Health Equity Council

**Health Equity Primer**

## Authors

* Health Equity Council Chair: Louise Square, BA, New York State Department of Health
* Gail Brandt, BS, MPH, EdD, NACDD Health Equity Council Member, Washington State Department of Health (retired)
* Cheryl Farmer, MD,
* Vivian Lasley-Bibbs, MPH, KY Dept. for Public Health
* Valerie McAllister, CDP, Virginia Department of Health
* Robyn Taylor, MBA, Senior Director of Health Equity, National Association of Chronic Disease Directors
* Lynn Walton-Haynes, DDS, MPH, California Department of Public Health
* Renaldo Wilson, MA, ACSM-CEP, Health Equity Consultant, National Association of Chronic Disease Directors

## Sections

1. Introduction and History of the Health Equity Council
2. Purpose of the Primer
3. What is Health Equity?
4. The Social Determinants of Health and our health and wellbeing
5. Build Capacity among Staff
6. Forge Multi-Sectoral Partnerships
7. Follow the Data
8. Evaluate our efforts
9. Sustainability

# Introduction and History of the Health Equity Council

The National Association of Chronic Disease Directors (NACDD) is well grounded in the principles of public health. Public Health is defined as “the art and science of preventing disease, prolonging life, and promoting health through the organized efforts of society” (Acheson, 1988; WHO)”. Areas of responsibility include assuring an effective public health infrastructure, promoting healthy communities, preventing the spread of disease, protecting against environmental health hazards, responding to emergencies, and assuring health services for all. Historically, public health focused on behavioral change at the individual level. After years of following this approach, there has been a recognition that goes beyond behavioral change to include efforts to create resources that influence where people live, learn, worship and play.

NACDD was an early adopter of the notion that the only way to improve the overall health of Americans, was to focus on health disparities. In 2005 the Association reached out to all state chronic disease programs to solicit individuals interested in becoming part of the newly formed Health Disparities Interest Group (HDIG). Increasingly the council began to better understand the data that showed some disparities/differences are, unfair, avoidable, and often seen along racial and socio-economic lines and are, in fact health inequities. As the interest group evolved to embrace these facts it seemed that a name change that reflected the goal of the group was in order. The HDIG was renamed the Health Equity Council, elevating its status to of the other Association councils.

The Council is open to every state and territory in the US and comprised of representatives from state chronic disease programs and other health equity entities. The Council is member driven group which means HEC members have worked hard to understand and respond to the needs of member states. Council members clarified terms used when discussing health equity and consistently focused on the urgent need to address it. The council created tools to help build states’ capacity to address health inequities and convened meetings with partners to promote health equity.

Working in alignment and often in collaboration with the Health Equity Council unified efforts, the council brings together members to respond to social factors that limit efforts to achieve equity. In summary, HEC members are responding to needs identified by states to help them move toward health and racial equity. In fact, members raised concerns asked the questions about the steps necessary for their organizations to have a health equity focus which inspired the development of this primer (rhymes with simmer).

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| Are you a member of the NACDD Health Equity Council? *Click in the box to start typing.* |

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| If so, who attends the HEC Meetings on your behalf? (name, email address)? *Click in the box to start typing.* |

# Purpose of the Primer

The purpose of this primer is to provide the reader with action steps to begin or advance work in organizational health equity. This primer lays out a foundation of health equity through well-defined terminology, evidence-based theory, and historical context. Through case studies, the primer offers examples of how to begin or advance health equity work. The goal is to offer a deeper understanding of health equity and the processes by which to achieve it, thereby increasing the reader’s confidence in pursuing health equity within an organization.

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| Do you have a health equity mission or vision statement? *Click in the box to start typing.* |
| If so, what is your mission and vision? *Click in the box to start typing.* |

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| Who is your health equity champion? *Click in the box to start typing.* |

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| Who is on your health equity team, committee, working group or collaborative? *Click in the box to start typing.* |

# What is Health Equity?

*Health equity* exists in an environment where everyone can attain their highest level of health through the inclusion of equitable access to opportunities and resources rooted in the social determinants of health – the conditions in which people are born, grow, work, live, and age. These conditions are shaped through economic, social, environmental, and political policies and systems. Health inequities and health disparities are not synonymous.*Health inequities*are outcomes in health that are avoidable, unfair and unjust.Health inequities are systematic differences in health outcomes. Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age, (The World Health Organization)

By contrast, *health disparities* are health differences between different groups of people. These health differences may include:

* How many people get certain diseases?
* How severe the diseases are?
* How many people have complications because of the diseases?
* How many people die from a disease?
* Whether people can get health care.
* How many people get screened for a disease?

