Health Inequities Series

Health equity is relevant to all staff members at KFL&A Public Health. Whether you talk to clients, plan programs, or deal with data, health equity is a philosophy that guides our work.

The Health Inequities Series are fact sheets to help you learn about:

concepts and terms,

resources to learn more about different topics, and

requirements in the health equity foundational standard.

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KFL&A
Public Health

Contents

Overview

Definition

Health inequities are differences in health that are:

systematic, meaning they are not random but show a pattern across the population,
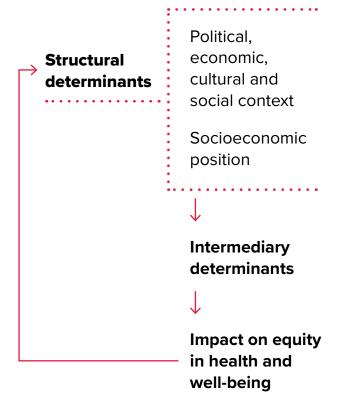
socially produced, and so can be avoided by changing how society distributes resources and opportunities, and

unfair or unjust, because bias and discrimination lead to differences in who can access resources and opportunities.[1]

How are they created?

According to the World Health Organization's framework, there are 3 elements that together shape the degree of health inequities in a society:

Socioeconomic and political context

Socioeconomic position

Intermediary determinants

Let's explore each one in turn.

Structural determinants

Political, economic, cultural and social context

Socioeconomic position

↓

Intermediary determinants

↓

Impact on equity in health and well-being

Figure 1. Elements that shape the degree of health inequities in a society. Adapted from the World Health Organization[2] and the National Collaborating Centre for Healthy Public Policy[6]

Socioeconomic and political context

These are the social and political mechanisms that create and maintain social hierarchies. Examples:

Economic and social policies

Systems of governance

Biases, norms, and values within a society

Socioeconomic position

Social hierarchies create unequal socioeconomic positions, where individuals are stratified (as in, arranged on a ranked order) according to income, education, occupation, gender, race, ethnicity, and other factors.

Together, these first two elements are called structural determinants because they shape how more downstream factors are distributed and are the root causes of health inequities.

Socioeconomic and political context

Governance

Macroeconomic policies

Social policies

Public policies

Culture and societal values

Socioeconomic position

Social Class
Gender
Ethnicity (racism)

Education
↓
Occupation
↓
Income

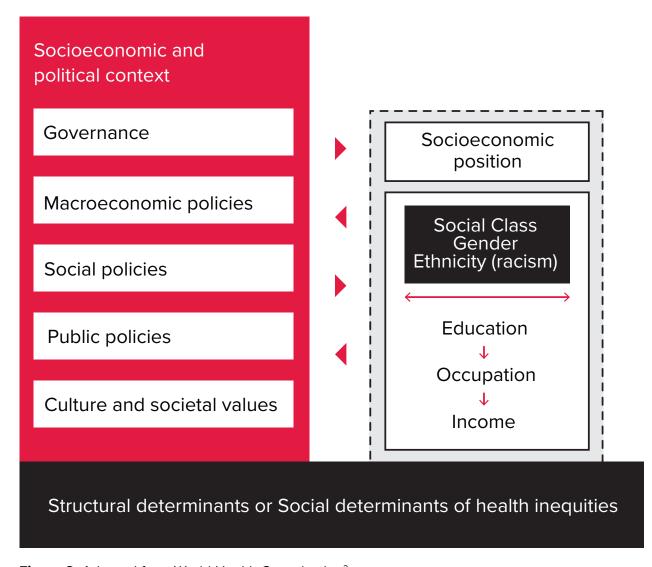Structural determinants or Social determinants of health inequities

Figure 2. Adapted from World Health Organization[2]

What are social hierarchies?

In every society, power, prestige and resources are unequally distributed in a systematic way. This inequality can be described as a system of social stratification or social hierarchies, where people are ranked based on characteristics such as gender, income, and education.[2]

Depending on their position on these hierarchies, people will have different access to power, prestige, and resources. Those at the top of a hierarchy are called the dominant group and will have the most access to these things. Those lower down on the hierarchy are called non-dominant groups and will have less access to these things relative to the dominant group.

Since we belong to many social identity groups, people can experience both dominant and non-dominant status (i.e., privilege and oppression) at the same time. Membership in more than one non-dominant group worsens the discrimination that people experience and increases inequities.[3]

Hierarchy	Oppression	Dominant or privileged social group	Non-dominant or targeted social groups
Ability or disability	Ableism	Temporarily able bodied people	People with disabilities
Class	Classism	Upper, middle class people	Poor, working class
Race	Racism	White people	Black, Indigenous, Latino, Asian people
Sexual orientation	Heterosexism	People who are heterosexual	People who are lesbian, gay, bisexual
Sex	Sexism or Androcentrism	Men	Women
Gender	Genderism	People who conform with male and masculine, female and feminine norms	People who are gender nonconforming or gender variant
Size	Sizeism	People who are thin	People who are fat
Etc.	---	---	---

Figure 3. People are categorized in a society based on characteristics like ability, class, and race. Groups get ranked into a hierarchy, with some identities being seen as better than others. Those groups that are advantaged have greater social power, while other groups that are disadvantaged face discrimination and violence.[4]

Intermediary determinants

Socioeconomic position influences health through intermediary determinants – the conditions in which people are born, grow, live, work and age. These determinants are unequally distributed and are reflective of people's position within social hierarchies.

