Georgetown Journal on Poverty Law and Policy
Volume XXXII, Number 2, Winter 2025

Transition Design as Health Justice Praxis

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ABSTRACT

The movement for health justice advances a vision of equity that centers the communities most impacted by health disparities. Amplifying marginalized voices through community-led problem solving disrupts the power imbalance of structural subordination, recognizes the limited capacity of legal institutions to secure health equity, and acknowledges the role that communal ties play in sustaining change efforts. Though health justice is well theorized, there is a gap in the scholarship related to its praxis – i.e., the intersection of theory and practice. Because community-led policy and problem-solving is integral to the realization of health justice, identifying practical means for producing such interventions is essential.

This Article advances transition design as a tool for realizing the community-centered problem solving aims of the health justice movement. Transition design is a six-step process for framing, analyzing, and addressing complex social challenges. When used to advance health justice, this process engages participants in "designing the transition" from current structural inequities toward a reality in which socio-economic status poses no barrier to accessing the social determinants of health. This Article argues that using transition design to engage with communities advances health justice praxis. Such praxis includes a structural perspective on the causes of health inequity; a pluriversal perspective on who constitutes "the community"; and a decolonial perspective on community engagement. This Article contributes to the scholarship in both health justice and law & design by demonstrating how transition design can be used to put the ideals of health justice into practice.

* Pierson-Brown's research for this article earned her recognition as a 2023 Health Law Scholar by Saint Louis University and the American Society of Law, Medicine & Ethics. As part of this recognition, Pierson-Brown was invited to workshop a draft of this article with a large group of interdisciplinary scholars. She would particularly like to thank Sidney Watson, and the Saint Louis University School of Law for hosting the Health Scholars' Workshop. Many thanks to Ruqaiijah Yearby, Dr. Fred Rottnek, Ellen Barnidge, Elizabeth Pendo, Kellie Gillespie, Jamille Fields Allsbrook, Dr. Michael Sinha, Rob Gatter, Jesse Goldner, Taleed El-Sabwi, Amy Sanders, Jill Weber Lens, Wendy Netter Epstein, Liz Chiarello, Britney Wilson, Dr. Anjali D. Deshmukh, and Lauren Roth. Finally, the author would like to acknowledge Terry Irwin and Gideon Kossoff of the Carnegie Mellon University Transition Design Institute for their guidance and expertise, and the team at UPMC Children's Hospital of Pittsburgh for their support and partnership on the transition design workshop described in this paper.

INTRODUCTION

"Nothing about us without us" has been a rallying cry within the disability rights community for decades.[1] This statement asserts that public policy and other problem-solving strategies aimed at addressing population-level harms should be created by the individuals who are subject to those harms. Beyond the disability justice movement, this idea can be seen in public health efforts ranging from the inclusion of persons who use illegal drugs in efforts to address the spread of HIV (human immunodeficiency virus) and HCV (hepatitis C), to centering those with dementia in the management of their own care needs.[2] The importance of community

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1. The phrase is the title of James Charlton's 1998 text describing the oppression of persons with disabilities. Charlton writes that he was introduced to this phrase by members of the disability rights movement in South Africa. *See* JAMES I. CHARLTON, NOTHING ABOUT US WITHOUT US: DISABILITY OPPRESSION AND EMPOWERMENT (1998). *See also* Julia Carmel, *'Nothing About Us Without Us': 16 Moments in the Fight for Disability Rights*, N.Y. TIMES, (July 29, 2020), https://www.nytimes.com/2020/07/22/us/ada-disabilities-act-history.html. Before its embrace by disability rights activists, the phrase (in Latin) was used to express a desire for self-governance, making the slogan especially relevant to the matter of community-generated policy. *See, e.g.*, Kazimierz Smogorzewski, *Poland's Foreign Relations*, SLAVONIC & E. EUR. REV., 558, 571 (Apr. 1938) ("...Nihil de nobis sine nobis. Poland will not permit any power or group of powers to interfere in her private affairs, or to pass judgment in respect to her vital interests.").

2. *See e.g.*, RALF JÜRGENS, "NOTHING ABOUT US WITHOUT US" GREATER, MEANINGFUL INVOLVEMENT OF PEOPLE WHO USE ILLEGAL DRUGS: A PUBLIC HEALTH, ETHICAL, AND HUMAN RIGHTS IMPERATIVE (International ed. 2008), https://www.opensocietyfoundations.org/publications/nothing-

participation to movement justice has become a central focus within the body of scholarship that has come to define the health justice movement.

Health justice is a framework that links the concept of equal justice to the work of securing access to the social determinants of health in order to eliminate health inequity.[3] Health justice represents the movement away from the traditional, transactional focus of health law, toward the progressive vision of eradicating health outcome disparities tied to social constructs, such as race, class, and gender.[4] Health justice scholarship emerged ten years ago, with the work of scholars Lindsey Wiley and Emily Benfer.[5] Their examination of health law's potential to advance social justice inspired a proliferation of efforts to bring awareness to the relationships between public policy and health outcomes.[6] According to Benfer, health justice exists when, "all persons have the same chance to be free from hazards that jeopardize health, [to] fully participate in society, and [to] access opportunity."[7] Benfer and Wiley's pioneering formation of the health justice framework presents a three-prong advocacy strategy: recognize the social and structural determinants of health; evaluate health-focused interventions for bias; and center community-led policy and problem-solving.[8] Their work, and the contributions of fellow scholars writing in this tradition, sees these objectives as essential to realizing "a fair and just opportunity" for individuals and populations to be healthy.[9]

Advocates need tools to realize the vision of justice that social movements call for. The tactics that legal advocates, and anyone problem solving from a position of power, use to engage with "the community" will have a significant impact

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about-us-without-us; and CHRISTINE BRYDEN, NOTHING ABOUT US, WITHOUT US! 20 YEARS OF DEMENTIA ADVOCACY (2016).

3. *See The Root Causes of Health Inequity*, in COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY 99, (James N. Weinstein, Amy Geller, Yamrot Negussie, & Alina Baciu, eds., 2017) https://www.ncbi.nlm.nih.gov/books/NBK425845/("*Health inequities* are systematic differences in the opportunities groups have to achieve optimal health, leading to unfair and avoidable differences in health outcomes.")[hereinafter, THE ROOT CAUSES].

4. *See* Angela Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 807 (2020) ("Advocates and scholars steeped in public health and law have begun to use the term health justice to describe advocacy that combines knowledge of the social determinants of health with a commitment to legal principles of equal justice.").

5. Benfer introduced health justice, "as an equity model that is critical to the delivery of health equity and social justice." Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275, n.2 (2015). In her foundational article, Wiley defines the scope of the health justice movement. *See* Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 84-85 (2014).

6. As an example of the continuing impact and evolution of health justice as an area of legal scholarship, *see eg.*, *Health Justice: Engaging Critical Perspectives in Health Law and Policy*, 50 J. OF L. MED. & ETHICS (Winter 2022).

7. Benfer, *supra* note 5, at 278.

8. *See* Benfer, *supra* note 5, at 278; and SOCIAL JUSTICE, *supra* note 5, at 86-87.

9. PAULA BRAVEMAN, ELAINE ARKIN, TRACY ORLEANS, DWAYNE PROCTOR, & ALONZO PLOUGH, WHAT IS HEALTH EQUITY? AND WHAT DIFFERENCE DOES A DEFINITION MAKE? 2 (2017), https://nccdh.ca/images/uploads/comments/RWJ_Foundation_-_What_Is_Health_Equity.pdf [hereinafter WHAT IS HEALTH EQUITY?].

on how representative or empowering those efforts turn out to be. Relevant considerations include: how broadly or narrowly is "community" being defined? How do the pertinent constituent groups determine the scope of the problem? How have they assessed what is and is not working? Whose vision of a preferred future is nurtured and used to guide the problem solving process? What steps are taken to address the unequal distribution of power between those invested in change and those with vested interests in the status quo? And, at what level(s) of scale and in what sequence should grass-roots proposals seek to intervene in complex challenges? As is the case with any good idea, "Tain't what you do, it's the way that you do it".[10] How these questions are answered – the approach to community engagement – forecasts the quality of the outcome.

Praxis is the synthesis of theory and practice.[11] Health justice praxis consists of approaches to community-centered problem solving that are consistent with the theoretical paradigms used by scholars and practitioners working to advance the movement. Articulating this praxis helps advocates distinguish tools which further the objectives of health justice from those that pay only lip service to its goals. Scholarship that identifies practical approaches advocates can use to collaborate with communities while accounting for the complexity of health justice challenges, the layered identities of effected populations, and the insidious nature of social hierarchies is needed. This Article responds to the call for legal advocates, medical providers, public health agencies, and movement organizers to use community-led policy and problem solving practices by offering transition design as a novel approach to meeting this objective.

Transition design was developed for those interested in designing the transition, as it were, from systems of resource depletion to systems of sustainability.[12] "Transition Design assumes that designing must play a central role in the systems-level change

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10. James Young, Sy Oliver & Ella Fitzgerald, *'Tain't What You Do (It's The Way That You Do It)*, DECCA RECORDS (1939), https://web.archive.org/web/20160808044611/http://ellafitzgerald.altervista.org/discog_01.htm.

11. *See* Chandra L. Ford & Collins O. Airhihenbuwa, *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis*, 100 AM. J. OF PUB. HEALTH, S30-S35 (2010) (defining praxis as an, "[i]terative process by which the knowledge gained from theory, research, personal experiences, and practice inform one another.").

12. Transition design has been developed by Carnegie Mellon University Professors Terry Irwin and Gideon Kossoff. *See* TERRY IRWIN, *The Emerging Transition Design Approach*, in DESIGN AS A CATALYST FOR CHANGE - DRS INTERNATIONAL CONFERENCE (C. Storni, K. Leahy, M. McMahon, P. Lloyd, & E. Bohemia, eds., 2018), https://dl.designresearchsociety.org/drs-conference-papers/drs2018/researchpapers/73/[hereinafter, THE EMERGING TRANSITION DESIGN APPROACH]; Terry Irwin, *Transition Design: A Proposal for a New Area of Design Practice, Study, and Research*, 7 DESIGN AND CULTURE: THE JOURNAL OF THE DESIGN STUDIES FORUM, 229-246 (2015). At note 1, Irwin states, "Transition Design draws part of its inspiration from the Transition Town Movement started by activist, author, and environmentalist Rob Hopkins. . .". Irwin further notes that transition design is a concept originally proposed in a 2011 doctoral thesis by Gideon Kossoff, titled "Holism and the Reconstitution of Everyday Life: A Framework for Transition to a Sustainable Society", and that the transition design framework was first introduced by Irwin, Kossoff, and Cameron Tonkinwise, at the AIGA National Conference in Minneapolis, October 2013.

that our societies need to undertake."[13] The field of design, generally, provides an array of human-centered approaches to addressing seemingly intractable challenges, like those at the root of health inequity. Design theory recognizes the scope of the designed product as extending beyond buildings and goods, to include matters of public policy.[14] Legal scholars have used design to address matters ranging from contracts[15] to access-to-justice barriers[16] to institutional antiracism.[17] As one scholar notes, "lawyers have been reaching for design to enhance their practice for at least 20 years."[18] Transition design, in particular, is a six-step process that advocates can engage in tandem with a broad range of community groups to frame, analyze, and address complex social challenges.[19] This design process provides scaffolded support for community-driven efforts to tackle "wicked problems," like inequitable access to the social determinants of health.[20] Use of transition design reflects a praxis of community engagement that aligns with three theories shaping the continuing discourse on health justice: systems thinking, pluriversality, and decoloniality. Such praxis includes a focus on the structural nature of health inequity, a pluriversal understanding of who constitutes "the community"; and a decolonial perspective on community engagement. When used to generate community-led approaches to improving access to health care and the resources needed to be healthy, transition design represents health justice praxis.

This Article proceeds, in Part I, with a discussion of the Health Justice Movement. I identify community-led policy among the three objectives of this push to integrate social justice considerations into health law and policy. As an outcome that represents the movement's ideal, I briefly discuss reasons why community generated problem-solving is essential to the pursuit of health justice. In

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13. Cameron Tonkinwise, *Design for Transitions – from and to what?*, 13 DESIGN PHILOSOPHY PAPERS, 85-92 (2015).

14. *See e.g.* TONY FRY, DESIGN AS POLITICS (2011).

15. *See e.g.*, HELENA HAAPIO & MARGARET HAGAN, *Design Patterns for Contracts*, in PROCEEDINGS OF THE 19TH INTERNATIONAL LEGAL INFORMATICS SYMPOSIUM 381-388 (Erich Schweighofer et al. eds, February 2016).

16. *See e.g.*, Margaret D. Hagan, *A Human-Centered Design Approach to Access to Justice: Generating New Prototypes and Hypotheses for Intervention to Make Courts User-Friendly*, 6 IND. J. L. & SOC. EQUAL. 199 (2018); and THE STANFORD LEGAL DESIGN LAB, https://www.legaltechdesign.com/ (last visited July 31, 2014).

17. *See e.g.*, Danielle M. Conway, *Institutional Antiracism and Critical Pedagogy: A Quantum Leap Forward for Legal Education and the Legal Academy*, 75 ALA. L. REV. 717 (2024).

18. Amanda Perry-Kessaris, *Making the 'Constitutive Idea' Empirically, Conceptually and Normatively Available Through Sociolegal Design*, 5 (July 2023), https://tinyurl.com/2bzdyk6u.

19. Transition design is not the only design approach developed to scaffold community engagement into structural problem-solving and policymaking. *See,* CreaTures Framework, https://creaturesframework.org/(last visited July 31, 2024); *see also* The Nesta Collective Intelligence Design Playbook, https://www.nesta.org.uk/toolkit/collective-intelligence-design-playbook/(last visited July 31, 2024).

20. The term "wicked problems" was coined by two urban planning scholars. It refers to long-standing, systemic challenges involving multiple constituencies with differing priorities, implicating multiple disciplines, and tending to resist solution by adapting to interventions or by evolving in presentation over time. See Horst W. J. Rittel & Melvin M. Webber, *Dilemmas in a General Theory of Planning*, 4 POL'Y SCIS. 155-69, 160-67 (1973).

Part II, I introduce transition design as a tool for realizing this objective. I explain what transition design is and describe each of the six mapping activities that comprise the approach. To illustrate the potential of transition design, I provide examples from a transition design workshop held at the University of Pittsburgh School of Law as part of an interdisciplinary effort to center community voices in the development of policies to support young adults as they age out of the pediatric healthcare system. In Part III, I argue that transition design is suited to advance health justice praxis because it incorporates aspects of systems thinking, pluriversality, and decoloniality. I discuss how these paradigms have added to the scholarly discourse on health justice and highlight how they are incorporated into the transition design approach. This paper concludes with a call for further scholarship that parses the theoretical core of health justice praxis and for further research on the use of transition design to promote community-led problem solving. This paper contributes to both health justice and to law & design scholarship by demonstrating how transition design can be used to put the ideals of health justice into practice.

I. The Movement for Health Justice

The health justice movement emerged from the scholarship, advocacy, and organizing of those who recognize that the pursuit of health equity is a form of social justice. Health equity describes a state in which differences in population-level health outcomes cannot be attributed to social constructs such as race, gender, or class.[21] Health disparities identified within these identity groups are the product of living with the benefits and limitations that attach to these socially-created and reinforced distinctions.[22] For example, in the U.S., the prevalence of asthma among non-Hispanic Black children is higher (14.5%) than among non-Hispanic White children (8.2%) or Mexican American children (7.5%).[23] Asthma mortality rates for Black Americans are twice that of White Americans.[24] Race-based health disparities like these reveal a correlation between social context –

21. *See* What is Health Equity?, *supra* note 9, at 2 ("...health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.").

22. *See* Paula A. Braveman, Shiriki Kumanyika, Jonathan Fielding, Thomas LaVeist, Luisa N. Borrell, Ron Manderscheid, & Adewale Troutman, *Health Disparities and Health Equity: The Issue Is Justice*, 101 Am. J. Pub. Health, S149–S155, S150 (Nov. 28, 2011) https://doi.org/10.2105/AJPH.2010.300062 ("Health disparities are systematic, plausibly avoidable health differences according to race/ethnicity, skin color, religion, or nationality; socioeconomic resources or position (reflected by, e.g., income, wealth, education, or occupation); gender, sexual orientation, gender identity; age, geography, disability, illness, political or other affiliation; or other characteristics associated with discrimination or marginalization. These categories reflect social advantage or disadvantage when they determine an individual's or group's position in a social hierarchy.").

23. *See* Mario F. Perez & Maria Teresa Coutinho, *An Overview of Health Disparities in Asthma*, 94 Yale J. Biol. Med. 497, 497 (2021).

24. *See id.* at 498.

the politics associated with marginalized group identity – and health outcomes.[25] These outcomes are not the result of biological or genetic differences between humans in different racial groups.[26] The logic of correlation between socio-political status and health outcomes suggests that disparities which fall along identity lines are preventable.[27] A society could choose to maintain policies that limit income inequality and level social hierarchy.[28] Adopting this point of view, health justice seeks to eliminate disparity rooted in non-biological factors such as racism, class prejudice, misogyny, homophobia, and xenophobia.[29]

The presence of health justice is evidenced by just policy.[30] Health Justice is a response to observations that, particularly after the passage of the Affordable Care Act, law and public policy should continue to acknowledge health as a collective good that can be realized through collective problem solving.[31] This work is an intentional expansion of the field of health law, to reflect an understanding of law as both: a contributing factor to the presence of construct and context-based health disparities; and a tool for eradicating such inequity.[32] Health justice encompasses means of acknowledging and addressing the complex interconnections between law and public policy, structural discrimination, and health outcomes. As a movement, health justice has been patterned from forerunner social justice programs like those calling for environmental and reproductive justice.[33]

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25. *See* Joia Crear-Perry, Rosaly Correa-de-Araujo, Tameera Lewis Johnson, Monica R. McLemore, Elizabeth Neilson, & Maeve Wallace, Social and Structural Determinants of Health Inequities in Maternal Health, 30 J. OF WOMEN'S HEALTH 230, 231 (February 2021) ("Taking social factors into account is essential to improving both primary and secondary prevention and the treatment of acute and chronic illness because social contexts affect the delivery and outcomes of health care.").

