Health Equity | A guidebook for public health practice

Metro Denver Partnership for Health

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BOULDER COUNTY PUBLIC HEALTH
Opportunity for a healthy life.

BROOMFIELD Colorado

DENVER PUBLIC HEALTH & ENVIRONMENT

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Tri-County Health Department

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INTRODUCTION

What Is This Guidebook, and What Are Its Objectives?

"Health equity" is an increasingly popular topic in public health conferences, events, and publications. This guidebook is a tool for public health practitioners in Colorado who are serious about walking their health equity talk but aren't quite sure how to get started. It aims to prepare its users to close gaps in health status that result from systemic, avoidable, and unjust policies and practices that create barriers to opportunity for certain people.

To engage effectively in health equity work, public health practitioners need to look inward at our own values and biases, and we need to equip ourselves and our colleagues to challenge and transform systems that disadvantage entire populations. To that end, this guidebook has three main objectives:

1. Foster a common understanding of health equity so we can work together using common language and definitions.

2. Identify the shared values of health equity work and help readers identify where their own values fit in.

3. Establish a common understanding of how our country's historical systems and policies continue to be a barrier to health equity, with a focused look at structural racism.

Reflection exercises are included in each section of this guidebook to provide opportunities for individuals and groups to process and to interact with the concepts presented. Ultimately, we intend that use of this guidebook will better prepare readers to identify opportunities to prioritize, implement, and practice equity and justice in our lives and work.

Is This Guidebook for You?

If you are a public health professional or student with some understanding of health equity, and (more importantly!) you want to incorporate health equity in your individual and organizational public health practice, then this guidebook is for you. If you are brand new to the concept of health equity, you might want to look at the National Association of County and City Health Officials' (NACCHO) health equity resources alongside this guidebook. If you are implementing health equity measures in your work and looking for tips on more advanced practice, this Health Equity Guide from Human Impact Partners or the Colorado Department of Public Health and Environment's tools for measuring health equity.

How Was This Guidebook Developed?

Members of the Metro Denver Partnership for Health's Health Equity Workgroup compiled this guidebook, drawing on resources we all use in our work and trainings we have attended or provided. The exercises included in the guidebook were tested in local public health agencies, including Boulder County Public Health, Denver's Department of Public Health and Environment, Denver Public Health, Jefferson County Public Health, and Tri-County Health Department. The guidebook has been

reviewed by the directors of the *Metro Denver Partnership for Health* and by the Colorado Public Health Association's Health Equity Director.

What Are the Limitations of This Guidebook?

This is not a treatise on health equity, nor is it a systematic review of health equity interventions, nor is it even a comprehensive treatment of issues relevant to health equity. We've chosen to focus primarily on racism in the discussions and examples that follow, knowing that racism drives poor health outcomes across population groups, but it's also important to address other forms of oppression and exclusion. We are on a journey to transform our collective ability to work with communities to reduce health inequities and improve the health of all people...we are learning as we go! We'd love to hear feedback on your experience of this guidebook, both the good and the bad. You can use this [Google form](#) to provide your feedback and ask for your support for future evaluations.

How Should I Use This Guidebook?

This guidebook consists of materials and exercises designed to encourage critical thinking, discussion, and growth — both individually and in a small group setting. The primary goal is to create an environment in which each person has the opportunity to share, explore, challenge, learn, and grow. Given the breadth of the material, you may want to work through sections and exercises in multiple sessions, with ample time for reflection and processing between sessions.

Consider using a facilitator who has experience leading these types of reflections

to help guide your sessions and make sure they are safe and supportive for all, with special regard for people who identify with a group often marginalized by society. Well-intentioned discussions can cause harm if handled poorly. Connect with your agency's health equity committee to discuss options for facilitators. You can also contact the [Colorado Association of Local Public Health Officials](#) (CALPHO) for assistance identifying a facilitator.

At your group's first meeting, establish guidelines or ground rules to help ensure that all participants are engaged and feel safe sharing about their experiences. These shared commitments encourage dialogue and lead to smoother and more respectful discussions.

Reflection Exercise

1. Review the Tenets of Equitable Participation from the *Office of Health Equity, Boston Public Health Commission, 2017* (below) as a group.

2. Ask each person to write down additional ground rules or tenets that support their discussion needs.

3. Provide the opportunity for each person to share and discuss as a team.

4. Write them down and affirm team commitment.

Tenets of Equitable Participation (Sample Ground Rules for Health Equity Discussions)

- We strive always for diverse membership and equitable representation across race, gender, culture, and levels of power at every table and at every meeting.
- We value everyone's voices and unique contributions by expecting active participation from all members and welcoming those who are new, those who hold less institutional power or authority, and those who are traditionally marginalized.
- We challenge the cultural norms for convening and facilitating meetings by broadening the definition of what is considered to be "acceptable" behavior or participation.
- We engage in new dialogue practices.
- We listen earnestly to others for understanding of different and shared needs.
- We actively practice the norm of making it okay to call attention to wrongs, mistakes, and slipups that occur doing the work.
- We acknowledge that inviting new and different voices to the table requires space, time, and flexibility.

DEVELOPING COMMON LANGUAGE AND MESSAGING

Learning Objectives

1. To understand the definition of "health equity."

2. To be able to explain health equity to different audiences.

Much of the following material is adapted from Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What Is Health Equity?* And *What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

Moving from health equity concepts to health equity action requires a shared understanding of terms. "Health equity" is more than a trendy catchphrase or the public health framework du jour. Health equity is, quite literally, a matter of life and death. Around the world, lower socioeconomic position is associated with higher risk of poor health.[1] This risk differential often arises from intentional or unintentional discrimination or marginalization, and its impact can reinforce social disadvantage.[2]

Health inequities persist because segments of the population experience systematic oppression and barriers to opportunity because of their race or ethnicity, gender or sex, sexual identity, age, disability, socioeconomic status, geographic location, or other characteristics historically linked to discrimination or exclusion.[3]

What Is Health Equity?

For general purposes, health equity can be defined as follows, "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to opportunity, such as poverty, discrimination, and their consequences, including lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. Being as healthy as possible refers to the highest level of health that reasonably could be within an individual's reach if society makes adequate efforts to provide opportunities."

