

Sociological theory on structural functioning, particularly Talcott Parsons' AGIL paradigm (short for “adaptation, goal-attainment, integration, and latent pattern maintenance”), helps us to understand how and why communities adapt to the environment (or have that environment adapt to it), pursue goal-seeking, and maintain norms, values, or institutionalized culture.^{23,24} Interruption of these functions is a goal of PHL. We consider structural functioning more as a philosophy than a theory

Table 1. Non-exhaustive, preliminary list of public health “factions”.

| | |
|--|---|
| • Hospitals | • Housing developers and owners who supply and maintain housing |
| • Health care providers | • Large commercial site developers |
| • Academic public health | • Small business owners |
| • Non-profit sector | • Water authorities |
| • Political parties | • Housing authorities |
| • Industrial polluters | • Administrators of workforce development |
| • Community advocacy groups | • Enforcers of housing codes and quality standards |
| • Informal and unorganized community groups | • Distributors of community health grants and support |
| • Certified independent health professions | • Elected officials - local, state, and federal |
| • Non-certified health professionals | • Regulators - local, state, and federal |
| • City and state economic planners | • Health departments |
| • Public-private business groups | • Gun manufacturers |
| • Employers | • Gun owners or someone who takes control over a gun |
| • Farmers and cattle ranchers | |
| • “Food product” manufacturers | |
| • Distributors of public and private health research funding | |

considering that it has not shown much verifiability in the literature.²⁵ It has helped to conceptually frame several authors' advocacy. They established their own neighborhood newspaper to discourage acquiescence (mal-adaptation) to a displacement economy and hosted a series of community chats that affected norms or perceptions (latent maintenance). This led to the establishment of a new community group (integration) that engaged with public officials on housing policy (goal attainment).

4.1.3. Praxis

In addition, Public Health Liberation advances the notion of "praxis," which refers to any doing involving human activity.²⁶ Of the three standard ways to define praxis according to Joel Wainwright, PHL would align with two - both a "unity of theory and practical activity" and transformative practice (*revolutionäre Praxis*).²⁶ PHL seeks a radical transformation of public health because the urgency of health inequity warrants it. We are far from the only contemporary voices. Vast health inequity is "constitutionally inconsistent, morally indefensible, politically insensitive, and economically insane," according to Rev. Dr. William J. Barber II, Co-Chair of the Poor People's Campaign.²⁷ It seeks a "Third Reconstruction" to establish a new social order in the US on the scale of the First Reconstruction (1865–1877) and Second Reconstruction (1946–1963).²⁸ PHL recently discussed the intersection of the anti-poverty and public health praxis aims of the Poor People's Campaign and its intersection with PHL in The Hub, our publication platform.²⁷

4.1.4. The special role of women

A final philosophical perspective that we will briefly share before we discuss liberation is the special role of women to achieve PHL aims. In our community experience, women are consistently overrepresented in community health spaces. Three authors (RH, PB, DW) are elected women council presidents from public housing. In fact, they are part of a leadership body across public housing councils in Washington, DC that is overwhelmingly women. RH and PB have led advocacy in housing and environmental quality. Both have published editorials, most recently in the Washington Post and Southwest Voice. Women are vital to accelerating health equity. Their leadership, perspectives, and experiences matter and should be supported through strong partnerships. Supporting a health equity agenda à la PHL is, in effect, to support women and healthier communities.

This is not typecasting or gender norming. Rather, it is a recognition that women and men, at least in our collective experiences, can sometimes occupy

different social spaces. In 1897, suffragist and activist Mary Church Terrell acknowledged as much in her inaugural presidential speech for the National Association of Colored Women (NACW), "Special stress has been laid upon the fact that our association is composed of women, not because we wish to deny rights and privileges to our brothers ..., but because the work which we hope to accomplish can be done better, by the mothers, wives, daughters, and sisters of our race ...".²⁹ We find this assertion to hold more than a century later.

The World Health Organization has tied women's health to a vibrant economy in Africa, "Because women are the dominant source of farm labour in the Region, and the mainstay of Africa's economy as a whole, investing in their health would generate significant economic gains."³⁰ We can say the same for women in our communities of practice. Given their community roles on health, economic, housing, and social issues, women should be the axis around which to pivot a radical transformation of public health. A manuscript author and elected president of a public housing community, PB underscores the immense pressure that African American women leaders like herself are under, having to look after the health of their own family and their tenants. She challenges common perceptions that blame poor health outcomes among low-income populations on behaviors alone because of her community experiences with environmental and housing conditions involving toxic mold, lead, asbestos, displacement of residents, and environmental racism from nearby industrial activity. Her local housing authority has recently had multiple investigations, legal action by the attorney general, and reports of fiscal mismanagement. She does not believe that fair and equal housing exists.

Mistreatment of women leaders, especially Black American women, and their communities is best understood as re-traumatization considering the legacies of historical trauma against women, Black Americans, and the poor. Women hold the key for realizing the aims of PHL theory and practice to accelerate health equity - that is a central PHL principle.

4.1.5. Historical trauma

Historical trauma is a social determinant of health, defined as the residual physical, emotional, and psychological effects of intergenerational injury.³¹ As opposed to individual posttraumatic stress, historical trauma is "adverse shared historical experiences".³² The term was meant to be distinguished from individual posttraumatic stress or Adverse Childhood Experiences, representing collective

trauma, such as slavery, colonization, and forced migration. Historical trauma manifests in language and culture (or their loss), the built environment, residential patterns, economic output, attitudes, behaviors, social norms, and political and economic determinants of health. As women, descendants of enslaved and apartheid families, and sexual minorities, the authors have legacies of historical trauma. JD explained that as a mental health professional working with families that have experienced dislocation and transgenerational trauma, he is always brought back to the individual story. Barriers of language, culture, and generation gradually yield to a mutual and empathic form of understanding, akin to the reader's experience with the greatest of written and oral history.