26. *See* Dorothy E. Roberts, *What's Wrong with Race-Based Medicine?*, 12 MINN. J. L. SCI. & TECH. 1, 15 (2011) ("It is implausible that one race of people evolved to have a genetic predisposition to heart failure, hypertension, infant mortality, diabetes, and asthma. There is no evolutionary theory that can explain why African ancestry would be genetically prone to practically every major common illness.").

27. *See* THE ROOT CAUSES, *supra* note 4, at 101 ("...structural inequities give rise to large and preventable differences in health metrics...").

28. For a check on my optimism, *see* Braveman et al., *supra* note 21, at S152 ("Avoidability can be highly subjective. For example, one person may believe that ill health caused by poverty is avoidable; another, however, may believe that both poverty and ill health among the poor are inevitable; hence, these disparities are unavoidable.").

29. *See* Benfer, *supra* note 5, at 278 (discussing that health justice seeks to bring about a reality in which, "...all persons have the same chance to be free from hazards that jeopardize health, fully participate in society, and access opportunity.").

30. *See id.* at 337 ("...health justice requires the development of laws and policies that prevent health inequity and increase individual capability.").

31. *See* Medha D. Makhlouf, *Health Justice for Immigrants*, 4 U. PA. J. L. & PUB. AFFS. 235, 275-76 (2019) (describing, "The passage and subsequent implementation of the ACA signaled a fundamental transformation in health care policy...This shift is one of several that reflect health law and policy's evolution from a field that focuses mainly on relational issues involving patients, physicians, and payers, to one that recognizes collective problems and solutions as critical.").

32. *See* Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833 (2016) (describing the health justice model as an alternative to existing health law model).

33. *See* Wiley, *supra* note 5, at 84-85; Harris & Pamukcu, *supra* note 3, at 808. Harris & Pamukcu identify that movements in this justice tradition share three tenets: "(1) a commitment to acknowledging

In keeping with this lineage, scholars have argued that fair and just opportunities for individuals to be healthy can be realized through the intentional engagement of three interrelated objectives: recognizing the social and structural determinants of health; evaluating health-focused interventions for bias; and community-led policy making. This section discusses each objective.

A. Recognizing the Social and Structural Determinants of Health

The social determinants of health (SDOH) are the non-medical factors that substantively bear on population health outcomes.[34] The U.S. Department of Health and Human Services defines the SDOH as, "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[35] Access to education, housing, environments free from pollution, and quality health care are among the SDOH. In contrast, the, "cultural norms, policies, institutions, and practices that define the distribution (or maldistribution) of SDOH," are recognized as the *structural* determinants of health.[36] To illustrate the distinction, one's neighborhood is considered a SDOH. The racism which ensures that certain neighborhood characteristics (low rates of home ownership, high property taxes, few civic investments in infrastructure, etc.) persist is a structural determinant of health.[37] "In 2022, the federal government explicitly recognized that structural discrimination — macro-level conditions such as residential segregation — limits the conditions and well-being of less privileged groups, which keeps these

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the centrality and complexity of subordination; (2) an understanding of the necessity yet insufficiency of legal advocacy and technical knowledge alone to redress subordination; and (3) a commitment to, through social movement organizing, centering state and market governance around broadly-articulated 'life rights.'" *Id.*

34. *See* Benfer, *supra* note 5, at 279 ("Ultimately, an individual's health is significantly influenced by economic, cultural, societal, environmental, and social conditions.").

35. U.S. DEP'T OF HEALTH AND HUM. SERV., OFF. OF DISEASE PREVENTION AND HEALTH PROMOTION, HEALTHY PEOPLE 2030: SOCIAL DETERMINANTS OF HEALTH, https://health.gov/healthypeople/priority-areas/social-determinants-health (last visited, November 6, 2023).

36. Crear-Perry et al., *supra* note 25, at 231. *See also* WHO, A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 6 (2010), https://www.who.int/publications/i/item/9789241500852 ("Together, context, structural mechanisms and the resultant socioeconomic position of individuals are 'structural determinants'. . ."); Lindsay F. Wiley, Ruqaiijah Yearby, Brietta R. Clark, & Seema Mohapatra, *Introduction: What is Health Justice?*, 50 J. OF L. MED. & ETHICS 636, 638 (Winter 2022) ("Realizing health justice requires addressing the structural determinants of health that are the root cause of health inequities. . .").

37. As a normative feature of life in the United States, racism explains certain differences in neighborhood quality. *See generally* Ruqaiijah Yearby, *Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States Due to Structural Racism*, 77 AM. J. OF ECON. AND SOCIO. 1113 (2018); Nancy Krieger and Mary Bassett, *The Health of Black Folk: Disease, Class and Ideology in Science*, 38 MONTHLY REV. 74 (1986); David R. Williams, Jourdyn A. Lawrence, Brigette A. Davis, & Cecillia Vu, *Understanding How Discrimination Can Affect Health*, 54 HEALTH SERV. RSCH. 1374 (2019); NANCY KRIEGER, *Chapter 3: Discrimination and Health Inequities* in SOC. EPIDEMIOLOGY 63 (2d ed. 2014).

groups from reaching their full health potential."[38] Structural determinants influence the quality of one's social determinants of health.

The pursuit of health justice started with the treatment of law and the legal system as social determinants of health, and evolved toward an understanding that law-related processes and institutions are structural determinants of health.[39] In 2015, Benfer wrote:

> "The legal system exacerbates, and in some cases causes, poor health in many ways, including (1) court systems that inconsistently apply legal standards and mandates or that do not evaluate individual circumstances in applying them, (2) the enactment of laws that perpetuate poor health, and (3) the haphazard enforcement of laws designed to protect or remove barriers to health."[40]

By 2020, Yearby's revised SDOH framework presented law, not as among the SDOH, but as an upstream factor; a conduit through which health-impacting systems produce unjust inequitable outcomes.[41]

Law is understood to be a structural determinant because it impacts how individuals realize the social determinants of health. Consider the example of education as a SDOH.[42] While public education is available to school-aged children in all 50 states, access to this resource is structured such that it is largely funded through property and income taxes.[43] State and local budgets for education

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38. Ruqaiijah Yearby, *The Social Determinants of Health, Health Disparities, and Health Justice*, 50 J. OF L. MED. & ETHICS 641 (2022) (citing Healthy People 2020, The Social Determinants of Health, https://www.healthypeople.gov/2020/topics-objectives/topic/social-deter-minants-of-health (last visited May 3, 2022)).

39. *See* Matthew B. Lawrence, *Against the "Safety Net",* 72 FLA. L. REV. 49, n.47 (2020) (Citing Wiley, *supra* note 32 at 874.) ("In light of that broadening of the vision of the relationship between the individual, community, state, and health, health justice then sees law itself as a determinant of health because of the impact it can have on every aspect of the lived experience.").

40. Benfer, *supra* note 5, at 307.

41. Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to include the Root Cause*, 48 J. OF L. MED. ETHICS 518 (2020). Yearby defines law broadly, to include statutes, political processes, judicial decisions and law enforcement.

42. For further discussions of education as a social determinant of health and an area of focus for health justice, see Thalia González, Alexis Etow, & Cesar De La Vega, *A Health Justice Response to School Discipline and Policing*, 71 AM. U. L. REV. 1927 (2022); and Yael Cannon & Nicole Tuchinda, *Critical Perspectives to Advance Educational Equity and Health Justice*, 50 J. OF L. MED. & ETHICS 776, 778 (2022).

43. *See* Susanna Loeb and Miguel Socias, *Federal Contributions to High-Income School Districts: The Use of Tax Deductions for Funding K-12 Education,* 23 ECON. OF EDUC. REV. 85, 85 (2001) ("Public elementary and secondary education in the United States is funded largely through property and income taxes at the state and local level."). According to the Cornell Law School Legal Information Institute, "Each state is required by its state constitution to provide a school system whereby children may receive an education." Education, https://www.law.cornell.edu/wex/education (last visited Juy 31, 2024). *See also* Alexandra Tilsley, *School Funding: Do Poor Kids Get Their Fair Share?*, URBAN INST. (May 2017), https://apps.urban.org/features/school-funding-do-poor-kids-get-fair-share/("All told, in nearly half of the states, students from low-income families receive less state and local funding, on average, than their nonpoor counterparts.").

spending depend upon the value of property within a school district and the rate at which these assets are taxed.[44] Race is a long-standing factor in the assessment of property value.[45] Such racist devaluation is tied to the reality that public schools serving predominantly non-white residential areas are more likely to be underfunded than public schools in predominantly white residential areas.[46] Stubborn reliance upon a public policy of funding public education through taxes and levies ensures disparities in educational opportunities and outcomes along race and class lines. Students attending underfunded schools disproportionately experience lower levels of academic achievement.[47] This, in turn is linked to lower wage earnings and depressed prospects for class mobility.[48] Public education funding schemes in the U.S. have long been challenged as discriminatory.[49]

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44. *See* Tilsley, *supra* note 43 ("A district with a large population of nonpoor students, for example, will be able to raise more in property taxes because the families paying those taxes have greater property wealth. In high-poverty districts, the opposite is true.").

45. *See* K-SUE PARK, *Race and Property Law* in THE OXFORD HANDBOOK OF RACE AND LAW IN THE UNITED STATES (Devon Carbado, Khiara Bridges & Emily Houh eds., 2021) ("The use of race to create value in property was entrenched by enslavement and colonization, and has continued to shape the regulation of property in powerful ways after the abolition of slavery, the Civil Rights Movement, and to the present day.") Park concludes this chapter by noting, "More than half a century after the formal end of redlining, appraisals consistently find that Black people's homes are less valuable for no other reason than that Black people live in them." See also, Jonathan Rothwell & Andre M. Perry, *How Racial Bias in Appraisals affects the Devaluation of Homes in Majority-Black Neighborhoods*, BROOKINGS (December 5, 2022), https://www.brookings.edu/articles/how-racial-bias-in-appraisals-affects-the-devaluation-of-homes-in-majority-black-neighborhoods/.

46. *See* Preston Green, Bruce D. Baker, & Joseph Oluwole, *School Finance, Race, and Reparations*, 27 WASH & LEE J. CIV. RTS. & SOC. JUST. 483, 491 (2021) ("The most obvious source of race-based, particularly Black-white disparities in school funding are those that result from differences in the taxable property wealth of taxing districts which provide revenue for schools serving Black versus those serving white students.") According to a February 2019 report by the non-profit organization EdBuild on racial disparities in school funding, "predominantly white school districts get $23 billion more than their nonwhite peers, despite serving a similar number of children. White school districts average revenue receipts of almost $14,000 per student, but nonwhite districts receive only $11,682. That's a divide of over $2,200, on average, per student." *See* EdBuild, 23 Billion (February 2019), https://edbuild.org/content/23-billion/full-report.pdf.

47. *See* Cannon & Tuchinda, *supra* note 42, at 782 ("Increased spending on education improves student outcomes, including in test scores, educational attainment, and wages, especially for low-income students.").

48. *See id.* at 777 ("...Americans with college degrees on average earn significantly more per year that those who do not complete high school. The lowest earners are Americans who do not complete high school, more than half of whom are unemployed.").

49. A sampling of state-level challenges to the constitutionality of public education funding schemes illustrates this point. See Serrano v. Priest, 5 Cal.3d 584, 589 (Cal. 1971) ("We are called upon to determine whether the California public school financing system, with its substantial dependence on local property taxes and resultant wide disparities in school revenue, violates the equal protection clause of the Fourteenth Amendment. We have determined that this funding scheme invidiously discriminates against the poor because it makes the quality of a child's education a function of the wealth of his parents and neighbors."); Abbott v. Burke, 575 A.2d 359, 362-63 (1990) ("We are asked in this case to rule that the Public School Education Act of 1975...violates our Constitution's thorough and efficient clause. We find that under the present system the evidence compels but one conclusion: the poorer the district and the greater its need, the less the money available, and the worse the education."); and Campaign for Fiscal Equity v. State, 86 N.Y.2d 307 (COA New York 1995) ("Thirteen years after we

However, in *San Antonio Independent School District v. Rodriguez*, 411 U.S. 1 (1973), the U.S. Supreme Court held that such financing systems do not violate the Fourteenth Amendment's equal protection clause.[50] Subsequent state-level court challenges to public education funding schemes have secured more favorable rulings, but have faced obstacles at the legislative branch.[51] The documented link between low levels of educational attainment and negative health outcomes, like shorter life expectancy, shows how education functions as a SDOH.[52] The use of law to entrench inadequate school funding shows how policy and case law function as structural determinants of health.[53] Naming the social and structural determinants of health contextualizes disparate, identity-based health outcomes.[54] Health justice requires an articulation of the links between social conditions, institutional structures, and health outcomes.[55]

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decided Board of Educ., Levittown Union Free School Dist. v Nyquist. . .we are again faced with a challenge to the constitutionality of New York State's public school financing system.").

50. San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 70-71 (1973) (Marshall, J., dissenting). "The Court today decides, in effect, that a State may constitutionally vary the quality of education which it offers its children in accordance with the amount of taxable wealth located in the school districts within which they reside. . .the majority's holding can only be seen as a retreat from our historic commitment to equality of educational opportunity."

51. *See, e.g.* DeRolph v. State, 78 Ohio St. 3d 193, 197 (Ohio 1997) ("Upon a full consideration of the record and in analyzing the pertinent constitutional provision, we can reach but one conclusion: the current legislation fails to provide for a thorough and efficient system of common schools, in violation of Section 2, Article VI of the Ohio Constitution."); and State ex Rel. State v. Lewis, 789 N.E.2d 195, 197-200 (Ohio 2003) (recounting the series of legislative delays and insufficient actions taken by the Ohio General Assembly in the wake of the DeRolph decision).

52. *See, e.g.*, Viju Raghupathi & Wullianallur Raghupathi, *The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015*, 78 ARCHIVES OF PUB. HEALTH 1-18, 1 (2020). https://doi.org/10.1186/s13690-020-00402-5 ("Even in highly developed countries like the United States, it has been observed that adults with lower educational attainment suffer from poor health when compared to other populations. This pattern is attributed to the large health inequalities brought about by education."); EMILY ZIMMERMAN & STEVEN H. WOOLF, NAT'L ACAD. OF MED. UNDERSTANDING THE RELATIONSHIP BETWEEN EDUCATION AND HEALTH (2014) https://doi.org/10.31478/201406a ("Death rates are declining among the most educated Americans, accompanied by steady or increasing death rates among the least educated. . .Despite decades of research documenting the connections between education and health, there is still much to learn about the mechanisms that enable this connection."). *See also* WHO, EDUCATION: SHARED INTERESTS IN WELL-BEING AND DEVELOPMENT (July 2011), https://www.who.int/publications/i/item/9789241502498.

53. *See* Benfer, *supra* note 5, at 307 ("The legal system exacerbates, and in some cases causes, poor health in many ways, including (1) court systems that inconsistently apply legal standards and mandates or that do not evaluate individual circumstances in applying them, (2) the enactment of laws that perpetuate poor health, and (3) the haphazard enforcement of laws designed to protect or remove barriers to health.").

54. *See* WHO, A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH (July 2010) https://www.who.int/publications/i/item/9789241500852 ("'Context' is broadly defined to include all social and political mechanisms that generate, configure and maintain social hierarchies, including: the labour market; the educational system, political institutions and other cultural and societal values.").

55. *See* Lindsay F. Wiley, *Applying the Health Justice Framework to Diabetes as a Community-Managed Social Phenomenon*, 16 HOUS. J. HEALTH L. & POL'Y 101, 129 (2016) ("I have argued that the nascent health justice framework suggests three commitments for the use of law to reduce health

B. Evaluating Health-Focused Interventions for Bias

Attending to the social and structural determinants of health orients those seeking equity to direct their efforts toward the upstream, root causes of health disparity, and away from responses that blame or pathologize individual or group behavior.[56] With this focus in mind, a second objective toward achieving health justice is to evaluate health-focused interventions for bias.[57] This involves assessing whether the strategy proposed or being used to improve health outcomes reinforces negative normative assumptions about members of a particular group. Evidence of such biases must be called out and corrected.

For example, public health campaigns targeting individual lifestyles (e.g., take 10,000 steps per day,[58] sleep eight hours,[59] eat organic[60]) risk obscuring the reality that, "no matter how empowered, knowledgeable, or willing someone is to change their behavior, they may not be able to do so because of structural determinants of health inequities."[61] These campaigns often assume that everyone has access to the same time, recreational space, money, and groceries necessary to make "healthy" choices. From this distorted view, assumptions of non-compliance, ill-formed values, and fixed "cultural" differences can explain observed behavior more readily than explanations which reflect structural competence.[62] Behavior change requires supports.[63] From a health justice perspective, interventions

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disparities. First, to a broader inquiry that observes access to health care as one among many social determinants of health deserving of public attention and resources.").

56. *Id*. at 106 ("As scientific understanding of the social determinants of health has become more sophisticated. . .many experts have questioned the effectiveness of individualistic strategies that emphasize urging at-risk individuals to change their habits, rather than making changes at the community-level to facilitate healthier lifestyles for everyone.").