**What are your short- and long-term health equity goals?**

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| Short-term *Click in the box to start typing.* |
| Long-term *Click in the box to start typing.* |

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| What chronic disease disparities are you working to address? *Click in the box to start typing.* |

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| What groups experience the greatest health disparities in your state? *Click in the box to start typing.* |

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| What action steps are you taking to achieve health equity in your state health department? *Click in the box to start typing.* |

# Understanding the Role that Social Determinants of Health (SDOH) Play in Health and Well Being

*Social determinants of health* (SDOH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age. These conditions affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Practical examples of SDOH can include, but not limited to a person’s socioeconomic status, education, neighborhood and physical environment, employment, access to quality fruits, vegetables and meats, social support networks, housing, social services, geographical location, transportation, and education. Societal systems of oppression (e.g., racism, sexism, ageism, etc.) which become unexamined community norms are also social determinants of health. To better support the practical understanding that social determinants of health play in a person’s health and well-being, I want to introduce you to Sarah.

**CASE STUDY**

Sarah is a 34 year old single parent of four children, all under the age of ten. Sarah is employed making $25,000 a year. The hours are long, and her job is a 45 minute drive away. There is minimal public transportation in her area. Therefore, her livelihood depends upon her use of a personal vehicle. Sara doesn’t get paid leave (vacation or sick). So, if she or one of her children become ill and she is unable to work she won’t be paid. Her employer does offer health insurance but, the coverage is minimal.

Sarah works hard to provide a better life for her children; however, the only affordable housing Sarah could secure was substandard and in a poor neighborhood. She doesn’t feel safe walking in the neighborhood or allowing the children to play outside. She has to deal with insects and rodents from time to time no matter how much she cleans. The droppings and the dust trigger her youngest child’s asthma. The location of her housing also places her children in a school district that provides sub-par education.

Sarah’s doctor told her recently that she has a heart condition that requires her to take several medications. The doctor also advised her to lose weight by exercising and making healthier food choices. The medications the doctor prescribed are not all covered by her minimal insurance.

After Sarah pays her rent, utilities, and after-school care for her four children while she works. Additionally, there are weeks when her paycheck falls short because she’s had to take (unpaid) time off to care for her child when their asthma flares up. There are times when Sarah is unable to afford her medication. She tries carry out the other instructions the doctor gave her about eating healthier but when she tries to purchase healthy foods, she must consider the minimal food budget left after she pays all her bills. Sarah must purchase foods that are economical and will last the longest until her next paycheck. Sarah wants to begin to exercise more. She used to run track in high school but, she doesn’t feel that running or walking in the neighborhood is an option. Joining a gym doesn’t fall within her budget and, even if it did when would she find the time and the childcare that would allow her to go? She has limited time between work, attending to the children after she picks them up from day care, cooking, helping them with homework, and preparing for the next day. Last week, Sarah’s car broke down. She has no extra money to pay to have it fixed. As a result, Sarah’s only source of income is now in jeopardy.

What social determinants are impacting health outcomes for Sarah?

\*Disclaimer: *The NACDD Health Equity Council recognizes that this case study is not reflective of all the intersectionality of challenges faced by the various demographic groups in diverse geographies who carry the burden of chronic disease and inequities in the United States.*

## CASE STUDY REFLECTION

In the case study we provided Sarah is an individual with specific issues that are reflected in her access to certain social factors that reach beyond her access to medical care. However, Sarah could just as easily be a neighborhood or a community in your state. Many of the issues she faces are systemic and go beyond her individual control.

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| What is the role of state public health in working to improve the social determinants of health?  *Click in the box to start typing.* |

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| What Social Determinants of Health partners have you engaged? *Click in the box to start typing.* |

There may be many answers to this question depending upon your state health department’s capacity, existing partners, etc., but the bigger questions are how would your state health department support measures to address upstream factors and the root causes of health inequities?

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# Building Capacity Among Staff

While Public Health strategies continue to evolve to engage the social determinants of health partners, formal education lags when preparing public health leaders to successfully implement strategies outside of the public health realm. National leaders such as the Robert Wood Johnson Foundation have created opportunities to expand capacity and experience by partnering with social and economic partners. Additionally, there are organizations such as the National Association of Chronic Disease Directors that provides capacity building opportunities for Chronic Disease Directors and their staff through an offering of trainings, communities of practice and tailored support.

