RACISM AND CHILD HEALTH:

A STRATEGIC REVIEW OF POSSIBLE INTERVENTIONS FOR THE HEALTH SECTOR

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INTRODUCTION

This strategic review is part of a broader Ministry of Health-funded project that aims to expand our understanding of racism as a determinant of child health and subsequent driver of future adult health inequities by considering the relationships between racism and child health in Aotearoa New Zealand. The first stage of the project involved secondary analysis of data from the 2006/07 and 2011/12 child and adult New Zealand Health Surveys (NZHSs) to explore associations between caregivers' experiences of racism and health outcomes and health service use for their children aged 0–14 years (Paine, Harris, Stanley & Cormack 2018). In addition, a monitoring framework was developed to provide recommendations about how the NZHS can be used to measure and monitor the child health impacts of racism in Aotearoa New Zealand.

The final output from the overall project is a strategic review of possible interventions to address racism and its impacts on child health at community, organisational and structural levels, based on findings from the earlier project components.

AIMS AND SCOPE OF THE STRATEGIC REVIEW

The aims of this strategic review are to:

- identify interventions within the health sector that specifically address racism (both experienced by children or vicariously via their caregivers) as a determinant of child health; and,
- discuss implications and potential relevance for the Aotearoa New Zealand health sector.

Drawing on the findings from our analysis of the NZHSs and from review of the current literature, the strategic review will have a particular focus on interventions that address racism and its impacts on child health:

- within the health sector, that is, interventions that can be undertaken within health systems, organisations and services, or by health agencies such as DHBs and health providers;
- that directly relate to children's experience of racism as well as vicarious exposure for children (e.g. via caregiver experiences of racism), as the analytical component of the study found significant relationships between caregiver experience of racism and child health;
- that focus on Māori child health;
- that aim to reduce and or eliminate racism, although interventions that aim to mitigate or minimise the impact of racism may also be considered in the short-term.

STRUCTURE OF THE DOCUMENT

The document includes an overview of the context for this report, including a brief discussion of child health in Aotearoa New Zealand, an outline of current research about the child health impacts of racism, and an overview of key concepts. We then discuss our approach to the strategic review, including the search strategy and processes, as well as the frameworks used to discuss the findings. The findings of the strategic review are then presented, including information about the type and setting of intervention, the goals and any information about outcomes. Finally, we discuss the overall findings of the strategic review, and consider the interventions in relation to their potential in the Aotearoa New Zealand context, as well as the broader context of anti-racism interventions outside of the health system.

BACKGROUND

In Aotearoa New Zealand, there are persistent inequities in child health between population groups (Craig et al 2013; D'Souza, Turner, Simmers, Craig & Dowe 2012; Ministry of Health 2016). For example, the 2015/2016 New Zealand Health Survey (NZHS) reported continuing ethnic inequities in the prevalence of chronic conditions such as asthma, and in unmet need for healthcare among children (Ministry of Health 2016). Aotearoa New Zealand also performs comparatively poorly internationally (OECD 2009; UNICEF Office of Research 2013). In the recent UNICEF *Innocenti Report Card*, Aotearoa New Zealand ranked near the bottom (38th out of 41 EU/OECD countries) for indicators of child health and wellbeing, with the highest youth suicide rate (15–20 year olds) of the 41 countries included in the report (UNICEF 2017).

Calls have been made for increasing attention to be paid to child health in Aotearoa New Zealand, including to address inequities in health care access and quality, and in the differential distribution of factors that are protective, or damaging, for child health (D'Souza et al 2012; Hale & Sharpe 2011; Turner, Hoare & Dowell 2012).

Racism is increasingly being acknowledged as a determinant of child health outcomes and driver of racial/ethnic child health inequities internationally (Priest et al 2013). While the research on the negative health impacts of racism for adults is now considerable (Paradies et al 2015; Priest & Williams 2017; Williams & Mohammed 2013a), studies focusing on the impacts of racism on child health remain relatively limited (Priest et al 2013). These studies have, however, aligned with the literature for adult health in showing that racial discrimination is associated with negative health outcomes for children and adolescents, with associations with mental health outcomes the most consistent (Priest et al 2013). There is also a growing body of research documenting the negative health impacts of maternal experiences of racial discrimination on both maternal and infant health (Giurgescu, McFarlin, Lomax, Carddock & Albrecht 2011). Racism experienced by children can also impact future adult health outcomes and health trajectories over the life course (Walker et al 2011), through the accumulation of exposures over one's lifetime.

DEFINING RACISM

Racism is a complex concept with definitions that vary depending on historical, political and disciplinary contexts. In line with the work of key scholars in racism and health, we understand racism as a system or a societal phenomenon (Priest et al 2013; Williams & Mohammed 2013a). Williams & Mohammed (2013a) conceptualise racism as "… an organized system premised on the categorization and ranking of social groups into races and devalues, disempowers and differentially allocates desirable societal opportunities and resources to racial groups regarded as inferior (Bonilla-Silver, 1996; Williams, 2004)" (2). Our approach to racism in this project recognises the processes and belief systems that underpin the system of racism, the racialised power structures and hierarchies that characterise the system, as well as the range of discriminatory practices that follow, at societal, institutional and interpersonal levels (racial discrimination) (Garner 2010; Jones 2001; Priest et al 2013; van Dijk 1993).

In Aotearoa New Zealand, racism is intricately linked to colonisation. Our understanding of racism, therefore, contextualises racism within the racialised hierarchies, institutions and practices established as part of colonisation, that remain entrenched in our society today.

PATHWAYS FROM RACISM TO CHILD HEALTH

Although the literature on the child health impacts of racism is relatively limited, a number of pathways by which racism may impact child health have been identified (Priest et al 2013). These include both direct and indirect pathways. Racism may impact on the health of children through the distribution of social determinants of health and health-damaging exposures, such as inequitable access to safe, healthy housing, and adequate living standards (Kelly, Bécares & Nazroo 2013; Priest et al 2013).

The experience of racism, including racially-motivated harassment and violence, may have direct impacts on the health of children (Quitana & McKown 2008). Quitana and McKown (2008) refer to this as the 'direct influence of racism', whereby the child themselves is the direct target of racism. The mechanisms here are likely to be the same as those discussed in studies of adult health, that is, immediate and ongoing physical and psychological impacts of direct experiences of racial discrimination, exclusions, harassment and violence.