57. *See* Wiley, *supra* note 5, at 86-87 ("I argue that three interrelated commitments should shape the health justice approach to using law to reduce health disparities. . .Second, the health justice framework demands that we probe the influence of social bias and structural advantage on interventions aimed at reducing health disparities, particularly those that adopt an individualistic personal responsibility approach."); *see also* Benfer, *supra* note 5, at 343 ("At a minimum, in the quest for health justice, society. . .must. . .commit to. . .(3) ending discrimination and racial bias").

58. *See e.g.*, Catrine Tudor-Locke et al*., How Many Steps/Day are Enough? For Adults*, 8 INT'L. J. BEHA.V NUTR. PHYS. ACT. 1 (2011), https://doi.org/10.1186/1479-5868-8-79.

59. *See e.g.*, Yong Liu, Anne G. Wheaton, Daniel P. Chapman, Timothy J. Cunningham, Hua Lu, & Janet B. Croft, *Prevalence of Healthy Sleep Duration Among Adults — United States*, 65 MORB. MORTAL WKLY REP. 137–141 (Feb. 19, 2016).

60. *See e.g.*, Pamela A. Dyson, S. Beatty, & D. R. Matthews, *A low-carbohydrate diet is more effective in reducing body weight than healthy eating in both diabetic and non-diabetic subjects*, DIABETIC MED. 24.12, 1430-35 (2007).

61. Crear-Perry et al., *supra* note 25, at 231.

62. *See* Jonathan M. Metzl & Helena Hanson, *Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality*, 103 SOC. SCI. & MEDICINE 126-33, 130 (2013) ("We define structural competency as the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health.").

63. *See* Emily Benfer, Seema Mohapatra, Lindsay Wiley, & Ruqaiijah Yearby, *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities*

that are individualistic and behavior-focused are suspect, because they tend to reinforce the discrimination at the root of health inequities.[64] Health justice scholars have identified bureaucratic exclusion, privatization of public goods, and fragmented access to goods and services, as among the barriers individuals face in their efforts to (simply survive, let alone) access the social determinants of health.[65] Evaluating health-focused interventions for bias reflects the need to maintain the focus of reform efforts on policies which aim to restructure systems, rather than on punishing or rewarding the behavior of individuals.[66] Health justice cannot exist for individuals unless it exists for groups.

The Centers for Disease Control and Prevention's (CDC) principles for inclusive communication provide an instance of recent efforts to disrupt bias in health-focused interventions.[67] The CDC defines "inclusive communication" as messaging that describes groups in a manner that is "respectful" and "non-stigmatizing."[68] It suggests acknowledging that "long-standing systemic social and health inequities have put some population groups at increased risk of getting sick," in ways that, "avoid implying that a person, community, or population is responsible for increased risk of adverse outcomes."[69] The CDC's guiding principles reflect an understanding that, "[a]ll people should be able to access and understand health promotion and disease prevention information without stigmatization of themselves or others."[70] These directives illustrate that naming the sources of systemic injustice is precursor to consciously abandoning practices that reinforce group stigma. The health justice movement champions initiatives that identify and root out social bias.

During and After COVID-19, 19 YALE J. HEALTH POL'Y, L. & ETHICS 122, 138 (2020) ("interventions mandating healthy behaviors must be accompanied by supports and protections that address inequities in the intermediary determinants of health."); Benfer, *supra* note 5, at 337 ("health justice requires the development of laws and policies that prevent health inequity and increase individual capability.").

64. Harris & Pamukcu, *supra* note 4, at 762 ("Our health is not just an individual matter; it is deeply influenced by institutional and structural forces that shape who has access to the opportunities and resources needed to thrive.").

65. *See* Aysha Pamukcu & Angela P. Harris, *Using Anti-Racist Policy to Promote the Good Governance of Necessities*, BILL OF HEALTH BLOG (Oct. 20, 2020) https://blog.petrieflom.law.harvard.edu/2020/10/20/anti-racist-policy-health/ (citing K. Sabeel Rahman, *Constructing Citizenship: Exclusion and Inclusion Through the Governance of Basic Necessities*, 118 COLUMBIA L.R. 2447).

66. *See* Crear-Perry et al., *supra* note 25, at 231 (discussing that this objective, ". . .shifts accountability from individuals to systems by acknowledging that the context of people's lives determines their health and that blaming individuals for having poor health or crediting them for good health is therefore inappropriate.).

67. The CDC's web-based resource, Health Equity Guiding Principles for Inclusive Communication, launched in August 2022. https://www.cdc.gov/healthcommunication/Health_Equity.html. *See* Renee M. Calanan et al., *CDC's Guiding Principles to Promote an Equity-Centered Approach to Public Health Communication*, 20 PREVENTING CHRONIC DISEASE (July 6, 2023), https://www.cdc.gov/pcd/issues/2023/23_0061.htm.

68. *Id.*

69. *Id.*

70. *Id.*

C. *Centering Community-Led Policy and Problem Solving*

The third objective of the health justice movement is to center community-led policy and problem solving. The movement is committed, "to collective action grounded in community engagement and participatory parity."[71] Health justice reflects a vision of equity that is realized in partnership with those who are most impacted by the structural discrimination at the root of health disparities.[72] Yearby and other scholars have referred to this movement-organizing prong of health justice as a call to empower low-income communities and communities of color to serve as, "leaders in the development and implementation of laws, policies, or other interventions aimed at protecting or promoting health."[73] Activism consistent with health justice centers the lived experiences and priorities of members of subordinated groups. The community must be engaged in the creation of policy and structural change at every level of scale, from micro to macro.

Community-led policy and problem solving as an objective of the health justice movement is, in part, a recognition that legal advocacy alone is insufficient to the project of ensuring that a fair and just opportunity to be healthy is available to all.[74] Harris and Pamukcu have identified that possibilities for using legislation or the courts to redress the structural discrimination at the root of health disparities are limited.[75] Undoubtedly, the success of conservative politics has "stymied" opportunities for civil rights advocacy though the judicial and legislative branches of U.S. government.[76] Because these institutions were not built with power-sharing or equity in mind, changes to laws, "that structure systems in a discriminatory way. . .must be done in partnership with individuals from less privileged groups to ensure that the laws address their needs."[77] Legal expertise must operate in tandem with tactics

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71. Wiley, *supra* note 5, at 53.

72. Yearby, *supra* note 38, at 642. (Yearby writes that "community-driven structural change" is among the three "guiding principles" of health justice, meant to empower, "less privileged groups to create and implement structural change").

73. Emily Benfer, Seema Mohapatra, Lindsay F. Wiley, & Ruqaiijah Yearby, *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, 19 YALE J. HEALTH POL'Y, L. & ETHICS 122, 138 (2020).

74. *See* Harris & Pamukcu, *supra* note 4 at 808 (discussing that Central to [x] justice movements is a recognition of the, "necessity yet insufficiency of legal advocacy and technical knowledge alone to redress subordination."); and Angela P. Harris, *Anti-Colonial Pedagogies: "[X] Justice" Movements in the United States*, 30 CAN. J. WOMEN & L. 567, 588 (2018) (". . .a third commitment shared by [x] justice movements in the United States and elsewhere is the view that legal tools are necessary, yet ultimately inadequate, to achieve movement goals.").

75. *See, e.g.*, Harris & Pamukcu, *supra* note 4 at 764-65 ("civil rights advocacy has been stymied by resistance to institutional and structural approaches to subordination. The belief that racism, for example, is an individual character flaw or a moral failing rather than a system woven over generations into politics, economics, history, and culture, overshadows civil rights jurisprudence as well as popular conversation").

76. *Id.*

77. Yearby, *supra* note 38, at 647. Decentering the legal expert in favor of centering community also seems to recognize that the next frontier in justice movement activism will not be focused on changing (or change through) legal institutions. See Amna Akbar, *Demands For a Democratic Political Economy*, 134 HARV. L. REV. 90, 97 (2020) ("Organizers are increasingly using the heuristic of non-

developed by those living with and effected by negative health consequences to advance health justice.[78]

Further, health justice activists recognize that community-level investment is needed to support behavior-level change. This line of reasoning is practical; community engagement increases the likelihood of buy-in and the feasibility needed for proposed health-expanding solutions to be sustainable.[79] Individuals are more likely to adopt new habits and practices when the people they are in relationship with or the norms of their environment support their doing so.[80] In response to this understanding, health justice scholars have identified a range of activities from participatory action research,[81] to taking a community-based participatory approach,[82] for use in generating community-level investment.

Finally, the movement insists upon community-centered approaches because they can disrupt the power imbalance caused by the social hierarchy. The ultimate aim of community-led policy making is empowerment.[83] At its best, community engagement is an act of resistance against the structural subordination at the root of the systems that perpetuate health injustice. To have this impact, community-centered engagement must channel the flow of power (decision making authority, self-determination, etc.) toward disenfranchised groups.[84] An anti-subordination approach to community engagement positions marginalized populations to play key leadership roles in crafting the replacement policies and system structures needed to realize full participation in society, and access to opportunity and

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reformist reforms to conjure the possibility of advancing reforms that facilitate transformational change.").

78. *See* Harris & Pamukcu, *supra* note 4, at 811 ("A good example is the California environmental justice movement. Environmental justice advocates have consistently fought to use the law as a tool, but with 'lawyers on tap, not lawyers on top.' This means that lawsuits, for example, should be designed with community engagement in mind. . .This insistence on frontline leadership counters the tendency for lawyers' voices to eclipse the voices of their subordinated clients.").

79. Benfer, *supra* note 5, at 346 ("Communities and individuals experiencing the negative consequences of injustice and health inequity firsthand are best positioned to identify the major challenges to overcoming inequity and to evaluate the viability of proposed solutions.").

80. *See* Harris & Pamukcu, *supra* note 3, at 811-12 ("[R]esearch projects driven from outside the community may overlook 'local knowledge' held by community members or make requests of residents using unfamiliar concepts.").

81. *See* Fran Baum, Colin MacDougall, & Danielle Smith, *Participatory Action Research*, 60 J. EPIDEMIOL CMTY. HEALTH 854 (2006). The authors describe participatory action research as an approach that integrates self-reflective inquiry and data collection.

82. *See* Benfer, *supra* note 5, at 346 ("The community-based participatory approach allows affected individuals to interact with policymakers while identifying issues and developing strategies that address social determinants of poor health.").

83. *See* Lindsay F. Wiley, Ruqaiijah Yearby, Brietta R. Clark, & Seema Mohapatra, *Introduction: What is Health Justice*, 50 J. OF L. MED. & ETHICS 636 (2022) ("As a movement, health justice seeks to recognize and build the power of individuals and communities affected by health inequities to create and sustain conditions that support health and justice.").

84. *See* Allyson E. Gold, Emily A. Benfer, Emily Coffey, Mona Hanna-Attisha, Bruce Lanphear, Helen Y. Li, Ruth Ann Norton, David Rosner & Kate Walz, *Health Justice Strategies to Eradicate Lead Poisoning: An Urgent Call to Safeguard Future Generations*, 19 YALE J. HEALTH POL'Y L. & ETHICS 146, 157 (2020). (Community empowerment must include opportunities to increase groups', "historic lack of bargaining power and become agents of change.").

resources.[85] A model in which community representatives take the lead redirects power from subject matter experts to those with the expertise of lived experience. Community empowerment, "can address the limitations of public health and legal advocacy, and also provide a check on elite abuses of power."[86] In carrying out this objective, heath justice advocates with access to institutional power must acknowledge that our involvement with communities and local organizers can actually work against this ideal of channeling power to the disempowered.[87] As Wiley notes, the movement's, "insistence on participatory engagement has. . . prompted fruitful examination of the tension between pursuing particular legal reforms that experts believe would best serve the interests of the poor and socially disenfranchised and the autonomy of those groups to choose other approaches that might be disfavored by experts."[88]

Achieving a reality in which everyone has fair and just access to the resources needed to be healthy will require a range of tools for centering those who are most affected by structural subordination and invested in sustainable systemic change. Transition design offers meaningful possibilities for realizing this objective of the health justice movement.

II. The Transition Design Approach

Transition design was developed to provide a means of addressing wicked social problems.[89] The approach, "aspires to transcend traditional one-solution-for-a-single-problem approaches that are inadequate in dealing with complex, systemic problems."[90] Health justice, like environmental justice, reproductive justice, and other social justice struggles, takes on systemic challenges involving competing interests, multidisciplinary issues, and problem terrains that are in constant flux. Whether the rights implicated in social justice issues will evolve in ways that serve or subvert humanity, is a question that legal and other scholars are increasingly responding to through approaches that come from the field of design.[91] Transition design is one such approach.

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85. Harris & Pamukcu, *supra* note 4, at 805. ("[A] health justice model brings frontline communities and their representatives into the partnership as leaders.").

86. *Id.*

87. *See* Amna A. Akbar, *Non-Reformist Reforms and Struggles over Life, Death and Democracy*, 132 Yale L.J. 2497, 2508 (2023) ("Law and lawyers have a place in social-change work, but to assert the roles as primary is to capitulate to a conception of power that is top-down and centralized rather than everywhere and relational.").

88. Wiley, *supra* note 5, at 101.

89. *See* Gideon Kossoff & Terry Irwin, *Teaching and Researching Transition Design*, 157 Cuadernos del Centro de Estudios de Diseño y Communicación 217, 218 (2022) ("Transition design is a transdisciplinary approach aimed at addressing the many 'wicked' problems confronting 21st century societies: climate change, forced migration, political and social polarization, global pandemics, lack of access to affordable housing/healthcare/education and countless others.").

90. Gideon Kossoff & Terry Irwin, *Transition Design as a Strategy for Addressing Urban Wicked Problems*, in Cities Without Capitalism 97 (Hossein Sadri, & Senem Zeybekoglu eds., 2022).

91. *See e.g.*, Hagan, *supra* note 16; Perry-Kessaris, *supra* note 18, at 2 ("[W]e must understand both law and design as forms of social relations, as playing a role in social relations, and as having a role to play in working for certain forms of social relations.") (emphasis omitted).

Transition, in this context, refers to the progression from one set of circumstances to another. The term speaks to the changes that occur, for instance, when populations adopt new technologies, as place demographics shift, or as "new normals" get established. The goals of justice movements can be understood as specific visions of transition – from systems that produce inequity by default, toward systemic equity by design. In the case of health justice, the goal is to catalyze the transition toward a world in which identity markers are no longer predictive of health outcomes. Approaching social change from a design perspective situates transition as a process that can be intentional, stewarded, and collectively constructed.

The "wicked problem" frame spotlights the need for non-linear strategies that respond to and account for the many layers of causality and connectivity that contribute to seemingly intractable challenges. Social justice movements are organized around wicked problems.[92] The challenge of addressing the impact of structural discrimination on access to the social determinants of health (SDOH) can be considered a wicked problem.[93] As discussed in Part I, structural discrimination occurs when institutions affirmatively or passively impose subordinating consequences on members of particular social groups.[94] Structural discrimination adversely affects access to SDOH at multiple levels of scale, from the local (the Flint, MI water crisis)[95] to the global (minoritized populations' disproportionate exposure to the effects of climate change).[96] The challenges produced by the impact of structural discrimination on one's ability to access the resources needed to be healthy are multiple and long-standing. Disparate access to food, clean drinking water, and health care continue to manifest notwithstanding efforts to address these needs head on, or to challenge the subordinating social hierarchies at the root of these disparities. Collective responses to these concerns, ranging from reform to disregard, reflect the multiple prerogatives of those with a stake in these social ills. No one discipline, interest group, or area of expertise alone, can comprehensively manage the consequences of structural discrimination on health.

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92. Sandra Waddock, Greta M. Meszoely, Steve Waddell, & Domenico Dentoni, *The Complexity of Wicked Problems in Large Scale Change*, 28 JOURNAL OF ORG. CHANGE MGMT. 993, 1004 (2015) ("Social problems are, mostly, by nature wicked.").

93. For a visual representation of the problem web created by the interconnectedness of structural discrimination, law, and the social determinants of health, see Ruqaiijah Yearby, *Structural Racism: The Root Cause of the Social Determinants of Health*, BILL OF HEALTH BLOG (Sept. 22, 2020) https://blog.petrieflom.law.harvard.edu/2020/09/22/structural-racism-social-determinant-of-health/.

94. *See* Nancy Krieger, *Discrimination and Health Inequities*, 44 INT'L. J. OF HEALTH SERV. 643, 644 (2014) ("[S[tructural discrimination, referring to discrimination enacted by institutions (e.g., laws or rules that impose adverse discrimination, by design, such as legalized racial discrimination, or in effect, such as the racialized impact of the New York Police Department's 'stop-and-frisk' policy).").

95. *See* Joe Brown et al., *The effects of racism, social exclusion, and discrimination on achieving universal safe water and sanitation in high-income countries*, 11 THE LANCET GLOB. HEALTH E606 (2023).

96. *See* Thilagawathi Abi Deivanayagam et al., *Climate Change, Health, and Discrimination: Action Towards Racial Justice*, 410 THE LANCET 1, 1 (2022) ("Together, racism and climate change interact and have disproportionate effects on the lives of minoritized people within countries and between the Global North and the Global South.").

Further, law is implicated in nearly every wicked problem. Case law, public policy, and legislative inertia contribute to the wicked nature of structural discrimination, and the inequitable access to the SDOH that results.[97] That civil rights and other reform efforts have, perhaps, altered – but not materially decoupled – the connection between structural discrimination and the SDOH, is evidence of the adaptive resilience of this relationship.[98] Health inequity fits the definition of the kind of wicked problem transition design was developed to address.

