Moving into Equity: The Public Health Journey

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Contents

About the Authors:

The Public Health National Center for Innovations (PHNCI) is a division of the Public Health Accreditation Board. Established in 2015, PHNCI serves as the national headquarters for empowering health departments to drive change and improve health. PHNCI:

- Provides a learning lab for health departments' innovations
- Develops and shares resources, tools, education, and expertise
- Connects innovators within public health and across sectors
- Monitors, disseminates, and builds the science of public health innovation.

PHNCI awarded an Innovation Grant to the Minnesota Department of Health (MDH) in 2017 to support public health transformation throughout the state by facilitating a Health Equity Learning Community. This work represented a shift toward statewide transformation, and PHNCI subsequently engaged MDH to draft this guide, based on their learnings. Specific recognition goes to Dorothy Bliss, Jeannette Raymond and Susan Brace-Adkins from MDH.

"The history of public health may well be written as a record of successive redefining of the unacceptable."

Sir Geoffrey Vickers, Harvard School of Public Health, 1957

Introduction

In the summer of 2019, the Public Health National Center for Innovations (PHNCI) approached the Minnesota Department of Health (MDH) with the germ of an idea: to create a "roadmap" to help public health departments move into work on equity in health. PHNCI selected MDH as part of their Innovation Learning Community, to work on tangible approaches for moving towards equity in health within their state. This guide was a collaborative effort between PHNCI and MDH.

To give substance to this idea, MDH convened a group of public health departments and community partners (primarily from Minnesota) for a two-day meeting to develop some practical suggestions for public health departments wanting to become equity focused. (See Appendix for participant list.) The meeting produced a wide range of ideas, which led to this document.*

Purpose

Why moving into equity for public health? According to the World Health Organization (WHO), equity is *the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically*.[1] Data at every level – local, state, national and international – are very clear about the fact that these differences exist. Research is also very clear that these differences lead to unacceptable differences in health outcomes across groups of people in every community. Public health has a responsibility to identify where and why these inequities exist and to develop strategies to eliminate them.†

Why this guide? While other resources exist to help public health departments advance equity to improve health in their communities, public health practitioners often express that these can be overwhelming to implement. Participants expressed a desire for a resource that is practical as well as visionary. Recognizing that becoming an equity-focused organization, both in awareness and practice, is not achieved through a class or program, and that different public health departments and individuals have different starting points and destinations, they expressed hope that this project would result in a tool to support their development in competency over time, and be a tool that would:

- Move people to be dissatisfied with the status quo and be willing to step into new practices
- Be useful in both rural and urban settings, for communities that are changing rapidly and those that are not
- Encourage respect and openness to different stories among all those involved
- Lead to more shared power and decision making with communities
- Encourage true transformation and honor the deep internal and personal work required

* For the purposes of this guide, "public health practitioners" refers to those who participated in the convening.

† Equity is not equality, especially when it comes to strategies for improving the health of populations. Equality means treating everyone the same, while equity means everyone has what they need to be healthy. Equity is not accomplished by treating everyone equally, but by treating everyone justly, according to their circumstances. Although equity is not equality, moving toward equity is a way to move toward greater equality in health outcomes.

Offered here, therefore, are a set of practical ideas from the field, intended as a starting point and a frame for thinking about what it means for a public health department to move into equity work.

Who might use this document: The primary audience for this effort are public health departments ready to explore tangible strategies to move towards a greater focus on equity. Those using this tool can examine specific strategies and select those that resonate with their department, or can use this as a roadmap of sorts to move along a continuum towards equity.

Limitations:

1. The short development timeframe did not allow sufficient time to vet the ideas with more partners in the community as well as more people outside of Minnesota.
2. Development of the tool and final product are not a research product nor are they research-based.
3. Equity in health is a developing area of practice for public health; the ideas and language of this document reflect only a single point in time.

Equity in health: challenges and possibilities for public health

It bears repeating: the U.S. has well-documented, significant and persistent disparities in health outcomes across populations defined by race and ethnicity, ability and disability, gender, age, sexual orientation, geography, and social class. The movement to advance equity in health recognizes that health disparities are rooted in similarly persistent inequities in power and in the social, economic and political conditions that shape the health of individuals and communities. It also is true that the field of public health, despite increasing conversations about health disparities and inequities over the last several decades, has been unable to "move the needle" on those health outcomes.

Health *inequities* involve more than lack of equal access to essential resources: they also derive from violations of human dignity. The health of populations is not possible when the dignity and basic rights of each person are not recognized and honored, and when communities are excluded from decision-making processes.[‡,2] The field of public health is committed to identifying and addressing the root causes of poor health outcomes, whether these be in individuals or in populations. Equity in public health means looking for and addressing the root causes of inequities in the systems and structures that shape the conditions in which people live their daily lives.

The movement to address equity recognizes that while the challenges are great, the rewards can be even greater. Improving health in populations experiencing the greatest inequities improves health for all. Engaging with communities and confronting the realities of inequities, structural racism, and historical trauma has the potential to generate creative ideas and open up new possibilities for action for public health and for their communities.

Racism, health, and equity

Arguably, one of the most important factors for understanding and moving toward equity in health is paying attention to racism, structural racism, and the pervasive nature of these in American society. No individual or organization in the U.S. is untouched by the history of racism. Even in areas that currently have little racial or ethnic diversity the narrative of racism says that some people are more worthy than others. This shows up in the ways that communities exclude or discriminate against certain groups that they view as different or "other." No community is exempt from this narrative.

[‡] The field of public health emphasizes the value and dignity of every person and their right to a healthy life. This emphasis includes the right of every child to have the best possible start in life for a healthy future, the right of every person to be free from unjust barriers to health, and the right of communities to participate in society and create their own healthy futures. (Reference 2)

Only in the last few decades has equity in health outcomes for people of color and American Indians in this country become a visible priority of public health.[§] Public health departments may be willing and eager to talk about other conditions that create health (e.g., education, housing, transportation), but still not ready or able to talk about how racism intersects with these.

Working to change systems brings public health face to face with people and groups who see no need for change, or who feel threatened by the kinds of changes equity demands. Equity requires conversations about racism, injustice, historical trauma, and oppression. White people, however, may find the issue of racism too difficult or threatening to approach, and may self-censor or face pressure to remain silent on these issues. People of color and American Indians may find that it takes too much of a personal toll to be the one in the room who consistently raises these issues. Yet all voices are vital and needed. Because many systems have their roots in the history of racist thinking and acting, the capacity to talk about racism and bring this lens to communities and health issues is fundamental for the movement to achieve equity in health.

Stages on the public health journey to equity

When a public health department decides that things "the way they are" is not good enough to accomplish the goals of public health (i.e., healthy people and healthy communities), they step into a journey toward equity in practice and in outcomes. This journey might manifest first as a priority in a community health assessment or improvement plan, it may get started with the appointment of a new public health leader, it may rise out of the practice of a single unit or a few individuals, or it may come from the community organizing for change.

Moving toward equity in health presents an incredible opportunity for public health departments: challenging, yes, but with the potential for dramatic change inside the organization and in the community. Importantly, this journey is much more than a matter of adopting a few new public health practices. To work on equity in health requires a deep level of change on many levels: personal, professional, organizational, relational, and systemic. These changes will not happen everywhere or for everyone, and certainly not at the same time. These kinds of changes often are incremental and non-linear – and not without turmoil. The work requires hearing new voices, engaging new partners, sharing power and decision making, and essentially changing much about the way public health currently works.