Recovering from historical trauma remains a pressing public health need, worsened by contemporary forms of trauma (e.g., rescinding reproductive rights, displacement, discrimination, police-involved shootings, environmental racism). These current forms, in turn, manifest as historical trauma. Liberation and cultural regeneration provide a pathway to overcome layered trauma due to the impact of the past on personal and community health.

4.1.6. African American liberation philosophy and the public health economy

Consistent with our liberation stance, each community of practice should be unconstrained to define relevant philosophical principles based on shared values and beliefs. This discussion of African American liberation philosophy is our way of connecting moral principles to public health practice. We draw inspiration for PHL from African American history, culture, and religion. Our rich heritage has shown us the way to find liberation in our own time. We have a social responsibility to carry forth the legacies of innumerable leaders such as Fannie Lou Hamer, Dr. Martin Luther King, James Baldwin, Bayard Rustin, John Lewis, Mary Church Terrell, Ida B. Wells-Barnett, among countless others. Some of our authors were young children during the height of the Civil Rights Movement, which shaped their lifelong commitment to community and social justice. We cull the vastness of our histories and cultures, that we may be spiritually whole — standing firmly and confidently in our humanity by connecting the past with the present. We are told in Romans 12:2, “Do not be conformed to this world, but be transformed by the renewal of your mind, that by testing you may discern what is the will of God, what is good and acceptable and perfect.”³³ Our manuscript reflects the separateness that we

must have — a critical positionality to assimilate beliefs, misplaced theories, and injurious policies. While our discussion may not apply to all communities, we feel that it provides an invaluable blueprint for a culturally relevant philosophy.

The moral argument for a conceptualization of the public health economy and liberation can also be found in emancipatory writings. Frederick Douglass said in his now famous “West India Emancipation” speech in 1857, “It is useless and cruel to put a man on his legs, if the next moment his head is to be brought against a curbstone.”³⁴ This is consistent with reconciling the contradictions of the public health economy. Investing resources in one aspect of public health based on anticipated outcomes may be unsubstantiated if other determinants of health clearly undermine those assumptions. We observe that this Douglassian phenomenology is so common as to be a root cause of health inequity reproduction, especially for Black Americans. The failure to address longstanding chasms in racial health equity is explained by the internal contradictions and tensions of the public health economy.

Advocacy for racial justice is a Douglassian struggle against historical trauma. Recognizing and recovering from the legacy of historical trauma remain a salient public health issue and a major philosophical cornerstone of our work. Consistent with our liberation stance, recovering from historical trauma necessarily requires: 1) recasting a de-hegemonized historical narrative, 2) uncovering untold histories and culture, 3) seeking to restore personhood and peoplehood in the present through cultural regeneration, education, and liberation space-making, 4) integrating historical trauma and personhood restoration into our own academic studies and career, and 5) leveraging the past to educate others in the public health economy about the legacy of historical trauma and linkages to contemporary forms of violence that have evolved from it.

Earlier we discussed the lead crisis in Washington, DC. During our manuscript development, PB, who was born and has lived her entire life in Washington, DC, reminded PHL members about the connection between historical trauma and the lead crisis in Washington, DC. Anecdotally, there were women who were traumatized, especially pregnant young women who were trying their best to take care of their unborn child. They made sure that they stayed hydrated, only to find that they were drinking poison. This was at a time when bottled water was not as plentiful as it is now. PB says that she knew women and men who relapsed and suffered immensely.

These and various forms of contemporary and historical trauma resonate with PHL because many

of our members are descendants of families who were enslaved during American slavery, then forced to live in an apartheid state during Jim Crow. Indeed, our members are not far removed from those atrocities. Our mothers and grandmothers tell stories of growing up in the segregated South. One PHL member (CW) has *living* relatives who knew the family patriarch who had been enslaved in childhood. Several members lead an annual commemorative and personhood restoration event in Washington, DC to honor the passengers of the Pearl Escape of 1848, the largest known escape on the Underground Railroad, and enslaved African Americans generally.³⁵ We have found healing and meaning in confronting historical trauma, fueling our efforts within the PHL non-profit to eliminate all forms of trauma and inequity. Many authors find spiritual comfort in cultural practices (e.g., ancestral prayer, rituals). Roughly, one-third of Black Americans believe “prayers to ancestors have protective power.”³⁶

4.1.7. *Gaze of the enslaved: an ontology and ethical research standard*

Further, we also devised a novel ontology and standard of ethics using the historical and fictionalized perspectives of African Americans who were enslaved during the nadir of US history. The Gaze of the Enslaved analogizes research on enslaved people with contemporaneous vulnerable populations (e.g., generational poverty, chronic disparities) — both have suffered under the weight of structural violence. This gaze questions the ethics of certain types of community-based research studies in which the benefits to the community are short-lived, if at all, and that fail to incorporate structural or advocacy interventions. Institutions that are fully capable of sustained engagement to advocate and affect change, yet fail to act, are particularly offending. Based on this standard of ethics, there are currently many publicly funded research studies on Black Americans that are unethical and should cease receiving public funding. The liberation leanings of PHL are intended to make ongoing research critiques a meaningful part of an inclusive public health agenda.