These determinants include:

- Housing
- Neighbourhood quality
- Physical work environment
- Stressful living circumstances and relationships
- Social support
- Coping skills
- Physical activity
- Alcohol consumption
- Nutrition
- Tobacco consumption
- Substance misuse
- Access to health services
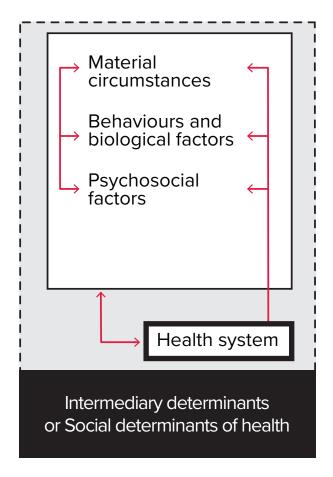
Based on their socioeconomic position, individuals have different risk of exposure and vulnerability to health-compromising conditions. For example, the lower an individual's social status, the greater their likelihood of exposure to unhealthy housing, dangerous working conditions, and inadequate food access.[7]
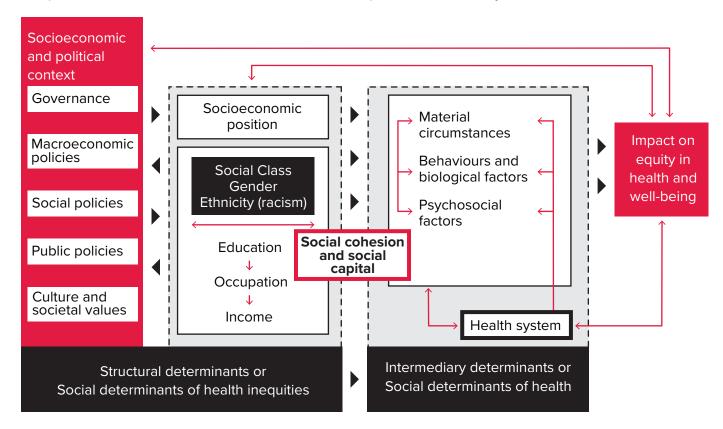
Based on their socioeconomic position, individuals also have different access to resources that protect health.[8]

Figure 4. Adapted from World Health Organization[2]

Putting it all together

Now we can put together the full model. As you can see from figure 5 below, structural determinants act through intermediary determinants to shape health outcomes and create health inequities in a society.[2]

Figure 5. Elements that shape the degree of health inequities in a society.[2] Note that in this framework, another name for intermediary determinants is 'social determinants of health'. Outside of this framework, the social determinants of health usually refer to both the conditions in which people are born, grow, work, live and age (i.e., intermediary determinants) and the wider set of forces and systems shaping the conditions of daily life (i.e., structural determinants), depending on the definition used.

Knowing the difference between the root causes of health inequities (e.g., the processes that give rise to unequal distribution of power and resources), and the everyday factors that affect health (e.g., housing, working conditions, healthy behaviours) means we can understand where our actions might have the greatest effect.

Working upstream

The health equity guideline encourages us to work upstream. Working upstream means trying to change the factors that maintain privilege and disadvantage, and inclusion and exclusion.[8] It involves partnering with different sectors since economic and social factors lie outside the authority of public health.

Why should we try to work more upstream? Without changing people's access to power, resources, and social inclusion, our other efforts – such as increasing access to health services and improving living conditions – won't be effective in changing health inequities.[2]

Upstream, midstream and downstream approaches [5]	
Upstream interventions seek to reform the fundamental social and economic structures that distribute wealth, power, opportunities and decision making. These changes generally happen at the macro policy level: national and transnational.	Examples: Advocating for living wage policies, wage capping, progressive taxation.
Midstream interventions seek to reduce exposure to hazards by improving material working and living conditions, or to reduce risk by promoting healthy behaviours. These changes generally occur at the micro policy level: regional, local, community or organizational.	Examples: Linking clients with welfare, social assistance, or back-to-work programs.
Downstream interventions seek to increase equitable access, at an individual level, to health and social services. These changes generally occur at the service or access to service level.	Example: Ensuring that chronic disease prevention programs are accessible to people who experience low incomes.

What can I take away?

Power and oppression are intimately linked with how health inequities are created and maintained. That's why the health equity guideline asks us to apply anti-racist, anti-oppressive and culturally safe approaches to our practice.

Reducing health inequities requires changing how power is distributed within society to the benefit of marginalized groups.[2]
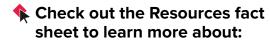
Action on health inequities is a political process.

There is a difference between the intermediary determinants of health and the social processes that shape their distribution.

There are different levels that public health and our partners can act upon to reduce health inequities.

It's not enough to act at the midstream or downstream levels. To reduce health inequities, there also needs to be action at the upstream level. That's why we need to work with those outside the health sector as they have authority over the economic and social factors that influence health.

Where can I learn more?

Check out the Resources fact sheet to learn more about:

Bias and oppression

Concepts

Intersectionality

Racism

References

1. Whitehead M, Dahlgren G. Levelling up (part 1): a discussion paper on concepts and principles for tackling social inequities in health [Internet]. Copenhagen (DK): WHO Regional Office for Europe; 2006 [cited 2018 Aug 16]. Available from: http://apps.who.int/iris/bitstream/handle/10665/107790/E89383.pdf?sequence=1&isAllowed=y.