Below are four stages of transformation to help public health departments consider where and who they are on equity, and where and who they want to be. The stages are:

Stage 1: Content with the status quo

Stage 2: Raised awareness/discontent

Stage 3: Willing to step into the unknown

Stage 4: Committed, engaged and activated

Each stage describes the characteristics of a public health department in that stage, including the organization overall, its staff, and the community at large.** Following those descriptions are ideas for taking practical steps to journey across the stages and some tools that can guide you.

[§] The first set of national objectives for health (U.S. Department of Health and Human Services. Promoting Health/Preventing Disease: Objectives for the Nation. Washington, DC; 1980) did not mention inequities by race. However, the year 1986 saw the creation of the Office of Minority Health within the U.S. Department of Health and Human Services (https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=1). By 1990, the national objectives included an overarching goal to "reduce health disparities" (Healthy People 2000. https://www.cdc.gov/nchs/healthy_people/hp2000.htm), which further compelled public health departments to collect and report health data by race/ethnicity. By 2000, the national goal had changed to "eliminate health disparities" (Healthy People 2010. https://www.cdc.gov/nchs/healthy_people/hp2010.htm). By 2010, the goal for Healthy People 2020 had become, "achieve health equity, eliminate disparities, and improve the health of all groups" (Healthy People 2020. https://www.cdc.gov/nchs/healthy_people/hp2020.htm).

** For more detailed assessment tools, please see the Appendix.

The stages and their descriptions here can serve to help assess where a public health department currently is in their equity journey. The boundaries between the four stages described here are not hard and fast, and organizations do not move smoothly from one to the next. Organizations are complex systems, composed of complex individuals, who do not move in lockstep. Thus, some people in the organization may have a lot of energy, passion, and experience in navigating the issues of equity, while others will not, and still others will not want to. Some leaders may be out ahead, others may pull back.

Stage 1: Content with the status quo

It might seem counterintuitive for a public health department to assess *themselves* as being content with the status quo. This awareness, however, could emerge from someone on staff or in leadership, or it could come from external influences (see "The Impetus Forward," below).

A public health department in this stage has not yet recognized (formally or informally) that they need to work on equity in health. A department (and its staff) in this stage:

- Doesn't know what "equity" means (or conflates it with "equality")
- Is not open to hearing data that might not positively reflect on their work
- Frequently misconstrues or shuts down suggestions to think differently or change the status quo
- Is more internally than externally focused; uses "us-them" language; engages community only as needed, if at all; is unwilling to share power with the community
- Operates with a helping approach that focuses on individuals (rather than the community or systems) and assumes that the public health experts know what people need
- Uses a "one-size-fits-all" approach to services, budgets, and resources
- Denies reality of systemic racism; tries to be "colorblind"[††]
- May recognize the reality of different languages or cultures, but is still unaware of concepts such as cultural humility or racial equity

Moving from contentment (Stage 1) to awareness and discontent (Stage 2)

- **Plans and Policies**
- **Staff Capacity**
- **External Engagement**
- **Data and Measurement**

Possible actions include:

Plans and Policies

- Assess organizational culture, hiring practices, staff diversity, and relationships with the community. Offer learning experiences for understanding how dominant white culture affects the organization
- Identify, elevate, and support equity champions in the organization. Make sure they have some organizational power

[††] Colorblindness is a racial ideology implying that the best way to end discrimination is by treating individuals as equally as possible, without regard to race, culture, or ethnicity. While it might seem like a good thing, it can actually cause harm. By being colorblind, white people can ignore racism in their communities and feel more comfortable with their relatively privileged standing in society. For people of color and American Indians, however, colorblind ideologies deny their negative racial experiences, reject their cultural heritage, and invalidate their unique perspectives. White people who say they are colorblind are in effect saying to communities of color, "We don't see you." When they say, "race doesn't matter," they are denying the realities of life for many – because race affects opportunities, perceptions, income, and more. When race-related problems arise, colorblindness tends to individualize conflicts and shortcomings, rather than examining the larger picture with cultural differences, stereotypes, and values placed into context.

Staff Capacity

- Broaden the understanding of what public health work is by naming and exploring all the conditions that contribute to health
- Learn to recognize dominant narratives about health and develop new narratives
- Offer training on unconscious bias
- Promote informal conversations among staff and managers on issues of equity, race, social determinants of health, etc.
- Encourage the consideration and asking of brave questions based on personal experiences

External Engagement

- Create experiential and shared learning experiences, such as equity walks (walking through neighborhoods, going to exhibits that talk about the history and experience of different groups)
- Participate in a learning cohort with other public health departments
- Develop a shared understanding of key equity concepts
- Start asking for community input and develop this practice

Data and Measurement

- Start looking at program/service data,
- health outcomes data, and other data by race and ethnicity, gender, disability, sexual orientation, geography, and income
- Uncover local stories and local data

Before diving into each stage, below are a few traveling tips to help set the foundation.

Traveling tips

Choose good traveling companions

A public health department cannot become an organization that advances equity by individuals acting alone. Nor can organizations travel this path without other organizational companions, such as partners from the community, and other local, state and national organizations engaged in equity work. At the beginning of the journey, it may only be a select few like-minded individuals or organizations who are committed to equity, with whom the department works closely and often, and who provide mutual support. As time goes on, the circles of involvement and support will and should grow larger. To start, choose people with established credibility, both internal and external, who can leverage and build relationships. These could be people with positional authority, organizational influence, or subject matter expertise. People who may have energy and passion for equity in public health work may include:

- Staff who are energized, already committed and passionate about advancing equity.
- Leaders who are aware and ready to lead the organization into equity.
- Community members who understand the role of equity in health and are organized to bring pressure on the places in the organization or community where change is needed.

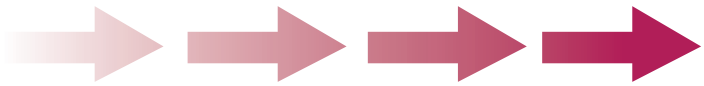
Stage 2: Recognition/awareness/discontent

A public health department in Stage 2 is absorbing messages about equity in health, is aware of national conversations about equity, and is starting to recognize that "business as usual" is not getting the results they want. A department in this stage:

- Has discrete programs talk to community members; this practice, however, is not systematic across the organization; some programs are good at it and some are not
- Has some informal equity champions emerging in the organization
- Is starting to express more curiosity about equity
- Is starting to expect equity as a consideration in many projects
- Is starting to use equity language, such as in grant applications
- Is becoming more aware of equity and taking ad hoc action because of specific situations that happen, e.g., traumatic events
- Has some growing organizational and staff capacity to engage in ad hoc work on equity

Moving from awareness and discontent (Stage 2) to a willingness to step out (Stage 3)

- Plans and Policies
- Staff Capacity
- External Engagement
- Data and Measurement



Possible actions include:

Plans and policies

- Provide clear and consistent messages from leadership that equity is a priority
- Develop an equity team and build systems of mutual support for the work
- Assess equity practices currently taking place in the organization and work to expand these
- Pilot training on equity, bias, diversity, etc.
- Define specific equity projects and look for targeted funding for equity to increase permission to work on these issues
- Start crafting organizational policies to include equity
- Work to create an organizational culture where people can bring their full selves to the table

Before diving into each stage, below are a few more traveling tips to help set the foundation.