The graphic below shows a framework for reducing health inequities at multiple levels.

Timeline

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Graphic courtesy of Bay Area Regional Health Inequities Initiative

Historically, public health focused on individual behavior change, health education and access to health care. Recently, public health continued to evolve working not only to affect positive behavior change such as promoting healthy eating and physical activity to partnering with social determinant of health partners. Public health professionals are positively impacting policies that influence the conditions where people live and look at the systemic and structural barriers to health for diverse populations by examining policy through an equity lens. And now efforts have included addressing classism, racism, sexism, and other isms.

Public health’s action to promote health equity and address health inequities and disparities must include ongoing capacity-building among public health staff and partners as the work continues to evolve. This will help practitioners be prepared to respond to the ever-changing challenges to promoting equity.

Another strategy is to make sure your state chronic disease program has identified an organizational health equity champion. The health equity champion should be someone in a leadership role who can help to advance and sustain the deployment of equitable strategies to promote optimal health for all.

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| What health equity training opportunities have you offered to your team? *Click in the box to start typing.* |

# Forging Multi-Sectoral Partnerships

With understanding that health is a result of a person’s access to the things needed to be healthy in their communities. Public health cannot do this work alone. Public Health should be intentional with forging multi-sectoral partnerships. It is important to seek a *collective impact*, a term first referenced in a 2011 article in the Stanford Social Innovation Review[[1]](#footnote-1). Collective action has proven to be a powerful approach in tackling a wide range of issues in communities all over the world. *Collective impact* is one of several tools that brings people together, in a structural way, to achieve social change. The collective impact starts with a common agenda, establishes shared measurement, fosters mutually reinforcing activities, encourages continuous communication and has a strong backbone organization.

We need to engage partners from a variety of different sectors in order to provide the best service and support to the communities we serve. It starts with effective communication which includes having diverse representation at the table from the start. Working with a diverse group to develop an action plan to address issues is important while making sure each voice is valued. Each journey begins with an initial step, developing and growing multi-sectoral partnerships is that first step in establishing a solid foundation for this work. Increasing awareness and attention has been focused on the need for inclusion of those directly impacted by work that is being done to create change.  From the disability justice community came the message “Nothing about us without us.”  This means not just having professionals who work with those impacted but ensuring that the community itself is mobilized and empowered to participate[[2]](#footnote-2).

The Robert Wood Johnson Foundation coined the phrase *Health Begins Where We Live, Learn, Work, Worship and Play.* It is important that Public Health organizations and professionals invest time and resources in developing partnerships with Social Determinants of Health partners. Strong partnerships spanning an array of sectors—including public health, housing, education, transportation, and others—are the bedrocks of healthy communities.

As public health professionals increasingly engage diverse partners, it is important to be intentional and to constantly add to the list of partners that are at the table. In addition to organizational partners, it is important to include community members at the table as well. Community members understand the challenges and potential solutions and will be instrumental to developing opportunities and solutions that resonate with community.

Common Agenda

All participants share a vision for change that includes a mutual understanding of the problem and a joint approach to solving the problem through agreed-upon actions.

Shared Measurement

All participating organizations agree on the ways to measure and report success, with a concise list of common indicators identified and used for learning and improvement.

Mutually Reinforcing Activities

A diverse set of stakeholders, typically across sectors, coordinate a set of differentiated activities through a mutually reinforcing plan of action.

Continuous Communication

All players engage in frequent and structured open communication to build trust, assure mutual objectives, and create common motivation.

Backbone Support

An independent, funded staff dedicated to the initiative provides ongoing support by guiding the initiative’s vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing resources.

Public health has a unique opportunity to use community organizing principles to frame issues to radically transform the living conditions and opportunities for communities. This includes working with the community to identify and frame the problem, develop messaging and connecting with decision makers to inform strategy. Community mobilization is essentially a process for reaching out to different sectors of a community and creating partnerships to focus on, and ultimately address, a public health issue.

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| What partners have you engaged? *Click in the box to start typing.* |

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| Which partnerships have been most affective for your department? *Click in the box to start typing.* |

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| Who is missing from the table? *Click in the box to start typing.* |

# Follow the Data

As health equity specialists we recognize the importance of data in addressing not only the social determinants of health (where we live, work, and play) but those systemic and institutional barriers (racism, genderism, ableism and the like) impacting marginalized and vulnerable populations. Research has shown that place truly does matter; your zip code is a determinant of health outcomes more than your genetic code (RWJF, 2009). These social indicators have been longstanding and continue to be the drivers of persistent disparity gaps seen in racial and ethnic minority communities and people of lower social economic status.