In relation to the child health impacts of racism, it is important to also consider the role of racism experienced by parents, caregivers and others in the child's world (Kelly, Bécares & Nazroo 2013; Priest et al 2013), whether or not this was experienced or witnessed by the child themselves (Quitana & McKown 2008). 'Vicarious racism' has been described as "…hearing about or seeing another person's experience of racism as well as carers or close family members experiencing discrimination that may or may not be witnessed by children and adolescents" (Priest et al 2014). Truong et al (2016) make a distinction between racism that is witnessed or experienced, or 'observed racism', and that which is not directly witnessed but still has impacts ('trickledown racism').

Vicarious racism, although not always directly experienced or observed, can still have direct pathways on the health of infants and children. For example, experiences of racism during pregnancy have been shown to have health impacts for mothers and babies, including on birth outcomes (Alhusen et al 2016). There is also the potential for caregiver experiences of racism to negatively influence caregiver physical health, mental health and health behaviours, with flow-on impacts for their child's environment in ways that might be health damaging (Kelly, Bécares & Nazroo 2013). Caregiver experiences of racism may also influence access to and experience of health services for their children, and subsequent health outcomes.

RACISM AND CHILD HEALTH IN AOTEAROA NEW ZEALAND

There is a small body of literature that has directly focused on the negative health impacts of racism for children in Aotearoa New Zealand, particularly in relation to quantitative studies. Most of the quantitative research has been published in the last five years and has focused on antenatal and infant health outcomes.

Thayer & Kuzawa (2015) investigated the relationships between experience of racial discrimination and maternal and infant cortisol levels among a sample of women in Auckland. Mothers who reported experiencing any racial discrimination had higher evening cortisol levels during pregnancy, and their infants also had greater cortisol reactivity (Thayer & Kuzawa 2015). This aligns with other evidence internationally demonstrating the physiological health impacts on babies and infants from maternal experiences of racial discrimination.

A recently published study using data from the Growing Up in New Zealand longitudinal cohort study (Hobbs et al 2017) found that maternal experiences of racial discrimination were associated with a higher

likelihood of hospitalisation for infectious disease in an infant's first year, supporting an association between caregiver racism and health outcomes for their children. A related study using the GUiNZ data explored the association between maternal and partner experiences of racial discrimination (in their lifetime and in the past year) with maternal mental health (Bécares & Atatoa-Carr 2016). The study found that racial discrimination was associated with pre- and post-natal maternal mental health. While outcomes for infants and children were not directly assessed, maternal mental health has been shown to be important for child health.

Analysis of the Youth 2007 Survey found that students who reported experiencing ethnic discrimination (as well as those who were 'unsure') were significantly more likely to also report poorer self-rated health, experience of depressive symptoms in last year, smoking, and hazardous alcohol consumption (Crengle, Robinson, Ameratunga, Clarke & Raphael 2012). Teevale et al (2013) found that over 10% of Pacific students in the Youth 2007 Survey reported that they had experienced ethnically-based unfair treatment by a health professional, compared with about 2% of NZ European students. Racism by a health professional was associated with a 3 times greater likelihood of reporting unmet need for healthcare for students (OR 3.18, 95% CI 2.68 – 3.78), adjusted for age, ethnicity and deprivation (Teevale, Denny, Percival & Fleming 2013).

Finally, as part of this project we examined the relationships between caregiver experiences of racism and measures of healthcare for their children, using the NZHSs child and adult data (Paine, Harris, Stanley & Cormack 2018). We found that caregiver experiences of racism in their lifetime was associated with higher unmet need for healthcare for their child and greater dissatisfaction with healthcare.

CURRENT POLICY AND SERVICE ENVIRONMENT FOR CHILD HEALTH

To date, there has not been a single child health strategy, although there are a number of key policy and strategy documents that are relevant to child health. Child health has been identified as a priority in key Ministry of Health documents. For example, one of the 'strategic priorities' identified by the Ministry of Health for the four years from 2017 is to 'Improve health outcomes for population groups, with a focus on Māori, older people and children' (Ministry of Health 2017: 17). In discussing this, the Ministry of Health (2017: 18) state:

> Children, especially those who are vulnerable or at risk, are the third Government priority. Consistent with the social investment approach, the system is working with the wider social sector to improve outcomes for New Zealand children. The Ministry will continue to support this Government priority. Investing well in children earlier can lower government costs in the future as they have better health and social outcomes. A key aspect of our system is the role of midwives and Well Child / Tamariki Ora nurses in supporting young families to have healthy pregnancies and healthy children in their early years. As we address the growth in demand for services for children aged 0–5 years, a focus will be on having universal services that are strong and include all children in this age group.

The 2017/2018 health targets included two targets with an explicit focus on child health, namely the 'increased immunisation' and the 'raising healthy kids' targets. The immunisation target was to achieve 95% coverage for 8-months-olds having "their primary course of immunisation (6 weeks, 3 months and 5

months immunisation events) on time" (Ministry of Health 2017). The 'raising healthy kids' target specified that "95% of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions by December 2017" (Ministry of Health 2017). The 'better help for smokers to quit' target included a target for offering quit advice and support to "90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer" (Ministry of Health 2017). While the other 6 targets did not necessarily exclude children, they did not include a specific child health focus.

More recently, the Government has announced the intention to increase the focus on child wellbeing, and the Department of Prime Minister and Cabinet (DPMC) is currently developing a child and youth wellbeing strategy, due to be released in 2019 (DPMC 2018). Work is being undertaken in various sectors, including health, to identify and define wellbeing indicators and input into the development of the strategy (Ministry of Health 2018). One of the priority areas of the strategy is that, "children are free from racism, discrimination and stigma" (DPMC 2018).

In terms of the health service context, access to primary care has been expanded in recent years to include under 13-year olds having access to General Practitioner visits at no cost (although costs remain for other primary care services, such as nurses, prescriptions, diagnostic and laboratory tests) (Ministry of Health 2016). Relatively high rates of unmet need for healthcare remain, however, in children and young people in Aotearoa New Zealand (Ministry of Health 2016).

More broadly, recent reports by the Office of the Children's Commissioner have identified the ongoing issue of racism for children and young people in Aotearoa New Zealand (OCC 2018), supporting the need for a focused response to racism as a social determinant.

APPROACH TO THE STRATEGIC REVIEW

The scope of strategic review is informed by our conceptual plan, findings from the secondary data analysis of the 2006/07 and 2011/12 New Zealand Health Surveys (Paine et al 2018), as well as other reviews and frameworks in this area. This section of the report outlines the methods we used to identify relevant studies and literature, as well as the frameworks that we employed to support the discussion of interventions.