Here are some other definitions that may be helpful in understanding healthy equity:

- *Health* means physical and mental health status and well-being, distinguished from health care.

- *Opportunities to be healthy* depend on the living and working conditions and other resources that enable people to be as healthy as possible. A population's opportunities to be healthy are measured by assessing the determinants of health (e.g. income or wealth, education, neighborhood characteristics or social inclusion) that people experience across their lives. Individual responsibility is important, but too many people lack access to the conditions and resources that are needed to be healthier and to have healthy choices.

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[1] http://www.who.int/features/factfiles/health_inequities/en/

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222512/

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222512/

What Is Health Equity? (cont.)

- *Health disparities* are observable (factual) differences in health outcomes between groups. The differences between the groups can be detected by applying the scientific method (i.e. it can be measured). Not all differences in health outcomes are inequitable. Women are more likely to die in childbirth than men; that's biology, not equity, in action. In contrast, black women in the U.S. are three to four times more likely to die in childbirth than white women, and biology is not the underlying cause.[4] Black women are not intrinsically more susceptible to death in childbirth because of their race; they are at greater risk of dying because of the lifelong impact of systemic racism, the individual bias and discrimination they experience every day, and because of bias and racism in systems like health care. This is a pressing equity concern. Health disparities such as this are called **health inequities.**

Defining Health Equity for Different Audiences

Different audiences may require different words or phrases to understand the complex concept of health equity. Below are a few examples of definitions that can be used with different audiences.

- **A 30-second definition for general audiences:** Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including the powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

- **A 15-second definition for technical audiences:** For purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

- **A 20-second definition for audiences asking about the difference between equity and disparities:** Health equity is the ethical and human rights principle that motivates us to eliminate health disparities; health disparities (worse health in excluded or marginalized groups) are how we measure progress toward health equity.

- **An 8-second version for general audiences – health equity as a goal or outcome:** Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

- **Another 8-second version for general audiences – health equity as a process:** Health equity means removing economic and social obstacles to health, such as poverty and discrimination.

Reflection Exercise

- With a partner, identify the audiences for which you are likely to be introducing or discussing the concept of health equity.
- Choose one of the versions above and practice using it with your partner.
  - Discuss how you felt making the statement.
  - Ask your partner to discuss how it felt hearing the statement.
  - Switch places.
- Based on this practice and using the examples as a guide, craft a version that you will use with a specific audience. Practice delivering it with your partner.

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[4] https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why

VALUES

Learning Objectives

1. To explore your personal and professional values and understand why they are important to the practice of public health.

2. To understand the connection between values and health equity, and discuss how the values underlying health equity play a key role in effective communication about health equity.

Personal values

The following material is adapted from the State of New South Wales, Australia, Department of Education and Training: https://sielearning.tafensw.edu.au/MCS/CHCAOD402A/chcaod402a_csw/knowledge/values/values.htm).

As human beings, we all have our own values, beliefs, and attitudes that we have developed throughout the course of our lives. Our family, friends, community, and the experiences we've had all contribute to our sense of who we are and how we view the world. As public health workers, we are often working with people who may be viewed by some people in mainstream society as being different or unacceptable, and they experience vulnerability when interacting with certain systems and institutions. If, as public health workers, we are to provide services that meet the needs of all groups and to help them feel empowered, we need to be aware of our own personal values and how they influence the decisions we make in our own work.

What are values?

"Values" are principles, standards, or qualities that an individual or group of people hold in high regard. These values guide the way that we live our lives and the decisions that we make. A value may be defined as something we hold dear — those things/qualities that we consider to be of worth.

A value is commonly formed by a particular belief that is related to the worth of an idea or type of behavior. Some people may see great value in saving the world's rainforests, yet a person who relies on the logging of the forest for their job may place a different value on the forest than a person wanting to save it.

Where do values come from?

Our values come from a variety of sources, including:

- Family
- Peers (i.e. social influences)
- Workplace (i.e. work ethics, job roles)
- Educational institutions (e.g. schools)
- Significant life events (e.g. death, divorce, job loss, major accident or trauma, major health issue, significant financial loss, etc.)

- Religion
- Music
- Media
- Technology
- Culture
- Major historical events (e.g. world wars, economic depressions, etc.)

VALUES

Dominant values

Dominant values are those that are widely shared among a group, community, or culture. They are passed on through sources like the media, institutions (e.g., education, political), religious organizations, or family. But what is considered dominant in one culture or society will vary in the next.

Consider this continuum of common values. Where do you fall on this continuum?

Values Preference Continuum

Most of us don't often think about our own culture. For this reason, identifying our personal cultural values or beliefs may seem like a strange or even difficult task. Yet before we can see and understand other cultures, we must first understand our own. Use the value continuum chart below, and place an "X" along each line to identify where your cultural preferences most typically lie.

Individualism — **Collectivism**
(I should be rewarded/recognized for my effort.)   (The group will benefit is what matters.)

Equality — **Hierarchy**
(I should have access to all levels of power.)   (Important to go through the chain of command.)

Risk taking — **Security**
(Risk taking rewarded, risk is opportunity.)   (Risky proposals avoided, ...carefully studied.)

Task — **Relationship**
(Primarily focused on outcomes/tasks.)   (Primarily focused on building trusting relationships.)

Future — **Past**
(Planning is done for tomorrow, change is promise.)   (Hold to tradition. Change should be slow.)

Direct — **Indirect**
(Speak your mind, even if it involves conflict.)   (Avoid conflict, meaning is expressed subtly.)

Emotional Expressiveness — **Emotional Restraint**
(Displaying emotion is encouraged.)   (Emotional displays are inappropriate/avoided.)

Cooperative — **Competitive**

Spiritual Identity — **Secular Identity**
(Recognize and value a spiritual identity.)   (Issues of religion are inappropriate, irrelevant.)

Formal — **Informal**
(Explicit rules about how people interact.)   (Few rules regulate relationships and interactions.)

Deductive — **Associative**
(Logical progression, one builds from the other.)   (Web of connections, interrelationships.)

VALUES

Reflection Exercise

1. Choose two values of which you have identified a clear preference on one side of the continuum. Share why each of them is important to you and how you learned the value.

