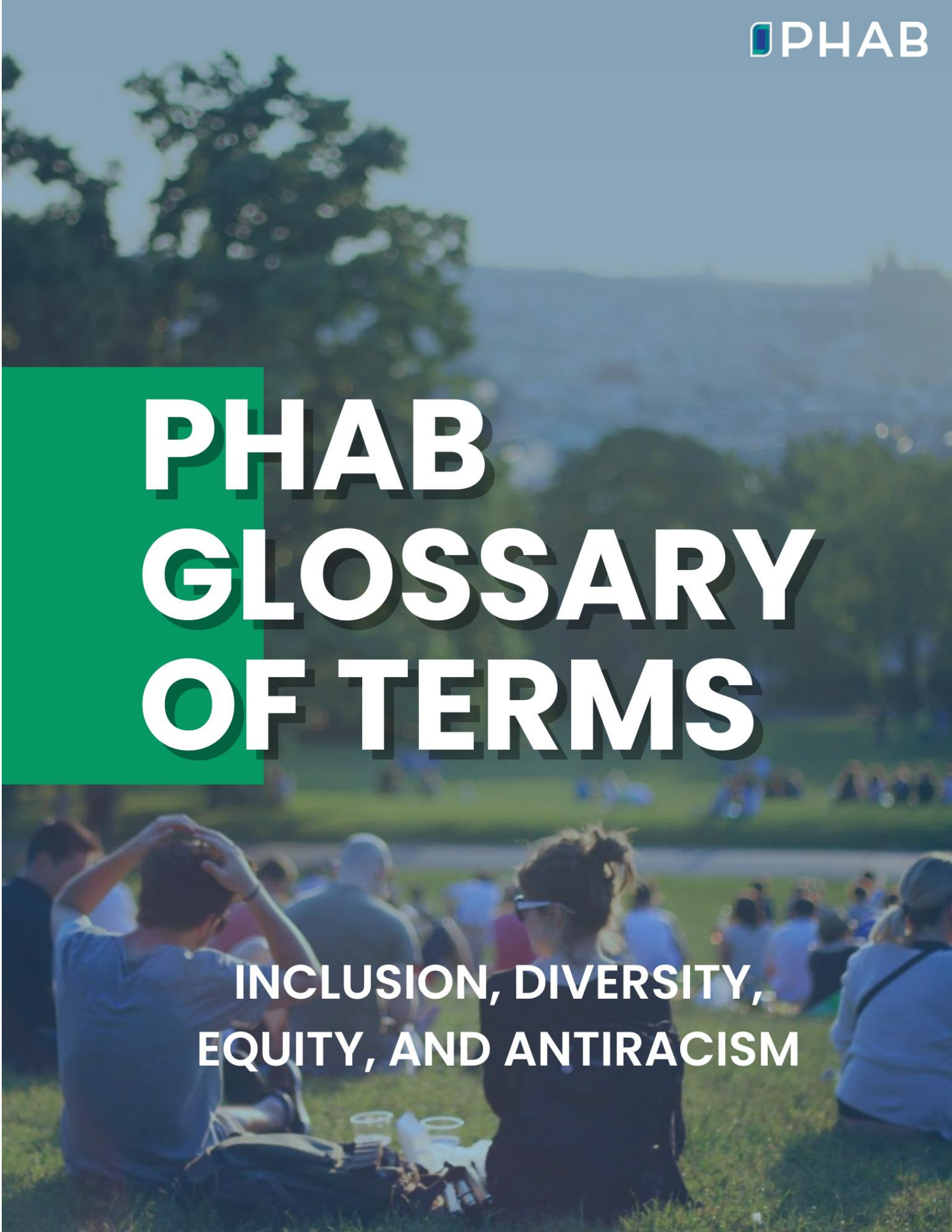

PHAB

PHAB GLOSSARY OF TERMS

INCLUSION, DIVERSITY, EQUITY, AND ANTIRACISM

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Introduction

PHAB is committed to advancing IDEA – inclusion, diversity, equity, and antiracism – both internally and externally. To create shared understanding around PHAB's IDEA work and to ensure that both our staff and the Board of Directors are operating from the same foundational understanding, we have developed the PHAB IDEA Glossary. This glossary provides a set of shared definitions and concepts aligned with PHAB's values. Each word or term has a definition followed by context for how the word or term can apply to PHAB's work. PHAB is committed to reviewing and revising this glossary as appropriate to ensure that it remains relevant to PHAB's work and the larger field of public health.