2. Solar O, Irwin A. A conceptual framework for action on the social determinants of health: social determinants of health discussion paper 2 [Internet]. Geneva (CH): World Health Organization; 2010 [cited 2018 Aug 27]. Available from: http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

3. Burke MA, Eichler M. The BIAS FREE framework: a practical tool for identifying and eliminating social biases in health research [Internet]. Geneva (CH): Global Forum for Health Research; 2006 Oct [cited 2018 Aug 23]. Available from: http://biasfree.org/full_BF.pdf

4. Goodman DJ. Oppression and privilege: two sides of the same coin [Internet]. Japan SIETAR Journal of Intercultural Communication. 2015;18:1-14. Available from: http://www.dianegoodman.com/PrivilegeandOppression.

5. National Collaborating Centre for Determinants of Health. Let's talk: moving upstream [Internet]. Antigonish (NS): National Collaborating Centre for Determinants of Health, St. Francis Xavier University; 2014 [cited 2018 Sep 13]. Available from: http://nccdh.ca/images/uploads/Moving_Upstream_Final_En.pdf

6. Mantoura P, Morrison V. Policy approaches to reducing health inequalities [Internet]. Montréal (QC): National Collaborating Centre for Healthy Public Policy; 2016 [cited 2018 Dec 5]. Available from: http://www.ncchpp.ca/docs/2016_Ineg_Ineq_ApprochesPPInegalites_En.pdf.

7. National Collaborating Centre for Determinants of Health. Common agenda for public health action on health equity [Internet]. Antigonish (NS): National Collaborating Centre for Determinants of Health, St. Francis Xavier University; 2016 [cited 2018 Dec 5]. Available from: http://nccdh.ca/images/uploads/comments/Common_Agenda_EN.pdf.

8. Pan-Canadian Health Inequalities Reporting Initiative. Key health inequalities in Canada: a national portrait [Internet]. Ottawa (ON): Her Majesty the Queen in Right of Canada, as represented by the Minister of Health; 2018 [cited 2018 Dec 5]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/hir-full-report-eng.pdf

Requirement 1 – Assess and Report

Assess and report on the health of local populations describing the existence and impact of health inequities, and identifying effective local strategies that decrease health inequities.

Information helps us to identify where the greatest inequities are and to uncover their root causes. It also helps us to decide where to put our resources and to identify the most effective actions. That's why it's important to uncover and present evidence about health inequities. It's critical to raising awareness among decision makers and most importantly, to drive change on policies and programs.

Program staff, researchers and capacity builders can...

Explore whether differences in health between groups are unfair and unjust.

Be aware of their assumptions, biases and stereotypes when looking at or collecting evidence.

Communicate information in a way that is understandable, inclusive, and that doesn't perpetuate stereotypes.

Consult with people who are most affected by the issue to ensure the validity of the data, approach and findings.

Look for opportunities to engage marginalized communities in assessment, surveillance, evaluation and research (e.g., hiring and training peer researchers to engage with community members).

Report back findings to people involved in the research.

Work with others to find policy solutions to the inequities that they've uncovered.

Communications staff, program staff, researchers and capacity builders can...

Learn about effective ways to frame social determinants to the public. For example, use the phrase "the everyday factors that affect our health" instead of the words "social determinants of health".

Use images that break stereotypes when designing presentations slides and reports.

Managers can...

Direct staff to consider social determinants of health and social inequities when identifying priority populations.

Look for opportunities to partner with agencies outside of the health sector to increase access to relevant local data.

Where can I learn more?

Check out the Resources fact sheet to learn more about:

Advocacy and policy

Application into practice

Bias and oppression

Communication

Engagement and partnerships

Indigenous Peoples and reconciliation

Measuring health inequities

References

1. National Collaborating Centre for Determinants of Health. Population health status reporting [Internet]. Antigonish (NS): National Collaborating Centre for Determinants of Health, St. Francis Xavier University; c2018 [cited 2018 Sep 5]. Available from: http://nccdh.ca/learn/reporting/.

Requirement 2 – Modify and Orient

Modify and orient public health interventions to decrease health inequities by:

> **Engaging priority populations in order to understand their unique needs, histories, cultures, and capacities, and**

> **Designing strategies to improve the health of the entire population while decreasing the health inequities experienced by priority populations.**

> **Who is not included in my work?**
>
> **What could contribute to this exclusion?**
>
> **What can I do differently to make sure these people are included?**

These questions can help you decrease inequities in your work. After all, we don't normally set out with the intention to worsen health inequities. They happen because we assume that everyone has the same needs, problems and resources as us. So we end up designing programs for people who are like ourselves. Or we base our decisions about another group on false knowledge and stereotypes. That's why it's important to consider how our own experiences and social identities shape the way we see the world.

The Modify and Orient requirement helps us to avoid creating and maintaining health inequities by involving those who are excluded in society when designing, carrying out, and evaluating programs and services. By reaching out and working with members of marginalized communities in a respectful, inclusive way, we open up opportunities for sharing power with those who have less access to information, resources, and decision making.[1] This requirement also asks us to redistribute our resources to meet different levels of need.

Everyone can...

Learn about terms used to respectfully describe various social groups.

Speak up against demeaning jokes or negative comments.

Be curious about the daily ways they benefit from being a member of a privileged group (e.g., being straight, able-bodied, or speak English as a first language).

Program staff can...

Collaborate with marginalized groups in a safe and respectful way when planning, carrying out, and evaluating programs and services.

Advocate for including diverse voices at decision making tables.

Assess whether a program or service widens health inequities by doing a Health Equity Impact Assessment.

Recognize that health inequities are never the result of a single factor but are shaped by many overlapping factors that interact with each other. This is called intersectionality.

Managers can...

Put resources towards those who face barriers to accessing services in the community.

Add an outreach component to current universal programs.

Acknowledge and challenge power imbalances when working with partners.

Challenge practices, policies, and procedures that create barriers.