The literature search and review methods incorporated two approaches to identifying health sector interventions, a focused review of studies of health system interventions in published literature, and a broader review of anti-racism activities and interventions.

IDENTIFICATION OF STUDIES OF HEALTH SYSTEM INTERVENTIONS

Firstly, a search of the literature to identify interventions was undertaken. The research question guiding the literature search was: What health system interventions exist to address racism as a determinant of child health? Studies were included in the review if they described strategies or interventions to eliminate or reduce racism (i.e. anti-racism or anti-bias) and were undertaken in settings related to the health sector (e.g. hospitals, community health services, educational institutions teaching health related courses, health workforce training). Studies were excluded if they described cultural competency in other non-health settings (e.g. education system).

Search strategy

Databases were searched using a detailed search strategy from the earliest time available to March 2018 for Medline, CINAHL, PsychInfo, and Cochrane Reviews databases, and to November 2018 for Academic Search Complete, and ProQuest. We also searched for relevant studies using Google, Google scholar and relevant websites. Finally, a hand search of reference lists for selected full text articles was undertaken and our study advisors were contacted to identify relevant studies. A copy of a search strategy is provided in Appendix 1.

Titles and abstracts were screened for eligibility based on the inclusion and exclusion criteria. Full text articles were retrieved for all studies where inclusion was in doubt, with discussion between the authors to determine inclusion. Data was extracted from the literature and organised into an Excel spreadsheet, categorising and summarising details about the interventions.

IDENTIFICATION OF HEALTH SYSTEM ACTIVITIES ADDRESSING RACISM

In addition to the identification of published studies, website searches were undertaken to identify activities that may be occurring in the health system to address racism but that were not necessarily written-up in the literature as studies. Google and Google scholar were searched drawing on the search strategy outlined above, with results scanned for alignment with the inclusion criteria. This broader search also considered anti-racism activities or interventions described in grey and unpublished literature.

THEORETICAL AND CONCEPTUAL FRAMEWORKS AND CONCEPTS

To support the discussion of interventions identified in this review and to define key concepts, we drew on key frameworks and documents. Specifically, this included:

- *Racism and health II: a needed research agenda for effective interventions* (Williams & Mohammed 2013);
- *Equity of health care for Māori: a framework* (Ministry of Health 2014)

Racism and health II: a needed research agenda for effective interventions (Williams & Mohammed 2013b)

Williams & Mohammed (2013b) discuss potential areas for intervention to address the health impacts of racism, including interventions that can occur within the health system itself. Within the broader goal of addressing 'cultural racism' (or societal racism), Williams & Mohammed (2013b) note the role of the health workforce and the need to consider anti-discrimination activities and interventions in health workforce hiring practices, training and healthcare environments. Williams & Mohammed (2013b) also note the potential for the health system (and health services) to mitigate the health impacts of racism. For the purposes of this strategic review, this paper informed our consideration of both interventions designed to reduce and eliminate racism, as well as those that might occur within the health sector to minimise the negative health impacts of racism.

Equity of health care for Māori: a framework (Ministry of Health 2014)

The *Equity of health care for Māori* framework provides a useful structure for considering the potential for interventions identified in this strategic review to contribute to achieving health equity for Māori. The framework was used to assess the likelihood of identified interventions to be able to contribute to the reduction or elimination of ethnic health inequity in Aotearoa New Zealand in terms of alignment (or not) with goals and activities of the framework in relation to 'Leadership', 'Knowledge' and 'Commitment'. In addition, the three levels of the framework, namely 'health systems', 'health organisations' and 'health practitioners' were used to categorise interventions in terms of where they were located.

OVERVIEW OF INTERVENTIONS TO ADDRESS RACISM IN THE HEALTH SECTOR

This section provides an overview of interventions that were identified in our review that address racism (or its health impacts) within the health sector. We have categorised interventions according to whether they were in Aotearoa New Zealand or overseas, as well as by the level of the sector they occurred in – that is, at the level of the health system, health organisations, or health practitioners (Ministry of Health 2015). The activities and interventions we discuss in this section may have been identified in either the focused review of published studies, or in the broader review that included websites, reports and other information sources.

HEALTH SECTOR INTERVENTIONS IN AOTEAROA NEW ZEALAND TO ADDRESS RACISM

While there are a number of interventions, programs and policies intended to develop cultural safety or cultural competency in the health sector and contribute to improved Māori health outcomes and reduced ethnic health inequities, there are few interventions that are explicitly framed as anti-racism interventions in the health sector in Aotearoa New Zealand. The interventions and activities discussed below are primarily those that are located within broader projects, rather than specific anti-racism initiatives *per se.*

Initiatives at the level of health practitioners

The majority of activities with a focus on addressing racism in Aotearoa New Zealand appear to be situated within health workforce education and training settings, at the level of health practitioners, and as part of broader interventions, such as cultural competency or cultural safety. These activities have been occurring over a number of years, although the approach and intensity has ranged over time and between health professional groups. In addition, much of the activity that could be broadly understood as anti-racist in intent, impact, or both, is not explicitly named as 'anti-racism', and is therefore difficult to identify in literature searches. Examples of key activities in health professional education and training are included below to illustrate activity that is happening at the level of health providers.

Kawa Whakaruruhau - Cultural safety is an approach introduced into nursing and midwifery education in the 1990s (Papps & Ramsden 1996). Developed by Irihapeti Ramsden, cultural safety was concerned with the importance of health providers being aware of their own culture and beliefs, as well as broader history and power relationships, in interactions with patients and their families (Papps & Ramsden 1996). As part of this, cultural safety was intended to include a focus on racism. As Papps & Ramsden note, "Cultural safety raises the issue of racism. It does address race relations… " (1996: 495). Kawa Whakaruruhau received pushback from within and outside the health sector (Ramsden & Spoonley 1994). While it remains an important approach for considering and addressing racism at the level of health providers, there have also been concerns raised about how well embedded Kawa Whakaruruhau is in nursing and midwifery practice in Aotearoa New Zealand (Cunningham & Finlay 2008).