4.1.8. *Morality Principle: immediate intervention*

Finally, our African American philosophy informs our position on formal research. We devised Morality Principle as the moral obligation to immediately intervene in the public health economy regardless of what is scientifically known or can be proven about its association with health outcomes. Here, we draw lessons from periods of historical

trauma - American Indian removal and genocide, slavery, Jim Crow, immigrant family separation, urban renewal, forced sterilization, mass quarantine for women (the US government's “American Plan”), criminalization of sexual orientation, and concentration camps during World War II. We endeavor to monitor activity in the public health economy that rises to the level of the Morality Principle. In fact, understanding the legacy of historical trauma and injustices helps us to identify such cases, by drawing linkages between once widely accepted immoral conduct to current events. The lead crises in Flint, Michigan and Washington, DC would have immediately risen to the level of the Morality Principle given what was known about contaminants in the Flint River and the susceptibility of lead pipe erosion, respectively. Another example is the common occurrence of Black Americans being displaced due to gentrification and housing policies in many US cities. This displacement has direct connections with racially discriminatory policies tied to urban renewal and prior periods of forced migration. The Morality Principle further recognizes that statements of regret following the event are rarely ever fully reparative. The descendants of US enslaved and apartheid families continue to demand reparations more than 150 years later.

To further explain our philosophical positions, we need to elaborate on a central tenet of PHL theory and practice, that of liberation. It informs all aspects of our approach and distinguishes us from other disciplines, within and outside of traditional public health.

4.1.9. *Liberation - A core PHL philosophical principle*

Liberation is a central principle of PHL that is a direct response to the anarchy of the public health economy. The perpetual state of competition in the economy requires all agents to take part or allow others to define the communities’ interests — or worse, to work against their interest. Liberation is a philosophized mindset and way of life that allow individuals and collectives to pursue emancipation from all manner of constraints on thought, expression, and collectivism. The gestalt of liberation is to circumvent barriers that impede idealized health. For every barrier, there is a liberation response, if not solution. Liberation reflects self-worth and higher cognitive demand that is valued in-and-of-itself and regarded as the lifeblood of Public Health Liberation theory and practice.

We find that this example is illustrative. Imagine that a group of university researchers received grant funding to build a community garden in a food desert in a low-income part of town. For the two-

year duration of that grant, everything went well. Student volunteers came in regularly to plant and cultivate vegetables and the community received supplemental nutrition. After the grant ended, no one in the community had any knowledge or skills to sustain the garden, so the community was left back exactly where it started. On the other hand, a liberation approach would ensure that the community garden benefited collective knowledge, skills, and liberation space-making (discussed below). It would allow the community to take part in crop cultivation and expand community investment in the garden, even using garden hours as time for social bonding and social capital building. When the grant ended, the community would have all the necessary resources to not only sustain the program independently, but also to build an organization that attracted more long-term funding.

Although research and measurement development of liberation constructs are in their early stages, we posit that cultivating and funding more liberation in society will help to accelerate health equity. Whether it does or not is not assured, but PHL exhorts that it is necessary to re-orient our public health teaching, research, and practice. Again, there are many philosophical and emancipatory traditions that we borrow to support our liberation stance. We turn once more to Frederick Douglass' "West India Emancipation" speech, "The whole history of the progress of human liberty shows that all concessions yet made to her august claims have been born of earnest struggle. The conflict has been exciting, agitating, all-absorbing, and for the time being, putting all other tumults to silence. It must do this or it does nothing. If there is no struggle, there is no progress."³⁴

At a rudimentary level, liberation first recognizes health inequity as a Douglassian "struggle" — to recognize that there exists a problem. It may then undergo a process of de-norming and de-hegemonization and shift toward critically evaluating extrinsic sources of harm and false ideologies. We also agree with Rev. William Barber that the struggle is non-linear, "The story of our struggle for freedom is not linear: Every advance toward a more perfect union has been met with a backlash of resistance."³⁷ PHL praxis is intended to contend with the indeterminacy or non-linearity in the public health economy. Even a one-time public testimony or letter to a public official articulating one's own suffering or others' or protesting against unjust policies is a valued expression of applied liberation or praxis, as are performative or media arts that highlight injustices. As it increases in cognitive demand, liberation thought seeks to

critically assess all claims by relying on moral, legal, and relevant sources of reasoning. It may shift toward greater praxis through data-gathering, writing, legal action, and forming goal-oriented coalitions. As horizontal integration expands, informal coalitions are formalized and speech, thought, and action are collectivized. Vertical integration opens up pathways across the public health economy to reconcile with the Douglassian struggle, equipped with a veritable arsenal of methods and an allyship of subject-matter experts and partners.

Liberation is a context-dependent concept that is similar to empowerment in the public health literature. Empowerment has been defined as gaining mastery over the impediments to health through changes in beliefs and behaviors, including over related organizations and institutions.³⁸ It places importance on intrinsic motivation, self-realization, and change from within. Our contribution is that empowerment should be broadened to PHL liberation wherein communities of practices have a maximal fund of knowledge and expansive skill sets to improve their health. We eschew a focus on individual empowerment found in the literature because PHL is oriented to collective problem-solving and striving. In addition, we regard individual solutions to collective problems of health inequity as a formal fallacy — individual-level interventions do not translate adequately to the complexity of collective approach and framework.

During our inaugural PHL national webinar in November 2021, Blackfeet tribal leader Lauren Monroe, Jr. Reflected, "We welcome friendships, but if we're going to address these things, it comes from our own communities because we know what's wrong."³⁹ Community autonomy and agenda-setting are important elements to liberation. It might be tempting for public health organizations and institutions of higher learning to believe that they are benevolent "saviors," but the notion of liberation cannot be "brought" to a community of practice by outsiders as a product or service.

