

Integrating Public Health Research and Teaching With Social Justice Activism: Lessons From 80 Years of Practice

Health Education & Behavior
2023, Vol. 50(3) 301–309
© 2023 Society for Public
Health Education
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/10901981231158403
journals.sagepub.com/home/heb



Nicholas Freudenberg, DrPH¹ , and Barbara Israel, DrPH²

Abstract

In this commentary, we reflect on the lessons we have learned from our successes and failures in aligning the roles of scholars and activists. Our hope is to provide insights that can guide public health students, faculty, practitioners, and activists seeking to chart their professional, political, and personal futures in today's polarized and catastrophe-burdened world. Several experiences motivate us to write this commentary now. In the last few years, inspired in part by the new activism against systemic racism sparked by the murder of George Floyd and others, growing climate emergencies, the COVID pandemic, anti-immigrant politics, increasing anti-Asian acts of violence, gun bloodshed, attacks on the right to reproductive and sexual health, resurgence of interest in worker organizing, and the ongoing quest for lesbian, gay, bisexual, transgender, and intersex (LGBTQI+) rights, we are impressed by the number of young people engaged in activism to defend and expand their rights and show that another world is possible.

Keywords

health disparities, social determinants of health, community based participatory research, health policy, professional development

Can public health researchers also be health activists? For the last 40 years, each of us, sometimes separately, sometime together, has endeavored to integrate our roles as community and public health researchers, faculty members, and practitioners with our commitment to social justice and equity. In the last 5 years, we have each noted the increasing number of students, recent graduates, and younger faculty colleagues who have discussed with us their struggles to find this balance for themselves. They describe their frustrations with academic bureaucracy and their despair about being able to contribute to meaningful changes in public health and health equity. In this commentary, we reflect on the lessons we have learned from our successes and failures in aligning these two roles. Our hope is to provide insights that can guide public health students, faculty, practitioners, and activists seeking to chart their professional, political, and personal futures in today's polarized and catastrophe-burdened world.

Several experiences motivate us to write this commentary now. In the last few years, inspired in part by the new activism against systemic racism sparked by the police murders of George Floyd, Tyre Nichols, and so many others; growing climate emergencies; the COVID pandemic; anti-immigrant politics; increasing anti-Asian acts of violence; gun bloodshed; attacks on the right to reproductive and sexual health; resurgence of interest in worker organizing; and the ongoing

quest for lesbian, gay, bisexual, transgender, and intersex (LGBTQI+) rights, we are impressed by the number of young people engaged in activism to defend and expand their rights and show that another world is possible.

In the 1960s and 1970s, when we started our education and practice in public health, we were inspired by similar movements. Now we want to share our reflections on how—with hindsight—we assess what enabled and constrained us from holding on to the passion for justice that led us into public health. As we seek to understand a vastly different world, public health landscape, and life experiences of young people from the ones we experienced, we want to spark a dialogue between our generation and those that follow us, a conversation on the future of public health and social justice in the 21st century.

¹City University of New York Graduate School of Public Health & Health Policy, New York, NY, USA

²University of Michigan, Ann Arbor, MI, USA

Corresponding Author:

Nicholas Freudenberg, Department of Community Health and Social Sciences, City University of New York Graduate School of Public Health & Health Policy, 55 West 125th Street, Suite 604, New York, NY 10027-4512, USA.

Email: Nick.Freudenberg@sph.cuny.edu

Box 1. Key Lessons.

1. Value a historical perspective and the benefits of taking the long view to achieve health equity and social justice.
2. Acknowledge the positive and negative changes in the fields of public health, community health, and health education since the 1970s.
3. Create workplace and professional cultures that nurture and value mentoring as an essential two-way, reciprocal process.
4. Build bridges across disciplines and sectors that enable public health professionals to contextualize our work and learn how to develop and implement transdisciplinary teams.
5. Advance underappreciated and sometimes controversial ideas, approaches, and concepts, often suggested by social justice activists, into professional practice while keeping an open dialogue with the mainstream.
6. Create a network of colleagues with social justice values that can support us and that we can support over a lifetime.

We describe several lessons, shown in Box 1, that we have extracted from our shared 80 years of practice. Our intended audiences are the public health students, recent graduates, faculty, and practitioners who regularly consult us for help in understanding how to advance their careers while living out their values and commitments.

Inevitably, our views on public health, academic, and social justice reflect our own backgrounds and the times in which we started our careers. We are both children of the middle class, grew up in mostly White suburbs, and went to selective universities. We have spent a lifetime acknowledging the privileges and limitations of these class, racial/ethnic, and educational backgrounds and critically analyzing their implications for our values and judgments. We also grew up at a time when the New Deal–inspired welfare state was strong, the U.S. economy was expanding, and young people like us could afford college without debt, find jobs with little difficulty, and combine advancing our careers with raising a family, privileges eluding even many middle-class young people today.