2. Provide an example of a time when you worked with someone who was on the opposite end of the continuum on one of those values. What was the experience like for you? What did you learn from it?

Professional Values

We all need to be aware of our own personal values and how they might impact our work. To work effectively, it's critical to understand our own values and beliefs and to understand that those we work for — and with — have their own values that may be different from our own.

Professional Values in Public Health
Public health is a field that is based on both science and values. Public health uses the scientific method of systematic observation, measurement, and experimentation to formulate, test, and modify hypotheses; this is how evidence is established. Public health also relies on values; that is, an assessment of the importance, worth, or usefulness of things. Values are not facts, but rather, they are important and lasting beliefs or ideals shared by members of a culture about what is good or bad and desirable or undesirable.

To explore these concepts further, consider the public health code of ethics, and answer the questions posed afterwards.

Principles of the Ethical Practice of Public Health
1. Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.

2. Public health should achieve community health in a way that respects the rights of individuals in the community.

3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.

4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.

5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.

6. Public health institutions should provide communities with information they have that is needed for decisions on policies or programs, and they should obtain the community's consent for their implementation.

7. Public health institutions should act in a timely manner on the information they have within the resources and mandates given to them by the public.

8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.

9. Public health programs and policies should be implemented in a manner that most enhance the physical and social environment.

10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.

11. Public health institutions should ensure the professional competence of their employees.

12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.

Source: Principles of the Ethical Practice of Public Health, Version 2.2, 2002 Public Health Leadership Society

VALUES

Reflection Exercise

1. Does this code of ethics speak primarily about science (.e. evidence and facts) or values?

2. Where do the values reflected here come from?

3. Are there statements in the code of ethics that reflect values that might not be shared with everyone in the culture?

4. Do you agree with the values reflected in this code of ethics?

5. Do you think all your coworkers agree with the values reflected in this code of ethics?

6. What about your community partners? Do they share these beliefs?

7. How does this code of ethics relate to health equity?

Health Equity as a Value

A common definition for health inequity is "systemic, avoidable, unfair, and unjust differences in health status." Our interpretation about what causes measurable differences in health outcomes across groups, and what — if anything — should be done about it, is a matter of our values.

For instance, if you think that all people have equal access to education, and it is their personal responsibility to pursue education, you might interpret the poor health outcomes experienced by those with less education as a consequence of an individual's choice. But if you think there isn't equal opportunity to pursue education due to societal barriers, you might interpret the resulting poor health outcomes as unfair or unjust. Both of these interpretations reflect value judgements.

Reflection Exercise

1. Based on the definition of health inequity as systemic, avoidable, unfair, and unjust differences in health status, which parts of the definition can be measured? Which are scientifically based? Which are values-based?

2. How would you talk about health inequities with people who might not share the same values as you or if you don't know what their values are?

3. Identify the evidence and values (yours and those that you don't share) that underpin the current conversation related to health care in this country. How can this debate be framed in the context of both science and values?

PRIVILEGE, POWER, AND BIAS

Learning Objectives

1. To understand privilege and implicit bias.
2. To explore your own social identities and areas of bias.

Social Identity and Privilege

A person's "social identity" — or identities — derives from perceived membership in a group (or groups) based on personal and cultural characteristics (e.g. age, race, social class, gender, ability, sexuality, religion, etc.). Some social identities are easily visible, but others are less so. Social identity may be the basis for discrimination that puts people with that social identity at a disadvantage, and it also may be the basis for privilege that advantages members of a certain social identity group.

"Privilege" is the special right or advantage that only one person or group of people has — a set of unearned benefits given to a group of people of a specific social identity. Privilege often confers power.

Privilege, discrimination, and social identity all operate within interrelated hierarchies of power, dominance, and exclusion. Who you are in the world affects your experience of it and other people; it also affects the way in which you approach your work. Individuals may experience different forms of privilege, being privileged in one way but underprivileged in another. It is important to be aware of our own social identities to be able to understand our participation in systemic discrimination and privilege.

Dig Deeper

Learn more about privilege from this five-minute video:

https://www.youtube.com/watch?v=qeYpvV3eRhY

PRIVILEGE, POWER, AND BIAS

Reflection Exercise

Note: The numbered suggestions were written by Natalie Burke, an experienced trainer and advocate for equity, diversity, and inclusion.[5] A strong degree of trust and safety is needed for group discussion of the personal reflections. If that cannot be guaranteed for people of all social identities, then this exercise would best be completed as "personal homework."
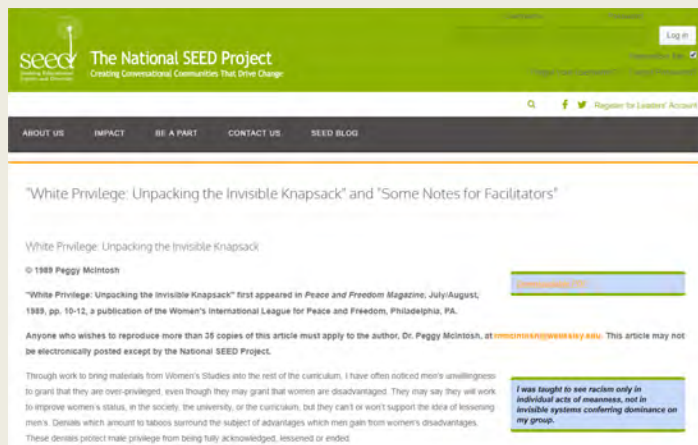
1. Identify your social identities and write them down. Social Identity is how you view yourself based on the groups (e.g. age, race, gender, class, physical ability, religion, education, etc.) to which you belong. What are your identities and how do they affect the way you experience the world and other people?

2. Read this article, and identify your privilege. Privilege and oppression reflect how society assigns disparate value to all of us based on social identities and how we, consciously or unconsciously, assign value to ourselves.

3. Leverage your privilege. People with privilege are uniquely positioned to be heard, acknowledged, and believed by others with power and privilege. You can assume risks that others without your privilege can't afford to take. Connect with people who share your privilege. Talk about it. Explore it. Challenge it. Use your privilege to call into question inequities and bias. Identify opportunities to use equity, diversity and inclusion (EDI) to make you bigger, faster, smarter, stronger, and better at doing what you do. Regularly consider who experiences the benefits and burdens of what you do in the world.