4.1.10. Liberation safe space

Liberation among individuals occurs within a social space that we call a "liberation safe space." These spaces are commonplace. Individuals with shared circumstances or suffering gather in-person or in virtual spaces and affirm congregants' feelings, perceptions, and experiences. Our conceptual model shows the variety of formulations. They can be purposive or indeterminate, monologic or dialogic, accommodation or radical, anti-structural or self-generative, spontaneous or planned. Moral

$$\text{Constant} \left(\frac{\text{Call for Change} * \text{Financial Impact}}{\text{Constraints}} \right)$$

Fig. 1. Health inequity reproduction equation.

reasoning, forms of liberation, motivation, and public or private forum determine the type of space-making. Our Guide on Liberation Safe Spaces, published in May 2022, provides a more detailed discussion.⁴⁰ Famous escapes of enslaved people such as the Pearl Escape of 1848 in Southwest, Washington, DC was planned well in advance whereas the 1811 German Coast uprising and Stono Rebellion were spontaneous.^{41–43} The First Continental Congress was accommodating whereas the Second Continental Congress was a radical, violent break from Britain. Not all spaces are morally defensible and legitimate, particularly where their aims seek to oppress others. As a general matter, we cannot reject purposive non-violent liberation space-making to challenge unethical laws given African American perspectives of US history - slave codes, fugitive slave laws, Jim Crow, poll taxes, and voting literacy tests.

PHL relies on a culture of liberation space-making within the public health economy because it produces the fertile ground for PHL theory and practice. However, PHL is most concerned with liberation safe spaces to reflect upon and address the public health economy. When liberation safe spaces occur, they catalyze collective energy to attenuate challenges in the economy. A sufficient level of liberation is a precondition for creation of a liberation safe space. There is, however, a need to recognize barriers to the progression of liberation toward praxis. Flourishing illiberation is a major concern for the full realization of PHL.

4.1.11. Illiberation - A public health issue

The lack of liberation is called “illiberation,” a word that does not exist in the English language. We devised the term illiberation. Our definition is a varying state of immobility, self-oppression, or internalized fear or silence that is both environmentally conditioned and internally maintained within individuals and collectives. Illiberation arises because there are actual or perceived threats to self-interests, whether individual or collective, in the hegemonized environment. It forces conflicts especially with existential needs such as employment, housing, or access to resources. Illiberation may be internalized, meaning an unconscious normalization of one's own suffering or the suffering of others. It may also manifest as cognitive dissonance such that an individual or collective may perceive

injustices in the public health economy but feel as though they are without options and accept the inevitability of harm. This can be associated the literature on “moral injury,” which describes the trauma arising from exposure to an event that violates one's moral values.⁴⁴ Further, illiberation may compel an individual or group to engage in forms of physical, psychological, or structural violence (e.g., implement or enforce an unethical policy) for fear of negative consequences. In other words, this fear may lead directly to traumatizing (or re-traumatizing) other groups. However, that does not mean that those individuals are not complicit or ethically exempt. Illiberation simply acknowledges that perceived powerlessness is a major force in the public health economy.

We often hear in racial discourse within our communities of practice that politicians will do what they want regardless of how well the community is organized or that someone may retaliate against them for speaking against a harmful policy. These sentiments convey a *fait accompli* that whatever policy or program, however structurally violent or racially discriminatory, is inevitable and invincible. Such a position is untenable. A manuscript author and public housing community leader, PB explains to her residents that they will do more harm than good by not speaking up at meetings. She leads by example because the community is experiencing a lot of discrimination based on their class and race.

Illiberation is highly similar to internalized oppression in the literature. It is a facet of oppression, “whereby oppressors maintain domination over the oppressed.”⁴⁵ Internalized oppression operates at the individual- or group-level and concerns conscious or voluntary self-damage or self-diminution associated with self-hatred, believing negative stereotypes, affective states, and behaviors.^{46–49} The literature on internalized oppression has focused on historically marginalized groups such as women, sexual minorities, people of color, and colonized populations.⁵⁰ However, PHL makes one important distinction between internalized oppression and illiberation. Illiberation is predisposing across the public health economy and is not limited to certain groups. To apply internalized oppression to our theory would highly deviate from its theoretical meaning and use. PHL regards illiberation as ubiquitous, including within dominant groups. Thus, we prefer illiberation.

Unfortunately, we suspect that these illiberative fears are common across the public health economy, which will become the focus of our research in time. Overcoming illiberation makes for better public health. We are reminded of the audacious work of

Rachel Carson who successfully challenged the use of synthetic organic herbicides and pesticides despite considerable, well-resourced opposition. As she exhorted in *Silent Spring*, “We urgently need an end to these false assurances, to the sugar coating of unpalatable facts. It is the public that is being asked to assume the risks that the insect controllers calculate. The public must decide whether it wishes to continue on the present road, and it can do so only when in full possession of the facts.”⁵¹

If there is refusal to treat flourishing illiberation as a legitimate barrier to health equity, then it logically follows that all things of importance are being said and done. In our experience, such a position would obscure the reality that dissent and divergence are hegemonically constrained. Further, we posit that all agents within the public health economy are susceptible to illiberation — from public health educators who feel that they cannot teach critical perspectives in the classroom to elected officials who knowingly take policy positions that will reproduce health inequity because that is the only avenue to win political office. PHL endeavors to develop research to study illiberation in the public health economy and to understand the connection between illiberation and historical trauma.

4.1.12. *Liberation vs anti-racism: two audiences*

One major clarification is in order. Liberation and anti-racism share the same goal of unconditional equity but are quite different in approaches. Our position is that anti-racism has been taken to mean changes in policies, beliefs, and practices by largely speaking to those groups with disproportionately greater power and resources. Although the need for change is great, this focus has come at the expense of liberation. We find the anti-racism literature to reflect longstanding beliefs that have existed in our communities since slavery. Frankly, we have grown tired of re-explaining ourselves.