In deciding to write this essay together, we have had numerous conversations about the most salient lessons from our joint and separate work. Not surprisingly, we discovered that we had some shared and differing lessons. In the following, we use “we” when describing our joint conclusions and switch to first person and our name to identify individual experiences or insights.

I (Barbara) was an active participant in the antiwar and feminist movements in the late 1960s and 1970s and worked as a community organizer in rural North Carolina for 3 years before returning to graduate school at the University of North Carolina at Chapel Hill for both my masters and doctoral degrees. As a young community organizer, I initially had no intention of going to graduate school, thinking school would not allow me to pursue my social justice aspirations. I had the good fortune to attend a lunch sponsored by a local health education group in which Guy Steuart, then Chair of the Department of Health Education, School of Public Health (UNC-CH), was the guest speaker. Guy spoke with a passion and commitment for community, inclusion, and equity that I had never experienced and touched me in a way that I did not fully understand at the time. I decided that if I ever went to graduate school, I wanted to learn from and work with him.

Two years later, after applying only to UNC-CH, I started my master’s program and subsequently doctoral program with Guy as my advisor (more on mentorship later).

To realize my commitment to work for community and social change, soon after arriving at the University of Michigan School of Public Health as an Assistant Professor, I recognized I had to achieve the traditional scholarly metrics of publications and grants while staying true to my social justice values. Doing so sometimes seemed at the expense of my professional success. For example, early on I received feedback from a senior faculty colleague that I was “spending too much time on community service.” At that point in my career, I was conducting participatory research in an automotive parts manufacturing plant, examining and addressing occupational stress. To keep my commitment to communities, I supported several community organizing efforts in Detroit. As I worked toward a time when I could better integrate my research and community activism, I made choices that made me feel more in control, although it meant working more.

Several early experiences shaped my career as a public health researcher. I grew up in the South, in North Carolina, and I am old enough to remember seeing separate entrances to the movie theater and water fountains labeled for “colored” people. As a child, the first person I was close to who died was an African American woman who worked for my family—she and I used to spend a lot of time together. When she died at a young age, I asked my mother why our family doctor could not save her. My mother replied, “because she wasn’t allowed to go to the white hospital where he worked.” She died of a burst appendix. At age 6, I did not have the language of equity and social justice, but I knew that exclusion was wrong. Another key influence in my early life was my Jewish upbringing and my family’s commitment to social justice. Neither of my parents were what we would consider activists. But in everything my mother did, she exemplified a respect for those different from us, a commitment to engage in deeds of kindness and giving, a deep regard for her Jewish roots, a dedication to equal opportunities in education, and a desire for her children to adopt her values of humility and justice. These experiences and underlying values have provided the cornerstone for my work in public health.

I (Nick) was an active participant in the antiwar, student, and environmental movements of the 1960s and 1970s,

(Freudenberg, 1985, 2018) and worked with and for community organizations in New York City (Freudenberg et al., 1994; Freudenberg & Kohn, 1982; Freudenberg & Trinidad, 1992). Based on those experiences, I chose to spend my career combining public health research and practice with social activism. As the child of parents who left Nazi Germany in the late 1930s, I was taught early that everyone has the obligation to protest inhumanity and injustice, an important influence on my later commitments to antiwar, civil rights, and other movements. I also grew up with four sisters who forced me—usually with affection—to confront the traditional notions of masculinity and patriarchy so prevalent at the time.

When I left suburban Long Island in 1966 to go to school at Columbia, I was thrilled to be in New York City, the beginning of my lifetime commitment to cities and my interest in urban well-being. In 1968, I was expelled from Columbia for my antiwar activism and protests (Freudenberg, 2018). Another lesson with lifetime impact was learning how closely Columbia was collaborating with military contractors, the Defense Department, and others to contribute to the war in Vietnam and how influential the university's banker, corporate, and real estate trustees were in charting the University's relationships with New York City and the Harlem community. These insights made me question the idealized vision of academic institutions and sparked my later decision to study and write about what is now known as the commercial determinants of health and how market actors influence health and disease (Freudenberg et al., 2021).

Another consequence of my antiwar protests was a 1-week sentence at Rikers Island, New York City's now infamous jail. I learned as much about how our society functions in my week at Rikers as in the prior 2 years of liberal arts education at Columbia. Eventually, I finished my undergraduate degree at City University of New York (CUNY), the oldest, largest, and most diverse urban public university in the nation. Going to class with students from different backgrounds and life experiences gave me a new appreciation of the pedagogical and social value of breaking down the class, race, and other stratification systems that then and now characterize higher education and the wider society. The experience also encouraged me to accept a faculty position at CUNY after I got my doctorate, both because my values resonated with the university's mission of promoting equitable access to higher education and the fact that tenure-track faculty at CUNY had hard money positions and a union to negotiate for us, two protections most elite research universities lacked.