Traveling tips

Find wise guides

Once the organization knows who their "travelling companions" will be, come together to choose guides for this transformational journey, people to whom to be accountable for the change that is sought. While it is tempting to want to retain the role of "expert" within the public health department, advancing equity and health often requires the wisdom of people and organizations with different life experiences and points of view. A wise guide may be an organization that has done some of this hard work of transforming already, or maybe people from the community who will challenge and disrupt the usual way of doing things. Whoever these wise guides are, choose those who are actively working for the kinds of changes needed to create equity for health in the community.

Carefully consider where to start

Becoming a public health department that actively confronts inequities and promotes equity can be a daunting prospect, and does not happen overnight. It is highly unlikely that an entire organization – from leaders to staff to funders – would ever be entirely ready for this kind of work. Instead, an organization should choose a place to start, and people with whom to start.

Sometimes the place for a public health department to start an equity journey is quite evident, such as an issue raised by a leader, by the community, or by the community health assessment. Other times it may be harder to discern. One suggestion is to start on issues that are causing the most "pain" (financial, personal, political, etc.) for policy makers, such as rising deaths from opioids, out of home placements, or youth suicide). Use these issues and activities to gain experience, gather stories, and serve as models for addressing additional equity issues. Another idea is to start by developing a new narrative around which to gather and garner commitment and energy.

Staff capacity

- Hold informal meetings, such as brown bag lunches, to find out who is interested and ready for equity work
- Assess capacity and commitment of staff to advancing equity in their work
- Require unconscious bias training to increase shared understanding across the department
- Confront dominant white culture features such as perfectionism and fear of making mistakes, especially around race. Create assurances that discomfort and imperfection – at the individual and organizational levels – are to be expected. Create space for staff to learn the new ideas, language, and practices of equity.
- Develop capacity of staff to articulate how they address equity in their work
- Encourage staff to develop relationships with people who are "different from me"
- Organize department-wide conversations

External engagement

- Start equity work by "doing with" others who can show the way and build confidence levels among staff and community partners
- Learn from and develop approaches that are specific to different communities of people (e.g., mobile home park residents). Intentionally seek for and include community members who traditionally have been excluded from decision-making processes
- Develop relationships with community advocates and other community partners to build power for change

Data and measurement

- Engage the community to interpret and understand disaggregated, qualitative and quantitative data on health inequities and identify priority areas

Stage 3: Willing to step into the unknown

The journey of transformation requires radical uncertainty.

Glenda Eoyang, Human Systems Dynamics

The journey to equity leads many public health departments to spaces and places they have not been before, and into practices with which they are unfamiliar, or where they do not feel like experts, creating discomfort. Moving into equity work can be a bumpy, messy process. Mistakes will be made! Stepping into the unknown, however, and embracing the tensions the work generates, creates opportunities for flashes of insight, new direction, the development of fresh relationships, and surprising solutions to intractable problems.

An organization that is willing/ready to step into the unknown:

- Has an equity administrator and staff to help lead and guide activities to advance equity
- Is willing to challenge the status quo – to redefine the unacceptable
- Has made a commitment to deconstruct and reconstruct policies, practices and procedures to be equitable
- Engages in cross-jurisdictional partnerships to address equity on a regional level to maximize impact
- Provides staff with the tools to plan, implement, and evaluate their work with regard to equity
- Provides opportunity and resources for staff continue to explore and confront biases
- Supports staff in a time of uncertainty and helps them gain confidence in the work of equity
- Embraces a broad definition of health that includes mental health

Moving from willingness to step out (Stage 3) to being committed and active (Stage 4)

- Plans and Policies
- Staff Capacity
- External Engagement
- Data and Measurement

Possible actions include:

Plans and policies

- Embed equity into organizational assessments and plans, including comprehensive plans, strategic plans, work plans, and training plans; equity policies; organizational policies; and budgets
- Incorporate equity into agency performance metrics
- Allocate or seek stable financial resources for building and sustaining equity efforts

Staff capacity

- Allow time at all departmental meetings to discuss equity work
- Require equity training for all new employees and provide advanced training for existing employees
- Incorporate equity expectations into job descriptions and performance reviews
- Review and change job descriptions and hiring processes
- Hold explicit conversations about racism and white supremacy
- Create an equity resource portal for staff
- Train coaches to provide training, assistance and support to others in the agency
- Empower staff to advance equity in their own work and regularly assess staff capacity
- Regularly assess the commitment and actions of the organization
- Communicate what the organization is doing to advance equity to staff, community, and governing entity

External engagement

- Build the organizational case for equity by connecting to other local, state, and national efforts to advance equity in health
- Identify new partners and strengthen the relationships that the organization has already built
- Engage people who have broad networks and can influence leaders ("power brokers") in reframing the narrative around equity
- Recruit non-traditional champions to share the need to address equity
- Hold many conversations with diverse groups of residents; integrate them into planning and evaluation processes
- Engage in one-to-one meetings with a wide range of partners and potential partners
- Build in time and resources for community engagement; compensate the community for their expertise
- Require community engagement as part of public health work across the board

Data and measurement

- Regularly track and report on equity progress in health outcomes
- Regularly track and report on equity within the department, such as workforce data for protected classes and other underrepresented groups (including data on hiring, retention, recruitment, and dismissals)
- Create an equity dashboard with clear metrics
- Co-release data on the community with the community

Stage 4: Committed, engaged and activated

An organization that is committed, engaged, and activated has accepted the challenge of equity in health, is actively pursuing change in its people, processes, programs, and partnerships. An organization (or part of the organization) in this stage:

- Has populations of color/American Indians in leadership positions and has clear paths to leadership
- Has developed organizational policies that reflect and support commitment to advancing equity
- Is considered an equity leader in the community; is included in all community conversations around equity and social justice; leads on equity policy
- Is actively anti-racist
- Accesses diverse funding sources to support the department in responding to equity issues
- Provides financial and other resources to staff and community to advance equity
- Creates budgets and seeks grants to reflect needs of the community; uses participatory budgeting
- Encourages cross-pollination of ideas across departments and organizations
- Is trusted and has relationships with all communities
- Shares power externally and internally, such as convening an external equity advisory council to advise departmental leaders, or equipping staff to participate in departmental decisions
- Compensates community members for their time, such as stipends for participation in public meetings or focus group, or reimbursement for travel or child care and expertise
- Uses the power of community organizing as an avenue to change
- Recognizes that the community has answers; uses community driven decision-making and priority-setting processes; community members and organizations see how their work contributes to public health overall goals
- Engages in data collection, and analysis and reporting about the community with the community
- Has both people and places that are welcoming and accessible
- Embraces different ways of being and working; employees are encouraged to bring their whole selves to work; every individual is welcome and feels valued
- Has a lot of diversity (including language, people of color, LGBTQ+, age, gender, ability) among staff, leadership, and external partners
- Prioritizes budgets and activities through an equity lens
- Communicates in ways that resonate with diverse audiences; enables multi-directional communication
- Is not limited to a physical structure; public health is not just about a public health building
- Influences other levels of public health (local, state, and national)

Staying committed

Once in Stage 4 (whether the department as a whole, or significant sections of the department), the public health department will continue to implement many of the strategies described in Stage 3. It is never a question of "arriving" and being "done" with the work. To a certain extent, an organization will move in, out, and among all the stages of this transformational journey, and that is to be expected.