Teaching about racism and anti-racism in health curricula has also increased in recent years in health provider education and training. In both undergraduate and postgraduate health sciences education, teaching about racism and its impacts on health and on health service provision, has been incorporated into curriculum, often within the context of indigenous health teaching (Pitama, Palmer, Huria, Lacey & Wilkinson 2018). For example, the Te Ara Graduate Learning Outcomes for Hauora Māori for students at

the University of Auckland medical school include that the graduates are expected to be able to "Identify approaches to reducing and eliminating inequalities including actively challenging racism" (Jones et al 2010: 3). The Meihana model (Pitama, Huria and Lacey 2014) has been integrated into medical education at the University of Otago for a number of years (Pitama et al 2017), as part of an Indigenous Health Framework (IHF) (Al-Busaidi, Huria, Pitama & Lacey 2018). The model includes explicit consideration of racism as one of the "historical and current societal influences on Māori as the indigenous peoples of Aotearoa/New Zealand" (Pitama et al 2017: 8), alongside colonisation, marginalisation and migration. Within the Meihana model, Pitama et al (2014) state that consideration of racism "…encourages the health practitioner to explore the patient's experiences of living in a racialised society, including questions around experiences in which they (or their whānau) have been discriminated against because they are Māori" (2014: 112). This aims to support "… health practitioners to tailor their practice to reduce further likelihood of racist experiences in the health system" (Pitama et al 2014: 112).

Targeted admission schemes in health education and training can be understood as an anti-racism initiative in that they aim to address racism in the education system that systematically and disproportionately impacts Māori and Pacific students in terms of their access to health professional education, including medical school. Both medical schools in Aotearoa New Zealand, for example, have targeted policies and programmes to respond to the under-representation of Māori in medical schools and to contribute to a more representative workforce (e.g. Curtis et al 2015; Māori Health Workforce Development Unit 2018).

Aki Hauora is an app designed to help health professionals learn health-related Māori language. In discussing the launch of the app, Associate Professor Suzanne Pitama notes its ability to contribute to reducing racial biases among medical students through encouraging greater competency in te reo Māori (Broughton 2017).

Interventions in health organisations and the health system

The review identified interventions more broadly directed at addressing institutional racism within the health sector as a whole, at the level of the health system or health organisations. This included activities undertaken in the 1980s as part of broader anti-racist social movements. A number of initiatives at this time were led by social workers and those working in social welfare. While these activities, such as the *Puao-Te-Ata-Tu* report, were broader than the health system, activities also occurred within health organisations, such as the Group Against Racist Practices (Sayers 2014: 84-85) established in one hospital. More recently, the Stop Institutional Racism (STIR) network has been established. Originally set up as a 'Special Interest Group on Institutional Racism' through the New Zealand Public Health Association (PHA), STIR "consists of Māori and Tauiwi (non-Māori) practitioners and scholars from across New Zealand, with a core of around a dozen and a network of over 100 associates in an e-network. Members contribute according to their capacity, circumstances and expertise under co-leadership by Heather Came (Tauiwi) and Grant Berghan (Māori)" (Came et al 2017). STIR aims to influence across the health system, and has facilitated a number of hui and workshops, engaged in the policy space (e.g. through policy submissions and commentary), and undertaken activities to monitor the government (Came et al 2017).

HEALTH SECTOR INTERVENTIONS OVERSEAS TO ADDRESS RACISM

This section describes interventions that were identified in the international literature. In line with the limited literature in Aotearoa New Zealand, many of the interventions identified internationally are located within health education and training settings and are focused on health providers as the intervention site (see Appendix 2).

Interventions at the level of health providers only (single-level interventions)

Most studies identified in this review were interventions at the level of individual health providers, commonly within health education and training (see Appendix 2). The majority of interventions were undertaken in the United States (Castillo et al 2007; D'Angelo et al 2013; Garrison et al 2018; Gonzalez et al 2014; Gordon, McCarter & Myers 2016; Nelson, Prasad & Hackman 2015; van Ryn 2015; Webb & Sergison 2003), with interventions also identified in the United Kingdom (Dodd, Hunkins-Hutchinson & Fulford 2011) and Australia (Allen et al 2013; Sjoberg & McDermott 2016). Interventions included activities in medical (Gonzales et al 2014; van Ryn et al 2015), nursing (Allen et al 2013), counselling (Castillo et al 2001), midwifery (Gordon et al 2016) and health professional education (Sjoberg & McDermott 2016), as well as initiatives among those already working as health providers, including mental health workers (Dodd et al 2011), physicians (Garrison et al 2018; Nelson et al 2015), and others working in health (D'Angelo et al 2013; Webb & Sergison 2003).

Interventions included single or one-off activities, modular training or educational initiatives, as well as complete courses. A range of theoretical frameworks underpinned the interventions, including cultural competence, health equity and anti-racism theoretical approaches. Further details of single-level health provider interventions are outlined in Appendix 2.

There were a range of approaches to evaluation of the interventions, from informal to more formal pre- and post-intervention approaches. In general, interventions appeared to have positive impacts, although not all interventions showed an effect or were assessed.

Interventions across health provider, health organisations and health system levels (multi-level interventions)

Most of the educational and training interventions identified and described above were focused only on health providers (e.g. were single level approaches). However, there were several interventions that included activities at the level of both health providers and organisations or systems (Bekart 2000; Boston Public Health Commission 2015; Browne et al 2018; Griffith, Yonas, Mason & Havens 2010; Hagopian et al 2018) (Appendix 2). The majority of these were also in the United States (Boston Public Health Commission 2015; Griffith et al 2018; Hagopian et al 2018), with one in Canada (Browne et al 2018) and one in the United Kingdom (Bekart 2000). Two of these interventions were mainly focused on health provider education and training (Browne et al 2018; Hagopian et al 2018) but also noted that the interventions included activities at organizational levels (e.g. in relation to human resources processes).

Several interventions have been undertaken within health departments. The Boston Public Health Commission's (BPHC) 'Racial Justice and Health Equity Initiative' included setting up an anti-racism advisory committee, preparing a health equity framework, and undertaking staff training and professional development in anti-racism (Bailey et al 2017). The Anti-Racism Advisory Committee was set up in 2008, and "… reviews, assesses, and develops recommendations on internal policies, practices, structures and systems using a racial justice and health equity framework" (BPHC 2015: 5). Organisational activities led

by the Anti-Racism Advisory Committee included leading the revision of the organisation's identity statement, undertaking a survey with staff understanding on "issues related to race and racism" and recommending new or changed policies in human resources and other areas (BPHC 2015: 5-6). In another US-based intervention, the Rural County Public Health Department undertook initiatives that included staff training (a 2-day Dismantling Racism workshop), as well as organisational level change including the development of an action plan to address racism across the organisation. As part of the evaluation, organisational factors were identified and subsequently addressed, such as changes to human resources processes, revisions of complaints processes, and the development of a system to monitor progress (Griffith et al 2010).

The Horton General Hospital undertook an intervention focused on improving care for 'ethnic minorities', that included consideration of institutional racism. A multi-cultural consultation group was formed and a range of activities undertaken, including in relation to staff training, complaints and human resources processes (Bekaert 2000).