Both of us chose to work in public universities and both of us had relative success in securing research funding, getting our work published, and getting tenured and promoted, although we worked outside more established academic traditions. In part, these accomplishments were facilitated by our class and race privileges, the times, and our decisions to work in universities that valued, or at least tolerated, our less conventional choices.

Lessons Learned

The paths we chose were shaped by our backgrounds and the times, but from our work with colleagues and students over the years, we are convinced that every person coming into public health can and should make active decisions about their future. These are the lessons we extract from our own experiences that we hope may help others to make their professional and personal choices.

Take the Long View to Achieve Health Equity and Social Justice

As teachers and activists, one of our most troubling experiences is to encounter students and younger colleagues who do not believe that positive change is possible. Their experiences, especially in the last decade or so, have convinced them that the status quo is so entrenched, elites so powerful, and resistance so futile that other worlds are no longer possible. We are struck that many of these understandably pessimistic individuals agree with our commitment to social justice and the value of equity and even our analyses of power relationships but have given up on the possibility of seeing change in their lifetimes.

Like any sentient beings, we too are often depressed by the cascade of public health catastrophes, social injustices, and unrestrained power of ruling groups. But several experiences and insights make us more hopeful about the future.

First, our read of public health history of the last two centuries is that victories often took 10, 20, or 50 years. In our lifetime, the successes of the women's, civil rights, anti-Vietnam war, environmental, and LGBTQ movements have materially improved the health and social conditions of many populations, improvements that were unimaginable in the 1950s and early 1960s.

Second, around the country and the world, we see hundreds of millions of people mobilizing for changes that will improve health, the environment, and social justice, clear evidence that many do believe another world is possible. Learning the lessons from these successful and unsuccessful efforts—an application of the public health approach of creating and using practice-based evidence (Green & Allegrante, 2020)—can provide a powerful antidote to pessimism.

Third, we have over the years collaborated with communities and partners who have faced multiple adversities, including being underrepresented in corridors of power, jailed, underresourced, facing discrimination and racism, and experiencing violence and trauma. As we noted, these experiences contrast with our more privileged lives. At times when we have felt despair at what could be accomplished, it has been the incredible commitment, passion, and optimism of these partners that have kept us going. We have each frequently asked, "How can I give up hope in the face of these courageous and resolute individuals?"

Box 2. Some Public Health Beliefs Common in the Mid-20th Century.

- The primary goal of public health practice is to change individual beliefs and behaviors.
- Biomedical interventions have the most promise to lead to improvements in health.
- Social, economic, and physical environments are merely the context within which individuals live, behave, and have little direct influence on health.
- Health inequities are inevitable, and the best solution to addressing them is to improve overall population health.
- Infectious diseases will soon end, a triumph for public health practices.
- Capitalism is the best political and economic system for promoting economic growth, prosperity, and well-being.
- The unquestioned public health leaders and researchers are White men from high-income countries and privileged backgrounds.
- Controlled scientific research, especially randomized clinical trials, and positivism (the belief that science is objective and value-free) have the best potential for contributing insights that can improve population health.

Fourth, on a more philosophical level, we have come to believe that whether change comes this year or a century from now, we want our children and grandchildren and professional successors to be able to say we were on the moral side of history. Both of us came to believe that we have the obligation to distinguish ourselves from those who collaborate with or ignore evil. By using our professional and political skills to contribute evidence about what promotes and undermines public health or what works to reduce health inequities, we provide insights that can guide future generations to improve the world. In our view, that is how history proceeds, and wallowing in despair has never changed the world.

Acknowledging Changes in Public Health Since the 1970s

When we first became public health professionals, several beliefs dominated the field, some listed in Box 2. Of course, some public health professionals have always contested these ideas, but younger professionals may not recognize how much these conventional wisdoms set the tone in the public health academic and professional worlds 50 years ago. Moreover, challenging these ideas was often seen as quixotic at best or subversive and anti-American at worst. We are proud of the role we and our many colleagues played in questioning these beliefs and establishing other bodies of evidence that expanded public health scholarship, theory, practice, and policy.

Some examples of these changes are the rise in interest in frameworks that explore the influences of the social, political, environmental and commercial determinants of health on public health (Bullard, 2018; Dawes, 2020; Freudenberg et al., 1994, 2021; Krieger, 2001; Marmot & Wilkinson, 2005; World Health Organization Commission on Social Determinants of Health, 2008); the growing recognition of community-based participatory research (CBPR) as a viable approach to understanding and addressing health inequities (Israel et al., 1998, 2006, 2010; 2020; Schulz et al., 2001; Ward et al., 2018); the application of critical race theory and anti-racist approaches to public health (Fleming, et al., 2023; Ford & Airhihenbuwa, 2010, 2018); and the emergence of feminist and intersectional public health research and theory (Couto et al., 1994; Schulz et al., 2006). For us, these ideas demonstrate the possibility of advancing our field and challenging limiting, outdated, or

oppressive theories and interpretations. They also function as an antidepressant to the despair we sometimes feel about today's prevalent beliefs denigrating science, reinforcing racism and misogyny, or espousing unfettered capitalism. By looking both backward at how far we have come and forward to how far we still must go, we can find a better balance than simply responding to today's headlines or fear-mongering Twitter messages.