On the other hand, we find that liberation speaks more closely to the needs within our community of practice. We are less concerned about enumerating all of the forms of racism from a hierarchical worldview as much as we are concerned about equalizing the playing field through liberation thought and practice. In the PHL research and praxis section, we discuss how to devise strategies and pathways to achieve equity through a process of social identity formation and strengthening. PHL focuses our attention on the lived experiences and visibility of affected populations and their capacity and desire to engage in a Douglassian struggle. As our theories below explain, there are ample reasons to be skeptical of anti-racism for public health

practice because it neither pivots around liberation nor provides explanatory models for racial inequity beyond manifestations of racism. The anti-racism explanations for racial concordance between those who inflict racism and those victimized by racism, is underdeveloped. In several authors’ community of practice in Washington, DC, we have only had Black mayors since “home rule” and a majority or near-majority of Black city councilors. Congress established “home rule” for the District of Columbia in 1973, which allowed it to freely elect its mayor and to have greater autonomy in self-governance.⁵² In the face of yawning chasms in racial health equity, we find that limiting racial equity to racial discourse is unnecessarily constraining. As discussed, we have developed theories to better elucidate this contradiction, as well as other contradictions in the public health economy.

4.2. *Central tenet II: Public Health Liberation as theory*

Public Health Liberation posits several theories to begin the work of a radical transformation of public health and the public health economy - theory of health inequity reproduction, public health realism, and hegemonic theory. As we stated from the onset, our discussion in this paper is intended to introduce and organize our values, theories, and form of public health practice. In subsequent months and years, PHL will endeavor to develop measures and conduct research on the constructs presented here.

4.2.1. *Theory of Health Inequity Reproduction*

We devised the Theory of Health Inequity Reproduction (THIR) to provide a general theory on health inequity reproduction by identifying four broad components. We have taken a reductionist approach to reduce the complexity of the public health economy for PHL practitioners and communities and to guide practice toward greater effectiveness. We posit that these theoretical constructs form the basis for accelerated applied equity without being mired in technical or specialized theories or challenged by academic speak. THIR theorizes that gains in health equity requires 1) improved social mobilization and more widespread calls for change, especially from affected populations and allies, 2) increasing constraints on conduct that contribute to disparities, and 3) impacting the bottom line — money and profit — to dissuade equity reproduction or to incentivize health improvement. The fourth component is a constant that acknowledges that some structural contributions to inequity are formidable and deeply

entrenched, requiring a seismic shift on a scale of major reform periods (e.g., Civil Rights Movement, Emancipation Proclamation). Inequity reproduction is the product of a constant (as yet undetermined) of structural inequity times the quotient of the product of desire for change and material benefit divided by constraints (Fig. 1).

Flourishing liberation, diminished illiberation, and liberation safe spaces are preconditions for social mobilization and productive dissent. It is beyond the scope of this paper, but there are many theories that support civic engagement and protests, especially for democratic accountability. PHL recognizes major barriers that prevent the extent to which agents or classes of agents within the public health economy can speak openly about their dissatisfaction with the public health agenda, much less to speak as one voice. PHL finds many sources that hamper liberation to prevent the emergence of vocal calls for public health reform. Employment conditions tied to promotion and workplace culture that drive estrangement of researchers and employees from continual community engagement and praxis are major sources. Other areas include the way that affected communities have been estranged in major public health organizations, as discussed earlier. We theorize that, if these and other barriers are removed, then social mobilization will follow.

We define constraints as norms or actions that affect health inequity reproduction. When the effect lessens health inequity, constraints are positive. Laws, regulations, and judicial decisions are the most common types. Because PHL is concerned with accelerating health equity, we focus on introducing greater positive constraints into the public health economy such as increased government regulation and oversight, health impact assessments for proposed legislation, or cross-sector dialogue and coordination. Whether to encourage community engagement or structural health interventions, the conditions tied to receiving public health research and healthcare dollars are also relevant. There are liberation forms of positive constraints that might include a shift in political support, increased political engagement, media campaigns, or public demonstrations to bring attention to public health threats. This manuscript is also intended to be one such constraint. Negative constraints can manifest as deregulation that reproduces harm (e.g., rescinding reproductive rights, permitting the sales of assault weapons, or granting permits to polluters that engage in environmental racism). PHL postulates that if positive constraints dramatically increase throughout the public health economy, then we will open pathways for addressing health equity.

The third component of THIR is to affect the economics of health inequity reproduction through punishment (e.g., fines, lawsuits, taxes) or incentive (e.g., cap and trade, Medicaid expansion). The assumption is that health equity must square with the economic reality that capitalism itself is at odds with achieving health equity. PHL is not just concerned with typical economic measures that are often to blame for health disparities. We are concerned with the financial balance across the public health economy, including the conditions placed on research awards and hospital reimbursement models. PHL sees the need to leverage fiscal policy to work toward accelerating health equity, especially to eliminate racial and income differences. Our idealized public health is predicated on health equity as a national, state, and local priority.

Finally, the fourth component is the “constant” in the theory of health inequity reproduction. While health gains can be greatly accelerated in our lifetime, not all forms of health inequity can realistically be eliminated. We borrow this assumption from Derrick Bell's racial realism, which assumes that racial equity will never be achieved.⁵³ We agree that not all sources of inequity can be resolved in our time, but we would succumb to illiberation if we did not try. The constant can be considered as a measure of the structural inequity between periods of social revolution on the scale of the American Revolutionary War, the Civil War, the Civil Rights movement, the women's liberation movement, or the gay liberation movement. The Black Lives Matter movement appears to have had a similar effect, although its social and political transformations are yet unfolding. Once the social transformation occurs, a new constant is redefined.

