Learning Objectives

1. Define and demonstrate knowledge of health equity, health inequalities and social determinants of health;
2. Mobilize leaders to engage in policy, systems and environmental change activities in support of health equity;
3. Leverage partnerships and cross sector collaborations to advance health equity; and
4. Identify at least two methods or strategies to increase health equity in local communities.
Health Equity Workshop

“FOREFLECTION” (5 MINUTES)

PLEASE RESPOND TO THE FOLLOWING:
Identify at least three things you will know at the end of the workshop and one thing you will offer to other attendees through your participation.

The three things I will know are:

1. 

2. 

3. 

The one thing I will offer other attendees through my participation is:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Health Equity Workshop

GLOSSARY

Community: A group of people who share some or all of the following: socio-demographics, geographic boundaries, sense of membership, culture, language, common norms, and interests (CommonHealth ACTION, adapted from Centers for Disease Control and Prevention [CDC]).

Community Capacity: The interaction of human, organizational, and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of a given community. It may operate through informal social processes and/or organized efforts by individuals, organizations, and the networks of association among them and between them and the broader systems of which the community is a part (Chaskin, 1999).

Disproportionality: Over- or under-representation of a particular group or race in a public system (e.g. the child welfare or criminal justice systems) compared to their representation in the general population (CommonHealth ACTION).

Environmental Change: A physical or material change to the economic, social, or physical environment (CDC, 2010).

Equity Lens: The “lens” through which you view conditions and circumstances to understand who receives the benefits and who bears the burdens of any given program, policy, or practice (CommonHealth ACTION).

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (The World Health Organization [WHO], 1948).

Health Disparities: 1. Differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities (Virginia Department of Health [VDH], 2012). 2. Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations (CDC. Community Health and Program Services (CHAPS): Health Disparities Among Racial/Ethnic Populations. Atlanta: U.S. Department of Health and Human Services; 2008).

Health Equity: Providing all people with fair opportunities to attain their full health potential to the extent possible (Braveman, 2006).

Health Inequities: Health disparities that are modifiable, associated with social disadvantage, and considered ethically unfair (Braveman, 2003).
Health Inequalities: Health inequalities are disparities in health, reflecting either differences in access to a range of promotional, preventive, curative, or palliative health services or differences in outcomes including disability, morbidity, and mortality spanning physical, mental, and social health (Sadana, R., & Blas, E. (2013). What Can Public Health Programs Do to Improve Health Equity?. Public Health Reports, 12812-20).

Oppression: The exercise of authority or power in a burdensome, cruel, or unjust manner (Merriam - Webster).

Perspective Transformation: The process of becoming critically aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about our world; changing these structures of habitual expectation to make possible a more inclusive, discriminating, and integrating perspective; and, finally, making choices or otherwise acting upon these new understandings (Mezirow, 1978).

Privilege: When one group has something of value that is denied to others simply because of the groups they belong to, rather than because of anything they have done or failed to do (McIntosh, 2000).

Public Health: The science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals (Winslow, 1920).

Racism: 1) A belief that race is the primary determinant of human traits and capacities, and that racial differences produce an inherent superiority of a particular race (Merriam-Webster). 2) Racism = Race prejudice + the misuse of power in systems and institutions (The People’s Institute for Survival and Beyond).

Social Determinants of Health: The circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics (WHO).

Systems Change: Change that impacts all elements, including social norms of an organization, institution, or system; may include a policy or environmental change strategy. Policies are often the driving force behind systems change (CDC, 2010).


Chapin Hall Center for Children. (1999). Defining community capacity: A framework and implications from a comprehensive community initiative. Chicago, IL: Chaskin, R.


CommonHealth ACTION (Institutional Glossary).


The People’s Institute for Survival and Beyond (Institutional Glossary).


<table>
<thead>
<tr>
<th>TYPE OF OPPRESSION</th>
<th>CHARACTERISTIC</th>
<th>PRIVILEGED / FAVORED GROUPS</th>
<th>OPPRESSED GROUPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racism</td>
<td>Race/Color</td>
<td>Whites</td>
<td>People of color (Black/African Americans, Asians, Pacific Islanders, Native Americans, Hispanic/Latino/Chicano Americans)</td>
</tr>
<tr>
<td>Sexism</td>
<td>Sex</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Classism</td>
<td>Socioeconomic Class</td>
<td>Middle/upper Class</td>
<td>Poor or working class</td>
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<tr>
<td>Elitism</td>
<td>Education Level</td>
<td>Completed at least high school degree or equivalent</td>
<td>Less than high school degree or equivalent</td>
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<tr>
<td>Religious Oppression</td>
<td>Religion</td>
<td>Christians</td>
<td>Muslims, Jews, other religious Identities</td>
</tr>
<tr>
<td>Militarism</td>
<td>Military Status*</td>
<td>WW I &amp; II, Gulf War Veterans</td>
<td>Vietnam Era Veterans [Vietnam war was unpopular and heavily protested in the US]</td>
</tr>
<tr>
<td>Ageism</td>
<td>Age</td>
<td>Young Adults (14-39 years old)</td>
<td>Elders (people 40 years old and over as defined by employment law)</td>
</tr>
<tr>
<td>Heterosexism</td>
<td>Sexual Orientation</td>
<td>Heterosexual/straight</td>
<td>Gay, lesbian, bisexual, transgender, queer (LGBTQ)</td>
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<tr>
<td>Ableism</td>
<td>Physical or Mental Ability</td>
<td>Able-bodied</td>
<td>Physically or mentally challenged</td>
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<tr>
<td>Xenophobia</td>
<td>Immigrant Status</td>
<td>U.S.-born</td>
<td>Immigrant to United States</td>
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<tr>
<td>Linguistic Oppression</td>
<td>Language</td>
<td>English as first language</td>
<td>English as a second language; do not speak English</td>
</tr>
<tr>
<td>Anti-Ruralism</td>
<td>Geographic Location</td>
<td>Urban/Suburban residents</td>
<td>Rural residents</td>
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* Veterans from the wars in Iraq and Afghanistan are not included because public opinion and policies are still in development. ADAPTED FROM VISIONS, INC.
Policy background:

Up until recently, Texas police officers in Dallas Independent School District were routinely issuing tickets (Class C misdemeanors with fines up to $500) to middle and high school students for disciplinary infractions that has previously been referred to school administration. In practice, actions that disrupted the learning environment—including chewing gum, wearing short skirts, and resting their head on their desktops—were referred to police officers for citation. In extreme cases, failure to pay fines resulted in warrants and referral to the courts system.

Policy scenario:

In 2013, the Texas State Legislature passed legislation redefining what students could get ticketed for; students could no longer receive a Class C misdemeanor for causing disruptions on school buses or in classrooms, for trespassing, or for possessing drugs or alcohol on school grounds. As a result, officers are no longer able to directly issue citations, but instead must file a complaint, accompanied by an affidavit from an eyewitness, to the local prosecutor’s office. Once submitted, it is up to the local prosecutor to decide whether a Class C citation is issued.

Since the laws were implemented, the number of tickets written by school police officers dropped by 71 percent. While there has been widespread praise for the effectiveness of the law at keeping kids in school and out of the juvenile justice system, many say that the reforms have gone too far. Many officers feel the changes in the law have stripped them of an effective tool for discouraging criminal behavior and leaves victims of school violence defenseless and vulnerable.
Program Background:

B’more for Healthy Babies is a program administered by the Baltimore City Health Department and the Family League of Baltimore City, a nonprofit designed to improve health & wellbeing of children in Baltimore, Maryland. Infant mortality rates in Baltimore City are the highest in the state. The program is designed to reduce the city’s high infant mortality and pre-term birth rates and to promote healthy babies and families. B’more for Healthy Babies focus areas include 1) access to family planning; 2) health education, including nutrition, physical activity, and safe sleeping; 3) family literacy, and 4) healthy, stable housing.

Housing is a critical component of the program; pregnant women with unstable housing—inability to afford rent, overcrowding, and periodic homeless—are three times more likely than women with stable housing to give birth to a preterm baby. B’more for Healthy Babies case managers follow women with high-risk pregnancies during frequent moves and increase access to stable housing units. Since the program’s inception, the overall infant mortality rate decreased by 28% and the racial disparity between white and black infants decreased by almost 40%.

Hypothetical Scenario:

The Epitome neighborhood of Baltimore, adjacent to a large university, is currently home to a large apartment complex that, while older, offers rental units that are both affordable and safe. Currently, 50 women participating in the B’more for Healthy Babies program live in these apartments. The Epitome neighborhood has recently been targeted for revitalization and economic development by the city.

Development Associates, the largest employer in the city, has proposed a new project to tear down the existing apartment complex and build mixed-income condominiums that are designed to attract families who are associated with the university. While Development Associates is earmarking 10% of units for affordable housing, B’more for Healthy Babies case managers are concerned that that many of the program’s women and children will be displaced, which could trigger homelessness.
Use the following roles to refer to steps 4 and 5 of the Equity Lens worksheet.

**Policy Scenario (ticketing in schools):**

1. High school student
2. Parent of middle school students
3. High school teacher
4. Police officer assigned to Dallas Independent School District
5. Principal of middle school
6. Dallas Independent School District school board member
7. Texas state legislator

**Program Scenario: (B’more for Healthy Babies):**

1. B’more for Healthy Babies mom living in Epitome Neighborhood
2. B’more for Healthy Babies case worker
3. Baltimore Housing Authority director
4. Baltimore City Council member
5. Local Baltimore foundation program officer
6. Local large university
7. Development Associates (development firm)
Health Equity Workshop

APPLYING EQUITY | Equity Lens Analysis Exercise

WORKSHEET

Note: Each member of your small group should have two of these worksheets.

Small Group Exercise Instructions:

1. Individually, review the background information on the policy or program scenario.

2. As a group, answer the following question:

   **In this scenario, who is receiving the benefits and who is bearing the burden?** Think about the different people, organizations, and institutions involved—including those not directly named in the scenario. Use the chart below to record your ideas.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Burdens</th>
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3. As a group, discuss the following question:

What is **one potential strategy or solution** that achieves the greatest equity in this scenario (i.e., the most fair and just balance of benefit/burden)? Use the space below to record your ideas.

4. Next, place yourself in the position of a key stakeholder in this scenario—refer to the role assignments on the handout.

5. Go around the group; each person should answer the following questions:

   **What is your stakeholder role?**

   From the perspective of your stakeholder role, what are potential actions you can take to contribute to the equitable solution?

   From the perspective of your stakeholder role, how does the more equitable solution create a positive outcome?
A HEALTHY FOUNDATION: Health Equity Training
designed for APHA by CommonHealth ACTION
CommonHealth ACTION envisions an America in which all people have equitable opportunities and neighborhood conditions to achieve their best possible health.

We are a national public health organization that aligns people, strategies, and resources to create community-generated solutions to health and policy challenges.
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GROUNDING: Building a Common Language

Module 1