Although system-level interventions were rare, some initiatives were identified that aimed to address racism at the level of the health system. This included the 'National Campaign Against Racism', led by Dr Camara Jones in the United States, during her time as President of the American Public Health Association in 2015 – 2016 (Jones 2018). The National Campaign Against Racism focused on three activities for the health system: "1) naming racism; 2) asking "how is racism operating here?" and 3) organizing and strategizing to act" (Jones 2018: 231). Jones (2018) also proposed the establishment of an Anti-Racism Collaborative of eight Collective Action Teams to work within the United States and globally to progress the goals of the Campaign. However, the infrastructure within the APHA was not able to support the Collaborative, although two centers in the United States have engaged with the Anti-Racism Collaborative Framework (the Center for the Study of Racism, Social Justice, and Health at UCLA, and the Social Medicine Consortium) (Jones 2018).

White Coats for Black Lives (WC4BL) is a national organisation in the United States, founded and run by medical students with the vision to "…safeguard the lives and well-being of our patients through the elimination of racism" (WC4BL 2018a). Their mission statement is to "…dismantle racism in medicine and promote the health, well-being, and self-determination of people of color" (WC4BL 2018a). While the organisation is run at the health provider level, it aims to achieve change and address racism across the health system through advocacy, recruitment and retention of Black, Latinx, and Native American medical students and doctors, and interventions and actions in health professional education and training (WC4BL 2018a). A key recent initiative of the White Coats for Black Lives is the development and application of the *Racial Justice Report Card*, with the goals for academic medical institutions to:

1. Articulate a vision of the specific ways in which academic medical centers can promote racial justice
2. Encourage students and health professionals to research and organize around the current policies and practices of their institutions
3. Generate public accountability for academic medical centers to promote racial justice (WC4BL 2018b :3).

The Report Card requires the 'academic medical centers' to score against 13 indicators or criteria. These criteria are:

- URM [Under Represented Minority] representation;
- Anti-racism training
- URM recognition

- URM recruitment
- URM leadership
- Anti-racist curriculum
- Discrimination reporting
- URM grade disparity
- URM support/resources
- Campus policing
- Marginalized patient protection
- Equal access for all patients
- Immigrant patient protection
- Staff compensation & insurance
- Anti-racism IRB policies (WC4BL 2018b: 13)

The Report Card has been piloted with 10 academic medical centers in the United States (WC4BL 2018b), and identifies areas for action in addressing racism within medical schools and the health system more broadly.

The Association for Prevention Teaching and Research (APTR) in the United States has developed an anti-racism policy that calls for all tertiary institutions, especially where involved in teaching about prevention and public health, "… to take action to reduce the impact of racism from within their walls and to assume proactive responsibility for teaching students and the general public about racism's causes and effects" (APTR 2018). The policy outlines expectations for institutions in terms of teaching and leadership, and an anti-racism toolkit is also available to support the anti-racism policy (APTR 2018).

In Australia, the *National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023,* includes a goal that "All health care, whether government, community or private, is free of racism" (Department of Health 2013), noting that the key activities to achieve this are: "implement the *National Anti-Racism Strategy 2010-2020; Significantly improve the cultural and language competency of health services and health care providers; Identify, promote and build on good practice initiatives to prevent and reduce systemic racism"* (Department of Health 2013). The extent to which this has been operationalised in policy, however, is unclear.

DISCUSSION

Although the health impacts of racism are increasingly acknowledged, including by the health sector, our review suggests that research on interventions to directly address the health effects of racism is limited (Williams & Mohammed 2013b), and anti-racism interventions in the health sector are few. The majority of interventions that do address racism identified in this strategic review seem to be at the level of health providers and are focused on increasing knowledge, awareness, or competencies of those working in the health sector, as has been noted by others working in this area (Came et al 2017). Rankine (2014), in talking about anti-racism campaigns, notes that the "majority of anti-racist interventions attempt to change individual or interpersonal racism and cultural norms, and most research focuses on this level (24).

While the health provider workforce is an important site of intervention, it is not clear from the research how effective these types of interventions focused on individual health provider behavior are as anti-racism strategies in the long-term (Williams & Mohammed 2013b). In part, this is because there has been limited evaluation of anti-racism interventions in relation to health (Came et al 2017; Williams & Mohammed 2013b) or more broadly (Rankine 2014). We also found this in our strategic review. In the absence of comprehensive data on the outcomes or effectiveness of particular interventions, it is difficult to assess their likely effectiveness in the Aotearoa New Zealand context. As Williams & Mohammed (2013b) note, research is required to "… address the challenge of the portability of interventions across various social contexts and institutions. More efforts are needed to enhance our knowledge regarding the needed adaptation of evidence-based interventions from one social and cultural context to another" (1218). In Aotearoa New Zealand, this includes consideration of colonisation and particular contexts relating to the Treaty of Waitangi and Indigenous peoples that may not be taken into account in approaches developed in other jurisdictions.

It is important to have interventions that address racism at the levels of health organisations and health systems if change is to be sustainable and long-term. The need for interventions to work across sectors and be multi-level has been acknowledged (Bailey et al 2017; Williams & Mohammed 2013b). However, our strategic review identified that most interventions were at one level, rather than multi-level strategies, and multi-level or system-level interventions were isolated. There needs to be greater emphasis on the development of multi-level anti-racism interventions that work at all levels of the health system.

This review was restricted to anti-racism interventions within the health sector. There may be transferable interventions in other sectors that the health system can learn from. Indeed, effective antiracism strategies in other sectors and society more broadly is likely to have a positive impact on ethnic health inequities. In addition, the relatively limited interventions in the field also create challenges in searching for literature. As noted earlier, much of the activity that could be broadly understood as anti-racist in intent, impact, or both, is not explicitly named as 'anti-racism', and is therefore difficult to identify in literature searches.

Current child health priorities in Aotearoa New Zealand emphasise the need for greater action to achieve equitable healthcare access and experiences, and health outcomes. Although the direct literature is relatively small, it supports the international research that shows that child health is impacted by racism in multiple, intertwined ways. Given its role as a determinant of child health, with impacts on future adult

health, it is important that the health sector takes seriously its role in addressing racism at all levels. The interventions occurring in relation to health practitioner training and education need to be supported and extended, and there is an urgent need for parallel interventions at the level of health organisations and the health system more broadly. This requires strong leadership and commitment from the Ministry of Health, DHBs, PHOs and other key health organisations, including investment in the development and evaluation of anti-racism initiatives in the health sector.