Initiate discussions at strategic planning sessions about how equity can be better integrated into goals, objectives, activities, and outcomes.

Concept spotlight

Proportionate universalism = Action is proportionate to the level of need and disadvantage in specific populations.

We are required to apply this concept within all processes for planning, implementation, and evaluation. Learn about proportionate universalism interventions:

- **Let's Talk: Universal and targeted approaches to health equity. (2013). National Collaborating Centre for Determinants of Health.**

- **Focus on: a proportionate approach to priority populations. (2015). Public Health Ontario.**

- **On-Demand Webinar 3: Approaches to developing equitable public health interventions and strategies. (2019). National Collaborating Centre for Determinants of Health.**

Where can I learn more?

- **Check out the Resources fact sheet to learn more about:**

    Application into practice

    Bias and oppression

    Engagement and partnerships

    Environmental health

    Health equity impact assessments

    Indigenous Peoples and reconciliation

    Intersectionality

References

1. Burke R, HC Link. Engaging marginalized communities: honouring voices and empowering change [Internet]. Toronto (ON): HC Link; 2011 [cited 2018 Dec 3]. Available from: https://www.hclinkontario.ca/images/Uploaded_files/2011/EngagingMarginalizedCommunitiesEnglish.pdf.

Requirement 3 — Engage in Multi-Sectoral Collaboration

Engage in Multi-Sectoral Collaboration with municipalities, LHINs, and other relevant stakeholders in decreasing health inequities.

Engagement with Indigenous communities and organizations shall include fostering and creating meaningful relationships in accordance with the Relationship with Indigenous Communities Guideline.

Because most of the everyday factors that affect health (e.g., housing, income, and gender equality) lie outside of the authority of public health, we need to engage non-health and health partners to decrease health inequities.

Although it's made explicit in this requirement, the principles of community engagement, partnership and inter-sectoral collaboration apply to all requirements. For example, if you were assessing and reporting on health inequities, you would want to engage stakeholders throughout to ensure that what you measure and report on are relevant, valid, acceptable and actionable to decision makers and communities.[1]

Staff who work with partners can…

Participate in coalitions and collaborative partnerships which address social determinants of health.

Bring community organizations together to set indicators and targets to reduce health inequities.

Initiate discussions about equity terms and concepts so that everyone has a common understanding about what they mean.

Build communication tools to help partners deliver key message about health equity.

Take an Indigenous cultural safety course and learn about reconciliation.

Promote health equity impact assessment of programs and policies in health and non-health sectors. Assessments should pay attention to how programs or policies create structural inequities and how certain groups benefit.

Monitor and evaluate partnerships to determine whether they are effective and to identify gaps.

Where can I learn more?

Check out the Resources fact
sheet to learn more about:

Concepts

Communication

Engagement and partnerships

Indigenous Peoples
and reconciliation

References

1. Canadian Institute for Health Information.
    Measuring health inequalities: a toolkit
    [Internet]. Ottawa (ON): CIHI; 2018
    [cited 2018 Dec 3]. Available from:
    https://www.cihi.ca/en/measuring-
    health-inequalities-a-toolkit

Requirement 4 – Participate in Advancing Healthy Public Policies

Lead, support and participate with other stakeholders in health equity analysis, policy development, and advancing healthy public policies that decrease health inequities.

Healthy public policies have the potential to decrease health inequities and to improve the conditions in which people are born, work, live and play. When advocating to improve health equity, we can frame the issue; gather and provide information to others; collaborate and develop alliances to amplify political power and coordinate strategies; and use legal and regulatory statutes to advance health equity.[1]

Those who do policy-related work can…

Learn how to frame and promote equity concepts in ways that resonate with different audiences.

Learn about the difference between structural determinants and intermediary determinants, and how policies can act upstream or downstream. (See Overview section.)

Watch for lifestyle drift, or the tendency for policy to start off recognizing the need for action on upstream social determinants, only to drift downstream to focus on individual lifestyle factors.[2]

Make a case for including health equity as a goal for policy-related work.

Demonstrate the cost benefits of addressing health inequities.

Develop reports, policy options and briefing notes that address health inequities experienced by marginalized populations.

Support the use of assessments and tools to understand the health impact and health equity impact of public policies including institutional policies, municipal by-laws and legislation.

Where can I learn more?

Check out the Resources fact sheet to learn more about:

Advocacy and policy

Concepts

Communication

Engagement and partnerships

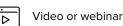Health Equity Impact Assessment

Housing

Municipalities

References

1. National Collaborating Centre for Determinants of Health. Let's talk: advocacy and health equity [Internet]. Antigonish (NS): National Collaborating Centre for Determinants of Health, St. Francis Xavier University; 2015 [cited 2018 Dec 5]. Available from: http://nccdh.ca/images/uploads/comments/Advocacy_EN.pdf.

2. National Collaborating Centre for Determinants of Health. Let's talk: moving upstream [Internet]. Antigonish (NS): National Collaborating Centre for Determinants of Health, St. Francis Xavier University; 2014 [cited 2018 Nov 23]. Available from: http://nccdh.ca/images/uploads/Moving_Upstream_Final_En.pdf

Resources

Advocacy and Policy

Let's Talk: Advocacy and Health Equity (2015)

National Collaborating Centre for Determinants of Health. Describes four roles for public health in supporting an advocacy strategy to improve health equity, including framing the issue; gathering and disseminating data; working in collaboration and developing alliances; and using the legal and regulatory system.