Creating Workplace and Professional Cultures That Nurture Mentoring

Both of us have been blessed with influential mentors. For Barbara, Andrew DeRocco, Guy Steuart, John Hatch, Noreen Clark, and Mark Chesler and for Nick, Michael Carrera, Noreen Clark, Helen Rodriguez, David Sanders, Donna Shalala, and others provided support, guidance, and occasional criticism. Getting advice and support from people with different backgrounds and perspectives helped to broaden and deepen our ability to find different ways to achieve our goals.

We each also benefited from many role models, some of whom we knew personally and others who inspired us from times past or places distant. Among our shared or separate role models are Rachel Carson, W.E.B. DuBois, Jack Geiger, Alice Hamilton, Myles Horton, John Lewis, Carlos Monteiro, Marion Nestle, David Satcher, Victor Sidel, Greta Thunberg, and Rudolf Virchow, a wildly disparate group of our social and intellectual influencers.

Over the years, we have also each had the privilege of serving as mentors to dozens of colleagues, students, graduates, and activists. Nothing brings us greater satisfaction than their successes. To our occasional surprise, our reputations for combining activism and research have increased our credibility as mentors for others seeking to combine the two, an experience that reinforces our practice of speaking openly about our activism in academic and professional as well as advocacy settings.

From these experiences, we have developed some insights on mentoring:

- Mentoring is a two-way process, and one learns as much from those whom we mentor as from those who mentor us. Making this reciprocal nature explicit

enables both mentors and mentees to gain more from the relationships.

- Creating academic cultures and environments that support mentoring is an important antidote to the competitive climate that sometimes pervades academia.
- Mentoring from those with whom we share academic interests, class backgrounds, race/ethnicity, and gender is critically important, but so is getting guidance from those who are different. We encourage everyone to seek similar and different mentors and mentees to gain and give the widest range of insights and advice.
- Many senior scholars like to provide guidance to those coming up in our fields—younger colleagues are encouraged to embrace these opportunities and structure distinct relationships that meet both parties' needs.

Building Bridges Across Disciplines and Sectors

While the field of public health involves different disciplines (e.g., health behavior and health education, epidemiology, environmental health sciences, health policy) that operate in different sectors (e.g., local health departments, federal regulatory agencies, schools, health systems, community-based organizations, the media), they often operate in silos, working separately to try to understand and address public health issues. Given the complexity of the issues we face as public health researchers and practitioners (e.g., lack of access to affordable food, racism, poor air quality, income inequality), there has been a growing recognition of the need to not only collaborate across disciplines and sectors but also work collaboratively to create new conceptual, theoretical, methodological, and translational approaches that build on synergies and integrate beyond discipline-specific strategies (Aboelela et al., 2007).

We have spent most of our careers trying to identify the most appropriate disciplines and sectors needed to address a specific issue and then bring together a diverse team of scientists and practitioners to tackle the problem. Furthermore, in accordance with our commitment to the CBPR approach (Israel et al., 1998, 2018, 2019), community partners have always been at the center of these team efforts. Embracing core principles of CBPR, including an emphasis on equity and power sharing, mutual benefits, co-learning and capacity building, and balancing research and action for social change, has enabled us to pursue our commitment to social justice even in the context of academia (Freudenberg & Tsui, 2014; Israel et al., 1998).

Building such bridges across disciplines and sectors in the context of a CBPR approach is not without its challenges. We have found that often our academic colleagues are neither familiar with nor skilled in working in such diverse teams. Issues arise around, for example, differences in language, cultural practices, methodologies, definition of science, and group decision-making. To be effective using such a team

approach, we have had to listen more and talk less, leave our egos at the door, be flexible and transparent, accept feedback without getting defensive, practice cultural humility, and reflect on and document our processes and outcomes (Israel et al., 2013).

In my experience (Barbara), I worked with multiple, highly committed community and academic partners using a CBPR approach to address complex health problems. Our Community Action Against Asthma, for example, focused on understanding and intervening to address the environmental triggers of childhood asthma. Our group included a civil engineer, pediatric pulmonologist, health educator, biostatistician, environmental justice advocate, local health department maternal and child health specialist, and a community organizer to create a transdisciplinary team (Keeler et al., 2002; Parker et al., 2008). Through our ongoing evaluation, we were able to show the effectiveness of building bridges across disciplines and sectors (Edgren et al., 2005).

Given our belief that many public health advances have come about as the result of the leadership by social movements, we have also come to recognize that building bridges between public health professionals and social movements is a key skill. In our teaching and partnerships, we seek to learn from movement leaders and activists as well as other researchers and to acknowledge that these movements often drive the changes needed to improve health (Freudenberg, Franzosa, et al., 2015).