New leaders might enter the organization (especially in agencies led by a political appointee) with less awareness or commitment to equity in health. People within the organization who have been making personal and professional journeys toward equity in health will need to find ways to bring new leaders along. Champions of equity might retire, and the organization may pause in its equity journey. The reality of ongoing staffing changes underscores the importance of nurturing multiple champions and developing the capacity and passion for equity at every level of the organization.

Each time the department makes the effort to move toward greater equity within the department and in health outcomes, their commitment and capacity for equity work is strengthened and deepened. For example, new equity issues will arise that at first face complacency or resistance. Meeting a new challenge likely will require the organization again to step into the unknown. Having made the journey in one area, however, will increase the courage and commitment of leaders and staff, and make it more likely that they will face a new challenge with a greater level of energy. They will recognize, based on experience, that forming new partnerships, stepping into the unknown, and seeking out new ideas and strategies will yield rich benefits for the community and for the organization's mission and purpose.

Building support for equity in health in the community, in the organization, and among many individuals assures that the work will continue despite setbacks, false starts, resistance, and changing times. Once an organization has experienced the positive results of advancing equity for health, it can use those results to increase its commitment, stay activated, and leverage ongoing change.

Measuring progress through principles

The equity journey is not a one-time trip to a prescribed outcome, and it most definitely is not a linear process from a "point A" to a "point B." The process will take multiple efforts, over time, with different starting points and different ends. Segments of the journey may be short or long, easy or arduous. Learning and refocusing are important parts of the process. The results of the work are in the community and in the organization. All these characteristics make progress hard to measure.

Public health departments should choose quantifiable health outcomes as an important way to measure whether their efforts toward equity are making a difference in the community. Another set of goals, however, should focus on the organization and might include:

- Stronger, more visible commitment from organizational leaders for the work of equity in public health
- An increased awareness and capacity of public health staff to engage in equity work
- Ongoing and authentic relationships with the community
- A shared narrative on equity across the organization and the community that is clear and compelling
- An improved information base (data and research) and communications tools to make a robust case for action on equity with policy makers and community leaders
- A policy agenda to improve equity in local conditions

Effectiveness principles

To measure these kinds of goals, a helpful approach is to focus on a set of principles to guide and evaluate the actions of the organization. Sometimes known as "effectiveness principles" or "principles-focused evaluation," these statements provide guidance about how to think or behave toward some desired results (either explicit or implicit) based on norms, values, beliefs, experience and knowledge.[5]

Well-crafted effectiveness principles indicate if the organization is moving in the direction provided by the principle, provide guidance when reaching key decision points, assure that the organization is acting in accordance with its values, and help to document progress.

Effectiveness principles should be active and actionable. While meaningful and inspiring (but not empty rhetoric), the principles should also be feasible. They are not goals, but should describe how the organization must act to be effective. Good effectiveness principles are clear, adaptable and enduring, and useful in different contexts. Here are some examples:

> "The people most affected by an intervention should be involved in selecting, designing and evaluating it." Also known as "nothing about us without us," this principle guides processes of the organization and can be used to evaluate the community engagement practices of the organization.
>
> "Vulnerable persons who find themselves homeless should be given safe and adequate housing BEFORE they can be expected to wrestle with their other vulnerabilities." Also known as "housing first," this principle can potentially change the approach of many different organizations working to help people who are homeless.

Other principles for organizations engaged in equity work, and the questions they generate, might include:

- We encourage open communication and courageous confrontation on the issues of race and racism. *(Do we talk openly and often together about race and racism? Have we worked to reveal and disempower racist ideas operating in our organization?)*
- We honor multiple ways of being and knowing. *(Do we open ourselves to different ways of working? Do we embrace a variety of cultural approaches?)*
- We support the power of communities to create change. *(Do we remove institutional barriers when they come to our attention? Do we undermine ideas that come from the community?)*
- We uncover and mitigate the impact of racist ideas on our communities and on our work. *(Do we engage in open and frank conversations about race and racism? Do we recognize and address dominant white culture in our organization?)*
- We embrace the tensions inherent in equity work. *(Do we seek either/or solutions or look for creative possibilities that are both? Do we silence voices that challenge the status quo?)*
- We place the lived experiences of people bearing the greatest burden of inequities at the center of our work. *(Do we listen to the voices of people with lived experiences of inequities? Do we start with the community?)*

These are only a few examples. Public health departments should develop their own set of effectiveness principles with their community partners.

The impetus forward

The movement toward equity in health is, in fact, international. Often all an organization can see are the barriers. Yet many factors are propelling the field toward change in public health practice at local, state, and national levels. These developments can serve as catalysts for change; public health departments can also build on these forces in their own efforts to move toward equity. For example:

External forces

- Activities of the community. Communities increasingly are engaged in community organizing and are mobilizing to advance equity, promote asset-based approaches to equity, and to champion collaborative efforts toward equity. Communities are bringing more pressure to bear on elected officials and systems to address the inequities that lead to health disparities
- National and state expectations. Increasingly, state plans include equity, which influences the activities of state and local health departments
- Accountability to advance equity. Regulatory and funding organizations require efforts to advance equity. For example, the Public Health Accreditation Board (PHAB) has requirements about health equity throughout the Standards and Measures, incorporating equity in requirements related to data, partnerships, health promotion, and policies, among others.[6,7] The move to quality improvement in public health also supports the work of equity through process improvement and performance metrics
- The availability of funding. More grants are available to address issues related to equity in health outcomes
- The expectations of peers. As more public health departments engage in equity work, others look to them for ideas, advice and support, and expectations rise for others to engage in equity work
- Activities of leaders. Bold leadership in the community and among leaders of organizations for equity supports the work of public health
- The cost of inequities. Recognition of the high cost and unsustainability of a reactionary (services only) approach to inequities builds support for the work of public health to advance equity
- An expanded understanding of what creates health. More people (in public health and beyond) recognize that health is more than health care, and that social and economic forces play key roles in health outcomes for different populations
- Research and data: A growing evidence base on the root causes of health inequities supports public health action on equity

Internal Forces

- The role of formal leaders: More leaders of public health departments are formalizing efforts toward equity within their organizations, setting and prioritizing an agenda for advancing equity, and encouraging staff efforts across the board
- Change in leadership: Changes in leadership, whatever their source (e.g., change in elected administration) create opportunities to open the organization to new possibilities for advancing equity
- The role of informal leaders: Staff champions who have a personal and professional commitment to equity can have a great influence on the direction of the organization and its capacity to advance equity
- Equity within public health departments: As state and local health departments work to identify and redress their own inequities – such as hiring and retaining a more diverse (on many dimensions) staff and staff who have "lived experience" of inequities – their capacity and momentum to advance equity in the community increases
- Understanding the "why" of equity. Learning to "see" inequities – internally and in the community, historical and contemporary – and a growing awareness of the data and research supporting public health activity on equity – strengthens the impetus toward equity.
- Discontent with the way things are. Growing understanding comes with recognition that there is much the field of public health still does not know, and much that has to change – which makes it harder to stand still
- Belief that change is possible. Engagement with the research, with communities, with other public health departments, taking an asset-based approach, and learning from each other's successes builds confidence that "doing something different" will yield better results
- Stepping into authentic engagement. Fostering genuine relationships with different kinds of people, being curious, asking questions and learning, can yield a much wider range of possibilities for action on equity and verify the belief that genuine change is not only necessary but possible

Getting over bumps in the road

Equity work is challenging. Despite the impetus for change, especially the compelling nature of existing health inequities, there always will be forces that resist change and push back against the movement toward equity in health. In this section, public health practitioners offer ideas for coping with and overcoming this resistance.