Identifying matters of structural injustice as "wicked" signals a belief that linear problem-solving methods will not produce just outcomes.[99] Transition design speaks to this perspective by offering an iterative problem solving approach that frames systemic challenges in ways that put their full complexity on display. Rather than attempt to simplify or essentialize a wicked problem, transition design consists of exercises that document the many ways a single issue presents within a variety of domains (legal, environmental, economic) across multiple levels of scale (household, community, state) over time (past, present, future).[100] This array of activities is intentionally responsive to the dynamic characteristics of wicked problems. Recognizing that, "there is no 'root cause' of complexity, diversity, uncertainty, and ambiguity—hence, there is no root cause of 'wickedness,'" the transition design approach scaffolds several forms of problem framing.[101] This holistic framework allows a challenging issue to be evaluated from multiple perspectives, giving those invested in stewarding the transition toward more desirable, sustainable outcomes a broad palette from which to "design" interventions.

This section discusses the activities which comprise the transition design approach. Participants in this multi-step design practice work in peer groups to: (1) define the scope of a complex challenge; (2) evaluate the relationships between constituencies with differing interests in how the challenge is resolved; (3) understand how the problem has evolved over time, (4) envision a future in which the problem is resolved; (5) determine what tools are needed or are presently available to usher in desired changes; and (6) develop a series of policy

97. *See* Benfer, *supra* note 5, at 306. Benfer writes of the SDOH, "Each of these has a nexus with the legal system, which is implicated in nearly every aspect of life."

98. *See* Harris and Pamuku, *supra* note 3, at 764-65, noting that "[C]ivil rights advocacy has been stymied by resistance to institutional and structural approaches to subordination."

99. *See* TERRY IRWIN, *Wicked Problems and the Relationship Triad*, in GROW SMALL, THINK BEAUTIFUL: IDEAS FOR A SUSTAINABLE WORLD FROM SCHUMACHER COLLEGE 3 (2012) ("Rittel's theory distinguishes between 'tame' and 'wicked' problems and he was one of the first design theorists to maintain that traditional linear, cause and effect design processes were inadequate for solving complex wicked problems."); *See also* Rittel and Webber, *supra* note 18, at 155-69 (arguing that wicked problems characteristically resist "reductionist" problem solving approaches).

100. *See* KOSSOFF & IRWIN, *supra* note 89, at 218 ("The applied approach argues that wicked problems can only be resolved by framing them within radically large problem contexts that include the past, present, and future.").

101. *See* Brian W. Head & John Alford, *Wicked Problems: Implications for Public Policy and Management*, 47 ADMIN. & SOC'Y 711, 715 (2015). The authors do not critique transition design specifically, however they caution that, "any proposed methods or approaches for addressing wicked problems. . .are likely to be provisional and incomplete in various degrees."

interventions that target the systemic problem at issue across different sectors and at different levels of scale. After a description of each step, I offer an illustration of how the approach was adapted for use in a 2023 transition design workshop convened by an interdisciplinary group of researchers from the University of Pittsburgh Schools of Law, Medicine, and Social Work.[102] This research team used transition design to identify a community-centered, health justice approach to addressing the health risks that arise as adolescent patients exit pediatric care.[103] This day-long workshop was held at the University of Pittsburgh School of Law (Pitt Law), and convened young adults, community service providers, health care providers, and young adult caregivers from the greater Pittsburgh, PA area.[104] This section concludes by discussing the benefits and the potential limitations of using this process to generate community-led policy. Transition design offers a novel approach centering the knowledge, aspirations, and priorities of those who are affected by, yet frequently left out of, institutional problem-solving and policymaking. Transition design can be used to meet the community generated policy objective of the health justice movement.

A. Mapping the Problem

Transition design facilitates problem solving efforts that are responsive to the persistent, complex, and adaptive nature of systemic challenges through the use of mapping activities. Mapping, or creating visual diagrams, is a process of

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102. In alphabetical order, the members of the research team are Juliet T. Jarrell, University of Pittsburgh School of Medicine; Traci M. Kazmerski, University of Pittsburgh School of Medicine; Loreta Matheo, University of Pittsburgh School of Medicine; Andrew McCormick, University of Pittsburgh School of Medicine; Marlo Perry, University of Pittsburgh School of Social Work; Tomar Pierson-Brown (this author), University of Pittsburgh School of Law; Jacqueline Rankine, University of Pittsburgh School of Medicine; and Olivia M. Stransky, Center for Innovative Research on Gender Health Equity (CONVERGE). Research assistance was provided by Jake Frazier, University of Pittsburgh School of Law. Terry Irwin and Gideon Kossoff, Carnegie Mellon University, consulted on this project.

103. Ensuring that young adults experience continuous access to health care as they "age out" of pediatric care has been an issue of health policy importance for over a decade. *See* Patience H. White & W. Carl Cooley, *Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home*, 142 PEDIATRICS 1-23, 8 (2018) ("In 2014, the US Maternal and Child Health Bureau articulated health care transition as 1 of its top 15 national priorities for state Title V programs."); American Academy of Pediatrics, American Academy of Family Physicians, & American College of Physicians-American Society of Internal Medicine, *A consensus statement on health care transitions for young adults with special health care needs*, 110 PEDIATRICS 1304 (2002); Jenna Sandler Eilenberg et al., *Disparities Based on Race, Ethnicity, and Socioeconomic Status Over the Transition to Adulthood Among Adolescents and Young Adults on the Autism Spectrum: A Systematic Review*, 21 CURRENT PSYCHIATRY REPS. 1–16 (2019).

104. This workshop would not have been possible without the generous funding this author and her colleagues in research received through a 2022 University of Pittsburgh Momentum Teaming Grant. Because this project involved human subjects, this author and her colleagues received ethical approval through the University of Pittsburgh IRB (STUDY22080028) in advance. For more on the research goals and methods associated with this workshop, see J. T Jarrell et al., *Using a Transition Design Approach to Explore the Adolescent Shift to Adulthood*, 23 INT'L J. OF QUALITATIVE METHODS 1-12 (2024).

contextualizing and organizing information.[105] It is principally an act of meaning making: "Visual rhetoric—whether expressed in textual metaphors and/or diagrams—has constitutive effects."[106] Mapping is considered useful to the project of addressing complex problems for several reasons. First, mapping activities help people to (literally and figuratively) connect the dots; to make connections between observations that lead to a fuller, more nuanced understanding of why a problem seems intractable. Second, diagrams can facilitate a shared understanding of what makes an issue complex and hard to resolve. Creating a visual representation of a complicated issue can help groups "see" a problem as a big picture matter that consists of several identified sub-issues. Third, visually framing different facets of a complex challenge positions those invested in change to come to shared understandings of both the long and short-term arc of how a problem manifests. Fourth, maps are not value neutral creations.[107] Maps are documents that communicate what a particular set of problem solvers see as falling within or outside of an issue. This could be considered by some to be a limitation on the value of creating and using diagrams to capture and convey an idea. Yet, prerogative has value. The underlying norms and assumptions that lie at the root of collective understandings can be instructive and are not always easy to put into words. Maps created as a part of a transition design process can be considered artifacts: evidence of the scope of the participants' understanding of the reach and genesis of a pressing problem; as well as data: content that can be used to inform potential solutions and track understandings over time.[108] Lastly, mapping supports the creativity and collaborative, critical brainstorming needed to eventually develop strategic, system-level interventions.

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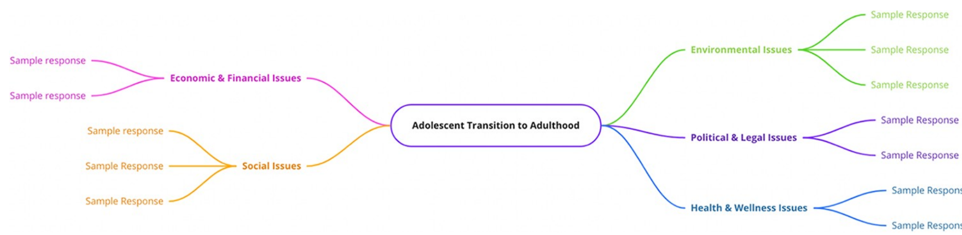
105. *See* PATRICK REINSBOROUGH & DOYLE CANNING, RE:IMAGINING CHANGE: HOW TO USE STORY-BASED STRATEGY TO WIN CAMPAIGNS, BUILD MOVEMENTS AND CHANGE THE WORLD 28 (2010) ("A map is a representational tool. . . an expression of the deeper shared mental maps a culture provides to make sense of the world.").

106. Perry-Kessaris, *supra* note 14, at 7.

107. *See* Perry-Kessaris, supra note 14, at 9 ("On the one hand, visual communications can make abstract ideas available to be understood, to be critiqued. On the other hand, they are not neutral. They are constitutive, and they can confuse as much as clarify.").

108. *See* Peter Scupelli, *Designed transitions and what kind of design is transition design?*, 13 DES. PHIL. PAPERS 75, 82 (2015) ("The challenge for Transition Design is to define enough to inform people about the goal, provide enough scaffolding to support the complexity at hand, but not overprescribe the path to get there, leaving enough ambiguity to encourage creative reinterpretation, thinking, and design.").

FIGURE 1: Template Used in the Pitt Law Workshop to Map the Problems Associated with the Adolescent Transition to Adulthood[109]



Transition design is meant to be a non-linear process; however, it typically begins by inviting participants to map the wicked problem at issue. Mapping wicked problems is an activity that captures participants' description of how a named problem manifests within different domains, such as economic, social, and environmental concerns. As the template shown in Figure 1 suggests, the wicked problem is written at the center of a piece of paper, on a white board, or whatever medium is being used to create the map. That issue is then presented as connected to each of five issue categories. Participants, next, discuss the issues related to the wicked problem. As issues are identified, they are listed under the relevant category. Participants complete this activity by contributing information from their own understandings as well as from any research or other formal inquiry they may have done.[110] Once participants have categorized the issues and sub-issues related to the wicked problem, they then identify as many relationships (interdependencies and interconnections) between the issues as possible. This task can be supported through the use of prompts, such as: *Does this issue cause or lead to another issue in this or other domains?* These connections are depicted in Figure 2 through the dotted lines. The text added to the dotted lines describes the connection between adjoining issues. The idea is to try to account for as much complexity as you can rather than attempt to simplify a complex situation. The process introduces an element of "play" and co-discovery as participants work to create a shared understanding of a complicated problem.[111] Reaching a shared understanding among participants is important. It is perhaps impossible to address a problem if there is no agreement as to what the scope of the problem is.

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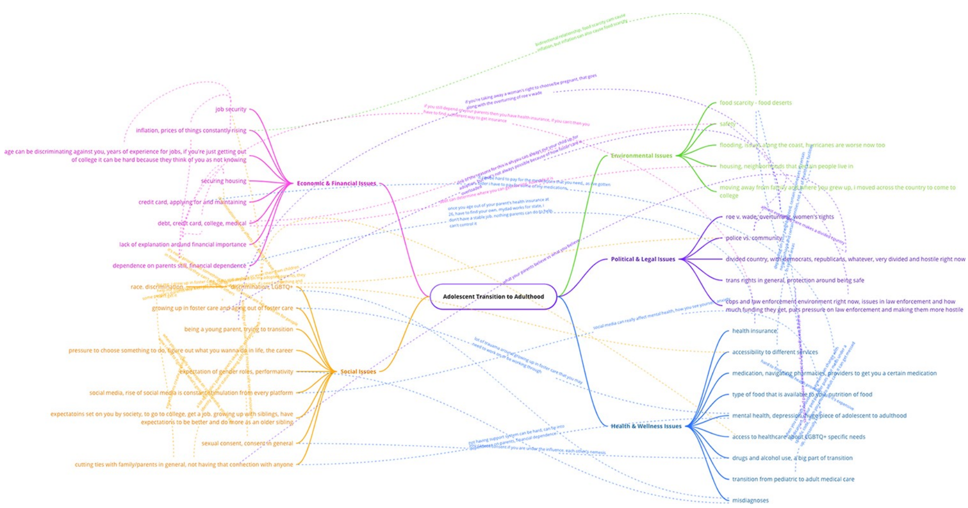
109. My template draws directly upon the template map Irwin created for this exercise. For examples of her templates, see #1: Mapping Wicked Problems, available at https://transitiondesignseminarcmu.net/assignments/#1483987943689-016372b2-8b49. My template was created using Miro, available at: https://miro.com/. The mapping activities that comprise the transition design approach can be completed by using one of Irwin and Kossoff's template maps or iterated upon by using whatever visual brainstorming materials happen to be available.

110. *See* Kossoff & Irwin, *supra* note 89, at 221("In educational workshops, participants must conduct internet research to try and understand these multiple issues and divergent perspectives (prior to the workshop). In research workshops, actual stakeholders participate to contribute their perspectives and knowledge.").

111. *See* THE EMERGING TRANSITION DESIGN APPROACH, *supra* note 15, at 7–8.

Understanding how a specific problem arises from and is connected to other issues is key to holistic problem assessment. Mapping a wicked problem puts it into context – it literally centers the problem as emerging from a series of other contributing circumstances. While a completed map can look messy and chaotic, its intricacy reflects the number of problem elements that are top of mind for participants, the extent to which those issues are considered related to other challenges, and (where relationships are drawn) the perceived nature of those connections.[112] This context is instructive: how a problem is seen influences how it will be solved.[113] A problem that is seen as having primarily economic, social, and health care implications will need interventions in each of those sectors. Mapping a wicked problem prepares participants to identify "zones of opportunity" where interventions could potentially solve for multiple issues at once.

FIGURE 2: A Completed Problem Map From the Pitt Law Transition Design Workshop[114]



Mapping wicked problems, like each of the activities used in transition design, is meant to be carried out by individuals with different interests in how an identified problem is addressed. In the Pitt Law workshop, participants were sorted into small groups according to whether they identified as a young adult, a community service provider, a health care provider, or a young adult

112. Some scholars point out that, "the construction of a single agreed-upon model of the whole situation is often not possible." *See* ADAM KAHANE, COLLABORATING WITH THE ENEMY 34 (Berrett-Koehler Publishers, 2017). The goal of mapping a wicked problem is not to achieve a single, exhaustive model, but to capture the scope of an issue to the best of the participants' perception.

113. THE EMERGING TRANSITION DESIGN APPROACH, *supra* note 15, at 6 ("How problems are framed determines how they will be understood and acted upon.").

114. Workshop participants completed their maps using Miro, available at: https://miro.com/.

caregiver.[115] Participants worked in their identity/interest group to complete the wicked problem mapping activity, as well as the subsequent maps called for in transition design. The health care professionals made their maps in one group, while the young adults worked on theirs in another, and so forth. At the end of each exercise, four maps had been completed, reflecting the collective knowledge and prerogatives of each group. Because multiple perspectives are needed to substantively frame and generate strategies for addressing wicked problems, transition design emphasizes, "The need for the stakeholders connected to and affected by the problem(s) to be involved throughout the problem framing, visioning, and solutioning process."[116] This process situates those with, perhaps, only the expertise of their lived experience in peer relationship with those who hold expertise through professional status. Transition design is adapted to advance health justice when the maps created by the most marginalized participant group are used as the focal point for issue analysis. Wicked problem mapping to contextualize the structural components of complex social issues is one feature of Transition Design. Problem framing that accounts for the differing power positions and perspectives of multiple interest groups is a further characteristic of this unique approach.

B. Mapping Constituent Relations

The second activity in transition design is mapping constituent relations.[117] Constituents are members of groups affected by the topic of a transition design process. Constituent groups can share a common problem or aspiration, while

115. There were seven participants in the young adult group. Four identified as persons of color, three identified as white. Two identified as male, 5 identified as female. There were four participants in the community service providers' group. They were all female. One identified as a person of color, three identified as white. There were eight participants in the health care professionals' group. There was one male and seven females. All participants in this group identified as white. There were five participants in the young adult caregivers' group. All were female. Three identified as white. Two did not provide their racial identity. Several participants held identities of multiple groups (i.e., a healthcare provider who was also the parent of a young adult); participants selected the group with which they most clearly identified for the workshop.

116. The Transition Design Seminar, Course Introduction, https://transitiondesignseminarcmu.net/classes-2/introduction/(last visited July 31, 2024). *See also*, The Emerging Transition Design Approach, *supra* note 15, at 3 ("We use the term "stakeholder" to refer to anyone who has a stake or interest in a specific issue or is affected by a particular problem."). Increasingly, this term has become the subject of critique. *See* Joshua M. Sharfstein, *Banishing "Stakeholders"*, 94 The Milbank Q. 476 (2016) (arguing that the word "stakeholder" has no communicative value because the term can have (and cloud) so many meanings). Some call for the term to be retired, given its relationship to colonialism. *See* Switching from Stakeholder, https://researchimpact.ca/featured/switching-from-stakeholder/(last visited, Jan. 15, 2024); 9 Terms to Avoid in Communications with Indigenous Peoples, https://www.ictinc.ca/blog/9-terms-to-avoid-in-communications-with-indigenous-peoples (May 11, 2018) (last visited, Jan. 15, 2024). Out of respect for this perspective, I describe this step of the transition design approach using the synonym "constituent."

117. *See* CMU Transition Design Seminar 2024, Mapping Stakeholder Relations + Assignment #2, https://transitiondesignseminarcmu.net/classes-2/mapping-stakeholder-relations/ (last visited July 31, 2024).

none the less having different interests in the outcome[118]. This exercise can aid in uncovering those relationships between groups which can be leveraged to create interventions or to coalesce the power needed to override competing interests. While "relations of conflict and opposition always require the greatest investment of time and energy to resolve. . . relations of affinity, agreement, and alignment (that are always present) often go unseen and unacknowledged."[119] Not only does this activity seek to reveal such possibilities for coalition, mapping constituent relations expands the problem frame from the issues involved to the prerogatives of those effected by those issues.