Finally, as more public health professionals rely on social determinants of health frameworks and take on causes of ill health in other sectors including housing, employment, education, community development, and food, we have appreciated the value and importance of developing links with those outside of public health, including those in academia, government, and civil society in the fields of economics, political science, urban planning, law, sociology, and others. Over the decades, learning about other disciplines, blending our theories and frameworks with those of new colleagues, and meeting smart people with new perspectives on our topics have kept the joy in our work.

Advancing Underappreciated and Sometimes Controversial Ideas, Approaches, and Concepts, Often Suggested by Social Justice Activists, Into Professional Practice While Keeping an Open Dialogue With the Mainstream

Throughout our careers, we have promoted ideas, approaches, and concepts that were aimed at a wider audience than traditional academic researchers, which has sometimes led to our work being less valued by more traditional colleagues. But over time, we have grown more confident about the power of new ideas to bring about change and the importance of engaging in dialogue and debate with those who disagree with us.

This can sometimes lead to uncomfortable situations, where we must defend our perspective without being defensive. For example, I (Barbara) was co-presenting with a faculty colleague at a doctoral seminar in which we were presenting the results from survey data from one of our CBPR partnerships. At the end of our presentation, a senior faculty colleague observed, “What you’re doing is good research and advocacy, but it isn’t science.” “That depends on your definition of science,” I said, and he replied, “there is only one definition of science.” “I agree to disagree” I said, but he stayed silent, suggesting that he did not agree to disagree. Later, several doctoral students, distraught since they valued the use of CBPR, asked me what this exchange suggested for their career goals. I recommended they prepare for this kind of conflict in advance and stay strong in their commitments.

Here again, we suggest professionals like us need to decide what positions we want to play—academic, professional practice, activist, or some combination of these—and determine in advance how best to defend these choices. Of course, intersectionality means that our identities are shaped by multiple forces, sometimes creating inner conflicts and external pressures that can constrain action. We acknowledge that some colleagues believe that the roles of academic and advocate are mutually exclusive, but we read public health history as demonstrating that those who combine the two roles make the greatest contributions to improved population health and public health science (Fairchild et al., 2010).

Over the years, we have become more confident about publicly acknowledging our activist roots both because more public health professionals share this background and perspective (e.g., the members of the Spirit of 1848 Caucus within the American Public Health [Spirit of 1848, 2005] and Public Health Awakened [Human Impact Partners, 2022]) and because the visible failures of public health business-as-usual overcome the most pressing global public health crises such as the COVID pandemic and climate change. This new environment has made us more comfortable about staying off the slippery slope of having to act as traditional academics in some settings and feisty activists in others.

While an activist stance inevitably elicits charges of bias from more traditional scholars, we have observed more acceptance of the concept that all researchers bring biases to their work (Liverani et al., 2013). In our teaching, for example, we strive to make the case for a broader definition of science and the acceptance of various types of convincing evidence. Our goals are to help students to incorporate these perspectives and apply them in settings where more traditional perspectives are being discussed. By disclosing our values, we enable others to evaluate the evidence we present on its merits and openly consider the biases of all parties.

Like others who recognize the value of controversy for advancing new ideas, we often have to ask whom we hope to influence and win over and who is unlikely to be moved. For example, we recognize that CBPR is not a viable research approach for everyone, and sometimes it is not worth trying to

convince others that it is. In another example, I (Nick) believe that public health professionals should use the term capitalism to describe our current global political economy and assess its impact on health. But I recognize many are uncomfortable with this word, so I choose with whom to have this discussion (Freudenberg, 2021). Reinforcing our belief in the value of a long-term perspective, over time we have seen broader acceptance of many ideas that initially encountered skepticism.

Creating a Network of Colleagues Who Can Support Us and Our Values Over a Lifetime

My (Barbara) early academic publications examined the role of social support and social networks on health status (Israel, 1982; Israel et al., 1983) and explored the relationships between occupational stress, social support, and health (Israel et al., 1989; Israel & Schurman, 1990). At the time, I joked that I studied occupational stress and social support and that I have too much of the former and not enough of the latter. We both realized early in our careers that in addition to mentors, a social network of colleagues and friends who share our values and perspectives could provide us with the support and advice we needed.

Over our careers, we have worked to build and maintain such a network. Some of our deepest relationships were established when we were graduate students, and we call on those with whom we share a lifelong history to help us work through our own crises, grief at the loss of a colleague or a public health defeat, or despair at some new global crisis, election result, or Supreme Court decision. By their proximity and availability for frequent interactions, other network members may respond to impromptu requests for advice (pre-COVID!) or feedback on new ideas. For each of us, our partners and children provide another source of support, willing to criticize us or temper our impulses in ways that others cannot. To keep our thinking current and to escape the limits of any fixed network, we also stay open to meeting new people and exploring new ideas.