Policy Approaches to Reducing Health Inequalities (2016)

National Collaborating Centre for Healthy Public Policy. Learn about the differences between structural determinants (also called social determinants of health inequalities) and intermediary determinants (also called social determinants of health), and how different policy approaches act upstream or downstream.

On-Demand Webinar 5: Policy development and advocacy to improve health equity (2019)

National Collaborating Centre for Determinants of Health. This webinar talks about public health roles in policy development and advocacy, steps involved in healthy public policy development, and choosing advocacy tools.

Application into Practice

Equity and Inclusion Lens Handbook (2018)

City for All Women Initiative. Learn about terms, walk through exercises to consider your diversity, and learn how to apply an equity and inclusion lens to your work. Handbook contains 11 checklists for different tasks (e.g., communications, leading and supervising, gathering information/research). 11 snapshots provide information on groups who risk exclusion. Version française.

Bias and Oppression

Oppression 101 (2013)

Interchange Counselling Institute. Video that explains different components and levels of oppression.

Oppression and Privilege: Two Sides of the Same Coin (2015)

Goodman DJ. Article that talks about how addressing both oppression and privilege are important to achieving greater equity.

The BIAS FREE framework: a practical tool for identifying and eliminating social biases in health research (2006)

Burke MA, Eichler M, Global Forum for Health Research.
Presents a tool for identifying and avoiding biases in health research that derive from any social hierarchy. The tool can also be used to identify biases in legislation, policy, programs, service delivery and practice, but these examples are not dealt with in this book.

Power Flower Exercise

(n.d.). LGBTQ2S Toolkit. This exercise will help you to reflect on your social identities and how they compare with the identities that hold power in society.

Are You an ALLY? Campaign (2016)

Human Rights & Health Equity Office, Mount Sinai Hospital.
Videos and tools to help you know how to react when discrimination or harassment happens.

Communication

A New Way to Talk about the Social Determinants of Health (2010)

Robert Wood Johnson Foundation. A guide that presents best practices to talk about the social determinants of health with different audiences.

Communicating the Social Determinants of health: Guidelines for Common Messaging (2013)

Canadian Council on Social Determinants of Health. Provides advice for expressing concepts, and for using facts, stories and images. Explores common worldviews and frames related to the social determinants of health.

Communicating About the Social Determinants of Health: Income Inequality and Health (2014)

National Collaborating Centre for Determinants of Health, Canadian Public Health Association. Uses income inequality as an example for how to apply best practices for communicating the social determinants of health.

FrameWorks Institute (2018)

FrameWorks Institute designs, conducts and publishes communications research to prepare non-profit organizations to further public understanding of specific social issues. They work closely with social policy experts to outline potential strategies for advancing healthy public policies. Check out the 'Research on Issues' section for research and recommendations on how to frame issues like addiction, mental health and early childhood development.

Concepts

Let's Talk: Health equity (2013)

National Collaborating Centre for Determinants of Health.
Discusses key concepts like health inequalities and health inequities.

Let's Talk: Moving upstream (2014)

National Collaborating Centre for Determinants of Health.
Talks about three levels (i.e., downstream, midstream, and upstream)
where public health can intervene to reduce health inequities.

On-Demand Webinar 1: Introduction to Health Equity (2019)

National Collaborating Centre for Determinants of Health. This webinar describes key
health equity concepts, including health; health equity and inequities; social justice;
social gradients in health; and intersectionality.

Concepts and principles for tackling social inequities in health: Levelling up: Part 1 (2006)

Whitehead M, Dahlgren G. Discusses key health equity concepts and principles
for non-technical audiences.

Key Health Inequalities in Canada: A National Portrait (2018)

A joint initiative of Public Health Agency of Canada, the Pan-Canadian Public Health
Network, Statistics Canada, the Canadian Institute for Health Information, and the First
Nations Information Governance Centre.
Pages 15 to 18 give a concise summary of the World Health Organization's Commission
on Social Determinants of Health conceptual framework for action on the social
determinants of health.

Engagement and Partnerships

Stakeholder Engagement Framework and Tools (2017)

KFL&A Public Health. A guide for our agency to engage more purposefully with
community members and stakeholders. Contains tools to plan and document stakeholder
engagement activities.

Resource Library (2018)

Tamarack Institute. Webinars, tools, case studies, and other resources for community
engagement, collective impact, collaborative leadership and more.

Liberating Structures

Lipmanowicz H, McCandless K. Offers 36 processes to get people thinking and working
together effectively. Try processes like '1-2-4-All' or '15% solutions' to enhance relational
coordination and trust among your group.

Engaging Marginalized Communities: Honoring Voices and Empowering Change (2011)

Burke R, HC Link. Article that recommends strategies and activities to build relationship and trust with members of marginalized groups. Version française.

Self-Evaluation Tool for Action in Partnership (2017)

Health Nexus. A tool that focusses on different aspects of effective partnership work, such as the range of perspectives relevant to the issue, and early stakeholder involvement in strategic decisions. It was designed to be used by members of a partnership who voluntarily participate in self-evaluation. Version française.

Partnership Essentials (2018)

Health Nexus. Explores definitions of partnership and considers different approaches for working in partnership. Version française.

Principles of Collaborative Leadership Towards Equity (2017)

Southwest Ontario Forum on Collaborative Leadership in Practice. Principles developed to help you discuss equity issues and practices within partnerships.

On-Demand Webinar 4: Moving upstream: Working across sectors to decrease health inequities (2019)

National Collaborating Centre for Determinants of Health.
Webinar that talks about upstream interventions, strategies for partnership, and key partners relevant to your work.