Graphical user interface, website

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## Why is Data so Important in Advancing Health Equity?

As we work to advance health equity it is necessary to understand where disparate health conditions occur and at the highest (worst) levels. We also need data to reflect how health disparities, health inequities and social determinants are distributed by geography. It is equally important to understand which social determinants are correlated with other disparate health issues. Data tools help us with:

* Resource allocation for COVID-19 Response (vaccines)
* Reaching vulnerable and minority populations for outreach and communications
* Doing Health Equity work (or adapting current work using a health equity lens)
* Source of sub-county data for Community Health Assessment Community Health Improvement Plan, & Public Health Accreditation Board (CHA/CHIP/PHAB) process
* Program Planning and evaluation
* Targeting interventions
* Program justification and work plans
* Grant writing
* Increase Community Capacity to understand and address community health inequities.

These data tools can support your health equity work being data-driven, support resource allocation decisions, prioritize vulnerable populations, show how place (environment) can impact our health, provoke thought and work on addressing root causes and social determinants of health.

## What data elements should we be capturing to address health inequities?

Data is often where we fall short in having the necessary information to address the health disparities and health inequities seen in our communities. The demographic data needed to access the impact of an occurrence or disease within and among populations, many times for minorities, is often time labeled as “missing”, “not collected”, “not applicable”, or entered as “other”. If the data is not representative of what is truly happening in communities, we may not recognize the severity of the problem resulting in not providing the necessary intervention or program to close the disparity gap. In addition, data collection often varies from state to state, program to program and across local health departments as well. The national emphasis is to standardize what is collected so we can have a more accurate picture of what poor heath and health outcomes are impacting communities of color and those communities with lower socio-economic status. The five minimal data elements we recognize as standard data elements to be used to describe the disparities seen in in specific populations: race/ethnicity, age, gender, disability status, and primary language spoken. *The data elements are ever-changing and evolving, but it is very important at the very least to collect the data using the standardized five data elements.*

## What Data Tools should I have to do Health Equity Work?

The path forward “is science and obtaining the data—and when we don’t have it, it impairs our ability to act effectively,” said Dr. Harris. Access to not only health data but other social indicators i.e., housing, graduation rates, employment, health care coverage, and home ownership can also speak to inequities that can be predictors of poor health and health outcomes. There are many data tools and data resources available and are listed here:

* County Health Rankings
* Community Commons
* Behavioral Risk Factor Surveillance Systems (BRFSS)
* American Community Survey
* Census Data
* Center for Disease Control and Prevention

## What if we do not have staff to analyze data?

* Both internal and external partnerships and collaborations are an important piece of your data collection plan. Sharing subject matter expertise can be a valuable resource in validating health disparities. They also allow programs to realize these disparities exist when stratified and sorted by the data elements mentioned above or those other social indicators that we know drive inequities. The conversations and resulting action steps that may result can be the first in creating an environment of change. In addition, partnering with organizations that have identified disparities, used a health equity framework, and used a health equity lens can also be very helpful in identifying the necessary transformation needed to address health inequities. Finally subject matter experts can also be supported through grants or other cooperative agreements.

## Telling the Story

It is important to note that quantitative data (the analysis of numerical data to explain what, who, and how an issue impacts a community) does not include important information regarding other factors that influence health, such as a personal values and beliefs about health or healthcare, housing stability, financial strain, culture, gender identity, food insecurity, social connectedness, and other social determinants of health. Qualitative data provides insight into the “why”. It gives us added information to help us understand how communities not only see themselves, but their future, their history, and the ways those can change over time. It also gives us information about the effect of structural and social influences on individuals and communities. Both qualitative and quantitative analysis gives us unique insight on how best to engage with communities in efforts to address inequities. Combining qualitative and quantitative methodology is a powerful tool in understanding certain occurrences and the circumstances surrounding them.