4. *Bonus question (suitable for group discussion):* Does your identity as a public health professional confer privilege? How does that play out in your interactions with "the community"?

Dig Deeper

White Privilege: Unpacking the Invisible Knapsack, and Some Notes for Facilitators, by Peggy McIntosh, 1989; available at:

https://nationalseedproject.org/ white-privilege-unpacking-the- invisible-knapsack

(Accessed 4/26/18)

PRIVILEGE, POWER, AND BIAS

Implicit Bias

Our associations are implicit when we are unaware of them, when we do not consciously recognize them. Associations become bias when we have a preference for or against someone, something, or a group of people. Implicit bias, or unconscious bias, is then the attitudes or stereotypes we hold without recognizing them. These associations affect our thoughts and actions without us choosing them.
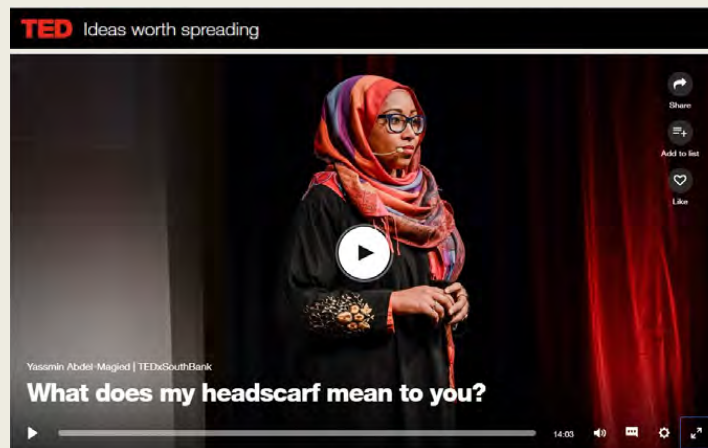
Evidence has revealed that implicit bias in interpersonal interactions is strong, widespread, and deeply rooted, and it could potentially take a heavy toll on health, considering current knowledge of physiological mechanisms involved in responding to stress, particularly chronic stress.

Everyone has implicit biases…EVERYONE! Recognizing our own is an important step towards safeguarding our work from discrimination and bias.

Dig Deeper

To learn more about implicit bias, watch this 12-minute TedTalk:

https://www.ted.com/talks/ yassmin_abdel_magied_what_does_my _headscarf_mean_to_you

Reflection Exercise

Note: This exercise is best done individually, leaving people to discuss at their own will.

The Implicit Association Tests measure your attitudes and biases towards various issues and social identities.

   a. Visit the website and take as many of the (free!) tests as you can. You will be surprised; you may feel guilty.

   b. Remember, everyone has implicit biases. They do not make you a sexist, a racist, or a bad person, and they do not predict discriminatory behavior.

   c. By assessing yours, you are beginning to learn how to take them into account in your life and work.

Dig Deeper

[Undoing Racism: The Connection Between Race and Poverty and What Can We Do About It](#) is a presentation from the organization Solid Ground, and it includes practical suggestions of what you can do to learn, act, and engage around issues of race and health equity.

STRUCTURAL INEQUALITY AND PUBLIC HEALTH

Learning Objectives

1. To understand the legacy and impact of structural or institutional inequality.
2. To discuss real-life examples of how to address structural inequality in public health.

Our Nation's History of Discrimination

Since the founding of this country and manifest destiny[6] , U.S. government laws, policies, and practices within all institutions have perpetuated a cultural and ideological myth about the American people. The narrative of the myth began in 1492 when Columbus "discovered" the Americas and brought enlightened colonialism to the "savage" continent. This narrative ignores the taking of land, wealth, and labor from indigenous people in the Western Hemisphere that led to their near extermination and ultimately the transatlantic slave trade, which led to a racial underclass in the U.S. For more history about codifying racism in the U.S., see http://www.dismantlingracism.org/history.html.

"Oppression" is defined as, "unfair cruel treatment by a powerful person or government." The experience of repeated, widespread, systemic oppression that marginalizes some communities or peoples is rooted in our nation's history. Some examples of oppression include slavery, apartheid, or the lack of right to vote.

Here are some key dates in our nation's past:

- Pre-Columbian: Indigenous populations (Native Americans) occupy varying lands within the United States for thousands of year.
- 1787: The U.S. Constitution is signed and the 3/5ths clause is enacted in which enslaved blacks in a state would be counted as three-fifths of the number of white inhabitants of that state.defines African American males as 3/5 of a man.
- 1790: The Naturalization Act specifies that free, white immigrants are eligible for citizenship and thus are allowed to vote and own land. These rules continue to influence policies until 1952.
- 1794: France emancipates all slaves in the French colonies. In the United States, Congress passes legislation prohibiting the manufacture, fitting, equipping, loading or dispatching of any vessel to be employed in the slave trade.
- 1800: The United States enacts stiff penalties for American citizens serving voluntarily on slave ships trading between two foreign countries.
- 1865: Reconstruction Amendments - 13th Amendment of the Constitution abolished slavery and the the 3/5th clause; 14th Amendment gave all slaves full citizenship; 15th Amendment provided the right to vote.

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[6] Manifest destiny is the 19th Century doctrine or belief that the expansion of the U.S. throughout the American continents was both justified and inevitable.

STRUCTURAL INEQUALITY AND PUBLIC HEALTH

Our Nation's History of Discrimination (cont.)