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APPENDICES

APPENDIX 1: EXAMPLE SEARCH STRATEGY

Search terms for search in Academic Search Premier

Racism OR prejudice OR (racial AND (discrimination OR bias OR harass* OR bully*))

AND

Program OR "program evaluation" OR training OR curriculum OR intervention OR anti-racism OR antiracism

AND

"Health service" OR "health sector" OR "health personnel" OR "health care" OR "health policy"

APPENDIX 2: OVERVIEW OF INTERVENTIONS TO ADDRESS RACISM IN THE HEALTH SECTOR INTERNATIONALLY

Intervention/study (e.g. name, location)	Intervention setting and participants	Intervention theoretical approach or framework	Intervention type (e.g. single strategy, multi-strategy)	Intervention overview	Intervention outcomes or evaluation
The Medical Student Cognitive Habits and Growth Evaluation Study (CHANGES); United States; (van Ryn et al 2015)	Medical schools; non-African American medical students	Implicit racial bias and inequities in medical care	Education intervention Study examining predictors of changes in medical student implicit racial bias. Hypothesised that medical school exposure in different domains could predict change in non-African American medical student implicit racial bias towards African Americans. Focussed in three domains: 1. Formal curricula 2. Informal curricula 3. Interracial contact	Formal curricula activities: - Participation in planned educational activities that focussed on quality of care for African American and other minority patients - cultural competence - interpersonal quality of care; Informal (or 'hidden') curricula including role models (i.e. behaviour of Faculty members) and organisational culture and climate Interracial contact included interactions with African American clerical and allied health, medical students and physicians	Not an intervention study per se so no formal evaluation available. Prospective observational study with measures taken during first and fourth year of medical school. Data collected via questionnaires and Black-White Implicit Association Test (IAT). Completing an IAT and student self-efficacy was significantly associated with a decrease in non-African American study implicit racial bias. Medical schools that had a learning orientation to interracial interactions were associated with a decrease in implicit racial bias.

					Negative role modelling associated with an increase in implicit racial bias Highly favourable contact with African American faculty associated with decrease in implicit racial bias. NB: small number of respondents to this item due to limited opportunities as medical schools employ very low numbers of African American faculty and other staff
Implicit bias and its relation to health disparities: A teaching programme and survey of medical students Albert Einstein College of Medicine, Bronx, New York United States (Gonzalez, Kim, & Marantz 2014)	Medical students	Health equity	Education intervention Required medical students to examine own experiences and explore their own biases.	Teaching program designed to address health disparities and physician bias. All content was delivered in a single session, with data collected over 2-year period Learning objectives: 1. describe the existence and impact of health disparities in health care and health outcomes; 2. discuss the impact of a patients age, race, ethnicity, sex, or sexual orientation on his/her medical care and understand the patients perspective;	Limited Evaluation at end of teaching session via self-report questionnaire (~69% response rate) At the end of the session: 22% of students 'denied' that unconscious bias could affect some of their clinical decisions or behaviours 87% of deniers showed a preference for people like themselves on the IAT Deniers more likely to report that the IAT is invalid and that the health system is fair

				3. examine personal attitudes, beliefs and biases regarding patients and health care issues and create a plan for improving your own professional behaviour. Program activities included small group teaching, required readings, student written description of an experience on the wards that may have reflected physician bias or stereotyping, and an IAT. Faculty attended a development session and received a guide in advance of delivery of the program Faculty-led discussions with students covering program content.	and equitable compared with “accepters”. Authors conclude that teaching medical students about their own biases and its role in health inequities is valuable but that it cannot be taught in a single session.
Race equality training and values-based practice Milton Keyes Joint Adult Mental Health Services, United Kingdom (Dodd, Hunkins-Hutchinson & Fulford 2011)	Mental health ward staff	Values Based Practice model to address race equality	Staff training Staff training program aimed to supporting ward staff to discuss issues of race and race equality and to understand different values of people from diverse cultural	Voluntary participation in training program. Project overseen by a Steering Group which consisted of study authors, independent evaluator, a Care Services Improvement Partnership representative, ward	Participant evaluation focussed on staff experiences of the training programmes. Data collected via focus group discussions led by the independent evaluator and a two-day observation period when participants could reflect on

	backgrounds so staff can be more confident and sensitive when making service-user assessments and devising care plans	managers and former member of ward staff. Equality training delivered by a race equality trainer across 1.5 days. Content not provided by the authors. Values Based Practice (VBP) delivered by the Primary Author of the study across 1.5 days. These sessions included discussion of VBP theory and demonstrations of how it can be applied in practice.	what they had learned in the focus groups and the independent evaluator observed how the training programmes and focus groups had changed practice. Staff reported that the theoretical sessions of VBP were difficult to follow and that the race equality sessions were more personally challenging than the VBP sessions. VBP principles provided a structure to the race equality sessions that enabled participants to discuss issues of concern to them. Authors did not provide information regarding how training changed practice. Concluded that talking about race equality is achievable via continual discussion vs a few training sessions and that discussions should be continued despite

					discomfort of the participants. NB: this study was a brief report therefore it is difficult to assess the robustness and/or validity of the findings using the limited information provided.
The influence of multicultural training on perceived multicultural counselling competencies and implicit racial prejudice. Study based in two "predominantly White universities in the southern and western regions of the United States". (Castillo et al 2007)	University; Graduate counselling students	Cultural competence	Staff training This study sought to investigate the effect of multicultural training on counsellors implicit racial bias and multicultural counselling competencies. Research participants included 84 graduate students involved in the 1st year Masters level course. 40 students enrolled in multicultural counselling classes, with 44 students enrolled in counselling foundations class (the 'control' group).	Multicultural counselling classes: 3-hours, once a week for 15 weeks. Objectives: 1. increase self-awareness of culturally-learned assumptions, of racial attitudes towards racial or ethnic minorities and of racial identity 2. develop knowledge and appreciation of African American, Asian American, Latino and Native American cultures 3. develop ability to skilfully match appropriate interventions with clients from culturally different backgrounds. Methods included lectures, videotaped demonstrations,	Multicultural Counselling Inventory (MCI) and IAT delivered pre- and post-course. Overall, enrolment in a multicultural counselling class significantly increased cultural self-awareness and reduced implicit racial bias. Participants in both classes increased their levels of cultural knowledge and skills. NB: based on self-report and maybe influenced by social desirability attitudes. Also, participants were not randomised which impacts validity of the effectiveness of the training.