4.2.2. *Public health realism and hegemony*

As mentioned earlier, the public health economy is defined by a state of anarchy. We rely on public health realism to describe the nature and relationship among agents or classes of agents. Drawing from a Madisonian critique that assumed a factious state in the body politic, we posit that these “factions” operate without a set of governing principles and a central authority. Taken to extremes, they can use violence and oppression of others to implement their agenda. In a public health context, this will mean that certain factions may knowingly engage in conduct that is deleterious to human health. Government will sometimes permit such harm to public health.

Take the exemption that cigarettes benefit from, for example. Typically, any other commercial product with the following public health statistics

would not be allowed on the US market, except tobacco has a public health exemption. Cigarette smoking is associated with about 80%–90% of lung cancer deaths.⁵⁴ Compared to those who do not smoke, cigarette smokers are “15 to 30 times more likely to get lung cancer or die from lung cancer.”⁵⁴ This is far from the only exempt activity in the public health economy which is known to reproduce health inequity. In our communities of practice, we can point to specific land use decisions, lax environmental regulation, proliferating firearms, and the withdrawal of federal support for public housing. What explains why such reproductive causes are common? Public health realism.

We were attracted to international relations theory on political realism to elucidate the public health economy because of its focus on universal motivations and emphasis on power. “The concept of interest defined as power imposes intellectual discipline upon the observer, infuses rational order into the subject matter of politics, and thus makes the theoretical understanding of politics possible.”⁵⁵ We translate this in terms of the public health economy as each agent (Madisonian “faction”) acts to realize their own interests through pursuit of actions associated with forms of power, from which we can contextualize motives and derive a universal rationality. As opposed to military size or nuclear arsenal in realist perspectives, power in the public health economy has many forms based on interest or activity. A manufacturer or polluter of a product may seek power over political and regulatory officials for deregulatory policies. A research university may seek power by attracting considerable health research funding and amassing endowments that buttress prestige and growth.

However, self-interests, properly understood, should be taken as a neutral term. All agents within the public health economy have issue areas – a finite set of agenda priorities and a population to which they are accountable. The PHL non-profit has self-interests – to accelerate health equity through a five-pronged public health transdiscipline, particularly for our communities of practice and similar communities. The key insight is how well those self-interests are aligned with the public good and encourage order and cooperation in the public health economy. Our 16 Principles of Public Health Realism create a common set of characteristics for all agents.

4.2.3. Principles of public health realism

1. The public health economy is a state of anarchy characterized by perpetual competition for resources where there exists no common principles or central authority. The public health economy reproduces health inequity.
2. Self-serving egoism is assumed to motivate action within the public health economy.
3. Each agent is responsible for its own survival within the public health economy.
4. Interest is defined in terms of power, most often defined by the pooling of financial assets and exerting influence over a defined population(s).
5. Moral imperatives are subsumed under self-interests because of the lack of common moral principles and central enforcing authorities.
6. Agents exercise power through rulemaking, gatekeeping, issue framing, resource distribution, or through control of authorities invested with those powers.
7. Agents' speech and conduct cannot alone be a reliable source for ascertaining their true self-interest. Agents are free to engage in misleading speech and actions that do not reflect their true self-interest. They may exploit human suffering and vulnerability to achieve maximum benefits that flow primarily to that agent or class of agents.
8. Each agent can have contradictions and conflicts in moralities and issues - internal inconsistency and dissonance.
9. Agents are free to seek control over or to create coalitions with agents in the public health economy where interests align.
10. Coalitions retain the characteristics of the public health economy wherein they are susceptible to fierce competition and power struggles.
11. Achieving health equity or supporting PHL theory and practice may directly compete with self-interests for an agent or class of agents.
12. Agents that benefit most from the public health economy seek to maintain their relative power position. Any reform efforts or calls for change are merely reflective of interest as power whereby they seek change insofar as they maintain relative power.
13. Coalitions are common in the public health economy and are best understood as a means for agents to maximize their interest through collectives. These coalitions become hegemonic arrangements when they seek dominance by reducing competition and focusing on directing benefits and resources to their advantage.
14. Agents can act hegemonically without coalitions through exercises in power.
15. Dominant powers have disproportionate power, influence, and resources within the public health economy that leverage vast complex networks to control rulemaking, gatekeeping, liberation space-making, and resource control.

The long-term effects of interest pursued as power tend to hegemonize.

16. Hegemonic powers, whether agents themselves or coalitions, pose a major threat to realizing health equity by seeking to maintain the public health economy to their advantage.

These principles incorporate political economy perspectives into public health theory and seek to explain the public health economy, rooted in the reality of our lived experiences. The centrality of self-interests, albeit a permanent state, is not immutable. PHL seeks to collectivize interest by diversifying the makeup and type of organizations (“horizontal integration”) and by possessing an array of praxis tools (“vertical integration”) for an inclusive public agenda.

One might ask how the aspirational vision of PHL reconciles such a pessimistic view of the public health economy. In truth, leveling with the real-world constraints derived from public health realism: 1) protects communities from being misled or instrumentally used by agents who are not safeguarding their interests, 2) priming communities to think deeply about their own interests and where they best align with other agents, 3) accepting that there might be give-and-take to maintain coalitions, and 4) building sufficient forms of power of their own making to influence outcomes. We will speak more about this in our praxis and research discussions. The realist perspective also suggests that coalitions take forms based on whether broad set of interests can be accommodated. The reader may recall earlier that we encouraged communities of practice to form based on shared physical and social spaces. Part of the reasoning assumed that residents are more prone to be engaged because the benefit to them, defined as furtherance of their interests, is apparent and personal.