PHAB's IDEA action plan has a stated objective to develop and implement a shared learning agenda for PHAB staff and Board of Directors. To do so, it was integral that we first established shared language that resonated with staff and Board members. We therefore embarked on the following series of steps to create the PHAB IDEA Glossary:

1. Members of PHAB's IDEA workgroup established which IDEA-related terms to include in the glossary. A first draft of the definitions was developed by the IDEA workgroup with research from similar glossaries in the field.
2. During a staff retreat where both staff and Board members were present, a group activity to further refine definitions took place. To ground the activity, those present were reminded that:
    - People will likely have a different understanding of key concepts and terms.
    - Everyone is coming to this space with very different backgrounds and at different places in their equity journeys.
    - It's okay if someone doesn't know how to define something.
    - The purpose of the activity is to undergo the process of developing a common understanding.

    Individuals were split into small groups which were then assigned a word from the glossary. The word was presented to each small group with three definitions, one of which was from the draft glossary and the other two from other sources. Small groups were then instructed to review the definitions for their word and discuss which parts of the definitions resonated with them and which parts could be reworked and expanded upon. Questions to consider included:
    - Which parts of the definition resonate? Which parts don't?
    - What is missing from the definition? Are there considerations not reflected in the definition?
    - How do these definitions impact our audiences – internal (staff and Board) and external (health departments, policymakers, stakeholders, etc.)?
    - Why are these terms important to public health, public health practice, and transformation?

    Groups were instructed to build a unique definition of their assigned word and be prepared to share with the larger group their final definition and thoughts. At the end of the allotted time for the small groups, all were brought back together to provide their definitions and reflect on the exercise.

    Group activity adapted from the "Building Common Understanding" activity from the Minnesota State Office of Equity and Inclusion: https://www.minnstate.edu/system/equity/docs/EbD---Creating-Shared-Language-Tool.pdf
3. The definitions created during the group activity replaced the existing definitions for those words within the glossary. The updated draft of the glossary was then disseminated so that staff and Board members could provide edits and feedback on the glossary before it was finalized. Once staff and Board members provided feedback, the IDEA workgroup reconciled comments and finalized the glossary.
4. Definitions within the glossary have become the official definitions used by PHAB – these definitions are what PHAB as an organization means when we use these words when interacting with and on behalf of PHAB. Please see PHAB's Acronyms and Glossary of Terms for a broader list of terms applicable to PHAB's work.

A

Accountability
Creating processes and systems that are designed to help individuals and groups be responsible for their decisions, actions, and work that reflects and embodies principles of justice.[1]

Accreditation strengthens *accountability* both internally within a health department and externally to their community and policymakers. When staff at all levels are invested in the successes and failures of the department and being accountable to their stakeholders, the department is incentivized to regularly engage with community partners.

Allyship
The lifelong practice of unlearning, active listening, re-evaluating, and building relationships of trust and accountability in partnership and consistent solidarity with individuals and communities who are marginalized or systemically disempowered.

When health departments practice *allyship*, it increases the likelihood of the surrounding community trusting that the health department has their best interest in mind. By taking the time to build relationships with people in communities that are historically and currently oppressed or marginalized, health departments illustrate that they want to assist those individuals in living their fullest lives without them having to change their culture. True allyship requires the knowledge that well-intentioned actions may cause harm and a willingness to take part in truth-telling or reconciliation processes.

Antiracism
The active practice of identifying, challenging, and eliminating racism by changing systems, organizational structures, policies and practices, and attitudes, so that power is shared equitably.[2]

Using a framework of *antiracism* allows health departments to address racism as a root cause of unequal health outcomes. Unequal health outcomes resulting from racism exist on personal, institutional, and systemic levels and health departments must examine their policies, practices, program structures, and culture to dismantle racism across their organization. When promoting *antiracism*, it is helpful to remember that race is a social construct.