The transition design approach to mapping relationships involves identifying and considering all groups affected by the problem at issue.[120] The intention is to bring as many perspectives into the problem frame as possible, address uneven power relations among groups, and to identify their beliefs, assumptions, and cultural norms.[121] Students of transition design are taught to complete this activity by first, identifying as many of the constituent groups impacted by the wicked problem as possible. From this list, students select the three groups which may be most apt to disagree or have conflicting needs/opinions about the problem. Then students are asked to list each group's hopes and fears about the problem. Finally, students are asked map the lines of agreement/affinity and conflict/opposition between the three groups.[122]

The Pitt Law transition design workshop iterated on this process. Rather than consider all groups affected by the adolescent transition to adulthood, the workshop focused only on the perspectives and interests of the four participant groups. Participants listed their own hopes and desires in one column, and their personal fears and concerns in another. Then, participants were asked to hypothesize the hopes and fears relative to adolescent transition to adulthood for each of the other three groups. Ultimately, participants made connections between their stated prerogatives and the perceived aspirations and anxieties of the other groups. This task was encouraged by giving workshop participants prompts such as, *Is your viewpoint aligned with, in agreement with, similar to, or in common with other viewpoints?* and *Is your viewpoint in opposition with or challenging to other viewpoints?* Aligned viewpoints were drawn using the same color (green) to distinguish them from conflicting viewpoints (drawn in red). As a further iteration on the transition design approach, participants were asked to indicate which group they believed was most empowered to address the challenges related to reaching

118. *See* KOSSOFF & IRWIN, *supra* note 90 ("Stakeholder groups often have conflicting definitions of the problem as well as ideas about how to solve it. . . due to differences in socio-economic-political status (uneven power dynamics and access to resources) as well as differing beliefs, values, assumptions, expectations and needs.").

119. MAPPING STAKEHOLDER RELATIONS + ASSIGNMENT #2, https://transitiondesignseminarcmu.net/classes-2/mapping-stakeholder-relations/ (last visited July 31, 2024).

120. *Id.*

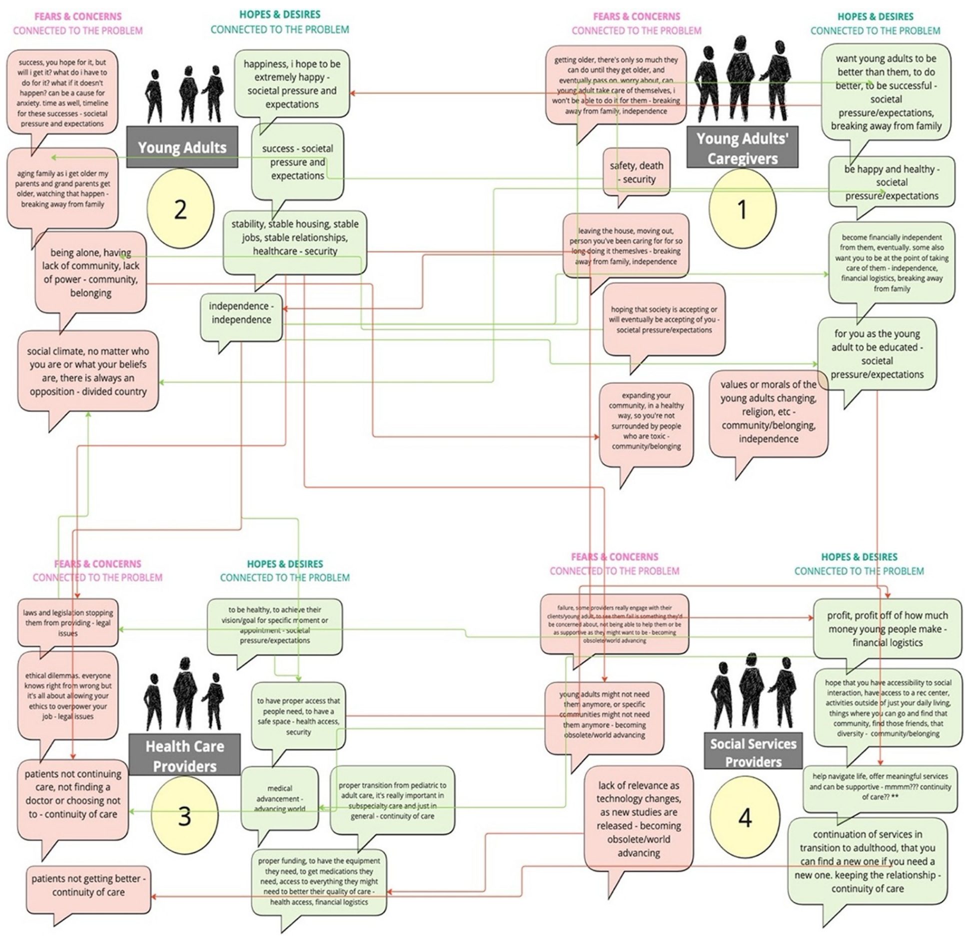
121. *Id.*

122. *Id.*

adulthood. This process engaged the workshop participants in analysis of three key outcomes. First, whether there are any aligned interests, or "low-hanging fruit" that can be leveraged to promote desired outcomes; second, what are the impasses or "pain points" that will need to be overcome to realize desired outcomes; and third, how much power to create change do the participants see themselves as having relative to other groups.[123]

123. One of the elements of the transition design approach is to, "Identify stakeholder concerns, relations, expectations and beliefs and factor them into both problem frames and designed interventions in order to leverage collective stakeholder intelligence" *See* THE EMERGING TRANSITION DESIGN APPROACH, *supra* note 12, at 2.

FIGURE 3: A Completed Constituent Relations Map Completed by Young Adult Participants in the Pitt Law Transition Design Workshop[124]



Using Figure 3 as an example, the young adult participants identified four of their own hopes and desires relevant to reaching adulthood, as well as four of their attendant fears and concerns. They also added what they think their caregivers,

124. Adapted from the Template Created by Irwin. For examples of her templates. *See #2: Mapping Stakeholder Relations,* TRANSITION DESIGN SEMINAR 2024, https://transitiondesignseminarcmu.net/assignments/#1515158978462-560b3918-061a. The numerals in Figure 3 correspond to the power ranking assigned to each constituent group by the young adult participants (1 = most empowered, 4 = least empowered). Workshop participants completed their maps using Miro, a web-based design platform. Available at: https://miro.com/.

health care providers and any social service providers are most concerned about and most hopeful for with respect to their becoming adults. Most points of relationship the young adults identified were between their own hopes and fears and those of their caregivers. They identified six points of perceived alignment with caregivers, and only three points of misalignment. In contrast, young adults identified only one point of alignment with their health care providers. They saw their fear about the social climate as being aligned with their perception that heath care providers worry about legislation that would limit the scope of care they can provide. This potential common ground between patient and provider points to a space where an allegiance could be developed. In terms of agency, the young adults saw themselves as having more power to impact change relative to their health care providers, but less power than their caregivers. Comparing the constituent relations maps of both the young adults and the health care providers would reveal any differences or similarities in how power differentials are understood, as well as any further allegiances which may be fostered to grow shared power. Identifying the assumptions and beliefs participants have about the groups they may have to work with or work around to address a systemic challenge can be a valuable strategic practice.

Mapping constituent relations treats the emotions individuals and groups have about the impact of a pressing problem as salient to the work of redesigning problematic systems. This practice makes transition design unique. "...[T]raditional design-led approaches...seldom examine the individual and collective stakeholder beliefs, assumptions, and cultural norms that have contributed to the problem."[125] Arguably, institutional failure to take the human experience into account frustrates systemic change efforts.[126] Identifying group mindsets and norms related to a wicked problem can aid in addressing, leveraging, or transcending differences within a community. Analysis of competing hopes and fears is linked to a better understanding of the human relationships impacted by a systemic problem, the flow of power between system participants, and the potential to build shared power. Such information is key to cultivating community-led policy.

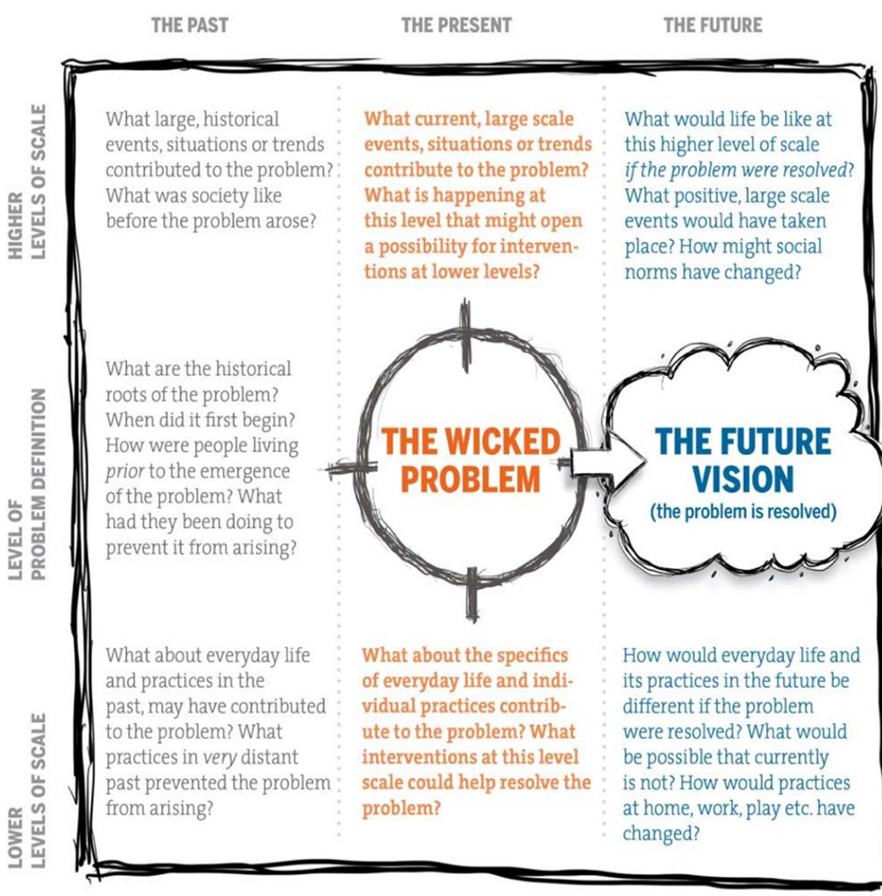
C. Mapping the Problem Evolution

The third activity in a transition design process is mapping the evolution of the wicked problem over time. This practice helps those using transition design gain insights into the historic trajectory of a complex issue. It can also serve as a reminder that systemic change takes time. "Because the problems... took a long time to become wicked, it will take a long time to resolve them and shift the transition trajectory."[127] Depending on the time and resources available, this activity can be completed

125. Terry Irwin, *The Emerging Transition Design Approach*, DESIGN RSCH. SOC'Y 2 (June 2018).
126. *Id.* at 8 ("Failure to consider stakeholder concerns, fears, hopes and desires related to the problem can be a barrier to problem resolution.").
127. KOSSOFF & IRWIN, *supra* note 118, at 96.

through reflection, the use of research, or a combination of both. Understanding how a problem accelerated, expanded, or otherwise manifested in the past can yield insights into how it might continue to morph in the future. Ideally, this activity leads to the identification of historical insights that can inform present day interventions.

FIGURE 4: Irwin's model of the questions transition design can address when mapping a problem's evolution over time[128]



128. *See* Irwin, *supra* note 124, at 981. Irwin and Kossoff currently use a multi-level perspective framework template to complete this exercise. For an example of the multi-level perspective approach, *see #3: Mapping the Evolution of a Wicked Problem*, TRANSITION DESIGN SEMINAR 2024, https://transitiondesignseminarcmu.net/assignments/#1483988152344-831f4c16-c48a (last visited July 31, 2024).

Students of transition design are taught to lead this activity using a multi-level perspective diagram.[129] Rather than instruct participants in how to use this more sophisticated mapping approach, the Pitt Law workshop used a template map based on an earlier conceptual diagram Irwin and Kossoff developed for mapping the evolution of a wicked problem.[130] This diagram lists the seven questions that workshop participants were asked to answer in order to complete this exercise:

> What large historical events, situations, or trends contributed to the problem? What was society like before the problem arose?
> What are the historical roots of the problem? When did it first begin? How were people living prior to the emergence of the problem? What had they been doing to prevent it from arising?
> What about everyday life and practices in the past may have contributed to the problem? What practices in the very distant past prevented the problem form arising?
> What current, large-scale events, situations or trends contribute to the problem? What is happening at this level that might open a possibility for interventions at lower levels?
> What about the specifics of everyday life and individual practices contribute to the problem? What interventions at this level of scale could help resolve the problem?
> What would life be like at this higher level of scale if the problem were resolved? What positive, large-scale events would have taken place? How might social norms have changed?
> How would everyday life and its practices in the future be different if the problem were resolved? What would be possible that currently is not? How would practices at home, work, play, etc. have changed?

Workshop participants were free to answer these questions in any order and could reference the earlier maps as useful in completing this exercise. Reconceptualizing the activity in this way maintained the authentic transition design approach of documenting past manifestations of a problem and linking them to present-day circumstances. This modified approach, which amounts to answering key questions about these connections in a graphic organizer, is arguably more accessible to participants who have not been formally trained in transition design.

D. Mapping Visions of the Future

Mapping visions of a future in which the problem has been resolved is the fourth stage of transition design. Here, participants use their creative, optimistic

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129. *See* F.W. Geels, *The Dynamics of Transitions in Socio-technical Systems: A Multi-level Analysis of the Transition Pathway from Horse-Drawn Carriages to Automobiles (1860-1930)* 17 TECH. ANALYSIS AND STRATEGIC MGMT. 445 (2005). *See also*, *#3: Mapping the Evolution of a Wicked Problem*, TRANSITION DESIGN SEMINAR 2024, https://transitiondesignseminarcmu.net/assignments/#1483988152344-831f4c16-c48a (last visited July 31, 2024).

130. *See* Irwin, *supra* note 124, at 981.

imaginations to envision aspects of a future in which the issues identified in their problem maps are resolved at five levels of scale: the household, the community, the city, the state, and the nation.[131] For this activity, the Pitt Law workshop closely followed Irwin and Kossoff's prescribed approach. Each participant group was given a template map with five thought clouds, one for each level of scale. Participants were encouraged to fill the thought cloud with digital "post-it" notes describing their future visions. The thought clouds could be completed in any order, and participants could use the earlier maps for reference.

131. For a more detailed explanation of this stage in the transition design process, see *Designing for Transitions: Visioning + Assignment #4,* TRANSITION DESIGN SEMINAR 2024, https://transitiondesignseminarcmu.net/classes-2/visioning/.

FIGURE 5: Image of the aggregate responses from all Pitt Law workshop participant groups in response to the prompt: What happens in cities when the issues related to adolescent transition to adulthood have been resolved.[132]

At the conclusion of the workshop, the researchers recorded all of the participants' responses on a single map to look for connections. Figure 5 is a frame from the aggregate map, showing the combined visions for what takes place at the city-level when the issues related to adolescent transition to adulthood have been

132. My template draws directly upon the template map Irwin created for this exercise. For examples of her templates, *see Assignment #4: Designing for Transitions,* TRANSITION DESIGN SEMINAR 2024, https://transitiondesignseminarcmu.net/assignments/#1483988163620-92b71ade-89d0 (last visited July 31, 2024).

resolved. Evidence of shared future visions can be leveraged to encourage groups to transcend their differences in the present and focus on the long-term results worth their collective investment. Divergent visions indicate that community members may be working toward different goals or are motivated by different desires. Both dynamics can inform the ultimate policy choices made going forward.

E. Designing for Transition

Designing for transition is the penultimate stage of transition design. Here participants assess aspects of the present in relation to the desired future they envisioned in the previous exercise. This activity involves documenting what current systems, supports, and services should be kept, what new processes need to be developed, and what ways of doing things should be left behind to achieve the desired outcomes. The answers to these questions become potential solutions; an inventory of the tools and resources available to work toward desired change.