Another advantage of public health realism is that it cautions communities against hegemonic control and encourages them to be vigilant of hegemonic influences. The concept of hegemony is defined as a system of beliefs and attitudes that reinforce the existing social arrangement and mal-distribution of resources.¹⁵ Introduced to us in the critical race literature, hegemonic control occurs when agents with disproportionate power feign an appearance of unity of interests with groups with less power and resources.¹⁵ As communities of practice horizontally and vertically integrate, public health realism cautions against hegemonic tendencies wherein communities may exercise power through rulemaking, gatekeeping, issue framing, resource distribution, or through control of authorities invested with those

powers away from public health and the common good. Communities of practice should seek to establish principles by which to conduct affairs as they expand so as to prevent furtherance of self-interest by suppressing liberation expression and liberation space-making of others. Diversity of liberation perspectives even within shared geographic areas is inherent to human activity, so it is best that communities focus on internal strengthening and effectiveness through principled action.

Communities may also be tempted to ally with hegemonic influencers to access power sources to realize self-interest. As a longtime community leader serving low-income populations, DW sees this social phenomenon occur all the time in underserved communities and calls it a form of poverty pimping, which occurs when an outsider seeks to extract value from a group's poverty status to further their own self-interest. It is necessary for leaders like her to engage in gatekeeping to prevent poverty exploitation. DW's community leadership substantially informed the following recommendations.

Communities should proceed with caution with allying with outsiders with disproportionate power - political clout, financial resources, etc. As with all agents, hegemonic powers may engage in misleading speech and actions that do not reflect their true self-interest. They may exploit human suffering and vulnerability to achieve maximum benefits that flow primarily to that agent or class of agents. Several steps may be required before formalizing a partnership: 1) conducting a “background check” and “social history” to assess others' perceptions of that group, 2) develop a document outlining principles of engagement or a legal contract, if necessary, 3) define clear benefits to the community in the contract, 4) stipulate conditions and consequences for premature withdrawal or unfulfilled commitments, 5) maintain the direct connection between community leaders and their constituents - do not hand over contacts or relinquish modes of communication, and 6) reserve the right to withdraw at any time due to hegemonic or offensive conduct.

Finally, the perpetual state of competition in the public health economy means that the effectiveness of agents' forms of power is not absolute. Power does not maintain constancy. Power is relative in the sense that it only defined by the conditions of the public health economy. Control over rulemaking, for example, can only advance hegemonic interest as long as there is no emergence of competing rules or rulemaking authorities. PHL neither assumes that

power can be maintained notwithstanding any changes in the public health economy. The tendency of agents to have competing moralities and interests from within is common. Hegemonic influence over a defined population should assume that other agents will try to compete for that same population — shaping attitudes and actions in furtherance of an agent's interest. Thus, the major conclusion is that applied liberation will immediately introduce a change in the public health economy because agents' relative power must account for competition, however small. It does not mean that an immediate change will favor or advantage a rising power, but it may cause the hegemonic powers to strengthen vertically or horizontally or to engage in false speech to discredit critical voices. They may also coopt the ideas of the rising power as a way of adapting to changing conditions and to maintain power status. PHL (the nonprofit) fully expects the above as a consequence of our activities, including this manuscript. Given this reality, it is incumbent upon communities to be fiercely competitive and shift toward PHL theory and practice to be equipped with a vast array of tools to withstand the inevitable hegemonic response to increasing liberation.

In fact, PHL arose from our interaction with hegemonic influencers in the public health economy. We described many instances of activism in our communities of practice and wish to discuss a more personal take. At the time of this writing, PHL founder (CW) enters his final PhD year in public health. He has found some institutions of higher learning or affiliated nonprofits to have immense reservoirs of racism and outright hostility to critical theories and perspectives. Violent, racially motivated attacks on Black students have been attributed to the failure of institutions to address a rampant racist climate.^{56,57} There abounds a lack of insight into and disregard for how institutional culture re-traumatizes students and employees, particularly those with legacies of historical and contemporary trauma. Accountability in curricular content, faculty conduct, and student treatment is wanting. Here, illiberation is elucidating since we hypothesize that no one would claim ownership of institutional culture.

Yet through confidence in liberation, the author (CW) resolved to circumvent curricular and theoretical deficits through independent study courses, creating training opportunities for other students, and by establishing PHL. In other words, this manuscript is itself a reflection of the shift necessary for critical voices to gain influence and apply liberation, as well as a personal means of recovering from trauma inflicted by institutions of higher

learning. Other authors also found the manuscript emancipatory or liberating, as giving a lot of satisfaction and providing language therapy (JB, PB).

4.3. In brief: central tenets III-V

4.3.1. Public Health Liberation as praxis, research, and training

Due to space limitations, we will more briefly explain the remaining PHL components of praxis, research, and training. We will more fully elaborate on these components as part of a PHL series. Praxis is applied liberation wherein an individual or collective overcomes illiberation to seek change in the public health economy toward health equity. It assumes that there is monitoring of major aspects of the public health economy. Praxis is considered the “doing” of PHL — working through the complexity and indeterminacy of the public health economy to achieve wins. PHL does not favor any single method. Rather, it embraces all forms of praxis and recognizes the importance of communities being fully informed and having access to a variety of praxis pathways; hence, why we encourage the inclusion of subject-matter experts to provide insight. In this respect, praxis is not linear and requires adaptation. A solution for one community of practice is unlikely to resemble another due to differences in the degree of internalized liberation or illiberation, commonness of liberation safe spaces, presence of hegemonic influencers, social functioning, and strength of social identity. Throughout this manuscript, we have included examples of praxis in our community - editorials, regulatory appeals, protests, citizen research, community conversations, and public testimony. We have discussed praxis in the context of philosophical tradition, liberation space-making (“occurs within a social space”), liberation expression (“one-time public testimony”), and estrangement (“estrangement of researchers and employees from continual community engagement”).