## Example of qualitative research:

* Interviews (one-on-one, focus groups)
* Notes of observations
* Case studies
* Video, audio, images
* Social Media
* Textual documents (written answers to survey questions, diaries, journals, logs, web pages)

## Trainings and resources

To address health disparities and inequities impacting population health; programs, divisions, and offices must assume responsibility for the interpretation, translation and dissemination of data of impacted communities. This may require additional training of staff and allocation of resources. This may involve recognizing the need for not only better collection of demographic data, but courses, webinars, and modules related to health disparities, culturally humility and racial equity, and other evidence-based approaches. Equity work is grounded in the socio-ecological model, but we must take that a step further and understand how current and historical injustices, research and interventions, structural and institutional barriers and the implications of structural racism and other “isms” impact on population health. Lastly recognizing continued learning and innovative ideas on advancing equitable policy and dismantling systems, and environmental injustices can all be improvement strategies—all with the goal of reducing health disparities and advancing health equity.

## What are the next steps?

The organization should continue to work to build capacity for data analytics and interpretation to understand the inequities and, the upstream factors or root causes driving the inequities that have been identified. Recommendations should be developed on how to address the inequities and actions to be taken based on the qualitative and quantitative data. This work should become normalized and operationalized throughout the organization, integrating health equity data into all its prevention efforts. In addition, continuous quality improvement should always be the goal in efforts to ensure the evolution of organizational capacity to recognize disparities where they exist to reduce health inequities throughout the organization and infuse those changes into program efforts that reach our minority and vulnerable

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| Does your state chronic disease program have a person dedicated to analyzing disparities data? *Click in the box to start typing.* |

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| What Census Tracts, Census Block Groups and/or Zip Codes carry the burden of chronic disease in your state? *Click in the box to start typing.* |

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| What groups carry the burden of chronic disease in your state? *Click in the box to start typing.* |

# Evaluating our Efforts

Often in Public Health we target our interventions to reach those disparate groups that might not otherwise be impacted by population-wide interventions. For example, population wide strategies may lead to overall health improvements but at the same time may cause inequities to widen. Similarly, a targeted program for diabetes prevention may be needed for a particular group or community that may not be impacted by a population-wide intervention. Evaluations with a health equity focus help us to understand what works, for whom, under what conditions, and reveal whether health inequities have decreased, increased, or remained the same.

The use of a logic model can be helpful in incorporating heath equity activities, goals and expected outcomes. This will allow you to clearly show the expectation or intended efforts of health equity on the program. Important things to consider when integrating health equity into your evaluation plan to ensure that health equity goals and outcomes are incorporated:

1. Engage stakeholders so they can help with evaluation design and focus questions.
2. Include evaluation questions that will determine what has worked for whom, under what conditions.
3. Make sure that the evaluation tool is culturally appropriate as well as the data collection methodology and tools.
4. Include both process and outcome evaluation.
5. Select indicators and variables that can be used across various populations or settings.
6. Use both qualitative and quantitative methods to determine the impact as it relates to health inequities.
7. Ensure health equity is reflected in the conclusions.

The evaluation results should be shared with the stakeholders, community or population impacted to share lessons learned as to what worked and what did and to increase awareness of those gaps that may ultimately help in program refinement, and policy or system change.

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| Do you have a health equity logic model? *Click in the box to start typing.* |

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| How will you measure success? *Click in the box to start typing.* |

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| What data will you use to track progress and how often? *Click in the box to start typing.* |

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| Considering the long-term outcomes, how will you evaluate your strategies? *Click in the box to start typing.* |

# Sustainability

Planning for sustainability of health equity efforts is as essential as initiating those efforts. “Intentionally building sustainability strategies, activities, and partnerships into your work will help you achieve impact goals and support continuation of your program.”[[3]](#footnote-3)

In addition to continuous evaluation processes described in the previous section, strategies for sustainability of health equity practices include:

* Build **community partner** buy-in to continue program implementation beyond funding allocations.
* Influence **clinical practice** through promoting continuing medical education
* Influence **organizational and institutional policies** (e.g., instituting social determinants of health screening protocols, sustaining changes in referral processes)
* Engage **health system administrators** to reshape organizational resource allocation and funding flows
* Secure additional **philanthropic, state, and federal funding**
* Work with **private and/or public payers** to change reimbursement eligibility
* Conduct and disseminate **research** that captures effectiveness of a new intervention/approach to spur replication by others.

Not every organization or program within an organization will be able to immediately utilize all the above strategies. Collaborate with partners (see Forging Partnerships section above) to increase adoption and operationalization of strategies to support sustained effort and achieve desired outcomes.