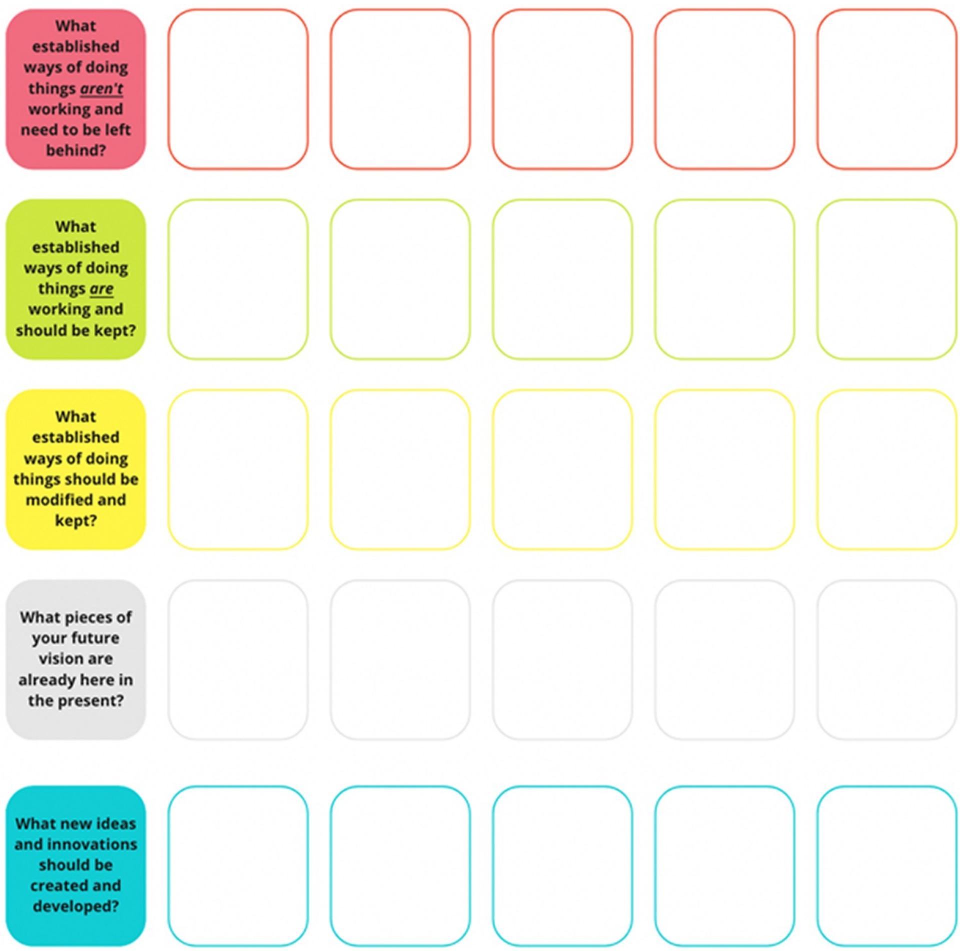
Figure 6 depicts the template map used in the Pitt Law transition design workshop. The Pitt Law workshop deviated from Irwin and Kossoff's template in several respects. First, the wording of the discussion questions for each prompt was modified for simplicity: [133]

> "What isn't working anymore and needs to transition out?", became *What established ways of doing things aren't working and need to be left behind?*
>
> "What should we keep? How can we not throw the baby out with the bathwater?", became *What established ways of doing things are working and should be kept?*; and
>
> "What pieces of our future vision are already here in the present?", became *What pieces of your future vision are already here in the present?*

Second, the question: "What existing innovations and practices can disrupt business as usual and ignite the transition?" was abandoned and replaced with *What established ways of doing things should be modified and kept?*, and *What new ideas and innovations should be created and developed?* Third, the Pitt Law template did not divide these questions into the categories of "established ways of doing things" and "emergent or nascent ideas and practices that can ignite transition". These adaptations were made in the hopes of simplifying the activity for the ease of the participants.

133. *Id.*

FIGURE 6: The design for transitions template used during the Pitt Law workshop.[134]



Participants were free to answer these questions in any order and to reference the earlier maps as useful in completing this brainstorming exercise. The actions to stop, start, change, and keep that participants identify through this process will become the steps used in the final stage of transition design to establish a change

134. My template draws directly upon the template map Irwin created for this exercise. For examples of her templates, *see id.*

strategy. Designing for transition completes the problem frame that links the past, present, and future.

F. Designing System Interventions

The final stage of transition design challenges users to create solution strategies to respond the identified wicked problem. There are two objectives at this stage. First, participants must determine which of their proposed divestments, investments, and current practices have the potential to address issues at different levels of scale. Second, they must determine a proposed sequence for taking on these interventions. This involves reflecting on what foundations need to be laid in order for other aspects of the strategy to have the best opportunity to succeed. Students of transition design endeavor to map their identified interventions with the precision needed to address multiple issues in tandem, sequentially and/or simultaneously.[135] Persons trained in transition design use the phrase "ecology of systems interventions" to communicate the commitment to a nonlinear strategy; of targeting a particular wicked problem across domains and at different levels of scale.[136]

Participants in the Pitt Law workshop followed a four-step process to develop a strategy for addressing their wicked problem. First, participants identified the level of scale their proposed actions address: the household, community, city, state, or nation. Second, they identified which life domain the actions address: economic and financial; social, legal and political; environmental; or health and wellness. Next, participants placed the activities they would like to start, stop, change, or develop onto the designing system interventions template. Finally, they added numerals to indicate the order in which they'd like to see each intervention implemented.

135. *Assignment #5: Designing Systems Interventions,* TRANSITION DESIGN SEMINAR 2024, https://transitiondesignseminarcmu.net/assignments/#1515159007205-8d57b764-12c3.

136. *Id.*

FIGURE 7: Image of the Young Adult Caregivers' Completed Designing for Transitions and Designing System Interventions Maps.[137]

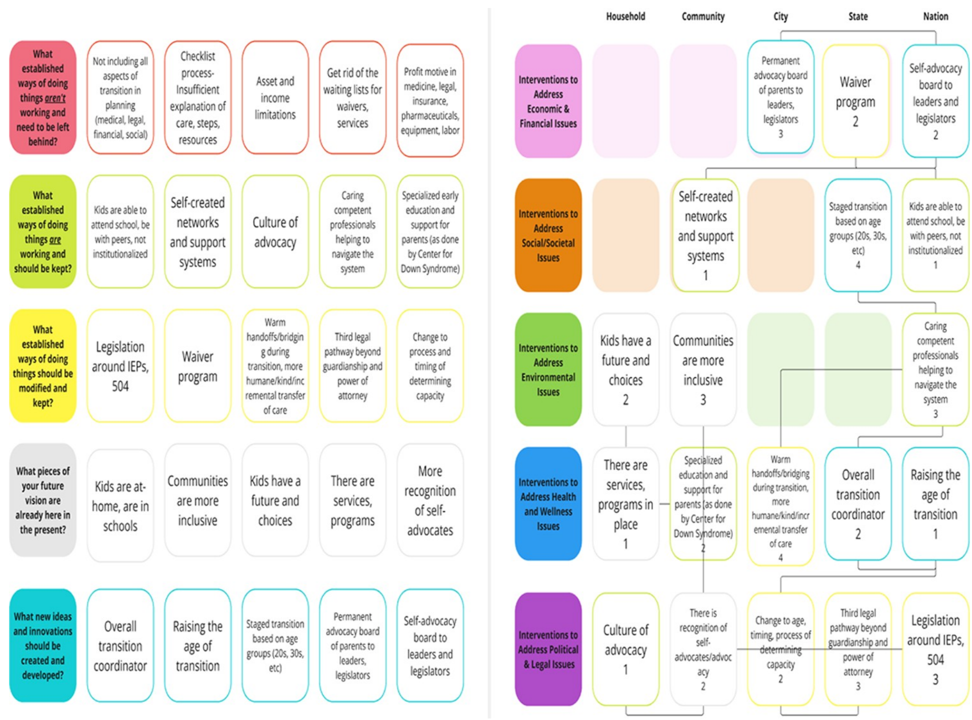


Figure 7 depicts the policy strategy developed by the young adult caregivers' group. Most of their recommendations for addressing the challenges associated with adolescent transition to adulthood target health and wellness, or legal and political issues (bottom two rows, right side table). At the national level (the column to the far right), for example, caregivers would like to see the age of transition raised.[138] They also identify, as a national and city level priority, the desire to create self-advocacy boards. By sequence, the caregivers indicate that the national board should be established first. Caregivers identified "not including all aspects of transition in planning (medical, legal, financial, social); "asset and income limitations"; and "get rid of the waiting lists for waivers, services," among the established practices that aren't working and need to be left behind

137. My template draws directly upon the template map Irwin created for this exercise. For examples of her templates, *see id*.

138. Such policy would not be unprecedented. The age of legal majority in the U.S. has not been static over the nation's history.

(top row, left side table). These takeaways demonstrate how the system intervention map provides a blueprint for advocacy in support of constituents' vision for addressing a wicked problem. "Solutions arise out of the design process," Irwin writes, "we are all designing, all the time."[139]

G. Using Transition Design to Center Community-Led Policy and Problem Solving

Given its effectiveness as a collaborative approach to addressing complex systemic issues, transition design can be used to realize the health justice objective of centering community-led policy and problem solving. The approach has three primary outcomes. First, it supports the creation of a shared understanding of the problem among those working to design solutions. Second, the process encourages participants to identify where and when interventions are likely to have the most impact. Third, transition design leverages participant knowledge and expertise to create interventions. The cumulative aspect of each exercise makes the work of conceptualizing structural interventions less abstract and thus, a more accessible experience. The innovation here is that rather than identify a single policy solution, transition design results in multiple strategies meant to operate in tandem to bring about desired results. This end product meets the call for dynamic problem solving raised by health justice advocates.[140]

A further benefit of using transition design to effect health justice, is that the process is already organized around the social determinants of health (SDOH). Transition design begins by framing the wicked problem in terms of how it manifests across five SDOH, and ends by prompting designers to identify strategies targeting the way the problem manifests in the context of one or more SDOH. The structure of transition design is oriented to addressing health-bearing factors at multiple levels of scale. Its structure makes transition design a ready tool for those looking for a way to center community voices in the development of policies to advance health justice.

Transition design is meant to be engaged by any group whose members are impacted by complex social challenges, not just subject matter experts in law, public policy, or design. A third benefit is that groups using transition design may do so without the assistance of subject matter experts in law, design, or other professions if they choose. The prompts for each activity are relatively straight forward and can be quickly learned by community group members. While some groups interested in using transition design may wish to have the support of one or more facilitators to guide the process (to moderate conversations, to assist with

139. Irwin, *supra* note 99, at 1.

140. Paula Braveman et al., *What is Health Equity? And What Difference does a Definition Make?*, 10 ROBERT WOOD JOHNSON FOUND. (May 2017), https://nccdh.ca/images/uploads/comments/RWJ_Foundation_-_What_Is_Health_Equity.pdf. ("Piecemeal approaches targeting one factor at a time are rarely successful in a sustained way. Approaches are needed that both increase opportunities and reduce obstacles. Successful approaches should address multiple factors, including improving socioeconomic resources and building community capacity to address obstacles to health equity.").

technology, to make the process accessible for persons with disabilities, etc.) professionals and subject matter experts serving as facilitators need only participate as allies or guests of the community, not as intervention designers. A second possibility involves having professionals and subject matter experts complete a transition design process in tandem with, but separately from other community members. This approach was taken in the Pitt Law study. As described earlier, both young adults and health care professionals completed the transition design process. Doctors completed the process with other doctors and young adults did so with their peer group. Structuring engagement in this way avoids replicating power dynamics of authority which could silence participants and upend the focus on community voices. Different maps can be compared and contrasted at the end of the process. Transition design allows for expert voices to be collected as a point of reference for communities; flipping the script, as oftentimes community prerogatives are captured for the benefit of experts. In this way, the process gathers together at the problem solving table those who share an interest, different though those interests may be, in how a particular wicked problem is addressed.

The use of transition design has its virtues and its challenges. For one, it is a participatory design approach that most people have never heard of. This, however, presents an opportunity; the novelty of transition design can be leveraged by those familiar with the approach to increase exposure to this tool. Second, transition design carries some accessibility limitations. While map making can be a low-tech activity (completed with post-it notes, whiteboard and markers, etc.), visual and dialogue-based engagement can be barriers to participation for community members who have certain disabilities. Transition design requires the cognitive capacity to engage with some abstract concepts (hypotheticals, sequencing, etc.). There may be limitations on how the process can be adapted for community members with cognitive impairments or neurodivergence. The amount of time to invest in completing a transition design process is a variable that community groups will also have to consider. Transition design can be as discrete a process as resources and logistics permit – completed in a day-long workshop, carried out over some longer period of time; or revisited at intervals as part of a continuous, iterative engagement. Third, transition design is a participatory design approach, not a participatory *research* approach. Ethical issues involving ownership of the maps and the data the maps contain may need to be addressed by community groups and any non-community member partners.[141] Finally, as policy priorities are identified, community groups must decide whether or not to work in coalition with those who have access to specific forms of institutional power in order to implement their strategies. Transition design's potential as a community engagement tool is not without its drawbacks.

141. While the ethics of community-based participatory research is beyond the scope of this paper, I suggest that those wishing to capitalize on the data generated through transition design look to the literature on CBPR to avoid exploiting socially marginalized participants. *See e.g.*, Lisa Mikesell, et al., *Ethical Community-Engaged Research: A Literature Review*, 103 Am. J. of Pub. Health 12 (2013).

Approaches to community engagement are not value neutral. The tools used to facilitate community-led collaboration between lawyers, health workers, and members of disempowered groups can have a significant impact on how representative, sustainable, or empowering their efforts turn out to be. To do this work in ways that can be understood as health justice praxis, the tools used to engage with frontline communities must draw upon the theories which shape and inform the broader movement. The next section discusses three such frameworks, and identifies transition design as an approach that can be considered health justice praxis.

III. Transition Design as Health Justice Praxis

Praxis can be understood as, "the unity of theory and practical activity."[142] Praxis describes the reciprocal cycle of thinking and doing. Health justice praxis is reflected in approaches to community-led policymaking that are consistent with the theories influencing the continued evolution of the health justice movement. Theory is crucial to evaluating the efficacy, appropriateness, and relevance of a particular approach to realizing movement objectives. From the perspective of a theoretical framework, health justice advocates can assess whether their actions are in alignment with the movement's values. Theory must be foregrounded in community engagement work in particular, because the way that such engagement is initiated and supported determines the quality of the outcome.

This section discusses three theories that have shaped scholarly conversations about the importance of health justice: systems thinking, pluriversality, and decolonial theory. Systems thinking informs actions that take a structural perspective on health inequity. A pluriversal perspective informs efforts to center marginalized voices and to acknowledge heterogeneity within those communities. Decolonial theory ties health inequity to the consequences of colonialism, and drives efforts to delink hierarchies of oppression from community engagement. Transition design is a way to put each of these ideas into practice. This section offers a brief introduction to each paradigm, followed by a discussion of how the theory shows up in health justice, and how the principle is practiced through transition design. Approaches to community engagement which incorporate these theories advance health justice praxis - they translate ideas into action. Engagement in conformity with theory ensures that justice movements remain dynamic and relevant. When applied to the project of advancing health justice through community-led policy making, transition design represents health justice praxis.

A. A Structural Perspective on Health Inequity

The eradication of health disparities rooted in injustice can only be realized through the intentional, strategic reordering of the systems and institutional structures governing access to the SDOH. Taking a structural perspective on the causes of health inequity is an element of health justice praxis that is informed by

142. Joel Wainwright, *Praxis*, 34 Rethinking Marxism 41, 42 (2022). Wainwright notes that the term "praxis" is a transliteration of an ancient Greek word for "action."

systems thinking. Systems thinking involves the work of structural decoding; of determining the elements and the procedural mechanisms between them which form interlocking networks of outcomes.[143] The paradigm assumes that all outcomes are produced by systems: interconnected parts performing some observable purpose.[144] This theoretical perspective informs a detailed, yet big picture understanding of complex social challenges.[145] It attributes patterns of conduct, such as the multiple instances of health harms disproportionately impacting Black and Indigenous communities, to a system's structure.[146] "As our awareness of interactions and interdependencies grows, we increasingly recognize the limitations of reductionist approaches to understanding complex health problems that have many determinants."[147] Health consequences, just and unjust, are a product of interdependencies between health determinants; which is to say that health outcomes are the product of structural design. From a systems thinking perspective, structure-informed solutions – change efforts that target societal problems at multiple points within a system – are needed to produce sustainable results.[148]

Systems thinking in health justice literature is exemplified in Yearby's revised social determinants of health (SDOH) framework, in which structural discrimination is situated as the root cause of health and wellbeing outcomes.[149]

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143. Contrast systems thinking with mechanistic or reductionist approaches in which, "the object is investigated as though it were isolated from the context; proceedings continue with the search for causal and linear, mono-directional relations to explain cause and effect." Sergio Barile & Marialuisa Saviano, *Foundations of Systems Thinking: The Structure-System Paradigm*, in CONTRIBUTIONS TO THEORETICAL AND PRACTICAL ADVANCES IN MANAGEMENT 1, 5 (2011).

144. In previous scholarship, I identify four tenets of systems thinking: every outcome is the product of some structure; these structures are embedded within and connected to one another; the structure for producing an outcome can be discerned; and these structures are resilient, but not fixed. "This four-part framework provides a theoretical foundation for understanding systems as the contextual environment in which law is practiced." Tomar Pierson-Brown, *(Systems) Thinking Like a Lawyer*, 26 CLIN. L. REV. 515, 524 (2020).

145. *See* MARTIN REYNOLDS & SUE HOLWELL, *Introducing System Approaches*, *in* SYSTEMS APPROACHES TO MANAGING CHANGE: A PRACTICAL GUIDE 1, 10 (Martin Reynolds & Sue Holwell ed., 2010) (writing that systems thinking, "is based on an understanding that if one considers a situation as a whole, rather than focusing on its component parts, then there are properties which can be observed which cannot be found simply from the properties of the component parts.").

146. *See* Erin Stringfellow, *Applying Structural Systems Thinking to Frame Perspectives on Social Work* Innovation, 27 RSCH. ON SOC. WORK PRAC. 154, 155 (2017) ("Another way to think of structure is in terms of an iceberg: events are at the top but analysts need to move below the surface to identify patterns. Deeper still is the structure driving those patterns; finally, at the base are the values influencing the structure.").

147. Deon Canyon, *Insights in Public Health: Systems Thinking: Basic Constructs, Application Challenges, Misuse in Health, and How Public Health Leaders Can Pave the Way Forward*, 72 HAWAI'I J. OF MED. AND PUB. HEALTH 440, 441 (2013).

148. *See e.g.*, Donella Meadows, *Leverage Points: Places to Intervene in a System*, SUSTAINABILITY INST. (1999), https://donellameadows.org/archives/leverage-points-places-to-intervene-in-a-system/.

149. *See* Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to include the Root Cause*, 48 J. OF L. MED. ETHICS 518 (2020); *See also* Ruqaiijah Yearby, *Structural Racism: The Root Cause of the Social Determinants of Health*, HARVARD L. PETRIE-FLOM CTR. (2020), https://blog.petrieflom.law.harvard.edu/2020/09/22/structural-racism-social-determinant-of-health/.