Lack of support from people in power

Organizational leaders, elected officials, administrators, and parts of the community may not support or may even push back against equity in public health efforts. To some extent, this may be because of a lack of knowledge and awareness, and may come about because of competing priorities. People with power may be ambivalent, or may use the language of equity and appear to assent, but refuse to challenge existing power structures. It can be frustrating and time-consuming for public health continually to have to prove to those with power the need to address and prioritize the issues of equity.

Practical ideas from the field:

1. Use leaders to influence leaders. Engage leaders from communities and organizations that are engaged in equity work and harness their energy and enthusiasm. Build on the guiding philosophies and values of leadership. Work to raise up new leaders and people with power for positive change. Teach from below.
2. Provide a business case for equity, sharing examples from communities where equity in health has benefitted not only the targeted communities but also the community as a whole.[8,9]

The deep complexity of equity issues

Equity for public health connects to multiple complex and interrelated concepts, including some with a high emotional charge, such as racism, social justice, and power. For many decision-makers as well as staff, grasping and wrestling with this complexity and its emotional content is challenging. Moving policy conversations about health into a larger context that brings community conditions into the picture is important but can be difficult. For staff, it can be difficult to understand their role in something that is so much more than a program that provides services to clients.

Practical ideas from the field:

1. Harness the power of stories to communicate the complexity of equity and emphasize the positive nature of changes that support equity in health.
2. Learn from organizations and communities that have engaged in complex issues, such as their strategies, resources, and different approaches.[10]

The legacy of racism

Racism in American society is both about people and about the structure of systems. Decisions of the past that came out of a racist ideology constructed the systems that continue to have an impact on the lives of every person in America today. Some people benefit from the way things are, others suffer.

Racist ideas exist deep in the American consciousness and interact with other, equally deeply rooted ideas. For example, racism interacts with individualism to lead people of every hue to conclude that if only "fill in the blank" person would dress right, act right, or work harder, they would not have the problems that they now face. The attitude often taken is that these problems are a product of the individual's actions, and not systems that structure the conditions in which they were born and raised. The unconscious presence of racist ideas can prevent the creative and cooperative efforts required to address inequities across the community and to improve health.

Practical ideas from the field:

1. Start talking about racism and racist ideas. Recognize that systems are built to function certain ways, and can be changed. Develop the capacity to articulate and expose how racism operates today – this will improve everyone's ability to articulate a host of other interrelated issues, including those associated with age, gender, sexual orientation, and ability.[11]

2. Learn the racial history of the local community and surrounding areas – especially if very few people of color or American Indians live there. This could include intentional policies to prevent people of color from moving in, or actions that removed American Indians from the land now occupied by white populations. Educate the department about historical trauma.‡‡ Adopt trauma-informed approaches for public health.§§

The people doing the work lack lived experience of inequities

In many public health departments, the staff charged to consider and address health equities do not personally have lived experience of inequities, nor do their families.

Practical ideas from the field:

1. Create avenues for more people from communities with lived experiences of inequities to become part of the organization. Uncover and address elements of the organizational culture (e.g., dominant white culture) that create barriers to success and advancement.

2. Bring the voice of the community into the organization. Strengthen the roles and decision-making power of community advisory boards or family voices councils. Require or encourage existing staff to seek opportunities to have meaningful encounters with people who are different from them, and to gain an appreciation of the sense of urgency felt by those who see the real impact of inequities on their families, friends and neighbors.

The limitations of bureaucracies

Bureaucracies tend to be inflexible, cumbersome, and thus hard to change. Bureaucracies are also subject to the changing nature of politics. Barriers to equity work that arise in a bureaucracy can include budget constraints (including restrictions on who can enter into contracts), categorical funding, contracting processes that favor certain kinds of organizations (especially those with greater financial resources), and restrictions on spending (e.g., for food, per diems, or reimbursement for community members). Bureaucracies are also full of divisions ("siloes") and are notoriously difficult to navigate, so knowing where to advocate for change can be challenging.

‡‡ The task of educating white people about historical trauma or structural racism is not the responsibility of people of color or American Indian communities. Each person involved in equity work needs to take steps learn about and own their own part in these issues.

§§ A trauma-informed approach realizes the widespread impact of trauma and understands potential paths for recovery. An organization that takes this approach works to recognize the signs and symptoms of trauma in the people they work with, and integrates knowledge about trauma into policies, procedures, and practices. An organization that takes a trauma-informed approach also seeks to recognize their own role in perpetuating trauma and actively resists re-traumatizing the people they work with and serve.

Practical ideas from the field:

1. Support and strengthen the capacity of communities to advocate and create change from the outside in. Organize and form alliances with a range of entities to advocate for bureaucratic change.[12,13]
2. Work with funders to create grants that do not create barriers for communities experiencing inequities. Work within the organization to change financial or grant policies and procedures that create unnecessary barriers for smaller, community-based organizations.

Discomfort, fear and self-censorship

Changing the way things are done can be very difficult for individuals who were trained in a particular way, have experience in particular ways of doing things, and do not feel competent when tasked to try to step into a new and less comfortable space. Even people committed to equity in health – especially white people – fear making mistakes, or worry about saying something potentially racist, so they may not speak up. Sometimes staff in public health departments stop before they start, by assuming the answer to what they seek will be "no." Fear of finding out about harm an organization or the individuals in it have done, whether intended or not, can create a hesitancy to look at the organization very closely.

Practical ideas from the field:

1. Discomfort is at the root of all growth and learning; welcome it as much as possible. Deepen historical awareness and political analysis of racism and oppression to provide a strong understanding of how personal experience and feelings fit into the larger picture.[14,15]
2. Remember that equity work cannot be done in an abstract, intellectual space, but requires safety, freedom, and generosity. Give people room to learn and to make mistakes. Offer each other support and space for talking and listening.

The work challenges power structures

Power can be a force for good as well as for ill. Work on equity often must interrupt systems of power and existing power dynamics, especially those held in place by the dominant white culture. The language of equity – words like "social justice" and "inequity" – can trigger political divisions, especially during a time of great social and political polarization. Sometimes people do not want to acknowledge that the work requires navigating political spaces, or to face the fact that to do the work of equity in health means challenging structures of power.

"Power is the ability to achieve a purpose. Whether or not it is good or bad depends on the purpose."

Dr. Martin Luther King, Jr.

Practical ideas from the field:

1. Partner with and learn from community organizers and others with experience confronting power structures, using techniques such as organizing people and resources, building enduring networks, and making meaning based on worldviews and values.
2. Do not let one political party "claim" the work of equity in health. Work with leaders across the political spectrum to build support. Find different ways to talk about what the public health department is doing that connects with different values across the political spectrum.

The culture of public health

The field of public health, while committed to "doing good," is not free of bias. For example, a long-standing public health principle prioritizes doing the greatest good for the greatest number of people. This principle reflects the public health approach that focuses on populations rather than individuals. It poses a problem, however, in areas where populations experiencing inequities are small and need targeted attention. In those cases, attention to the greatest good for the greatest number of people might result in policies that fail to benefit and may even harm small subsets of the population.

Another challenge of public health culture is that most public health departments unconsciously function within the norms and standards of the dominant white culture (e.g., perfectionism, only one right way, priority given to the written word, etc.). Because the dominant white culture is seen as "normal," it makes it difficult, if not impossible, to open the door to other cultural norms and standards. Thus many public health departments, while saying they want to be multicultural, really only allow other people and cultures to come in if they adapt or conform to already existing cultural norms.