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| What is your strategy for sustaining health equity strategies? *Click in the box to start typing.* |

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| Considering the long-term outcomes, how will you evaluate the impact and sustainability of your actions? *Click in the box to start typing.* |

# Conclusion

In public health areas of responsibility include assuring an effective public health infrastructure, promoting healthy communities, preventing the spread of disease, protecting against environmental health hazards, responding to emergencies, and assuring quality health services for all. Through the National Association of Chromic Disease Directors, the Health Equity Council members have worked hard to understand and respond to the needs of member states. This tool offers guidance based on experience of members in applying these recommendations within state public health departments. The purpose of this primer is to share action steps to begin or advance work in organizational health equity. This primer lays out a foundation of health equity through well-defined terminology, evidence-based theory, and historical context. Through case studies, the primer offers examples of how to begin or advance health equity work. The goal is to offer a deeper understanding of health equity and the processes by which to achieve it, thereby increasing the reader’s confidence in pursuing health equity within an organization. Not every organization or internal program will be able to immediately apply all these strategies. Time, patience, and collaboration will help to increase adoption and operationalization to support sustained effort and achieve desired outcomes.

# Appendix

1. Terminology
2. Resources
3. The NACDD Health Equity Council Meeting Schedule, Purpose and the Work

## Terminology

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| **Term** | **Definition** | **References and Further Reading** |
| **Ableism** | Ableism is a set of beliefs or practices that devalue and discriminate against people with physical, intellectual, or psychiatric disabilities and often rests on the assumption that disabled people need to be ‘fixed’ in one form or the other. | [Center for Disability Rights](https://cdrnys.org/blog/uncategorized/ableism/)[Why You Need to Stop Using These Words and Phrases](https://hbr.org/2020/12/why-you-need-to-stop-using-these-words-and-phrases/)[Healing Justice Commons](https://www.healthjusticecommons.org/)[Sins Invalid](file:////Users/paigerohe/Desktop/Comms%20Quick%20Stuff/yworkday.com/tcsedsystem/d/inst/13102!CK5mGhEKBggDEMenAhIHCgUI1A0QDxq-AQoGCAMQgawCErQBEjoI22gaCgoGCAMQp7EBEgAaEQoGCAMQ-qsCEgcKBQjjGRAvGgoKBggDEP_rAhIAGgoKBggDEICsAhIAEjoI22gaCgoGCAMQp7EBEgAaEQoGCAMQ-qsCEgcKBQjjGRASGgoKBggDEP_rAhIAGgoKBggDEICsAhIAEjoI22gSCQoFCAQQ0HYSABoSCgYIAxD_qwISCAoGCOMZEJECGgoKBggDEP_rAhIAGgoKBggDEICsAhIA/cacheable-task/2997$2151.htmld#backheader=true) |
| **Bias** | Bias is an inclination of temperament or outlook. Bias is also a personal and sometimes unreasoned judgment. | <https://www.merriam-webster.com/dictionary/bias>[Health Care Has a Bias Problem: Here’s how to fix It Podcast](https://www.commonwealthfund.org/publications/podcast/2019/nov/health-care-has-bias-problem-heres-how-fix-it?gclid=CjwKCAjw95yJBhAgEiwAmRrutIpB6J8cXFKcgr_E7l0mOsCbSlfzIsfLcqUosZLwVMVdhKVTVodZFRoCGAsQAvD_BwE) |
| **Classism** | Classism is differential treatment based on social class or perceived social class. Classism is the systematic oppression of subordinated class groups to advantage and strengthen the dominant class groups. It’s the systematic assignment of characteristics of worth and ability based on social class. | [What is Classism?](https://classism.org/about-class/what-is-classism/) [Health inequalities by class and race in the US: What can we learn from the patterns?](https://scholar.harvard.edu/files/davidrwilliams/files/2010-health_inequalities_by-williams.pdf) |
| **Downstream Strategies** | Downstream strategies are interventions which often involve individual-level behavioral approaches for prevention or disease management. | [Measuring the Impact of Public Health Policy](https://www.cdc.gov/pcd/issues/2010/jul/09_0249.htm) |
| **Elitism** | Elitism is when a group of individuals who may be of higher intellect, wealth, power, and/or special skills and experiences higher influence in society. | [Elitism in Medicine](https://healthcare.utah.edu/the-scope/shows.php?shows=1_sbf643ky)[The Unintended Elitism of Health Care Policy](https://insidesources.com/unintended-elitism-health-care-policy/) |
| **Ethnicity** | Ethnicity is a state of belonging to a social group that has a common national or cultural tradition. | [The Difference Between Race and Ethnicity](https://www.verywellmind.com/difference-between-race-and-ethnicity-5074205) |