In building and maintaining our networks of support, we recognize that we are engaged in difficult work, that often we do not have the answers, may not know what to do next, and need to have the humility and strength to call upon others when we need them. As with mentors, when our networks embrace reciprocal relationships, they contribute to even stronger and more valuable support.

Conclusions and Recommendations

Our goal is to share lessons that may help others to pursue a career in public health committed to social justice. We remain active in our efforts to advance a progressive public health and social justice agenda, which to us includes preparing and supporting the next generations doing this work. As those who came before taught us, we cannot do this alone and we welcome, embrace, and are often awed

by the creative work of our students and younger academic and practice colleagues.

We also note that opening pathways to facilitate younger colleagues to achieve their public health and social justice goals will require institutional changes in the policies and practices of schools of public health, universities, and funding institutions. We encourage readers to become familiar with and apply insights from growing bodies of literature on anti-racist pedagogy and practices (Chandler et al., 2022; Fleming et al., 2023); diversity, equity, and inclusion initiatives; faculty tenure and promotion practices; use of CBPR approaches; and critiques of National Institutes of Health (NIH) funding priorities (Aday & Quill, 2000; Fleming et al., 2023; Ford & Airhihenbuwa, 2010; Freudenberg, Klitzman, et al., 2015; Goodman et al., 2020; Merino, 2019).

By applying these new developments to our institutions, we create spaces that can nurture change. For example, Nick has worked with a national public policy network and a group of CUNY doctoral students to apply insights from public health critical race theories to developing policy recommendations for reducing racial/ethnic health inequities in New York City (Scholars Strategy Network, 2022). Barbara has worked with a group of national academic and community scholars to articulate the connections more clearly between anti-racist principles and CBPR, and to recommend policy changes that will assist researchers, academic institutions, and funding agencies to promote research that can transform institutional practices to ensure racial equity (Fleming et al., 2023).

As we each enter our fifth decade of public health and social justice work, we look back on our accomplishments, failures, and experiences with pride and humility. We are struck by how far the field of public health has come in these years—and how much farther we need to go to assure all the world's people the right to health. We have had the privilege of participating in the most vital social movements of our time, studying the world's most serious public health problems; educating hundreds of hardworking, brilliant, and passionate students; and being supported by smart, compassionate, and innovative colleagues. We hope these reflections provide even a modest paying forward of what we have learned from others.

Acknowledgments

We thank our mentors and mentees for their inspiration and guidance. We also thank Erinn Bacchus, Shari Jardine, and Monica Ortiz Rossi; doctoral students of Freudenberg; and Melanie Ward, a former doctoral student of Israel, for their helpful comments on an earlier draft of this article. Both authors contributed equally to this article and are listed in alphabetical order.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Nicholas Freudenberg  <https://orcid.org/0000-0001-5159-6914>

References

- Aboelela, S. W., Larson, E., Bakken, S., Carrasquillo, O., Formicola, A., Glied, S. A., & Gebbie, K. M. (2007). Defining interdisciplinary research: Conclusions from a critical review of the literature. *Health Services Research, 42*, 329–346. <https://doi.org/10.1111/j.1475-6773.2006.00621.x>
- Aday, L. A., & Quill, B. E. (2000). A framework for assessing practice-oriented scholarship in schools of public health. *Journal of Public Health Management and Practice, 6*(1), 38–46. <https://doi.org/10.1097/00124784-200006010-00007>
- Bullard, R. D. (2018). *Dumping in Dixie: Race, class, and environmental quality*. Routledge.
- Chandler, C. E., Williams, C. R., Turner, M. W., & Shanahan, M. E. (2022). Training public health students in racial justice and health equity: A systematic review. *Public Health Reports, 137*(2), 375–385.
- Couto, M. T., Oliveira, E. D., Separavich, M. A., & Luiz, O. D. (1994). The feminist perspective of intersectionality in the field of public health: A narrative review of the theoretical-methodological literature. *Salud Colectiva, 15*, Article e1994.
- Dawes, D. E. (2020). *The political determinants of health*. Johns Hopkins University Press.
- Edgren, K. K., Parker, E. A., Israel, B. A., Lewis, T. C., Salinas, M. A., Robins, T. G., & Hill, Y. R. (2005). Conducting a health education intervention and an epidemiological research project involving community members and community partner organizations: The community action against asthma project. *Health Promotion Practice, 6*, 263–269. <https://doi.org/10.1177/1524839903260696>
- Fairchild, A. L., Rosner, D., Colgrove, J., Bayer, R., & Fried, L. P. (2010). The EXODUS of public health: What history can tell us about the future. *American Journal of Public Health, 100*(1), 54–63. <https://doi.org/10.2105%2FAJPH.2009.163956>
- Fleming, P. J., Stone, L. C., Creary, M. S., Greene-Moton, E., Israel, B. A., Key, K. D., . . . Schulz, A. J. (2023). Antiracism and community-based participatory research: Synergies, challenges, and opportunities. *American Journal of Public Health, 113*(1), 70–78.
- Ford, C. L., & Airhihenbuwa, C. O. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health, 100*(Suppl. 1), S30–S35. <https://doi.org/10.2105%2FAJPH.2009.171058>
- Ford, C. L., & Airhihenbuwa, C. O. (2018). Commentary: Just what is critical race theory and what's it doing in a progressive field like public health? *Ethnicity & Disease, 28*(Suppl. 1), 223–230. <https://doi.org/10.18865/ed.28.s1.223>
- Freudenberg, N. (1985). Not in our backyards! Community action for health and the environment. *Monthly Review Press, 12*(2), 212–215. <https://doi.org/10.1177%2F109019818501200207>