				required attendance at cultural events, guest speakers. Included "control" classes which were similar in format but differed in terms of the required text book and course objectives. Instructors for multicultural counselling classes were Latina assistant professors with expertise in multicultural counselling. Instructors for control classes were White American professors.	
The deconstruction exercise Flinders University, Australia (Sjoberg & McDermott 2016) Has been incorporated by Te Kupenga Hauora Maori, University of Auckland as part of Maori health curriculum.	Health providers; health professional students Target group are non-indigenous health professionals and health profession students. Sometimes used by and with indigenous students and academics as an anti-racism and decolonial tool with	Decolonisation Anti-racism Indigenous knowledge	Education and training intervention The paper describes an individual level deconstruction exercise as one tool in the indigenous health curriculum. The exercise has dual objectives: as an anti-racism strategy and a criticality-extending exercise.	The deconstruction exercise involves an assessment piece whereby students are required to deconstruct the language from questions about indigenous people. As described by the authors the deconstruction exercise involves a "structured, assessed paper wherein students articulate the sociological space from which the question is asked, rather than *answer the question* itself. In their	Student evaluations. The authors are involved in the development and validation of a tool to assess attitude change among students and faculty following aboriginal health and cultural safety training programme. This has not yet been applied to the intervention.

New Zealand	peers and the academy.			analysis, students are required to identify assumptions, racialised language and/or approaches, and to identify omissions. A successful analysis will identify whiteness, institutional racism and an understanding of the social determinants of Indigenous health" (p30) The exercise is undertaken in a context of wider teaching and facilitation to assist students in engaging with issues of racism, colonisation, history and social determinants of health in critical ways enabling them to understand and uncover the underlying assumptions and stereotypes in the ways in which indigenous people are negatively framed.	
Cross-cultural care and antidiscrimination curriculum; Australia (Allen, Brown, Duff, Nesbitt & Hepner 2013)	Undergraduate nursing students	Social constructivist model of health; transcultural nursing	Education intervention Curriculum intervention developed through literature search and consultation	Includes a combination of lectures, tutorials and labs, with a total of 72 hours across 8 weeks. The course includes components that focus on racism and discrimination.	Pre- and post-assessment done to measure change using the Transcultural Self-Efficacy Tool (TEST) and the Quick Discrimination Index (QDI); There was a significant difference in TEST scores,

					but no significant difference in QDI pre- and post-intervention; Only 22 (of 251) students completed both surveys, so generalisability of findings is limited
"Health Equity Action Training (HEAT)", Hartford Department of Health & Human Services; United States; (D'Angelo et al 2013)	Staff of a health department	Health equity	Staff training intervention Single training across modules; part of a broader Health Equity Alliance project	Mandatory training project designed with partners at the Hispanic Health Council (12 hours, across three modules); Three modules were: 'Social & Health Equity', 'Undoing Racism', and 'Stereotyping & Bias'; Included both 'didactic' and 'experiential' components in the training	Assessed with satisfaction survey (72/85 participants), as well as pre- and post-test assessments with 42 participants Overall, satisfaction with the training was high and training felt to be useful Assessments demonstrated an increase in knowledge about racism and discrimination
"Race Matters: Addressing Racism as a Health Issue" seminar; United States; (Garrison, McKinney-Whitson, Johnston & Munroe 2018)	Physician residents	Racism and health; implicit bias and patient care	Training; Single seminar	One-of 90-minute seminar developed for underserved residency program; Facilitated seminar with discussion and activities	Reports that evaluations of the seminar were positive (No formal pre- and post-testing reported)
Antiracism coursework in midwifery curriculum; United States;	Midwifery students; [Midwifery faculty]	Cultural competence; Antiracism	Education intervention; 12-week course	A 12-week course was developed for midwifery students, based on feedback from students and	Evaluated through anonymous student feedback

(Gordon, McCarter & Myers 2016)				experiences with a 2-day anti-racism workshop); The 'Power and Privilege in Midwifery" course aimed to make antiracism teaching more integrated into the curriculum; Mandatory programme for all students A programme was also developed for faculty, as students identified needs in faculty	Authors report positive feedback from students, although the feedback also indicated that different student groups had different experiences of the course (i.e. White students compared to minoritised students) Feedback also led to the development of a course to address faculty competence in the area
Pilot of physician training module on race and racism; United States; (Nelson, Prasad & Hackman 2015)	Physicians	Race; racism; whiteness	Training intervention; Single training across modules	The intervention involved 6-hours of modules (3 2-hour sessions over 3 months); The modules covered topics of race, racism and whiteness	Participants completed 5-point Likert questions pre- and post-training; 19 participants completed the training; Awareness of racism increased significantly, as did feelings of being able to deliver care; White participants, however, felt less able to deliver equitable care effectively following training, which authors suggest relates to

					them having to reflect on racism and whiteness
Equal Rights Equal Access (EREA) training; United Kingdom; (Webb & Sergison 2003)	Professionals working with children in child health services	Cultural competence; Anti-racism	Staff training; Training course on cultural competence and antiracism	One-day training course, developed by facilitators Six sessions covered, including sessions on racism, stereotyping and discrimination	Evaluated informally with satisfaction questionnaires and formally with two evaluations Authors report training generally well received, with behaviour changes reported
"Anti-racism Public Health Curriculum Competency"; University of Washington; United States; (Hagopian et al 2018)	Public health students Organisational	Anti-racism	Education intervention Multi-strategy; paper focuses on curriculum competency but activities also occurred at organisational levels	A racism competency was developed to apply as a 'schoolwide' competency within the public health curriculum Each degree programme is required to incorporate the anti-racism competency into their course	No formal evaluation Paper outlines the development and processes around the curriculum competency as well as impacts at the organisational level
Equipping Primary Health Care for Equity (EQUIP) intervention; Canada (Browne et al 2018)	Health providers Organisational	Equity	Staff training Intervention designed to build capacity within a health organisation for the staff to provide "equity-oriented care"	Included staff education and training around: Trauma- and Violence- Informed Care; Contextually-Tailored Care; and, Cultural Safety The Cultural Safety dimension included "…understanding the impacts of inequitable power relations, racism, discrimination, colonization, and historical and current inequities on health and	Evaluated with survey of staff, interviews and observations. Staff reported positive changes as a result of the intervention, and in relation to the cultural safety component The study noted that staff changes in relation to

				health care" (2018: 4). The programme included in-person workshops, group discussions and online modules. Activities were also undertaken to promote change at the level of the organisation.	awareness, understanding and competencies around racism were an important outcome of EQUIP.
Racial Justice and Health Equity Initiative; Boston Public Health Commission; United States	Organisational; Health providers	Anti-racism	Multi-strategy intervention at different levels within the Boston Public Health Commission. Described as a, " broad organizational transformation process, which aims to integrate health equity and racial justice principles and practices into all of the health department's work, both internal and external, to measurably reduce inequities in Boston.	Led by an anti-racism advisory committee that "reviews, assesses and develops recommendations on internal policies, practices, structures and systems using a racial justice and health equity framework". Actions include internal policy development (e.g. in employment practices), provision of staff training, language justice, equity goals, quality improvement and performance management system.	Upcoming
Horton General Hospital (UK) Multicultural Consultation Group; United Kingdom	Organisational; Health providers	Health equity	Multi-level strategy aimed at equality of treatment and service for minority groups within a hospital setting	Multi-cultural consultation group Implementation:	Limited evaluation Audit forms filled out by staff, informal visits to wards and random questioning