Practical ideas from the field:

1. Instead of a "greatest good" approach, adopt a strategy of setting universal goals with targeted processes. That is, set universal goals for all groups (such as a goal for childhood immunizations), but target the strategies differently, depending on the situation of different sub-groups (such as geographically isolated families, or groups with language/cultural barriers).[16,17]
2. Recognize the harm that the organization may have done, or may still be doing, because of its limited perspective. Develop the capacity to identify and name the cultural norms and standards that currently operate within the organization. Work with a diverse range of staff to identify a set of needed or desired organizational norms, and start working on change.

Individualism and the bootstraps narrative

Humans are social animals with a natural tendency to cooperate. The persistent notion in American culture that individuals are able to "pull themselves up by their own bootstraps" obscures that reality and poses an ongoing challenge to equity work in public health. This narrative shows up in many ways, such as in an emphasis on healthy behaviors without attention to the social and economic context, or in the reluctance of elected officials to assist people without evidence of hard work.

The focus on individual effort also shows up in the design of many public health departments, focused on providing individual services to meet individual needs. This approach, however, fails to see how current social and economic conditions have favored some populations (reducing their need for services) and posed barriers to others, and fails to recognize the responsibility of public health to shape conditions in the community to benefit the health of all people.

Practical ideas from the field:

1. Use data and stories to point out how cooperation and collective action have led to improvements in health, such as the way communities come together after a disaster. Lift up values such as "community spirit" to turn attention away from individualistic ideas.
2. Consider the history of the community and elevate examples of ways working together helped solve problems and make a better life for the community. Emphasize the fact that long-term personal interests actually correspond to the interests of the whole. Remove barriers that discourage cooperation, and actively encourage social connection and collective action.[18]

The notion of success

Sometimes ideas of success can get in the way of recognizing progress. A transformational journey is not a straight line, but has both positive and negative aspects. Equity work is complex, an emerging science, which needs continued experimentation and experience. Not everything tried will work, or work the first time.

Success in public health also is heavily influenced by some aspects of the dominant white culture, such as perfectionism, one right way, preference for the written word, fear of open conflict, and either/or thinking.

Practical ideas from the field:

1. Realize that "success" is multidimensional: success may occur along one dimension even as the organization struggles on another. Try to identify as many of the interrelated issues as possible, and look for incremental change and small and unexpected positive occurrences in a variety of places.
2. Remember that success depends on point of view. Think about who is looking at the activity or initiative, what their interests are, and what their vision is. Then engage all these points of views in developing goals, principles, timelines, and actions. Remember that multiple points of view can all be true. Try to prevent only one point of view from deciding if something has been a success or failure.

Looking back and looking forward

Sometimes the best way to mark progress is not by looking ahead (it may still be very far off!), but by knowing where the journey started. Even when it doesn't seem as though much has been accomplished, and when the going gets hard, remembering what it was like "before" can be a powerful motivator to carry on.

Look back at where the department started. Review the characteristics of an organization in Stage 1. How much of that is still true for the organization? What has changed? Do the same for each stage. Then throw a party to celebrate all the people and the efforts made so far.

Review the guiding principles. Can the department say that they have adhered to these? Are its actions in line with what was expected or hoped?

Engage in deep conversations with traveling companions. What do they have to say about where the journey started and where it is now? Celebrate each other. Make room at the table for more.

Look forward. Take time to recharge and regroup, and then set some new goals. Think about what's coming; take on a new name.*** Have ribbon-cutting or groundbreaking ceremonies to celebrate the future.

*** Entire public health departments may not have the option of renaming themselves. However, divisions, sections, programs, units of public health departments often restructure or reorganizing and take on new names. Equity work provides an opportunity to revisit and rethink the mission and strategies of various parts of the organization. Renaming can be a way to signal, celebrate, and reinforce the commitment to equity.

Appendices

Participants

Participants from the Minnesota Department of Health (MDH)

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- Cindy Borgen, Beltrami County Health and Human Services
- Sara Coulter, Rice County Public Health and Nursing Services
- Sara Hollie, St. Paul-Ramsey County Public Health
- Mark Riegel, Washington County Public Health and Environment
- Amy Reineke, Horizon Public Health
- Richard Scott, Carver County Public Health
- Liliana Tobon-Gomez, Hennepin County Public Health

Other participants:

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- Jenna Carter, Blue Cross/Blue Shield of Minnesota Center for Prevention
- Reena Chudgar, Public Health National Center for Innovations

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- Sarah Hernandez, Office of Health Equity, Colorado Department of Public Health and Environment
- Chelsie Huntley, Center for Public Health Practice, MDH
- Monica Hurtado, Voices for Racial Justice
- Paula Tran Inzeo, USniversity of Wisconsin Population Health Institute
- Maria Regan-Gonzalez, Mayor, Richfield, Minnesota
- Bruce Thao, Center for Health Equity, MDH

Participant-recommended Reading

Below are books participants in the two-day process recommended as reading that contributed to their understanding and growth for advancing equity:

Boyle G. *Tattoos on the Heart: Stories of Hope, Parables of Compassion*. New York, NW: Free Press; 2010.

Brown B. *Dare to Lead: Brave Work, Tough Conversations, Whole Hearts*. New York, NY: Random House; 2018

Diangelo R. *White Fragility Why It's So Hard for White People to Talk about Racism*. Boston, MA: Beacon Press; 2019.

Erdrich L. *The Round House*. New York, NY: Harper Collins; 2012.

Farley T. *Saving Gotham: a Billionaire Mayor, Activist Doctors, and the Fight for Eight Million Lives*. New York, NY; W.W. Norton & Company; 2015.

Haidt J. *The Righteous Mind: Why Good People Are Divided by Politics and Religion*. New York, NY: Penguin Random House; 2012.

Harris NB. *Deepest Well: Healing the Long-Term Effects of Childhood Adversity*. Boston, MA: HMH Books; 2019.

Kendi IX. *Stamped from the Beginning: the Definitive History of Racist Ideas in America*. New York, NY: Bold Type Books; 2016.

Lupton RD. *Toxic Charity: How Churches and Charities Hurt Those They Help (and How to Reverse It)*. New York, NY: HarperOne; 2012.

Menakem R. *My Grandmother's Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies*. Las Vegas, NV: Central Recovery Press; 2017.

Miller K. *Extreme Government Makeover: Increasing Our Capacity to Do More Good.* Folsom, CA: Governing Books; 2014.

Okun T. *The Emperor Has No Clothes: Teaching about Race and Racism to People Who Don't Want to Know.* Charlotte, NC: Information Age Publishing; 2010.

Oluo I. *So You Want to Talk about Race.* New York, NY: Seal Press; 2018.

Payne RK, DeVol PE, Smith TD. *Bridges out of Poverty: Strategies for Professionals and Communities*. Highlands, TX: aha! Process; 2009.

Wood Z. *Uncensored: My Life and Uncomfortable Conversations at the Intersection of Black and White America.* New York, NY: Dutton; 2018.

Tools and Resources

Assessing Readiness

Balajee SS, et al. *Equity and Empowerment Lens (Racial Justice Focus)*. 1st version. Portland, OR: Multnomah County; 2012: pp. 23-25. Available at: https://multco.us/diversity-equity/equity-and-empowerment-lens/equity-and-empowerment-lens-first-version.