- Freudenberg, N. (2018). The lessons of Spring 1968 for public health. *American Journal of Public Health, 108*(6), 724–725. <https://doi.org/10.2105%2FAJPH.2018.304387>
- Freudenberg, N. (2021, May 6). Why do we ignore capitalism when we examine the health crises of our time? *The BMJ Opinion*. <https://blogs.bmj.com/bmj/2021/05/06/why-do-we-ignore-capitalism-when-we-examine-the-health-crisis-of-our-time/>
- Freudenberg, N., Franzosa, E., Chisholm, J., & Libman, K. (2015). New approaches for moving upstream: How state and local health departments can transform practice to reduce health inequalities. *Health Education & Behavior, 42*(Suppl. 1), 46S–56S. <https://doi.org/10.1177/1090198114568304>
- Freudenberg, N., Klitzman, S., Diamond, C., & El-Mohandes, A. (2015). Keeping the “public” in schools of public health. *American Journal of Public Health, 105*(Suppl. 1), S119–124. <http://doi.org/10.2105/AJPH.2014.302534>
- Freudenberg, N., & Kohn, S. (1982). The Washington heights health action project: A new role for human service workers. *Catalyst, 13*, 7–23.
- Freudenberg, N., Lee, J., & Germain, L. M. (1994). Reaching low-income women at risk of AIDS: A case history of a drop-in center for women in the South Bronx, New York City. *Health Education Research, 9*(1), 119–132. <https://psycnet.apa.org/doi/10.1093/her/9.1.119>
- Freudenberg, N., Lee, K., Buse, K., Collin, J., Crosbie, E., Friel, S., & Zenone, M. (2021). Defining priorities for action and research on the commercial determinants of health: A conceptual review. *American Journal of Public Health, 111*(12), 2202–2211. <https://doi.org/10.2105/ajph.2021.306491>
- Freudenberg, N., & Trinidad, U. (1992). The role of community organizations in AIDS prevention in two Latino communities in New York City. *Health Education Quarterly, 19*(2), 219–232. <https://doi.org/10.1177/109019819201900206>
- Freudenberg, N., & Tsui, E. (2014). Evidence, power, and policy change in community-based participatory research. *American Journal of Public Health, 104*(1), 11–14. <https://doi.org/10.2105%2FAJPH.2013.301471>
- Goodman, M. S., Plepys, C. M., Bather, J. R., Kelliher, R. M., & Heaton, C. G. (2020). Racial/ethnic diversity in academic public health: 20-year update. *Public Health Reports, 135*(1), 74–81.
- Green, L. W., & Allegrante, J. P. (2020). Practice-based evidence and the need for more diverse methods and sources in epidemiology, public health, and health promotion. *American Journal of Health Promotion, 34*(8), 946–948. <https://doi.org/10.1177/0890117120960580b>
- Human Impact Partners. (2022). *Public health awakened*. <https://publichealthawakened.org/>
- Israel, B. A. (1982). Social networks and health status: Linking theory, research, and practice. *Patient Counseling and Health Education, 4*, 65–79. [https://doi.org/10.1016/s0190-2040\(82\)80002-5](https://doi.org/10.1016/s0190-2040(82)80002-5)
- Israel, B. A., Coombe, C. M., Cheezum, R. R., Schulz, A. J., McGranaghan, R. J., Lichtenstein, R., & Burris, A. (2010). Community-based participatory research: A capacity-building approach for policy advocacy aimed at eliminating health disparities. *American Journal of Public Health, 100*, 2094–2102. <https://doi.org/10.2105/ajph.2009.170506>
- Israel, B. A., Eng, E., Schulz, A. J., & Parker, E. A. (Eds.). (2013). Introduction. In J. A. Schulz, E. Eng, B. A. Israel, & E. A. Parker (Eds.), *Methods for community-based participatory research for health* (2nd ed., pp. 4–37). Jossey-Bass/Wiley.
- Israel, B. A., Hogue, C. C., & Gorton, A. (1983). Social networks among elderly women: Implications for health education practice. *Health Education Quarterly, 10*, 173–203. <https://doi.org/10.1177/109019818301000304>
- Israel, B. A., House, J. S., Schurman, S. J., Heaney, C. A., & Mero, R. P. (1989). The relation of personal resources, participation, influence, interpersonal relationships and coping strategies to occupational stress, job strains and health: A multivariate analysis. *Work and Stress, 3*, 163–194. <https://doi.org/10.1080/02678378908256942>
- Israel, B. A., Krieger, J. W., Vlahov, D., Ciske, S. J., Foley, M., Fortin, P., . . . Tang, G. (2006). Challenges and facilitating factors in sustaining community-based participatory research partnerships: Lessons learned from the Detroit, New York City, and Seattle Urban Research Centers. *Journal of Urban Health, 83*, 1022–1040. <https://doi.org/10.1007/s11524-006-9110-1>
- Israel, B. A., Lachance, L., Coombe, C. M., Shou-Yih, D. L., Jensen, M., Wilson-Powers, E., & Brush, B. L. (2020). Measurement approaches to partnership success: Theory and methods for measuring success in long-standing community-based participatory research partnerships. *Progress in Community Health Partnerships: Research, Education, and Action, 14*(1), 129–140. <https://doi.org/10.1353%2Fpcpr.2020.0015>
- Israel, B. A., Schulz, A. J., Coombe, C., Parker, E. A., Reyes, A. G., Rowe, Z., & Lichtenstein, R. (2019). Community-based participatory research: An approach to research in the urban context. In S. Galea, C. Ettman, & D. Vlahov (Eds.), *Urban health* (pp. 272–282). Oxford University Press.
- Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health, 19*, 173–202. <https://doi.org/10.1146/annurev.publhealth.19.1.173>
- Israel, B. A., Schulz, A. J., Parker, E. A., Becker, A. B., Allen, A. J., Guzman, R., & Lichtenstein, R. (2018). Critical issues in developing and following CBPR principles. In N. Wallerstein, B. Duran, J. Oetzel, & M. Minkler (Eds.), *Community-based participatory research for health: Advancing social and health equity* (pp. 31–34). John Wiley.
- Israel, B. A., & Schurman, S. J. (1990). Social support, control, and the stress process. In K. Glanz, F. Lewis, & B. Rimer (Eds.), *Health behavior and health education: Theory, research and practice* (pp. 187–215). Jossey-Bass.
- Keeler, G. J., Dvonch, T., Yip, F. Y., Parker, E. A., Israel, B. A., Marsik, F. J., Morishita, M., & Sam, M. (2002). Assessment of personal and community-level exposures to particulate matter among children with asthma in Detroit, Michigan, as part of Community Action Against Asthma (CAAA). *Environmental Health Perspectives, 110*(Suppl. 2), 173–181. <https://doi.org/10.1289/ehp.02110s2173>
- Krieger, N. (2001). Theories for social epidemiology in the 21st century: An ecosocial perspective. *International Journal of Epidemiology, 30*(4), 668–677. <https://doi.org/10.1093/ije/30.4.668>
- Liverani, M., Hawkins, B., & Parkhurst, J. O. (2013). Political and institutional influences on the use of evidence in public health policy. A Systematic Review. *PLOS ONE, 8*(10), Article e77404.