Environmental Health

Health Equity & Environmental Public Health (2018)

BC Centre for Disease Control. Handbook, videos, workshop toolkit and other resources to help the environmental public health system promote equity.
Health Equity Impact Assessment (HEIA)

Health Equity Impact Assessment (HEIA)

Health Equity Impact Assessment course (2017)

Public Health Ontario. This 5 module online course helps you understand equity concepts, recognize when to use the HEIA tool, and has you apply the HEIA tool to a practice-based example.

Health Nexus Resources

Health Nexus. Tip sheets for doing Health Equity Impact Assessments.

Health Equity Impact Assessment – Past webinars

CAMH. Webinars on case studies, tools for specific populations, and help to prepare and carry out a HEIA.

Health Equity Impact Assessment Tool (2012)

Ministry of Health and Long-Term Care. The tool includes a template and workbook. Supplements outline special considerations for different topics.

Housing

Housing as a Focus for Public Health Action on Equity: A Curated List (2018)

National Collaborating Centre for Determinants of Health.
List of tools and resources that public health practitioners can use
to understand the impact of housing on health equity.

Indigenous Peoples and Reconciliation

Approaching Reconciliation: Tips From the Field (2015)

Smylie J. Four field tips from a respected international leader
in the field of Indigenous health.

150 Acts of Reconciliation for the Last 150 Days of Canada's 150 (2017)

Fraser C, Komarnisky S, ActiveHistory.ca. Acts of reconciliation
that individuals can undertake.

Aboriginal Relationship and Cultural Competency Courses (2016)

Cancer Care Ontario. 13 stand-alone free online modules that cover topics such as First Nations, Inuit and Métis Culture, Colonization and the Determinants of Health. Time investment of 1 hour per module.

Indigenous Health Equity Training Series (2019)

Public Health Training for Equitable Systems Change.
Register with PHESC for free to access this Indigenous-led training stream. Includes introductory readings, four webinars on Indigenous health equity topics, and resources for further learning.

Indigenous Cultural Safety Learning Series (2019)

National indigenous Cultural safety learning Series. This series of webinars are
for anyone interested in Indigenous cultural safety and/or working with Indigenous people in various settings.

Aboriginal Cross Cultural Reference for Health Care Providers (2010)

South West Local Health Integration Network. Tools and resources to assist health care providers in providing culturally competent health care to Aboriginal communities.

Relationship Building with First Nations and public health (2018)

Locally Driven Collaborative Project Team. This LDCP project intends to explore and share promising strategies, principles and practices for engagement with First Nations communities and public health units.

Our Health Counts Urban Aboriginal Health Database Project (2012-2018)

Well Living House. Learn about this first-of-its-kind health database for urban Aboriginal People in Ontario, created to fill the gaps in Aboriginal health information and to understand the full extent of health issues and challenges experienced by this population. Urban centres included in this project are Ottawa, Hamilton, Toronto, London, Kenora and Thunder Bay.

Indigenous Evaluation (2012-2018)

Well Living House. Reports and articles on Indigenous evaluation from an action research centre focused on Indigenous infant, child and family well being. Check out reports like "Emergent Principles and Protocols for Indigenous Health Service Evaluation".

Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada (2015)

Truth and Reconciliation Commission of Canada. Summary of the discussions and findings contained in the Commission's final multi-volume report. Read and discuss sections as a group. Version française.

Truth and Reconciliation Commission of Canada: Calls to Action (2015)

Truth and Reconciliation Commission of Canada. 94 calls to action for all levels of government.

Application + Action: TRC Reading Guide for Non-Indigenous Organizations (2018)

Manitoba Harm Reduction Network. Reading guide created by a non-Indigenous organization that supported its staff in reading and reflecting on the Summary of the Final Report of the TRC. Includes independent study and group discussion questions.

United Nations Declaration on the Rights of Indigenous Peoples (2008)

United Nations. The UN Declaration establishes a universal framework of minimum standards for the survival, dignity and well-being of Indigenous peoples of the world.

Intersectionality

Public Health Speaks: Intersectionality and Health Equity (2016)

National Collaborating Centre for Determinants of Health and National Collaborating Centre for Healthy Public Policy. Public health practitioners share perspectives on the relevance and application of intersectionality in public health.

Intersectionality 101 (2014)

Hankivsky O. A clear language guide to intersectionality that explores its characteristics and how it can be applied in research, policy, practice and teaching.

Measuring Health Inequities

On-Demand Webinar 2: Assessing and reporting on health inequities (2019)

National Collaborating Centre for Determinants of Health. This webinar talks about indicators and approaches used to identify health inequities; using disaggregated data and intersectional analysis; and reporting on health inequities in a way that leads to action.

Pan-Canadian Health Inequalities Data Tool (2017)

Public Health Agency of Canada, Pan-Canadian Public Health Network, Statistics Canada, and Canadian Institute of Health Information. This interactive tool contains national and provincial data on indicators of health status and health determinants, stratified by a range of social and economic characteristics.

Key Health Inequalities in Canada: A National Portrait (2018)

Public Health Agency of Canada, the Pan-Canadian Public Health Network, Statistics Canada, the Canadian Institute for Health Information, and the First Nations Information Governance Centre. Report that describes the degree and distribution of key health inequalities in Canada.

Social Determinants of Health Map (2018)

Public Health Ontario. An interactive tool that shows the distribution of social determinants of health indicators across the province, LHINs and public health units. The map provides 2006, 2011, and 2016 Ontario Marginalization Index and 2011 Statistics Canada taxfiler data at the dissemination area level in Ontario.