Guide to a series of tools to help an organization assess programs or policies for equity and implement an action plan to improve equity. An organizational readiness assessment starts on p. 23; Multnomah County took pieces of a more comprehensive assessment, the BARHII Organizational Self-Assessment for Addressing Health Inequities Toolkit, and turned it into a reflective tool to examine an organization's readiness to do equity work.

Learning about Organizational Change

Kania J, Kramer M, Senge P. *The Water of Systems Change*. Boston, MA: FSG; 2018. Available at: https://www.fsg.org/publications/water_of_systems_change.

Explains the "six conditions of systems change" (graphic on page 4), which can help organizations improve their strategies for systems change. This is an actionable model for those interested in creating systems change, specifically for those who are working to advance equity. A one-hour webinar on the same website provides more detail about system change and "shifting the conditions that are holding a problem in place." (20 pages)

Transition Actions – Stage One

Assess organizational culture:

Bloss D, Canady R, Daniel-Echols M, Rowe K. *Health Equity and Social Justice in Public Health: A Dialogue-Based Assessment Tool*. Okemos, MI: Michigan Public Health Institute; 2018. Available at:https://www.mphi.org/wp-content/uploads/2018/06/HESJ-Dialogue-Based-Needs-Assessment-MPHI-CHEP.pdf. Published 2018.

Provides guidance on how to have a discussion on the organization's readiness and capacity to address health equity and social justice. The process is described on page 6 and the assessment begins on page 11 – 14. Pages 16 – 19 include space to record discussion of the strengths, gaps, action steps and notes. (20 pages)

Public Health Department Health Equity Assessment. Minneapolis, MN; Hennepin County Public Health Department. 2018. Available at: https://www.health.state.mn.us/communities/practice/resources/equitylibrary/hennepin-staffassessment.html.

In 2018-2019, the Hennepin County Public Health Department in Minnesota adapted the BARHII assessment (cited above) to assess its knowledge and practices on promoting health equity. The survey also gave staff an opportunity to reflect on their own experiences addressing health inequities in their work. Hennepin County used survey results to identify opportunities for improvement. The county followed the initial assessment with a shorter follow-up survey a year later. (First survey: 17 pages; second survey: 8 pages)

Assess relationships with community:

Centers for Disease Control and Prevention – Division of Community Health. *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Atlanta, GA: US Dept of Health & Human Services; 2013: 10-17. Available at: https://www.cdc.gov/NCCDPHP/dch/pdf/health-equity-guide/Practitioners-Guide-section1.pdf.

> Guide to help public health professionals incorporate the goal of health equity into current public health practice. "Meaningful Community Engagement for Health and Equity" (pp. 10-13) and "Developing Partnerships and Coalitions to Advance Health Equity" (pp.14-17) identify strategies to foster authentic relationships and amplify the voices of populations most directly affected by health inequities. Pages 13 and 17 include questions to reflect on current engagement efforts, who is missing from those efforts and barriers that exist for meaningful engagement.

Nexus Community Engagement Institute. *Community Engagement Assessment Tool*. St. Paul, MN: Nexus Community Partners; 2018. Available at: https://www.nexuscp.org/wp-content/uploads/2017/05/05-CE-Assessment-Tool.pdf.

> Asks organizations to indicate where they are on a scale of engagement. Poses a series of questions related to each public health activity being considered. On the last page is a list of questions for reflection to help interpret results.

Assess hiring practices and staff diversity:

Ready for Equity in Workforce Development: Racial Equity Readiness Assessment Tool. New York, NY: Race Forward; 2018: 5, 6, 9. Available at: https://www.raceforward.org/practice/tools/workforce-development-racial-equity-readiness-assessment.

> Includes reflection questions in five key areas and a scoring guide (page 5) on a continuum. The authors suggest the assessment be completed as a team and that discussion take place to identify gaps and growth opportunities. The reflection questions on page 9 are specific to leadership and staff morale. It may also be helpful to address the reflection questions on page 6, which are specific to mission, values, and culture that can help identify gaps in making sure organizations can retain diverse staff.

Staff Capacity

Understand conditions that create health: *Cliff Analogy of Health by Dr. Camara Jones*. https://www.youtube.com/watch?v=2zAol4eKdFo. In this 15-minute video, Camara Jones, MD, MPH, PhD, presents the Cliff Analogy at the University of Denver, Graduate School of Social Work. Dr. Jones uses a cliff to show the impact of social conditions on health – including racism, poverty, and other inequities. She calls for communities and health professionals to take action on those social conditions to eliminate health disparities.

Spent. http://www.playspent.org/. The Urban Ministries of Durham created this web-based game to help people better understand how low wage jobs affect individuals and families. The game ends when the player runs out of money, which takes about 15-20 minutes.

Recognize dominant narratives and develop new narratives: *Training and tools for public narratives.* https://www.health.state.mn.us/communities/practice/healthymnpartnership/narratives/training.html. The Healthy Minnesota Partnership (a partnership of the Minnesota Department of Health), with the help of Grassroots Policy Project, developed a structured training to help participants understand what narrative is and how public narratives shape policy decisions. The link to the "Opportunities for expanding narrative" page provides concrete ideas for things to do to expand narrative personally and professionally. The "Shaping New Possibilities" document helps think through how to use the Partnership emerging narrative and do work differently.

The Danger of a Single Story. https://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story. In this 18-minute TED Talk, author Chimamanda Ngozi Adichie shares how having a single story (narrative) about another person or country leads to lots of misunderstandings.

Unconscious bias: *Managing Unconscious Bias.* https://managingbias.fb.com/. Videos that show Facebook's training program on implicit bias. Describes what implicit bias is, where it originates, how different forms of bias play out in the workplace and things individuals and organizations can do counteract biases. Topics are divided into 10-15 minute segments.

External Engagement

Learning cohorts: *Roots of Health Inequity.* http://www.rootsofhealthinequity.org/. Structured online learning collaborative that includes a series of videos, documents, slide shows and interactive presentations. Designed for group participation, so even if someone signs up alone, they will be asked to share and strategize with others in a larger group. Does not have to be completed in any particular order or in one sitting.

Understand key equity concepts: *What is Health Equity?* https://www.youtube.com/watch?v=ZPVwgnp3dAc&feature=youtu.be. Three-minute video that uses animation to explain how conditions can create health inequities.

How I explained Health Equity to my Mom. https://www.youtube.com/watch?v=PKZhhinomd4&feature=youtu.be. A 55-minute video from Harris County Public Health Department in Texas. From the 3:00 minute mark to the 21:00 minute mark, Jen Hadayia, MPH, the Health Equity Coordinator shares how she explained health equity to her mom using the upstream parable and her own life story.

From Concepts to Practice: Health Equity, Health Inequities, Health Disparities and Social Determinants of Health. https://www.train.org/main/course/1061047/. Thirty--minute webinar explains the concepts around health equity that can provide a grounding for all staff in a health department. (Someone in the department will need to create an account in TRAIN to be able to view the webinar.)

Community input: *Community Engagement Toolkit – Page 26.* https://www.collectiveimpactforum.org/resources/community-engagement-toolkit. Includes a number of tools to ensure engagement with the community is transparent and authentic. Appendix 1 (page 26) provides details of a fun activity as a way to begin a conversation with staff about community engagement.