- 1876-1965: Separate but equal state laws (also known as Jim Crow); examples of laws included:
    - Segregation of public schools, public places, and public transportation, and the segregation of restrooms, restaurants, and drinking fountains for whites and blacks.
    - Segregation of the U.S. military.
    - Segregation of federal workplaces and discrimination based on race when awarding defense contracts; initiated in 1913 under President Woodrow Wilson, the first southern president since 1856. His Administration practiced overt racial discrimination in hiring, requiring candidates to submit photos of themselves.
    - In the 1930s, the Federal Housing Administration implemented a policy that overtly discriminated against minorities by denying to back mortgages to buy homes in certain areas; this practice is known as "redlining."
    - Exclusion from white-only business systems.
    - Exclusion of marriage between whites and people of color.
- 1882: Chinese Exclusion Act restricts immigration of Chinese immigrants for 10 years and prohibits Chinese naturalization.
- 1896: The Supreme Court upheld segregation in Plessy v. Ferguson, which ruled racial segregation was legal under the doctrine of separate-but-equal.
- 1906: Naturalization Act requires immigrants speak English.
- 1920: 19th Amendment of the Constitution gave women the right to vote.
- 1938: Fair Standards Labor Act established a minimum wage, overtime rules, and child labor laws.
- 1942-1945: Executive Order 9066 required people of Japanese descent to be interred in isolation camps.
- 1954: State-sponsored segregation was declared unconstitutional by the U.S. Supreme Court in Brown vs. the Board of Education.
- 1963: Equal Pay Act prohibits sex-based wage discrimination between men and women working in the same job.
- 1964 and 1965: The remaining Jim Crow laws were overruled by the Civil Rights Act and Voting Rights Act.
- 1967: Loving v. Virginia was a Supreme Court case that struck down state laws banning interracial marriage in the United States.
- 1990: American with Disabilities Act - prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.
- 2009: Lilly Ledbetter Fair Pay Act enables individuals rights to file pay discrimination lawsuits over a longer period of time.
- 2015: Obergefell v. Hodges; U.S. Supreme Court overruled state bans on same sex marriages.

Our Nation's History of Discrimination (cont.)

As seen above, discrimination against people of color and other historically marginalized populations (e.g. immigrants, women, disabled, people of differing sexual orientations or gender identities, incarcerated individuals, etc.) is not always conscious, intentional, or personal. Often, it is built into institutional policies and practices; for example, policing and sentencing practices, bank lending procedures, and school funding that depends heavily on local property taxes. These can have inequitable effects, whether or not any individual now consciously intends to discriminate. This is called "structural or institutional discrimination," and examples include:

- **Racial segregation:** The product of deliberate discriminatory policies, called redlining, enacted in the past. Although it is no longer legal to discriminate in housing, many people of color continue to be tracked into neighborhoods with limited opportunities for health based on poor quality schools, housing, and limited access to goods and services in general; poor employment prospects; and exposure to physical and social health hazards, including social norms and role models that can kill hope. These places have been systematically denied the assets required for optimal health.

- **Voter registration:** Some states have requirements (e.g. showing a birth certificate) that can discriminate against immigrants, as they are less likely to have the necessary documentation despite meeting federal voter qualifications.

- **Incarceration:** Many nonviolent, first-time criminal offenses may qualify for diversion programs that help to keep them out of jail and get the offense expunged from their records; however, often such programs require offenders to pay substantial fees. That means people with lower incomes who cannot pay the fees are far more likely to serve jail time. As a result, they have criminal records that impact their future employment, schooling, or housing opportunities more than affluent people who have committed similar or worse offenses but were able to participate in the diversion programs.

- **Unequal pay:** In Colorado, the average working woman earns 84 cents for each $1 that a man earns, and women who are not white earn even less.[7]

Structural racism: Policies and practices that normalize and legitimize historical, cultural, institutional, and interpersonal dynamics that routinely advantage people who are white, while producing cumulative and chronic adverse outcomes for people of color, constitute "structural racism." Our history and culture have provided privileges to white individuals and disadvantages to people of color. Racism as a social construct for legitimizing power and discrimination has been a feature of our nation since its founding. Through the passage of policies, racism has been codified to the extent that it has become integrated into every facet of our nation's social, economic, and political systems.

Dig Deeper

Watch [Adam Ruins Everything: The Disturbing History of the Suburbs](), a short video that illuminates redlining, a housing policy that still affects us today.

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[7] 2018. America's Women and the Wage Gap. National Partnership for Women and Families. http://www.nationalpartnership.org/research-library/workplace-fairness/fair-pay/americas-women-and-the-wage-gap.pdf

Reflection Exercise

1. What types of discrimination do you see in your community and in society at-large today?

2. What are some examples of oppression that still exist?

3. What policies and practices are needed to minimize or eliminate discrimination?

Public Health's Role in Addressing Root Causes

Historically, when the field of public health has reflected on data when discussing health disparities, there is a tendency to blame individuals for their poor health outcomes. However, what has come to light is that the field was missing a big piece of the story related to causation. It wasn't until public health practitioners began to explore "further upstream" and return to the original public health values of fairness and justice that they began to understand how it could best serve those who are most vulnerable to poor health outcomes. By looking through a lens of race, power, and poverty, the public health field began to move forward toward real solutions that can address inequities and root causes (i.e. social determinants of health) that lead to and perpetuate health disparities.

Public health as a discipline is a product of the history of the United States where everyone has grown up absorbing misinformation about people who are "different" from themselves and their families. Despite race being a social construct (i.e. it is not scientifically or biologically real), people have learned (often subconsciously) negative beliefs, prejudices, and stereotypes that are so ingrained in U.S. culture and so widespread that a person may not even realize their beliefs are based on misinformation.

Even though public health may be said to be "neutral" in its approaches or perspectives, human beings are intimately involved with creating, interpreting, and ultimately communicating the meaning of health data or how policies get interpreted. Because of the implicit biases we all hold, public health inquiry (i.e. who gets to ask the questions or gets to decide what questions are important) and messaging (i.e. who gets to formulate or answer the questions, and who gets to decide what the solutions are that address a public health issue) can unintentionally result in prolonging poor outcomes and inequities, and thus perpetuate structural racism.

Often unseen, or seen as "normal," structural racism is characterized by preferential treatment, privilege, and power for white people at the expense of black, Latino, Asian, Pacific Islander, Native American, Arab, and other racially oppressed people. [8] In order to confront social determinants and the root causes of poor health, public health practitioners must be willing to openly talk about structural racism, oppressive institutional policies and practices, and personal biases that perpetuate health disparities. These topics can make people uncomfortable or even defensive; however, by engaging officials and community stakeholders in inclusive conversations, public health can help to drive changes needed to increase health equity and transform systems.