We wish to discuss two recent praxis success stories in Washington, DC. First, several authors participated in citywide and neighborhood work groups in 2021 to provide the city with feedback on its “Comprehensive Plan” (the “Comp Plan”) - the single most important document for neighborhood planning and development. The Comp Plan establishes guiding principles and policies on twelve elements including housing, economic development, community services, and recreation. Although health is not its own element, public health issues, including social determinants of health, are covered throughout the plan.

Authors led community webinars to explain proposed changes to collect feedback, and to propose revisions to further racial and economic equity. They partnered with community representatives to discuss neighborhood-level issues on environmental justice, neighborhood change, public subsidies to developers, and public amenities. RH led a coalition of public housing residents, researchers, and environmentalists in her community of practice in the Southwest neighborhood. They formed two workgroups on housing and environmental indoor and outdoor air quality. Across the city, similar groups formed and caused the proposal to undergo substantial revision that recognized racial equity as a guiding principle and put in guardrails to ensure that government agency acted in accordance with the law. It represented a fundamental shift in city planning. Although an evaluation of outcomes is premature given how recently the Comp Plan passed, we are confident that we are helping to attenuate health reproduction within the next five years.

Our success with the Comp Plan exemplifies PHL in practice. However, we should note that we benefited from several factors that enabled us to pivot quickly. Here, we will interweave Public Health Liberation as research and training, which are subsumed under praxis. First, there was already infrastructure in place - flourishing liberation and liberation safe spaces. RH had already formed the Near Buzzard Point Resilient Action Committee (NeRAC) in 2018 to tackle problems involving air pollution, public health, and housing. NeRAC had conducted citizen research on air pollution arising from nearby industrial activity. She and her colleagues recently published their study findings that concluded that air quality standards are not adequate, especially for communities with existing structural vulnerabilities.⁵⁸

In addition to joining RH's efforts, CW had conducted an original (unfunded) research study prior to 2021 (under review). He served as the principal investigator for a study on mental health stress associated with neighborhood change and gentrification. He leveraged private contacts to access a list of residents in his study population that enabled stratified random sampling, then used convenience sampling in later phases of the study. As well, he compiled a dashboard enumerating neighborhood harm, especially on Black Americans, arising from rapid land redevelopment. He was able to compile data from GIS mapping services, scholarly journals, and mainstream media sources, which he published in a digital newspaper that he had founded in 2019. He then used these data to persuade the public during citywide webinars, to interface with city

councilors, and to support recommendations. Public Health Liberation as research means conducting quality formal academic research and gathering data, as these examples illustrate.

The second success story comes from JE, founding director of the Rodham Institute. At the height of the Covid pandemic, the institute immediately recognized at least two problems that prevented people, particularly minority populations, from getting vaccinated. The first was the online registration process, which required internet access. The phone option experienced long wait times. The second was widespread reluctance. The Rodham Institute partnered with community groups in the impacted areas to host a series of mass vaccination events preceded by a train-the-trainer program. Representatives went into the community to register residents using the coalition's own registration system. Nearly 900 residents were registered through this mobilization effort.

In his role as editor-in-chief, CW engaged in Public Health Liberation as training providing internship opportunities. He enlisted students to help with the aforementioned study on mental health stress and neighborhood change. He has further educated them about community culture, history, and numerous challenges with health as a way of laying the groundwork in PHL theory and practice. As PHL training evolves as a formal curriculum, it will equip students with a broad base of skills and knowledge that can be applied in law, regulatory appeals, lobbying, policy analysis, legislative writing, community organizing, training, research within real-world constraints, media and performative arts, community history-taking, cultural preservation and regeneration, religion/faith, community relations, clinical work, journalism, and identifying ad hoc opportunities for community engagement and intervention.

5. Future directions

We recognize that this paper is dense and considerable. It may not be accessible to all audiences. We needed to proceed in this fashion for several reasons. First, if we published separate manuscripts for each component of PHL, our vision risks becoming fragmented. Second, we seek to establish our work as theoretically rich, compelling, and strident, as this inaugural manuscript sets the stage for our growth and influence. Finally, we needed a way to convey the complexity of who we are — our history, values, knowledge, expertise, training, and human experiences — and also of the public health economy. We recognize that

academicians and researchers may not be fully satisfied, even vehemently disagree, with the arguments presented here. While we appreciate feedback and ideas for subsequent writings on PHL, we are confident that our discussion resonates with the populations of most interest to our public health practice. Further, we intended to show that transdisciplinary discourse can take shape and coalesce into a general theory to meet the needs of the public and scholars. Our next step is to host sessions with more communities of practice to create a paper written in layman terms and in different languages.

PHL will endeavor to build on our theory and practice. Due to space limitations, many theoretical discussions such as urban regime theory and elite theory, are deferred for later. In addition, our theory and constructs will benefit from future measure development, psychometric evaluation, and testing of causality.

6. Conclusion

This paper has presented a general theory of the public health economy in keeping with transdisciplinary approaches. The well-being of humanity duly depends on holistic approaches to public health that ensure health equity. The novel construct of the public health economy is an analytic and conceptual starting point for a transformative public health discipline to establish greater order. As discussed, PHL philosophy and practice provide the radical reconceptualization of the public health economy that is necessary.

Conflict of interest

The authors have no conflict of interest other than that they are all members of Public Health Liberation - a non-profit.

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