B

Belonging
A sense of acceptance, inclusion, and identity that allows one to express their whole self.[3]

Individuals that feel a sense of *belonging* in their community are more likely to have better health than those who are isolated.[4] Health departments can promote *belonging* in their communities by valuing and investing in community health practices and programs that are produced and designed with the community.

Bias
Being in favor of or against one thing, person, or group compared with another, usually in a way considered to be unjust.[5]

Explicit *bias* is when individuals are aware of their prejudices towards a certain group whereas implicit *bias* consists of the subconscious feelings, attitudes, and perceptions one might feel toward a certain group. Health departments are strongly encouraged to conduct implicit *bias* training to expose people to their own implicit *biases*, provide tools to adjust automatic patterns of thinking, and ultimately eliminate discriminatory behaviors.

BIPOC
An acronym that stands for Black, Indigenous, and People of Color. The term *BIPOC* is intended to highlight the

unique relationship to whiteness that Indigenous and Black people have, which shapes the experiences of and relationship to white supremacy for all People of Color within the context of the United States.[6]

It is best to use precise language – if you're talking about Black people, use the word Black, if you're talking about Indigenous people, use the word Indigenous. Use BIPOC when appropriate, not as a default. While some people prefer the term *BIPOC*, no one term is going to be embraced by every member of its community. What people like to be called is a matter of personal preference so if someone prefers a different term, adapt your language appropriately.

C

Cultural humility
The ability to continuously self-reflect, build knowledge, understand, appreciate, and appropriately and positively interact with people from cultures or belief systems different from one's own. It leverages institutional accountability to redress oppression, discrimination, and harm individually, interpersonally, institutionally, and structurally.[7]

To use a lens of *cultural humility*, health departments may consider how cultural, social, and environmental factors affecting a population(s) may influence their perceptions and actions. For example, deeply rooted beliefs, including personal experiences, historical trauma, societal pressures, or disenfranchisement may prohibit individuals from seeking health care or adopting changes in behavior.

D

Diversity
The existence of differences and similarities among people including, race, gender, ability, and many other elements related to one's identity and experiences. Fully engaging and benefiting from diversity requires equitable conditions and a culture of inclusion.

Diversity is an appreciation and respect for the many differences and similarities we encounter when serving communities and public health jurisdictions. This includes the variety of perspectives, approaches, and competencies of coworkers and populations we serve. Greater diversity of experiences and perspectives supports greater innovations in public health practice.

E

Equity
A fair and just opportunity for all to achieve good health and well-being. This requires removing obstacles to health such as poverty and discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare. It also requires attention to health inequities, which are differences in population health status and mortality rates that are systemic, patterned, unjust, and actionable, as opposed to random or caused by those who become ill. To achieve equity, the Essential Public Health Services actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve optimal health and well-being.[8]

Promoting *equity* means that a health department invests in resources, programs, and services in a manner that elevates historically and currently disproportionally affected and excluded groups. It is integral to break down internal and external structural, systemic, and social barriers that have promoted inequities.

H

Health equity
Achieved when everyone has a just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[9]

It is integral that health departments be bold and explicit that *health equity* is central to governmental public health practice. *Health equity* should shape and guide health department strategic plans, health improvement efforts, and performance measures.

I

Inclusion
The act of welcoming, respecting, supporting, and valuing all people, all voices, and truly engaging them, listening to, and valuing their experiences and perspectives, to inform and drive decisions on collective priorities. Inclusion requires sustainable and meaningful engagement with people and organizations that represent diversity in experience, thought, and culture.

"Diversity is being invited to the party; *inclusion* is being asked to dance." Public health as a profession must demonstrate that *inclusion* is central to the mission and consistently evaluate diverse groups of their perception of progress.

Indigenous
A term used to identify ethnic groups who are the earliest known inhabitants of an area in contrast to groups that have settled, occupied, or colonized the area. In the United States, Indigenous people include both American Indians and Alaskan Natives. In practice, refer to specific Tribes or peoples whenever possible.

Regardless of whether a health department has Tribal affiliation, *Indigenous* public health practice should be culturally grounded and honor *Indigenous* knowledge, sovereignty, and understanding of public health.