- Marmot, M. & Wilkinson, R. (Eds.). (2005). *Social determinants of health*. Oxford University Press.
- Merino, Y. (2019). What do schools of public health have to say about diversity and inclusion? *Pedagogy in Health Promotion*, 5(4), 233–240. <https://doi.org/10.1177/2373379918811820>
- Parker, E. A., Israel, B. A., Robins, T. G., Mentz, G., Lin, X., Brakefield-Caldwell, W., & Lewis, T. (2008). Evaluation of community action against asthma: A community health worker intervention to improve children's asthma-related health by reducing household environmental triggers for asthma. *Health Education & Behavior*, 35, 376–395. <https://doi.org/10.1177/1090198106290622>
- Scholars Strategy Network. (2022). *Reducing the impact of systemic racism on health in New York City by 2025*. <https://scholars.org/reducing-systemic-racism-health-nyc>
- Schulz, A. J., Freudenberg, N., & Daniels, J. (2006). Intersections of race, class, and gender in public health interventions. In A. J. Schulz & L. Mullings (Eds.), *Gender, race, class, & health: Intersectional approaches* (pp. 371–393). Jossey-Bass/Wiley.
- Schulz, A. J., Israel, B. A., Parker, E. A., Lockett, M., Hill, Y. R., & Wills, R. (2001). Community-based participatory research: Integrating research and action to address health disparities. *Public Health Reports*, 116, 548–557.
- Spirit of 1848. (2005). *Caucus. Mission statement*. <http://www.spiritof1848.org/>
- Ward, M., Schulz, A. J., Israel, B. A., Rice, K., Martenies, S. E., & Markarian, E. (2018). A conceptual framework for evaluating health equity promotion within community-based participatory research partnerships. *Evaluation and Program Planning*, 70, 25–34. <https://doi.org/10.1016/j.evalprogplan.2018.04.014>
- World Health Organization, Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health: Commission on social determinants of health final report*. World Health Organization.