The Office of Health Equity, in partnership with community organizations and other state agencies, released an Equity Action Guide, accessible here in August 2018. The Equity Action Guide looks at the root causes of inequity across Colorado through an in-depth review of historic laws and policy, present-day stories, and data. The Guide provides direction for cross-sector dialogue and sustainable community informed decision-making.

The First Step Toward Addressing Inequities

First, it is important for public health practitioners to critically examine their values and the institutions they interact with. By not recognizing or acknowledging the societal falsehoods about people and segments of U.S. society, public health practitioners can unintentionally become active participants in the perpetuation of inequality. The onus is on each person to explore these issues, take responsibility, and think more critically about how to make visible the falsehoods that have been learned over a lifetime, and to begin to deconstruct and dismantle the dynamics in this country that give advantages to some people while disenfranchising others. By working together with communities and multisector organizations, public health can help to facilitate change.

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[8] Lawrence, K., & Keleher, T. (2004), Structural Racism and Chronic Disparity: Strong and Pervasive Evidence of Racial Inequalities POVERTY OUTCOMES. Race and Public Policy Conference

STRUCTURAL INEQUALITY AND PUBLIC HEALTH

Indicators of structural racism are inequalities in power, access, opportunities, treatment, and policy impacts and outcomes, no matter whether they are intentional or not. Structural racism is often difficult to pinpoint within institutions because of the reinforcing effects of multiple institutional policies and cultural norms that continually produce new and reproduce old forms of racism. To unpack and disentangle the complexities that perpetuate inequities requires a long-term commitment to creating systems change.

Reflection Exercise

1. Look at local data related to a variety of indicators/topics. If you don't have data readily available, you can access Colorado Department of Public Health and Environment (CDPHE) Center for Health and Environment data [here](#). Data to consider include:

   - Poverty
   - Patterns in home ownership
   - Access to credit (e.g. credit denial rates)
   - High school dropout and graduation rates
   - Access to food
   - Access to transit routes
   - Vehicle ownership
   - Health outcomes

   a. Are there disparities between racial or ethnic groups? Does this vary by geography or neighborhood?

   b. Discuss upstream and systems reasons that may have led to these disparities based on what is known about the history of the community. Start by asking "why?" five times to unpack the issues that might contribute to a public health problem. Explicitly consider and discuss the role of institutional or structural discrimination in the differences.

   c. Consider adding a statement of why those inequities exist, any time your agency publishes data on health disparities.

2. To make observations about local public health offices:

   a. Critically examine the race/ethnicity of the people who appear in educational materials, campaigns, and posters in the office that are distributed to the public.

   b. Consider who makes up the board of health, organizational leadership at the director and management levels, and mid-level and frontline staff.

   c. Examine pay equity by race and gender within your organization.

   d. Examine your organization's recruitment policies and practices.

Case Study: Structural Racism and Food Systems in Denver

Lack of access to nutritious, affordable food and food insecurity contributes to poor health outcomes related to cardiovascular disease, diabetes, and obesity. Many local public health agencies and numerous community-based organizations are addressing health disparities and upstream "root causes" in local food systems that contribute to poor outcomes. What many may not realize is that lack of access to healthy food is one result of the long history of structural racism. When delving into this complex issue, it may not be immediately evident; however, access to food is connected to early policies in this country related to who can own land — explicit and implicit redlining (the practice of denying housing and other essential goods and services based on race) and the systematic disinvestment in certain neighborhoods by grocery retailers, financial entities, and public institutions, and even the continued commodification of land by developers impacts access for many low-income communities and communities of color.
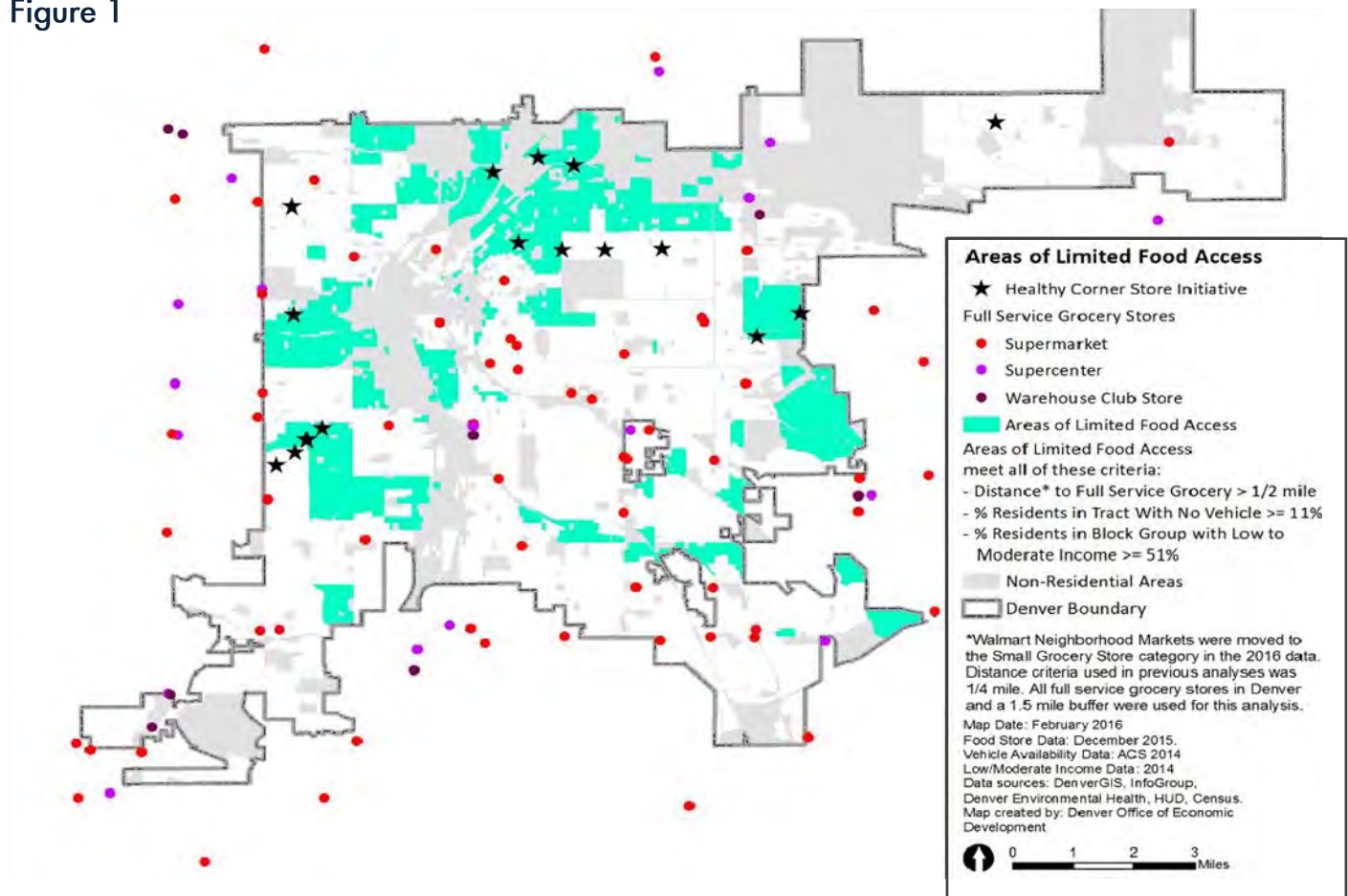
Many neighborhoods in Denver, for example, do not have convenient access to nutritious, affordable foods. Figure 1 below highlights the areas in Denver (shown in turquoise) that have limited access to nutritious foods based on distance to a full-service