| **Fair** | Fair is marked by impartiality and honesty: free from self-interest, prejudice or favoritism | [Merriam-Webster Dictionary](https://www.merriam-webster.com/dictionary/fair#:~:text=(Entry%201%20of%205),importance%20%3A%20due%20a%20fair%20share)[Health Disparities and Health Equity: The Issue is Justice](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222512/) |
| **Genderism** | Genderism is the systematic belief that people need to conform to their gender assigned at birth in a gender-binary system that includes only female and male. | [Effects of gender discrimination on health](https://www.medicalnewstoday.com/articles/effects-of-gender-discrimination) |
| **Health Disparity** | Health disparities are differences in health among groups of people that are linked to social, economic, geographic, and/or environmental disadvantage. | [Reaching for Health Equity](https://www.cdc.gov/minorityhealth/strategies2016/) |
| **Health Equity** | Health equity is when everyone has the opportunity to be as healthy as possible. | [Paving the Road to Health Equity](https://www.cdc.gov/minorityhealth/publications/health_equity/index.html)[Reaching for Health Equity](https://www.cdc.gov/healthequity/features/reach-health-equity/index.html) |
| **Health Inequity** | *Health inequities* are systematic differences to opportunities leading to unfair and avoidable differences in health outcomes. | [Health Inequities Exposed by the COVID-19 pandemic](https://uihc.org/news/health-inequities-exposed-covid-19-pandemic) |
| **Heterosexism** | Heterosexism is prejudice against any non-heterosexual form of behavior, relationship, or community, particularly the denigration of lesbians, gay men, and those who are bisexual or transgender. Whereas [homophobia](https://dictionary.apa.org/homophobia) generally refers to an individual’s fear or dread of gay men or lesbians, heterosexism denotes a wider system of beliefs, attitudes, and institutional structures that attach value to heterosexuality and disparage alternative sexual behavior and orientation. | [APA Dictionary of Psychology](https://dictionary.apa.org/heterosexism), [What Is Heterosexism and What Can I Do About It?](https://www.adl.org/education/resources/tools-and-strategies/what-is-heterosexism-and-what-can-i-do-about-it) [Definitions:Homophobia, Heterosexism, and Sexual Prejudice](https://lgbpsychology.org/html/prej_defn.html) |
| **Implicit Bias** | Implicit bias is **unconscious, automatic**, and relies on associations that we form over time. We can form bias toward groups of people based on what we see in the media, our background, and experiences. Our biases reflect how we internalize messages about our society rather than our intent. | [Implicit Bias](http://kirwaninstitute.osu.edu/implicit-bias-training/#:~:text=Implicit%20bias%20is%20unconscious%2C%20automatic,society%20rather%20than%20our%20intent) |
| **Intersectionality** | Intersectionality is the interconnected nature of social categorizations such as race, class, and gender, regarded as creating overlapping and interdependent systems of **discrimination or disadvantage** | [Kimberlé Crenshaw on Intersectionality, More than Two Decades Later](https://www.law.columbia.edu/news/archive/kimberle-crenshaw-intersectionality-more-two-decades-later) |
| **Just** | It is acting or being in conformity with what is morally upright or good | [Merriam-Webster Dictionary](https://www.merriam-webster.com/dictionary/just)[Health Disparities and Health Equity: The Issue is Justice](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222512/) |
| **Oppression** | Oppression is the systematic subjugation of one social group by a more powerful social group for the social, economic, and political benefit of the more powerful social group.  Oppression = Power + Prejudice | “[What Is Racism?](https://www.dismantlingracism.org/racism-defined.html)” − Dismantling Racism Works [web workbook](https://www.dismantlingracism.org/). |
| **Power** | Power is a special right, advantage, or immunity granted or available only to a particular person or group | Sources: Intergroup Resources, “[Power](https://www.intergroupresources.com/power/)” (2012).  “[Racism and Power](http://web.archive.org/web/20181218143252/http:/www.aclrc.com/racism-and-power)” (2018) / “[CARED Glossary](http://www.aclrc.com/glossary)” (2020). |
| **Privilege** | Privilege refers to certain social advantages, benefits, or degrees of prestige and respect that an individual has by virtue of belonging to certain social identity groups. | <https://www.arteachingcollective.com/privilege.html>  [García, Justin D. 2018. “Privilege (Social Inequality).” Salem Press Encyclopedia.](https://athena.rider.edu:6443/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ers&AN=113931207&site=eds-live&scope=site.) <https://guides.rider.edu/privilege> |