(Bekaert 2000)			This intervention is more explicitly focussed on improving care for ethnic minorities although measures to address institutional racism are discussed as part of programme and providing services that are not racially discriminatory are included in the justification	-Record keeping and monitoring -Information and communication -Religious and cultural needs -Training -Complaints -Human resources NB: institutional racism explicitly considered in HR including (staff training on cultural diversity, recruitment and selection, equal opportunities, monitoring staff performance)	Problems identified included: Some initial staff objection to 'special provisions' for minority groups. Poor ethnicity data collection. Patient mistrust and uptake of service. Ongoing inappropriate use of families for translation (including children) by staff. Patient privacy in ethnic specific clinics e.g. running into relatives.
Rural County Public Health Department; United States (Griffith, Yonas, Mason & Havens 2010)	Health providers; Organisational	Anti-racism	Dismantling Racism focussed on individual and organisational levels.	Two-day dismantling racism workshop conducted by specialised organisational consultants. Workshop designed to address institutional racism at individual level via - development of a common language and conceptualisation of racism - highlighting the role of institutional gatekeepers	Qualitative evaluation process included staff and board of health members. Identified that policies and practices, decision-making processes and leadership structure were contributing to disparities via institutional racism. Changes since then include - mandatory participation in the Dismantling Racism workshop for all staff

				Practical examples used to help participants refine their understanding between who has power and control over community resources and social/health outcomes of communities of colour Follow-up opportunities include caucusing where people from specific identity groups come together to provide support and address issues particular to their group Organisational "Change Team" coordinates and guides the intervention process within the organisation, develops the organisational vision and goals for dismantling racism and health mode people toward actively supporting the changes required. Change team included reps from each caucus, health department administrators, the consultants and community residents. Change Team designed an action plan to address institutional racism at	- increasing membership on Change Team - changing recruitment and hiring processes - revising staff and client grievance procedures - development of a tool to assess perceptions of institutional racism on an annual basis Creation of data monitoring system to track organisational progress and community health and health care disparities currently underway

				multiple levels within the organisation and also collected and analysed data for the evaluation.	
Southern City's Health Disparities Collaborative (HDC); United States; (Griffith, Yonas, Mason & Havens 2010) – see above	Individual; organisational; system-level	Anti-racism	Structural intervention to identify, illustrate and address institutional racism and other sources of health and health care disparities. Intervention members included community members, medical professionals, academics, and representatives from local community-based organisations.	HDC members participated in 2-day "undoing racism" workshop (similar to the Dismantling Racism workshop). Facilitated small-group story-telling sessions to explore the institutional dynamics perceived to be associated with racial health care disparities in their community. This led to the HDC collaborating, designing and submitting a research proposal which examined the quality of care provided to African American and White women using cancer registry records and patient perspectives. This was funded by National Institutes of Health. Study is ongoing but will form the basis of a system-level intervention that will incorporate the partnerships expertise to promote change	None available

				using the Dismantling Racism approach.	
Localities Embracing and Accepting Diversity (LEAD) program; Victorian Health Promotion Foundation; Australia (Ferdinand et al 2014; Ferdinand et al 2013; Ferdinand et al 2017; VicHealth 2014)	Place-based; local government, educational, employment and retail settings Run in conjunction with the Victorian Health Promotion Foundation, Australia	Building on our Strengths framework – an evidence-informed approach to addressing systemic and interpersonal racism	Multi-strategy intervention designed to reduce race-based discrimination and support cultural diversity. Councils have responsibilities for areas where discrimination may occur and have potential to develop pro-diversity organisational environments. Educational, employment and retail settings chosen as known sites of discrimination and because promotion and prevention interventions are easily introduced.	Governance including LEAD Program Advisory Group & Program Operational Group; Project and Funding partners. Mix of common and locality specific activities, including the following: Community assessment Organisational audit Policy reform Pro-diversity and cultural awareness training Work experience and mentoring Internal organisation communication strategies Awareness-raising activities Connections with media Social marketing campaign (*See Beyond Race*)	Three components involving both quantitative and qualitative methods and program specific tools developed by the project team: 1. Community assessment 2. Process evaluation 3. Impact evaluation Overall, evidence suggests that LEAD had a positive impact on individuals, organisations and communities, including for example: - Increased pro-diversity attitudes in council and workplace settings, although no change in attitudes in educational and retail settings - Greater support for inclusive policies and positive change in attitudes towards cultural diversity - Greater connections between council, local media and communities, including improved

					media coverage of Aboriginal and CALD communities and significant events
National Campaign Against Racism; United States (Jones 2018)	Health system level	Anti-racism	System level campaign	Launched by American Public Health Association President Dr Camara Jones. Campaign had three tasks: "1) naming racism; 2) asking "how is racism operating here?" and 3) organizing and strategizing to act" Proposed a framework for an 'Anti-Racism Collaborative', but was not launched Activities taken up by Center for the Study of Racism, Social Justice, and Health at UCLA, and the Social Medicine Consortium	NA
White Coats for Black Lives (WC4BL); United States (WC4BL 2018a; 2018b)	Health providers; Organisational; Health System	Anti-racism	Campaign at all levels of the health system (physicians, medical schools, health system)	National organisation run by medical students in the United States Promotes and engages in a number of anti-racism activities and initiatives (e.g. protest, advocating for anti-	Activities not formally evaluated A report on the Racial Justice Report Card is available (WC4BL 2018b)

			racism in health care, advocating for recruitment and retention of Black, Latinx and Native American medical students and doctors) Recently piloted a Racial Justice Report Card across 10 'academic medical centers', assessing the centers against 13 criteria