Case Study: Structural Racism and Food Systems in Denver (cont.)

grocery store, vehicle ownership, and household income levels. Types of full-service grocery stores are indicated by the red, purple, and black dots. Stores currently participating in the Denver Department of Public Health and Environment Healthy Corner Store Initiative are indicated with stars. If other maps related to obesity rates, poverty and SNAP (i.e., food stamp) eligibility were to be overlaid on top of the map, many of the same neighborhoods would be highlighted.

Figure 1

The issue of limited access to healthy, affordable food in Denver neighborhoods is not new. In fact, Denver's first integrated neighborhood lost 3 grocery stores in the late 1960s — over 40 years ago — and they have yet to be replaced. The loss of full-service grocery stores occurred during a time (simultaneous with the Civil Rights movement) when white city dwellers moved from racially mixed urban areas to more racially homogenous, suburban parts of the Denver Metro area in response to a so-called "invasion" of African American residents moving into the neighborhood.

The large-scale out-migration from urban settings, or "white flight," was seen in urban areas across the country during the 1960s and 1970s. As African American residents moved in, many white people moved out, and the local businesses followed, including the grocery stores. The loss of these economic "anchors" within neighborhoods also resulted in loss of other goods and services in the neighborhood when other smaller stores closed in response to the departure of larger grocery stores. Over time, the grocery retailers changed their model to the larger supermarkets in suburban areas seen today.

Despite the ongoing outcry of local residents and relatively recent development of multiple incentive programs (e.g., Colorado Fresh Food Financing Fund) that encourage grocery retailers to open stores in underserved communities, no grocery store has returned to many of the urban neighborhoods losing grocery so long ago. Numerous grocery stores have been built in other parts of the city, including some within relatively close proximity to the neighborhoods that lost stores. As private companies, grocery retailers consistently choose to place new stores in areas perceived as higher-profit locales. In fact, the Sprouts
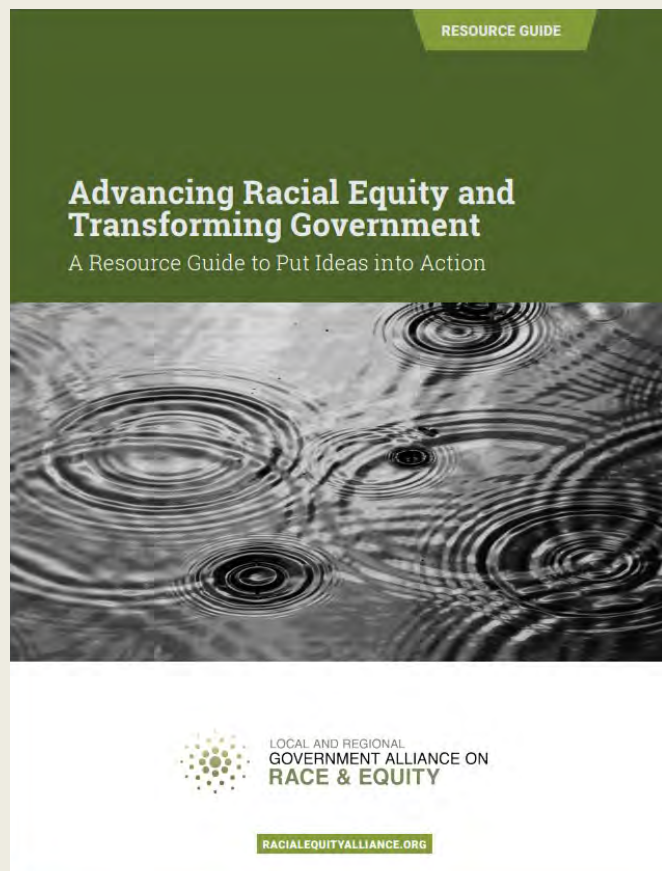
Case Study: Structural Racism and Food Systems in Denver (cont.)

Farmers Markets website plainly states that they seek customers with above-average per capita incomes, which are mostly white collar workers with at least a four-year college degree. Grocery store selection criteria like that perpetuate inequities by further focusing goods, services, and capital toward more advantaged neighborhoods that ultimately benefit more advantaged households. These selection criteria, common among most grocery store chains, could be interpreted as a form of perpetuating the systems and structures that reduce access to services based on income, education, and occupation, all of which are strongly correlated with race.

Resource:

[Advancing Racial Equity and Transforming Government: A Resource Guide to Put Ideas Into Action,](#)

from the Local and Regional Government Alliance on Race and Equity, is an excellent tool for local government agencies looking to build organizational capacity, implement racial equity tools, use data and metrics, and communicate and partner with others .

STRATEGIES FOR ADVANCING HEALTH EQUITY

"Equity is about creating systems where everyone can thrive."