Yearby's model displays structural decoding. Through her research, Yearby has identified multiple ways that law (including political process statutes, cases, budgetary decisions, regulation and enforcement) and structural discrimination are tools and root causes, respectively, of the system generating health outcomes.[150] Her model highlights how these elements, missing from earlier efforts to address health inequity, connect reciprocally with the commonly recognized SDOH. Yearby's framework visually communicates that health and wellbeing outcomes are a product of the systems through which health care, the built environment, education, and economic stability are accessed. These systems in turn shape and are shaped by law-related institutions, each of which are tainted by and perpetuate structural discrimination. The pattern of disproportionate health harms borne by communities of color results from the system depicted in the revised SDOH framework. Yearby explains that any framework which fails to acknowledge structural racism as a root cause of racial health disparities, "is inadequate as a means to achieve racial health equity."[151] One's mental model, their understanding of the scope of an issue, drives problem-solving. Use of this more complete framework supports, "a multi-layered approach" to achieving racial health equity.[152] Proposals informed by the revised SDOH framework must target the system it depicts at multiple points; at the systems through which SDOH are accessed and at the points where law institutionalizes sub- and super-ordination.[153] The revised SDOH framework contributes to a complete understanding of the drivers of racial health disparities, highlighting previously overlooked components of this complex systemic issue.

Another example of systems thinking in health justice scholarship can be found in Michener's model for realizing health justice through the building of community power and the breaking of power relations that preserve inequity.[154] Michener defines building community power as, "cultivating the political capacity of people with the most at stake, those who are disproportionately harmed by health injustice."[155] She defines breaking power relationships as, "weakening and destabilizing power relations that undergird health inequity. . ."[156] While she does not explicitly name the theoretical framework, Michener's model reflects systems thinking in its

150. Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 J. OF L. MED. ETHICS 518 (2020) (discussing how legal racial apartheid under Jim Crow laws and current labor and employment policy have adversely effected the health and wellbeing of low-wage workers, particularly women of color).

151. *Id*. at 523.

152. *Id.* at 519.

153. Victor Ray, *A Theory of Racialized Organizations*, 84(1) AM. SOCIOLOGICAL REV. 26, 27 (2019) ("Schemas of sub- and super- ordination are encoded in the concept of race, providing a template for organizational action.").

154. Jamila Michener, *Health Justice Through the Lens of Power*, 50(4) J.L. MED. & ETHICS 656 (2022).

155. *Id.* at 659.

156. *Id.*

analysis that the present system of health inequity is maintained by two feedback loops.[157] One operates to perpetually disenfranchise those most vulnerable to health inequity. The other serially enriches those least likely experience negative heath disparity. She recognizes these patterns as "institutional constraints".[158] Given the structure of this dual, reinforcing-loop system, Michener proposes a two-part structural reform effort. First, combine community organizing and institutional negotiation with coalition and social movement development to create a new feedback loop that builds community power over time. Second, implement profit minimization with institutional negotiation and progressive regulation and enforcement regimes to institute a feedback loop that breaks down the incentives for remaining invested in our inequitable system. The structural interventions Michener proposes target the power struggle involving different constituencies' capacity to influence how the resources associated with good health get distributed. Michener identifies power as a SDOH.[159] She writes, "policy changes essential for realizing health justice are only possible if people and groups seeking to eradicate obstacles to health. . . have significant power. Even further, such people and groups must have greater influence over policy than those who oppose them."[160] This system-informed strategy targets the relationships between incentive and agency which perpetuate the status quo.

Health disparities are understood to be the product of systems.[161] The influence of systems thinking on health justice is evidenced by scholars' efforts to decode the components of these systems and to advance problem solving strategies that target points within a system's structure. Transition design puts systems thinking into practice. The activities included in this design practice jumpstarts systems thinking among participants, by supporting their efforts to connect the dots between issue, system structure, and outcome. Irwin notes that mapping activities, "helps [to] facilitate an embodied understanding of complexity."[162] The wicked problem mapping activity engages participants in structural decoding by inviting them to document how a problem of injustice manifests across social sectors. This activity supports participants in making connections between instances of a problem and collateral consequences elsewhere in the system. The wicked problem maps yield a detailed, yet big picture understanding of complex

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157. A dual feedback loop system, where one process reinforces in tandem with a process that depletes is known as a homeostatic loop. *See* Andrea Kiesewetter et. al, *Understanding Homeostatic Regulation: The Role of Relationships and Conditions in Feedback Loop Reasoning*, 21 CBE LIFE SCI. EDUC. (2022) ("Understanding the properties and mechanisms of such complex homeostatic systems requires feedback loop reasoning, which is a part of systems thinking.").

158. Michener, *supra* note 154, at 659.

159. *Id*. at 658.

160. *Id.*

161. *See* Braveman et al., *supra* note 22, at S151 ("Health disparities are systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups."); Michener, *supra* note 154 at 658 ("Importantly, the unequal health status of marginalized populations is primarily a product of systemic forces, not individual behavior.").

162. Notes from Irwin on an earlier draft of this paper (August 2024), on file with this author.

challenges from the point of view of those most exposed to its negative consequences. The transition design approach scaffolds, from wicked problem mapping to designing solutions. The template for this policy making activity reinforces the systems thinking perspective that change efforts must target multiple points within a system to be sustainable. The template prompts the assignment of interventions at different levels of scale across several social sectors. Every element of the approach includes visual models of the participants' decoded system. Using transition design to provide a structural perspective on the causes of health inequity advances health justice praxis.

B. A Pluriversal Perspective on Community

Communities are systems of people.[163] "Community" in the context of health justice necessarily consists of those who, due to their relative position in social hierarchies, have a limited ability to enjoy the benefits of, or to fully access the SDOH.[164] Communities facing structural barriers to the resources needed to be healthy may have certain characteristics in common. While communities organizing in pursuit of health justice might tend to consist of people of color, persons identifying as LGBTQ+, or low-wage earners, for example, there are unique norms and prerogatives within each community, fueling their self-determination and collective organizing. Adopting a pluriversal perspective – resisting monolithic understandings of "the community" by acknowledging diversity between communities and intersectionalities among community members - ensures that engagement affirms the values of health justice.[165] This element of health justice praxis is informed by theories of pluriversality.

Pluriversality is a theoretical framework developed in the 20th century.[166] This complex body of political thought holds multiple perspectives. For one, pluriversal

163. *See* Makhlouf, *supra* note 31, at 290 (citing Amitai Etzioni's definition of community as, "a web of affect-laden relationships among a group of individuals, relationships that often crisscross and reinforce one another (as opposed to one-on-one or chain-like individual relationships)").

164. *See* Lawrence, *supra* note 39, at 60 ("At its core, health justice is centered on the lived experiences of disenfranchised people."); *see also* Braveman, *supra* note 22, at S151 (defining social disadvantage as, "the unfavorable social, economic, or political conditions that some groups of people systematically experience based on their relative position in social hierarchies. It means restricted ability to participate fully in society and enjoy the benefits of progress. Social disadvantage is reflected, for example, by low levels of wealth, income, education, or occupational rank, or by less representation at high levels of political office.").

165. *See* Harris, *supra* note 4, at 568 ("[x] justice movements embrace the concept of "interlocking oppressions," often centring [sic] around communities for which single-axis identity analysis works poorly or not at all.").

166. *See* Ralf Michaels, *Private International Law and the Legal Pluriverse* 3, MAX PLANCK INST. FOR PRIV. L., RSCH. PAPER NO. 23/10, https://ssrn.com/abstract=4446451(forthcoming 2025) (identifying pluriversality as, "a concept that emerged in the 20th century in several places. . . in political theology. . . Latin American philosophy. . . and in decolonial theory."); *see also* Katsu Masaki, *Do pluriversal arguments lead to a 'world of many worlds'? Beyond the confines of (anti-)modern certainties* 3 (Glob. Dev. Inst., Working Paper no.056, 2021) https://ssrn.com/abstract=3923554 (noting, "The idea of pluriversality has entered development studies and gathered momentum with the publication of Pluriverse: A Post-development Dictionary in 2019. Kothari, A., Salleh, A., Escobar, A.,

theories challenge the idea of universality.[167] Here, the universal is morally suspect as it has been used to impose dominating "power-over" worldviews, such as Western modernism, on people who become structurally subordinated by widespread adoption of these beliefs.[168] In contrast to the pursuit of such universal ideologies is the idea of a pluriverse, "world that is one and many at the same time – a pluralistic universe, a world of many worlds."[169] The argument is that this paradigm better reflects reality. Humans live in a word of many worlds, shaped by their social position(s). From a pluriversal perspective, "our experiences are always partial," and "one world is not everybody else's world. . ."[170] Pluriversal thinking rejects the idea that there is a mono-culture of, for example, living in poverty or living with a particular racial identity. Pluriversality acknowledges the subaltern – the perspective of the disenfranchised other[171] – and encompasses resistance to practices that render invisible or inferior ways of being that aren't tied to capitalist or technology-forward priorities.[172] From a big picture perspective, pluriversal theories promote holding political space for multiple ways of being.

The paradox at the outset of any argument that sees elements of pluriversal theory in health justice is that the ultimate goal of the movement *is* universal. As stated earlier in this paper, and elsewhere, the mission of health justice is a world

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Demaria, F. and Acosta A. (eds) *Pluriverse: A Post-development Dictionary*. New Delhi: Tulika Books (2019)).

167. Lena Salaymeh & Ralf Michaels, *Decolonial Comparative Law: A Conceptual Beginning*, 86 RABEL J. COMPAR. AND IN'L PRIV. L. 166, 180 (Jan. 2022), https://ssrn.com/abstract=4014459 ("The alternative to Northern universalism is pluriversality.").

168. Masaki, *supra* note 168, at 4 ("The notion of pluriversality questions the universalism integral to Western-centric global coloniality. It calls for a 'civilizational transition' away from the current Western-centric order.").

169. Michaels, *supra* note 164, at 13 (discussing U.S. psychologist and philosopher William James' concept of the pluriverse); *see also* Masaki, *supra* note 164, at 15–16 (contrasting two pluriversal approaches, one which rejects Western notions of modernity and another which mainstream and alternative worlds interrelate and coexist); ARTURO ESCOBAR, DESIGNS FOR THE PLURIVERSE: RADICAL INTERDEPENDENCE, AUTONOMY, AND THE MAKING OF WORLDS 15-16 (2018) (here the author references the Zapatista movement, a source others have pointed to as the origin of pluriversal thinking: "The World Social Forum echoed what the Zapatista of Chiapas had already voiced with amazing lucidity and force: *Queremos un mundo donde quepan muchos mundos* (We want a world where many worlds fit)" (emphasis in the original)).

170. Michaels, *supra* note 168, at 13.

171. *See* José-Manuel Barreto, *Human Rights and Emotions from the Perspective of the Colonised: Anthropofagi, Legal Surrealism and Subaltern Studies*, REVISTA DE ESTUDOS CONSTITUCIONAIS, HERMENÊUTICA E TEORIA DO DIREITO (RECHTD), 5 (2): 106-115, 112 (2013) ("Those who have been converted into subalterns by the advance of imperialism are precisely the communities fighting for independence and against neo-colonialism."); Rashmi Dyal-Chand, *Pragmatism and Postcolonialism: Protecting Non-Owners in Property Law*, 63 AM. UNIV. L. REV. 13 (generally describing the subaltern as those who lack access to "social mobility within American society").

172. *See* Saurabh Arora & Andy Stirling, *Intervention – "Don't Save 'the World'; Embrace a Pluriverse!"*, ANTIPODE ONLINE (October 27, 2020), https://antipodeonline.org/2020/10/27/dont-save-the-world-embrace-a-pluriverse/("Despite centuries of disqualification and destruction of (formerly) colonized peoples' lifeways, the Earth is still home to many worlds that have resisted assimilation into modernity. These represent the Earth's pluriverse.").

in which *all* humans have a fair and just opportunity to be healthy.[173] At the same time, however, its objective in achieving that mission – centering community – represents a pluriversal endeavor. Each community is meant to define for itself how to secure health justice. The call to center community-generated policy solutions to health inequity contains an implicit recognition that "the community" is "a world within a world". A further challenge lies in determining who "the community" consists of. A presumptive binary accompanies the use of the term: individuals are either a part of "the community" or they are not. One is either doing the work of community engagement or among those being engaged.

From this perspective, community members are presumed to hold prerogatives and a world view that differs from those who have access to institutional power or professional expertise. Acknowledgement that the lived experiences of particular communities are not fully knowable by those who are not community members, drives the belief that community-generated solutions are more likely to be successful and sustainable.[174] The assumption is that since community members inhabit a different world, so to speak, the strategies they come up with for addressing barriers to the SDOH will take the terms of these differences into account.[175] "Interventions adopted under the banner of public health - including interventions expressly aimed at eliminating disparities - are often tainted by racism, classism, and other forms of subordination," which, arguably, cannot be led by those who benefit from these oppressive systems.[176] Instead, "empowerment of affected communities in decision-making processes helps ensure that the design and implementation of interventions intended to benefit them are actually tailored to their needs."[177] To argue otherwise undermines the idea of "communal logic" at the core of this objective. Citing an example from COVID-19, Benfer et al. note, "without involving the community in decisions regarding testing, many of the initial testing facilities and resources were not available to predominantly

173. *See* Benfer, *supra* note 5, at 278 ("[H]ealth justice requires that all persons have the same chance to be free from hazards that jeopardize health, fully participate in society, and access opportunity. Health justice addresses the social determinants of health that result in poor health for individuals and consequential negative outcomes for society at large."). Some scholars would argue that the assertion of any universal position is anti-pluriversal. *See* Salaymeh & Michaels, *supra* note 169, at 182 ("Put simply, the notion of 'universal human rights' is suspect from a decolonial perspective, which emphasizes pluriversality (i.e., local normativity) over universality.").

174. *See* Emily A. Benfer & Allyson E. Gold, *There's No Place like Home: Reshaping Community Interventions and Policies to Eliminate Environmental Hazards and Improve Population Health for Low-Income and Minority Communities,* 11 HARV. L & POL'Y REV. S1, S48 (2017) ("The success and sustainability of community-based interventions are dependent upon community engagement in identifying and defining the problems.").

175. Benfer, *supra* note 5, at 346 ("Communities and individuals experiencing the negative consequences of injustice and health inequity firsthand are best positioned to identify the major challenges to overcoming inequity and to evaluate the viability of proposed solutions.").

176. Emily A. Benfer et al., *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, 19 YALE J. HEALTH POL'Y, L., & ETHICS 122, 139 (2020), https://ssrn.com/abstract=3636975.

177. *Id.*

Black and low-income communities"[178] The recognition that individuals who do not have equitable access to institutional power or the SDOH inhabit a world that differs from the reality of those whom the system empowers (or at least placates, lulls, etc.) seeds the health justice investment in community-led policy.

A strict in-or-out of community binary, however, risks collapsing those health justice advocates who carry multiple intersecting identities into a monolithic group of outsiders. The assumption that persons who have access to institutional forms of power and authority are not who is meant by "the community" glosses over the fact that place and identity-based groups experience both political subordination through unjust policies *and* various forms of empowerment simultaneously. A community's positionality is layered. Incorporating a pluriversal perspective signals an attunement to this reality and can serve as a reminder that a nuanced framing of who is "the community" has value, and can serve the ends of health justice.

Centering community requires respect for heterogeneity within communities and among their members. While health justice advocates may speak of centering community (singular), a posture of engaging with and centering communities (plural) can be found in scholarship by Galarneau and Smith. In advancing an ethics of respect for community, these authors highlight several characteristics of communities which health justice must be responsive to. They state:

> "many communities are constituted by multiple smaller, often overlapping communities, for example, most local communities have numerous ethnic, religious, and other communities within them. Another feature is that communities have somewhat fluid memberships as members' community identification and involvement shift over time. . .many persons are simultaneously members of multiple communities, communities that may hold compatible and/or conflicting values regarding health and health care."[179]

This recognition that communities consist of overlapping subcommunities, with fluid memberships and heterogenous belief systems, is also consistent with the pluriversal idea of worlds within worlds. Communities are not monolithic groups. Within groups of people there will always be a diversity of prerogatives, experiences and values. Individual lives consist of multiple group memberships, and there are multiple perspectives within any group experience.

Further, centering the lived experiences, meanings, and priorities of those who have been structurally disempowered, positions communities as sites of resistance to the mainstream values that hold health inequity in place. Galarneau and Smith discuss respect for communities in ways that are consistent with pluriversal

178. *Id.* at 147.

179. Charlene Galarneau & Patrick T. Smith, *Respect for Communities in Health Justice*, 50 J. OF L., MED. & ETHICS 650, 651 (2020).

ideas of holding space for multiple ways of being."[180] They define communities as "important sites of meaning-making about social goods including health and health care."[181] Respect for community requires that these meanings – these "normative conceptions of justice," – are acknowledged and taken seriously.[182] Galarneau and Smith quote Michael Walzer's theory of complex equality, which argues that, "men and women. . .resist tyranny, by insisting on the meanings of social goods among themselves."[183] Embodying difference through communal practices and beliefs can be a rejection of the dominant power structures and ways of being that perpetuate structural injustice.

As a process that is meant to be engaged by a broad collective of problem-solvers transition design employs a pluriversal worldview. Those choosing to use transition design understand that wicked problems cannot be addressed from a sole vantage point, because there is no singular, common experience of a complex, adaptive social problem. Returning to the example of education as a social determinant of health, structural inequities in public education funding are experienced differently by different households. The same system touches those from upper-income neighborhoods, working-class suburbs and inner-city projects, but the lived realities of engaging with this system are worlds apart. This reality confounds the idea of a singular universal experience of inequity that can be targeted by a single, one-size-fits-all solution. Engaging participants who come to a problem from different postures increases the likelihood that the issue will be framed to include their concerns.[184] Bringing together individuals with a range of perspectives and with different, but shared, stakes in how a pressing issue is addressed acknowledges the reality that sustainable change can only occur through collective action.[185] Health justice cannot be achieved by collapsing "the community" into a monoculture, or by imposing the world view, expectations, and norms of those who benefit from the social hierarchy upon those disenfranchised by it. As one scholar notes, "law exists in, because of, and for a world having a multiplicity of interrelated normative orders."[186] The inclusion of multiple interest groups in a transition design

180. *Id.* at 653.