Equity-Integrated Population Health Status Reporting: Action Framework (2015)

National Collaborating Centre for Determinants of Health. Presents an accessible action framework for those who are creating community health status reports, as well as people interested in learning how to use population health status reporting to drive action on improving health equity.

Measuring Health Inequalities: A ToolKit (2018)

Canadian Institute for Health Information. Toolkit to assist analysts and researchers with measuring and reporting on health inequalities, with a focus on stratifying health indicators.

Measuring Health Equity: Demographic Data Collection in Health Care (2018)

Human Rights & Health Equity Office, Sinai Health System. A comprehensive guide to demographic data collection in health-care settings.

Municipalities

Advancing Equity and Inclusion: A Guide for Municipalities (2015)

City for All Women Initiative. A guide aimed at municipalities, it may inform the work of those organizations that partner, collaborate and advocate with municipal governments to achieve greater inclusion.

Racism

On-Demand Webinar 6: Racial Health Equity: Embracing a decolonial, anti-racist practice (2019)

National Collaborating Centre for Determinants of Health. This webinar describes the different forms and levels of racism, why racism is a public health issue and the public health roles for racial equity.

Deconstructing White Privilege with Dr. Robin DiAngelo (2017)

General Commission on Religion and Race of the UMC. This 20 minute TEDx-style video is an introduction to understanding key concepts in white racial socialization and why it's often so hard for white people to talk about racism.
but these examples are not dealt with in this book.

Terms: General concepts

Ally

A person who works to end a form of oppression that gives them privilege(s). Allies listen to, and are guided by, communities and individuals affected by oppression.[1]

Anti-oppressive practice

The strategies, theories, actions, and practices that seek to recognize the systems of privilege and oppression that exist in society, to actively mitigate their effects, and to equalize power imbalances over time. This requires individuals and institutions to acknowledge and accept responsibility for their role in perpetuating oppression, whether intentionally or unconsciously.[2]

Although they go hand in hand, anti-oppression is not the same as diversity and inclusion. Diversity and inclusion have to do with the acknowledgement, valuing, and celebration of difference, whereas anti-oppression challenges the systemic biases that devalue and marginalize difference.[3]

Bias

Ingrained ideas, prejudices, stereotypes, and assumptions that we are often unaware. These ideas influence our perceptions, expectations, judgments, and behaviours. All people have biases which are developed through socialization and personal experience.[2]

Collusion

Thinking and acting in ways that support dominant systems of power, privilege, and oppression. Both privileged and oppressed groups can collude with oppression.[4]

Cultural competency

An approach that focuses on practitioner's attaining skills, knowledge and attitudes to work in more effective and respectful ways with Indigenous patients and people of different cultures.[5]

Cultural humility

An approach to health care based on humble acknowledgement of oneself as a learner when it comes to understanding a person's experience. A life-long process of learning and being self-reflective.[5]

Cultural safety

An environment which is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. Cultural safety is conceptualized

on a continuum that begins with unsafe practises, moving to cultural competence, and culminating in culturally safe practices that account for the role and consequence of power in relationships between providers and communities, and in which the needs and voices of communities take a prominent role.[2] As an approach, it considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences. Practitioners are self-reflective/self-aware with regards to their position of power and the impact of this role in relation to patients.[5]

Discrimination

Any form of unequal treatment based on a ground protected by human rights legislation, that results in disadvantage, whether imposing extra burdens or denying benefits. Discrimination can be intentional or unintentional; and it may occur at an individual or systemic level.[1] In contrast to prejudice, discrimination is behaviour.[6] It may include direct actions or more subtle aspects of rules, practices and procedures that limit or prevent access to opportunities, benefits, or advantages that are available to others.[1]

Dominant group

People whose social identity confers on them unearned power and privilege. Most of us have one or more dominant identities. In most parts of Canada, dominant identities are White, male, English-speaking, heterosexual, able-bodied, Christian, affluent and middle class, thirty to sixty-five years of age, university educated, from central Canada.[7]

Health equity

All people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance.[2]

Health inequalities or Health disparities

Measurable differences in health between individuals, groups or communities.[8]

Health inequities

A sub-set of health inequalities. Refers to differences in health associated with social disadvantages that are modifiable and considered unfair.[2]

Intermediary determinants of health

The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.[9]

Internalized oppression

When members of a marginalized group accept negative aspects of stereotypes assigned to them by the dominant group, and begin to believe that they are inferior. The incorporation by individuals within an oppressed group of the prejudices against them within the dominant society can result in self-hatred, self-concealment, fear of violence, feelings of inferiority, resignation, isolation, and powerlessness. It is a mechanism within an oppressive system for perpetuating power imbalance.[1]

Internalized dominance

When members of the dominant group accept their group's socially superior status as normal or deserved, and when they deny the existence of oppression experienced by target groups.[7]

Interpersonal oppression

Interactions between people where people use oppressive behaviour, insults or violence.[10]

Institutionalized oppression / systemic oppression

The systematic mistreatment of people within a social identity group, supported and enforced by the society and its institutions (such as laws, the legal system and police practice, the education system and schools, hiring policies, public policies, etc.), solely based on the person's membership in the social identity group.[11,12] When a woman makes two thirds of what a man makes in the same job, it is institutionalized sexism. When racialized Canadians earn only 81.4 cents for every dollar earned by White Canadians, it is institutionalized racism.[13] Institutionalized oppression can happen regardless of intent.[11,12]

Intersectionality

A way to think about and act upon social inequality and discrimination[14], where inequities are never the result of single, distinct factors[15]. It recognizes that multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism).[16]

Marginalized populations

Groups and communities that experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions.[8]