Dr. Nita Mosby-Tyler, Chief Catalyst, The Equity Project, LLC

Achieving health equity requires vigilance and strategic action by public health practitioners and other stakeholders to ensure that communities, whether defined by geography or social identify, have equal opportunity to be as healthy as possible. Progress toward health equity should be assessed by measuring how health disparities and structural inequities change over time, in absolute and relative terms. The gaps are closed by making special efforts to improve the health of groups that have been excluded or marginalized. Recognizing that we are all connected, it should be noted that policies and programs designed to benefit vulnerable groups often end up benefiting all of society.

A wide array of upstream actions can be used to advance health equity and reduce health disparities. These include, but are not limited to, working with community partners toward:

- Creating good jobs with fair pay.
- Expanding access to affordable high quality education.
- Expanding access to high-quality health care, including specialty care.
- Expanding access to nature and high-quality parks.
- Offering affordable and safe housing.
- Improving our communities' social capital through volunteering and community events.

Reflection Exercise

1. Review the upstream actions listed above.

   a. Thinking about communities that your agency works with, what upstream challenges are being faced by those community members right now?

   b. What can public health do to help address those issues?

   c. What upstream challenges must be addressed to move toward health equity?

STRATEGIES FOR ADVANCING HEALTH EQUITY

Engaging the Community

Working on these upstream actions requires an inclusive approach where all voices are heard and included in decision making. Often, the groups most affected by health disparities are excluded from conversations and may be excluded from the health-promoting resources public health has to offer. Society has pushed these groups to its margins, depriving them of inadequate access to key opportunities. Examples of groups historically marginalized include, but are not limited to:

- People of color
- People living in poverty, particularly across generations
- Religious minorities
- People with physical or mental disabilities
- LGBTQ persons
- Women
- Undocumented people
- Incarcerated people
- The homeless
- Elders
- Veterans

Community engagement efforts must be intentional about diversity and inclusion and afford equal access to participation.

Reflection Exercise

1. Review the list of historically marginalized groups of people above.

    a. Are there any other groups that have been marginalized in your community?

    b. Thinking about your community, which groups would you want to focus on engaging? Why or why not?

    c. What supports might be needed to bring their voices to the table (e.g. child care, meals, off-hour meetings, language interpretation and translation, etc.)?

Key Considerations for Strategic Planning in Public Health and Transforming Our Institutions

"When we move toward a society committed to health equity, we work to ensure that everyone – regardless of race, neighborhood, or financial status – has fair and equal access to a healthy community of opportunity ." PolicyLink

Our work is shifting. Multisector partnerships are working together to create solutions to complex problems that support inequitable conditions within our society. In public health, we must look upstream at the inequitable policies and systems that contribute to health disparities we see across all of our communities, and we must include those most impacted in the community in the problem-solving efforts. We also must examine our personal values and seek to transform our public health institutions.

Key Considerations for Strategic Planning in Public Health and Transforming Our Institutions (cont.)

Actions that can be taken to accomplish that include:

1. **Change the narrative.** This can be done by including groups that have been excluded and/or marginalized in planning and implementation efforts in the past. These community and cultural experts know what is happening within their own communities, and they have powerful ideas and stories about their lived experiences. Invite these people in. Remember that individuals within a social identity group have different experiences of disadvantage.

2. **Monitor disparities.** Commit to health equity by monitoring not only overall (average) levels of health and the resources needed for health in a whole population, but also routinely comparing how more and less-advantaged groups within that population are faring on those indicators. It's important to measure health disparities, not only to document progress, but also to motivate action and identify resources needed to achieve greater equity.

3. **Consider developing a data index** outside of health to measure and document changes in community discrimination practices (e.g. hate crimes; denial of voting; marriage violations; discriminatory practices in housing, bank lending, and criminal justice; etc.).

4. **Begin the work of transforming public health institutions:**
   - Embed health equity into your day-to-day practices.
   - Use a common language and develop guiding principles for your staff.
   - Build community coalitions and partnerships.
   - Advance policies and practices that use equity indicators.

5. **Improving hiring practices to increase agency diversity**
6. **Increase diversity at the top**

Dig Deeper:

Check out the Colorado Office of Health Equity's Sweet Tools to Advance Health Equity, and put them into practice.

Resources:

The Human Impact Partners Health Equity Guide is a great tool to facilitate internal and external change for health equity. The guide outlines key strategies for building internal infrastructure, working across government, fostering community partnerships, and championing transformative change. You can find real life public health examples of this work in King County, Washington; Madison & Dane County, Wisconsin; and Boston Massachusetts.

RESOURCES

[City and County of Denver Health Equity Index:](#) This index considers socioeconomic, built environment, and health conditions at a geographic level. This index can help strategically target resources to improve access to opportunity in Denver for jobs, education, transportation, safety, and physical and mental well-being. It is being used in the city's comprehensive and neighborhood planning initiatives.

[PolicyLink:](#) This is a national research and action institute that advances racial and economic equity; it seeks to "lift up what works" and scale to impact equity. PolicyLink offers a variety of policy publications, tools, resources, and educational opportunities.

[Human Impact Partners Health Equity Guide:](#) This is a great tool for facilitating internal and external change for health equity. The guide outlines key strategies on building internal infrastructure, working across government, fostering community partnerships, and championing transformative change.

[Advancing Racial Equity and Transforming Government:](#) A Resource Guide to Put Ideas Into Action: This guide is from the Local and Regional Alliance on Race and Equity and is an excellent tool for local government agencies looking to build organizational capacity, implement racial equity tools, use data and metrics, and communicate and partner with others.

[Undoing Racism:](#) The Connection Between Race and Poverty and What Can We Do About It: This is a presentation from Solid Ground, an organization that provides practical suggestions on what you can do to learn, act, and engage around issues of race and health equity.

[White Privilege: Unpacking the Invisible Knapsack and Some Notes for Facilitators:](#) This is by Peggy McIntosh, 1989, and is available at https://nationalseedproject.org/white-privilege-unpacking-the-invisible-knapsack; accessed April 26, 2018.

CDPHE [Health Equity and Environmental Justice Resource Page](#)

[Waiting for Health Equity: A Graphic Novel:](#) By the Center for Health Progress.