Transition Actions – Stage Two

Plans and Policies

Develop equity team: *Advancing the Mission: Tools for Equity, Diversity, and Inclusion – pp. 36-48.* https://www.aecf.org/resources/advancing-the-mission-tools-for-equity-diversity-and-inclusion/. Includes an overview of the work done by Anne E. Casey Foundation's internal planning group to "hardwire" equity, diversity and inclusion within the organization, which included developing and sustaining what they call an "affinity group." Information on "Creating and Sustaining an Affinity Group" starts on page 36 and includes an FAQ section to help an organization identify what type of group to form, roles and responsibilities and what is needed to get started. Once an equity group is formed, the tips (starting on page 40) can help the group continue moving forward.

Assess equity practices: *Equity and Inclusion Lens Handbook – pp. 24-45.* https://www.cawi-ivtf.org/publications/equity-and-inclusion-lens-handbook-2018. Developed to support Ottawa's work to embed equity into its programs and operations. Pages 24-45 include specific questions to assess equity and inclusion in a variety of practices from communications to supervision to planning events. Use to consider what the department currently does and what it could do differently to ensure equity and inclusion in these practices.

Funding for equity work: *Taking Action to Promote Health Equity Series: Show me the Money –Innovative Funding approaches to Promote Health Equity.* http://www.dialogue4health.org/web-forums/detail/show-me-the-money. Ninety-minute webinar features two speakers sharing how they have been able to fund some of their innovative health equity work. From the 25:30 minute mark through 37:45 minute mark, the Rhode Island Department of Health shares how braided funding helped their department fund community priorities through their "Health Equity Zones." At the 1:12:37 through the 1:21:40 minute mark, they offer suggestions on how to fund these activities in rural communities, the importance of alignment and braiding funding sources, and working with funders to look at new and innovative ways to fund health equity work.

Supporting healthy communities: How rethinking the funding approach can break down silos and promote health equity – 20 pages. https://www.tfah.org/wp-content/uploads/2018/04/DUP_supporting-healthy-communities-1.pdf. Provides information on the "Healthy Communities Funding Hub Model" where funding and spending were coordinated to address community needs. A graphic model of this funding hub is on page 5 and the article includes highlights of how this works in different communities.

Staff Capacity

Confront dominant white culture: *Unpacking the Invisible Knapsack* (7 pages). https://www.racialequitytools.org/resourcefiles/mcintosh.pdf. Seminal article on white privilege written by Peggy McIntosh in the late 1980s. Reading the article separately or together, and then having a focused conversation about the article, can open up conversations about dominant white culture.

Deconstructing White Privilege with Dr. Robin DiAngelo. https://www.youtube.com/watch?v=DwIx3KQer54. Dr. Robin DiAngelo wrote an article in 2011 on white privilege titled "White Fragility." She most recently published a book titled, *White Fragility: Why It's So Hard for White People to Talk about Racism.* This 22-minute video of Dr. DiAngelo describes white privilege and challenges listeners to see how racism and white supremacy is in the very fabric of American society.

Why "I'm not racist" is only half the story. https://www.youtube.com/watch?v=M1SlOWmONRI. Six-minute video where Dr. Robin DiAngelo describes how the definition of "being a racist" in American culture makes it almost impossible to keep race conversations on the table.

External Engagement

Developing different approaches. *Community Engagement Toolkit – pp. 7-8.* https://www.collectiveimpactforum.org/resources/community-engagement-toolkit.Includes a number of tools to ensure engagement with the community is transparent and authentic. Tool 3 (pp. 7-8) briefly describes "Asset-Based Community Development" and lists the five key questions to ask before any community engagement effort. Also includes space to reflect on how community members contribute to the effort and how to support connection of community members as parts in the result.

Data and Measurement

Health Equity Data Analysis (HEDA) – 48 pages. https://www.health.state.mn.us/data/mchs/genstats/heda/index.html. Provides information on collecting, analyzing and interpreting local data in partnership with the community. In each of the steps of the HEDA, the guide explains the role of the community in that step. Once the HEDA is completed, the authors write that the results should be shared with community members to review and determine next steps. The section on "Sharing Findings" (page 24) provides a list of questions that may help tailor language and messaging for various audiences.

Why Am I Always Being Researched? A guidebook for community organizations, researchers, and funders to help us get from insufficient understanding to more authentic truth, https://chicagobeyond.org/researchequity/. While developed to address power dynamics in research, much of what is here can be applied when gathering data from communities. A graphic on page 17 explains the seven inequities held in place by power. Pages 42-43 includes ideas for inclusion as well as questions to think about when identifying what data to gather. There are a list of questions to ask when sharing results with community to address historical context, participant voices and format on page 58-59 and 80-82.

Transition Actions – Stage Three

Plans and policies

Build equity into plans, policies, etc.:

Racial Equity and Social Justice Initiative. *Racial Equity and Social Justice Tool: Comprehensive Version.* Madison, WI: City of Madison Civil Rights; 2018. Available at: https://www.cityofmadison.com/civil-rights/programs/racial-equity-social-justice-initiative/tools-resources (under Equity Tools)

> Tool for a government entity to consciously consider equity and assess how policies, plans, programs and budget might impact low-income populations and communities of color. Intended to lead to strategies to prevent or mitigate adverse impacts on marginalized populations. (8 pages)

Equity in the Center. *Awake to Woke to Work: Building a Race Equity Culture.* Kansas City, MO: Nonprofit Leadership Alliance; *11, 13-19*. Available at: https://static1.squarespace.com/static/56b910ccb6aa60c971d5f98a/t/5adf3de1352f530132863c37/1524579817415/ProInspire-Equity-in-Center-publication.pdf.

> Builds the capacity of organizations to have a race equity culture. Identifies seven levers in building this culture. On page 11 is a graphic that represents the Race Equity Cycle (Awake/Woke/Work) and the seven levers. From pages 13 through 19, there are details describing each lever with an example of what it looks like in practice, which can be used to get ideas on how to build equity into an organization's policies, practices, culture, and more.

External Engagement

Minnesota Department of Health. *Community Engagement Guide: Statewide Health Improvement Partnership (SHIP 4).* St. Paul, MN: Minnesota Department of Health Office of Statewide Health Improvement Initiatives; 2017: 31-32. Available at: https://www.health.state.mn.us/communities/ship/support/docs/implementation/commengage.pdf.

Developed to highlight considerations for building strong partnerships in the context of this initiative. Pages 31 and 32 include tips for conducting one-on-one meetings specifically to establish relationships.

Staff Capacity

Color brave space – how to run a better equity focused meeting [blog post]. Fakequity Web site. https://fakequity.com/2017/05/26/color-brave-space-how-to-run-a-better-equity-focused-meeting/. Published May 26, 2017.

Article from the "Fakequity" blog that explains the authors' development of "Color Brave Space Principles." While the term "safe space" is often used as a ground rule for difficult discussions, this often translates into safety and comfort for white people. The challenge from the authors is that to learn and grow, people must hold themselves accountable to these brave space principles.

Hobson M. Color blind or color brave [video]. TED. https://www.ted.com/talks/mellody_hobson_color_blind_or_color_brave. Posted March 2014.

Fourteen-minute TED Talk where the speaker challenges listeners to start talking about race, specifically for the purpose of diversity in hiring.

Data and Measurement

Well-Being in the Nation (WIN) measures. 100 Million Healthier Lives Web site. https://www.winmeasures.org/statistics/winmeasures.

Website that "offers a set of common measures to assess and improve population and community health." Measures include the well-being of people, the well-being of places, and equity. An 18-minute video in the "About" section explains the website and how it can be used. The well-being measures may be helpful to identify what a health department might want to track in terms of equity metrics.

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