Microaggressions

Brief and commonplace daily verbal, behavioural, and environmental indignities (whether intentional or unintentional) that communicate

hostile, derogatory, or negative slights and insults to target persons based solely on their marginalized group membership.[17]

Oppression / "isms"

Oppression exists when one social group exploits (knowingly or unconsciously) another social group to its own benefit.[7] It is more than the prejudicial thoughts and actions of individuals – oppression is institutionalized power that is historically formed and perpetuated over time. It allows certain groups to assume a dominant (or privileged) position over other groups, either knowingly or unconsciously. This dominance is maintained and continued at the individual/interpersonal, cultural, and structural/institutional levels.[2,3] Oppression is achieved through force or through the control of social institutions and resources of society. After a while, it does not require the conscious thought or effort of individual members of the dominant group, and unequal treatment becomes so much part of the social institutions and structures that it seems normal.[7]

Examples include: able-ism, ageism, audism, classism, biphobia, homophobia, transphobia, racism, sexism, and others.[1]

Power

The ability to exert control and influence.[18]

Prejudice

To pre-judge, based on stereotyped ideas about a group of people. It is an attitude about the inferiority of another person or group. Prejudice is often very hard to change because in an environment of discrimination, many other people may have the same idea. It can look like "common sense" and can be a normal explanation used to justify acts of discrimination.[7]

Priority populations

Those that are experiencing and/or at increased risk of poor health outcomes due to:

> the burden of disease and/or factors for disease;

> the determinants of health, including the social determinants of health; and/or

> the intersection between them.

They are identified by using local, provincial, and/or federal data sources; emerging trends and local context; community assessments; surveillance; and epidemiological and other research studies.[2]

Privilege

Unearned power that gives members of a dominant group economic, social, and political advantages.[2] People are not always aware of the privileges they have. Examples include: cissexual privilege, straight privilege, male privilege, white privilege.[1]

Reflexivity

A form of critical reflection whereby practitioners become aware of and examine their underlying values, assumptions, and beliefs and how those may affect their work. When seeking to address the determinants of health or health inequities, it is critical that practitioners recognize their internal biases that can sometimes result in important considerations being overlooked. By examining these biases, we can uncover their limitations and avoid becoming complacent or ritualistic in our work. To do so, we must first understand the lens through which we view the world, including the broader social and political contexts that influence us. Reflexive practice is not only a mental event; it must be reinvested and applied to how one does their work.[19]

Social determinants of health

The interrelated social, political and economic factors that create the conditions in which people live, learn, work and play. The intersection of the social determinants of health causes these conditions to shift and change over time and across the life span, impacting the health of individuals, groups and communities in different ways.

Key social determinants of health include:

- Access to health services
- Culture, race, and ethnicity
- Disability
- Early childhood development
- Education, literacy, and skills
- Employment, job security, and working conditions
- Food insecurity
- Gender identity and expression
- Housing
- Income and income distribution
- Indigenous status
- Personal health practices and resiliency
- Physical environments
- Sexual orientation and attraction
- Social inclusion/exclusion
- Social support networks [2]

Stereotype

A stereotype is a preconceived or oversimplified generalization about an entire group of people based on some observed or imagined trait, behaviour or appearance without regard for individual differences. While often negative, stereotypes may also be perceived as complimentary. However, even positive stereotypes can have a negative impact simply because they are broad generalizations. The stereotypes we hold form the basis of our prejudice.[18]

Structural determinants of health / Root causes of health inequities

Factors that cause or reinforce stratification in society and that give rise to individual socioeconomic position, where groups are stratified according to income, education, occupation, gender, race/ethnicity and other factors.[20]

Systematic

a) Methodical in procedure or plan. b) Marked by thoroughness and regularity.[21] Not to be confused with 'systemic' which means 'system wide'.

Systemic

System wide: affecting or relating to a group or system (such as a body, economy, or market) as a whole, instead of its individual members or parts. Not to be confused with 'systematic' which means 'methodical'.[22]

Vulnerable populations

Groups and communities at a higher risk for poor health as a result of the barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability.[8]

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Terms: Interventions

Targeted approach

An approach that uses selection criteria, such as income, neighbourhood, health, or employment status, to target eligibility and access to programs and services to priority sub-groups within the broader population.[1]

Universal approach

An approach to providing programs and services that makes them available to an entire population (e.g., all women, all children under age 6).[2,3]

Targeting within universalism

An approach to providing programs and services that makes them available to all (universal) and reaches out to vulnerable and marginalized populations so that they get supports and services that meet their needs (targeted).[2]

Proportionate universalism

An approach that balances targeted and universal population health perspectives. This approach makes health actions or interventions available to the whole population, but with a scale, intensity and delivery that is proportionate to the level of need and disadvantage in particular populations.[1]

Upstream

Upstream interventions and strategies seek to reform the fundamental social and economic structures that distribute wealth, power, opportunities, and decision-making. These changes generally happen at the macro policy level: national and transnational.[1]

Midstream

Midstream interventions and strategies seek to reduce exposure to hazards by improving material working and living conditions, or to reduce risk by promoting healthy behaviours. These changes generally occur at the micro policy level: regional, local, community or organizational.[1]

Downstream

Downstream interventions and strategies seek to increase equitable access, at an individual level, to health and social services. These changes generally occur at the service or access to service level.[1]

Lifestyle drift

a) The tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factor.[4] b) The tendency in public health to focus on individual behaviours, such as smoking, diet, alcohol, and drugs, that are undoubted causes of health inequities, but to ignore the drivers of these behaviors—the causes of the causes.[5]

Population health

An approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.[6]

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