J

Justice
The responsibility to challenge and diminish barriers, avoid causing harm, and create opportunities for an equitable society so that all individuals and communities can live meaningful lives.

Justice requires the fair disbursement of common advantages and the sharing of key burdens. *Justice* is essential to public health in order to advance human well-being by improving health and to do so particularly by focusing on the needs of the most disadvantaged.[10]

M

Microaggresion
The everyday verbal, nonverbal, and environmental slights or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages based solely upon a person's membership in a marginalized group.[11]

When a public health practitioner commits a *microaggression*, the comfort and trust a community member may feel with the practitioner are likely to become damaged, rendering the visit a source of stress and anxiety. It is important that all public health practitioners assess their unconscious biases and practice self-reflection and intentional actions to achieve high quality and culturally sensitive care. *Microaggression*s are rooted in longstanding implicit and explicit behaviors and linked to health disparities. Confronting *microaggressions* is a critical step in the process of mitigating racism and structural racism, as well as achieving the aspirational goal of reducing health disparities.

Misgendering
Deliberately or unintentionally addressing someone, typically a transgender person, with pronouns, phrases, names, or references that do not align with the person's gender identity.[12]

Misgendering a transgender person may make them feel a range of emotions from uncomfortable to unsafe. If you *misgender* someone, briefly apologize and use correctly gendered language in the future. If you hear someone *misgendering* someone, correct them.

N

Neurodiversity
The full range of variations in cognition, learning, behavior, and socialization that exists within the population.[13]

Neurodiversity describes the idea that people experience and interact with the world around them in many different ways; there is no one "right" way of thinking, learning, and behaving, and differences are not viewed as deficits.[14] *Neurodiversity* does not imply any specific diagnosis, although some common diagnoses associated with *neurodiversity* include autism, ADHD, and dyslexia. Health departments can support the neurodiverse community by having accessible health systems and workforces.

P

Power
The capacity or ability to direct or influence the behavior of others, the course of events, or the allocation of resources. Power comes from positional, moral, or relational authority. Authority is granted by appointment or earned by trust and credibility.

Power is a tool that is not inherently good or bad – it can be used destructively by further entrenching health gaps, or can be used constructively to ensure equitable access to services. Health departments should use their *power,* with the guidance of the community they serve, to allocate resources and create opportunities that enable the ability to do, act, or accomplish things in a manner that promotes health, equity, and justice. Community members most impacted by decisions made by health departments should be key members of those decision-making processes.

Prejudice
A preconceived judgement or preference, especially one that interferes with impartial judgment that may be rooted in stereotypes. The preconceived judgement or preference leads to intentional behaviors that have negative outcomes for individuals or groups affected.

People who live in communities that face higher levels of racial *prejudice* have worse health outcomes including mortality rates, adverse birth outcomes for birthing people and infants, cardiovascular outcomes, mental health, and overall self-rated health.[15] Public health practitioners play a key role in developing evidence-based interventions to reduce the harm caused by racial *prejudices*.

Privilege
When one group has an unquestioned and unearned set of advantages, benefits, entitlements, or choices, that are denied to others simply because of the group(s) they belong to, rather than because of anything they've done or

failed to do.[16]

Privilege is a more recently recognized social determinant of health. Health departments can acknowledge *privilege* by using their voice and power to advocate for underserved communities who are disproportionately affected by historical injustices.[17]

S

Structural racism
A system of social structures that produces cumulative, durable, race-based inequities, rooted in widespread historical and persistent barriers that keep people of color from having equal access to opportunity, resources, and power.[5] [18]

Structural racism is present in the United States through countless policies and actions that impact public health including redlining and racialized segregation, police violence, and unequal healthcare. Achieving health equity for all in the United States will require dismantling this country's historical legacy of *structural racism*.[19]

W

White supremacy
A political, economic, and cultural system in which whites overwhelmingly control power and material resources including health. Unconscious and conscious as well as implicit and explicit ideas of white superiority and entitlement are widespread but not always acknowledged.

Public health research evaluates variation in the accessibility, effectiveness, and quality of health services by race but the impact of racism and white supremacy on these outcomes are often ignored.[20] Public health institutions have a responsibility to develop and enforce policies to dismantle practices that maintain *white supremacy*.

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