| **Race** | In practice, the designation of race is based on socially defined visual traits as seen through the filter of individual and social perspective, while ethnicity is a category determined by genes, culture, and social class, a product of social evolution. | [Use of Race and Ethnicity in Public Health Surveillance Summary of the CDC/ATSDR Workshop](https://www.cdc.gov/mmwr/PDF/rr/rr4210.pdf) |
| **Racism** | Racism is a system consisting of structures, policies, practices, and norms that assigns value and determines opportunity based on the way people look or the color of their skin. This results in conditions that unfairly advantage some and disadvantage others throughout society.  Racism is not just the discrimination against one group based on the color of their skin or their race or ethnicity, but the structural barriers that impact racial and ethnic groups differently to influence where a person lives, where they work, where their children play, and where they gather in community. | [Racism and Health](https://www.cdc.gov/healthequity/racism-disparities/index.html#:~:text=Racism%20is%20a%20system%20%E2%80%94consisting,and%20disadvantage%20others%20throughout%20society),[CDC Director’s Commentary](https://www.cdc.gov/healthequity/racism-disparities/directorcommentary.html) |
| **Sizeism** | Sizeism is prejudice or discrimination on the grounds of a person's size or weight. | [Obesity Stigma: Important Considerations for Public Health](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2866597/) |
| **Social Construct** | A social construct is an idea that has been created and accepted by the people in a society. | [Social Constructionism](https://www.youtube.com/watch?v=5dp56gUQr4s&t=26s)  [Social Construction](https://www.youtube.com/watch?v=gVCkJ7jLnz0) |
| **Social Determinants of Equity** | The social determinants of equity are quality experiences in the early years, education and building personal and community resilience, good quality employment and working conditions, having sufficient income to lead a healthy life, healthy environments, and priority public health conditions. | [The Social Determinants of Equity](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4151898/)  [Social Determinants of Equity and Social Determinants of Health](https://minorityhealth.hhs.gov/Assets/pdf/Checked/1/CamaraJones.pdf) |
| **Social Determinants of Health** | The social determinants of health are the non-medical factors that influence health outcomes. Social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. The state social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. | [World Health Organization](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1) |
| **Social Identity** | Social identity is a person’s sense of who they are based on their group membership. The groups that people belong to can be a source of pride and self-esteem. | [Social Identity Theory](https://www.simplypsychology.org/social-identity-theory.html) |
| **Systemic Racism** | Systemic racism is what happens when cultural institutions and systems reflect that individual racism. | [The Aspen Institute](https://www.aspeninstitute.org/wp-content/uploads/files/content/docs/rcc/RCC-Structural-Racism-Glossary.pdf)  [What is systemic racism? [Videos]](https://www.raceforward.org/videos/systemic-racism)  [Systemic racism](https://www.today.com/parenting-guides/how-talk-kids-about-race-racism-t179138) |
| **Unearned Access** | Unearned access is access based on an identity someone holds traditionally associated with privilege. | [Understanding Race and Privilege](https://www.nasponline.org/resources-and-publications/resources-and-podcasts/diversity-and-social-justice/social-justice/understanding-race-and-privilege) |
| **Upstream Strategies** | Upstream interventions involve **policy approaches that can affect large populations through regulation, increased access, or economic incentives**. For example, increasing tobacco taxes is an effective method for controlling tobacco-related diseases (7). Midstream interventions occur within organizations. Downstream interventions would be the rate of self-reported exposure to secondhand smoke (downstream) | [Measuring the Impact of Public Health Policy](https://www.cdc.gov/pcd/issues/2010/jul/09_0249.htm) |
| **Xenophobia** | "Xenophobia is fear of people from another country or group. | [What Is Xenophobia—And How Does It Affect a Person’s Health? Here’s What Experts Say](https://www.health.com/mind-body/health-diversity-inclusion/what-is-xenophobia) |

1. [Collective Impact (ssir.org)](https://ssir.org/articles/entry/collective_impact) [↑](#footnote-ref-1)
2. [Home - Human Impact Partners](https://humanimpact.org/) [↑](#footnote-ref-2)
3. <https://www.fsg.org/tools-and-resources/sustaining-and-scaling-health-equity-impact> [↑](#footnote-ref-3)