181. *Id.* at 652 ("Meaning-making about health/health care also takes place in numerous cultural and religious communities: Indigenous, Black, Latinx, Christian Scientist, and other communities create, recreate, and embrace community-specific ideas and values regarding life, health, healing, and death.").

182. *Id.* at 653.

183. *Id.*

184. The Transition Design Seminar, *Mapping Stakeholder Relations + Assignment #2,* https://transitiondesignseminarcmu.net/classes-2/mapping-stakeholder-relations/("Understanding and addressing the social roots of a wicked problem demands that all stakeholder groups are identified and their concerns integrated into the problem frame.").

185. Herman Brower et al., *The MSP Guide: How to Facilitate and Design Multi-Stakeholder Partnerships*, CENTRE FOR DEVELOPMENT INNOVATION, WAGENINGEN 19, https://mspguideorg.files.wordpress.com/2021/12/the_msp_guide_3rd_ed_2019_wcdi_brouwer_woodhill.pdf ("[C]hange happens as a result of the combined actions of many individuals who are all interconnected in the system. Nobody is in full control.").

186. Michaels, *supra* note 168, at 1.

process represents an effort to create interventions which address the pluriversal experiences of seemingly intractable social challenges. Because transition design promotes a pluriversal perspective on community, it can be used to advance health justice praxis.

C. A Decolonial Perspective on Community Engagement

Some scholars recognize pluriversality as an outgrowth of decolonial theory.[187] Placing value on the plural ways of being in the world can be understood as a form of resistance to the world-collapsing violence of colonization. "As a normative concept, settler colonialism refers to an arrangement of social institutions that support a structure of oppression."[188] Structural oppression is essential to the ongoing success of the colonial project.[189] Through colonization, the institutional mechanisms of law, economics, and narrative are weaponized to supplant and erase both the human lives and the cultures considered to be at odds with the goals of the colonizer.[190] A decolonial perspective highlights the ways that current phenomena stem from colonization, and indicates the responsibility justice advocates have to disrupt and replace practices that perpetuate structural oppression.[191] Health justice praxis includes incorporating a decolonial perspective into community engagement efforts.

Decolonial theories name the effects of colonization on non-white, non-European societies around the world.[192] Observing the continued "colonial domination" exercised through Western culture, Quijano wrote:

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187. *See e.g.*, Salaymeh & Michaels, *supra* note 169, at 180 ("Decolonial theory. . . advocat[es] instead for fluctuating and pluriversal morality. Pluriversality is not only an epistemology, it is also an ethical and political stance because anti-universalism and anti-colonialism overlap."); DARREL WANZER-SERRANO, THE NEW YORK YOUNG LORDS AND THE STRUGGLE FOR LIBERATION 22 (2015) ("Decoloniality is an alternative accent – one marked by pluriversal commitments.").

188. KYLE WHYTE, INDIGENOUS EXPERIENCE, ENVIRONMENTAL JUSTICE AND SETTLER COLONIALISM 14 (Apr. 25, 2016), https://ssrn.com/abstract=2770058.

189. Salaymeh & Michaels, *supra* note 169, at 177 ("Decolonial theory begins with the recognition that the formal end of colonial states did not end 'coloniality.'").

190. Whyte, *supra* note 189, at 15 ("To expunge any markers or physical barriers challenging their legitimacy, settler societies engender social institutions designed to erase the socioecological contexts required for indigenous collective continuance.").

191. There are scholars who would disagree with this broad characterization, insisting that the sole purpose of decoloniality is to secure reparations, if not repatriation of land formerly possessed by indigenous peoples. *See* Eve Tuck & K. Wayne Yang, *Decolonization Is Not a Metaphor*, 1 DECOLONIZATION: INDIGENEITY, EDUC. & SOC'Y. 1, 3, 7 (2012) ("[D]ecolonization is not a metaphor. When metaphor invades decolonization, it kills the very possibility of decolonization; it recenters whiteness, it resettles theory, it extends innocence to the settler, it entertains a settler future . . . [D]ecolonization in the settler colonial context must involve the repatriation of land. . . that is, all of the land, and not just symbolically."). This critique raises the question of whether the references I include in this paper are more accurately understood as "anti-colonial" rather than "decolonial." *See* Angela P. Harris, *Anti-Colonial Pedagogies: "[X] Justice" Movements in the United States*, 30 CAN. J. WOMEN & L. 567, 579 (2018) (resolving the question by arguing, "that the commitments of these [x] justice movements support anti-colonial, and, potentially, decolonial, struggle").

192. *See* Stefan Zagelmeyer, *Moving beyond delinking and the pluriverse: reflections on the "decolonizing international business" debate*, 20 CRITICAL PERSPECTIVES ON INT'L. BUS. 71, 72 (2023), https://doi.org/10.1108/cpoib-04-2023-0028 ("An offspring of postcolonial theory, the decolonial thinking approach emerged and gained prominence in cultural studies, and then spread through critical

> "if we observe the main lines of exploitation and social domination on a global scale, the main lines of world power today, and the distribution of resources and work among the world population, it is very clear that the large majority of the exploited, the dominated, the discriminated against, are precisely the members of the 'races', 'ethnies' [sic], or 'nations' into which the colonized populations, were categorized . . . from the conquest of America and onward."[193]

Health justice scholars have drawn from decolonial theory to connect structural discrimination as a root cause of health injustice with structural discrimination as an instrument of the colonial project. In laying out the framework for the civil rights of health, Harris and Pamukcu note that, "from the colonial period to the present. . .dispossession, labor exploitation, and political domination on the basis of race have affected the distribution of political power and economic resources."[194] This ongoing legacy of racism and structural subordination links colonialism in the U.S. to characteristics of its present-day health care system, in which the brunt of health injustice is borne by Black and Indigenous populations. Tying colonialism to the fight for health justice emphasizes that access to the SDOH are meted through the very economic, normative, and racializing tactics used to establish and preserve the colonial order.[195]

The connection between health inequity and the consequences of colonialism must inform efforts to engage with community. Such engagement must actively avoid practices that perpetuate the hierarchy of oppression on which structural discrimination is built. Non-physical spaces, such as moments of collective discourse and strategizing, can be "colonized" by Eurocentric assumptions of what expertise looks like, what priorities are valid, and what constitutes meaningful participation.[196] Decolonial theory argues that this oppression is carried out

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education to other academic fields. This approach involves ideas such as the colonial matrix of power, decoloniality and delinking. . . the broader literature on decolonisation displays a high degree of diversity, with countless definitions and authors from different academic fields, including 'historians, philosophers, sociologists of knowledge, post-colonialists, postmodernists, literary scholars, [and] Indigenous scholars.").

193. Aníbal Quijano, *Coloniality and Modernity/Rationality,* 21 CULTURAL STUD. 168, 168-69 (Apr. 3, 2007).

194. Harris & Pamukcu, *supra* note 4, at 20 (acknowledging that this political domination extends to subordination based on gender, sexuality, disability, and class).

195. *Id*. ("The major pathways through which health disparities travel—population, place, and power—can all be traced back to historic and continuing patterns of exploiting or marginalizing some communities for the benefit of others.").

196. *See* Tristan Schultz, *Design's Role in Transitioning to Futures of Cultures of Repair,* 2 SMART INNOVATION, SYSTEMS AND TECHNOLOGIES 225, 226 (A. Chakrabarti & D. Chakrabarti eds., 2017) ("[D]ecolonial design is disobedient to dominant Western design research in that it follows a political objective of three streams: (a) unlearning: critical unravelling and exposing of Eurocentrism, (b) learning: directing thinking-in-action toward identifying what can be learnt from different modes of being-in-the-world, (c) praxis: redirecting away from the hubris of European modernity towards amplifying pluriversal worlds, while not ignoring inescapable entanglements amongst modernity/coloniality."). *See also* Rachel Charlotte Smith et al., *Decolonizing Participatory Design Practices:*

through the establishment of Western norms and institutions in subversion of, and in supremacy over, all other forms of knowledge or cultural practices.[197] Maldonado-Torres writes that Western modernity situates, "Europeans and everything that is produced by them superior to everyone else," in tandem with, "a constant skepticism toward the full humanity of others."[198] A decolonial approach to community engagement then, must include means of relearning what has been, "forgotten, buried or discredited by the forces of modernity, settler-colonialism, and racial capitalism."[199] Scholars call this practice of rejection and relearning, these affirmative efforts to disrupt the social hierarchy: "delinking".[200] The work of health justice advocates in the public health space provides an example of how decolonial theory has been used to delink approaches to data collection from practices that cause harm to communities.[201]

Public health researchers in Oregon describe using decolonial theory in three ways. First, to attend to "the commodification of knowledge," or the ways that community knowledge is extracted through engagements with outsiders.[202] This pattern of dispossession benefits those who have access to institutional power and does little to channel power into surveilled communities.[203] Second, researchers reflected upon the "research gaze."[204] This practice raised concerns about access to and ownership of collected data; is public health information for the benefit of those doing the looking or those being looked at?[205] Researchers also used decolonial theory to consider matters of community "(mis)representation".[206] These concerns involve the relationship between the data collected, its use, and the portrayal of the communities under surveillance that results. They cite the influence of Eve Tuck, who wrote that characterizations of urban and Indigenous

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Towards Participations Otherwise, 16TH PARTICIPATORY DESIGN CONFERENCE (June 15-20, 2020) ("A postcolonial perspective points to the fact that design practices are far from universal, and are still based on Western epistemologies.").

197. *See* Zagelmeyer, *supra* note 193, at 74-75 (Decolonial thinking, "criticises the universality of knowledge produced and controlled by the West, which is implicitly assumed to be superior to local and indigenous knowledge, and which supports the hegemony of European/Western knowledge systems.).

198. Nelson Maldonado-Torres, *Outline of Ten Theses on Coloniality and Decoloniality*, 1, 11 (2016).

199. College of William and Mary, *What is Decoloniality?*, DECOLONIZING HUMANITIES PROJECT, https://www.wm.edu/sites/dhp/decoloniality/(last visited, July 20, 2024).

200. *See* Salaymeh & Michaels, *supra* note 169, at 179 ("[D]ecoloniality begins with a delinking from Eurocentrism. . . Delinking results in imagining alternatives that the status quo in the Global North views as impossible." The authors go on to describe delinking as a "deconstructive move that must be followed by a reconstructive strategy."); Zagelmeyer, *supra* note 193, at 74-75 ("The strategy to achieve decoloniality is inextricably linked to delinking through decolonial projects, which are meant to identify and erase old customs, culture, habits, and ideas associated with colonial thinking patterns.").

201. *See* Ryan J. Petteway et al., *Engaging Antiracist And Decolonial Praxis To Advance Equity In Oregon Public Health Surveillance Practice,* 43 HEALTH AFF., no. 6, 813, XX (2024).

202. *Id.* at 817 (citing L.T. SMITH, DECOLONIZING METHODOLOGIES: RESEARCH AND INDIGENOUS PEOPLES (Zed Books Ltd. ed., 2013)).

203. *Id.* at 817.

204. *Id.*

205. *Id.*

206. *Id.*

communities as, "sites of disinvestment and dispossession. . .become spaces saturated in the fantasies of outsiders. . .over researched but underseen."[207] In response to these decolonial perspectives, the researchers developed strategies for conducting data analysis through "community-led data hubs" as a step toward delinking research from the harms of surveillance and outsider narratives.[208]

There is a parallel to be drawn between the decolonial critique of public health data collection and approaches to community engagement. As is the case with certain research methods, community engagement practices risk re-creating the hierarchies endemic to the colonial project. Health justice work can be decolonial if its efforts at community engagement, "engage in dynamic de-centering within and outside the academy to reduce the possibility of privileging our individual perspectives over those of the communities within which and for which we labor."[209] This means amplifying community voices, making space for groups to tell their own stories about themselves; preserving community control over community data, and mitigating any power imbalances that may exist during collaborative engagement. Approaches to supporting community-led policymaking cannot advance "subordination-blind policy frames" and be considered health justice praxis.[210]

Drawing from these conceptual roots, transition design incorporates decoloniality in two ways. First, through the mapping constituent relations activity, participants should promptly identify the uneven distribution of power (in its many forms: social capital, access to resources, autonomy, etc.) among the various constituents holding an interest in how a wicked problem is addressed.[211] This activity requires reflection upon the social and relational hierarchies at work within and between groups, whether based on race, gender, class, or access to institutional authority. These power imbalances create pluriversal lived experiences, and represent the social structure through which efforts to realize justice are sought. The nuanced, yet largely hierarchical positioning we are all a part of reenforces the conflicting positions that contribute to the intractable nature of wicked problems.[212] "Decolonized space" presents the opportunity for participants in a collective to see themselves and each other as participants in, "systems of responsibilities. . . actual

207. Eve Tuck, *Suspending Damage: A Letter to Communities*, 79 HARVARD EDUC. REV. 409, 412 (2009).

208. Petteway et al., *supra* note 198, at 818.

209. Chandra L. Ford, *Public Health Critical Race Praxis: An Introduction, an Intervention, and Three Points for Consideration*, 2016 WIS. L. REV. 477, 489 (framing the imperative to engage in such de-centering as a question which signals the need for "health crits," "to continuously reflect upon the privilege we hold vis-à-vis our identification with the margins").

210. Harris, *supra* note 75, at 582.

211. *See e.g.,* Salaymeh & Michaels, *supra* note 169, at 187 ("[D]ecolonial comparative law examines relationships of power between legal systems or traditions").

212. KOSSOFF & IRWIN, *supra* note 90, at 224 ("The roots of many wicked problems are connected to conflictual relations among the stakeholder groups connected to and affected by the wicked problem in question.").

schemes of roles and relationships that serve as the background against which particular responsibilities stand out as meaningful and binding."[213]

Second, the transition design approach is not extractive. Rather, it is a generative process through which community members create data for their own use. In a transition design process, community members create a narrative about the arc of a complex challenge that they have identified and defined for themselves. While communities will likely choose to make public the strategies they have designed, the maps may remain within the stores of community knowledge, insulated from extraction and dispossession. While the field of design merits critique for the ways in which it has aided the colonial project, transition design's distinct capacity to be used by communities for their own self-defined ends allows it to avoid "what decolonial theory argues must be overcome: authoritative speaking rather than pluriversal engagement, implicit prioritization of one (or two) speaker positions over those of others, reducing options instead of allowing them to be revealed."[214] The use of transition design to generate community-led policy can be considered health justice praxis because it puts decolonial perspectives into practice.

IV. Conclusion

Health justice requires community-led policy. Health justice advocates seek such policies to build systems that sustainably produce a fair and just opportunity for individuals and populations to be healthy. Solutions and strategies that come from the collective wisdom of communities can generate a level of buy-in unavailable in the case of expert-led problem solving. Further, centering marginalized voices channels power toward those who have been structurally disempowered. Community engagement tools that employ a structural perspective on the causes of health inequity; a pluriversal perspective on community; and a decolonial perspective on community engagement define the contours of health justice praxis. Health justice praxis can be effected by using transition design. The field of design sees all outcomes as the product of design, whether intentional or passive. This idea finds resonance in the work of those who have insisted that, if humanity can create structures of injustice, it can forge structures of justice. Where systems have evolved to practically ensure health disparity there is a design challenge to be resolved. Transition design offers an approach to community-led policymaking and problem-solving that incorporates systems thinking, pluriversal, and

213. Whyte, *supra* note 189, at 9-10. In linking settler colonialism to environmental injustice, Whyte argues that colonization disconnects humans from their relationships to one another and to the ecosystems in which they live. This disconnect distorts the nature of our relationships to one another and to the natural world in ways that limit empathy, and by extension, limits our motivation to be invested in restoring these relationships. Identifying colonized spaces as those in which our relationships to self, other, and natural world have been strained, distorted, and cut off points to a particular definition of decolonization. Decolonized spaces are those in which connection, mutual dependance, and accountability have been restored; catalyzing the empathy and motivation needed to drive sustainable humanizing change.

214. Salaymeh & Michaels, *supra* note 169, at 188.

decolonial perspectives. Transition design accurately conceptualizes structural inequity as a wicked systemic problem. The approach convenes multiple interest groups in the design of interventions which can be used to steward the transition from present reality toward desired future.

This piece concludes with another rallying cry: *Another world is possible*.[215] Like all justice movements, health justice is the product of a particular design imagination; a vision of a world in which one's health is not determined by race, income, or zip code. Health justice is a movement that continues to be parsed and defined. As it evolves, further scholarship that articulates the theories and practices that comprise health justice praxis will be needed. In addition, the use of transition design to address health justice issues must continue to be studied. This research should evaluate the effectiveness of using transition design to produce community-led policy, as well as the quality of the interventions and strategies created through a transition design process. Such understandings would advance, not only the health justice framework, but the development of approaches and methods that unite the fields of law and design.

215. *See e.g.,* NATASHA HAKIMI ZAPATA, ANOTHER WORLD IS POSSIBLE: LESSONS FOR AMERICA FROM AROUND THE GLOBE (2025); NOAM CHOMSKY, IMPERIAL AMBITIONS: CONVERSATIONS WITH NOAM CHOMSKY ON THE POST-9/11 WORLD (2005) (chapter 9 is titled "Another World is Possible").