

Building Public Health Capacity to Advance Equity

A National Environmental Scan of Tribal, State, and Local Governmental Public Health



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Background

Project Purpose

Building Public Health Capacity to Advance Equity is an environmental scan funded by the W.K. Kellogg Foundation (WKKF) to explore governmental public health's role in advancing health equity with racial equity as a major priority and community engagement as a central strategy. The project team consisted of ten partner organizations collaborating to examine the federal landscape and the capacity of local, state, and Tribal health agencies to play a role in promoting equity. Through literature reviews, in-depth interviews and focus groups with health officials, public health experts, and community leaders across the country, we have identified a variety of opportunities for governmental public health to advance equity. Public health can support and lead change efforts by partnering across and within departments, creating and leveraging opportunities for community input, buy-in, and collaboration, and aligning the work of public health with broader social movements and other community efforts to build transformational partnerships that restructure power dynamics and build political will for racial and health equity.

Project Partners & Environment Scan Approach¹

The project partnership consisted of six national partners and four academic research teams in WKKF's priority places:² Michigan, Mississippi, New Mexico and New Orleans. Three of the six national organizations were core partners that collaborated to design and guide the work. Each project team was selected for their expertise in a particular aspect of the environmental scan.³

The national core and constituent partners explored federal resources and the policy environment, the nature of community engagement among public health agencies across the nation, and the degree of capacity among Tribal, state, and local health departments to advance equity in their work. The four academic partners in priority places provided case studies on how capacity issues play out in specific geographic contexts.

National Core Partners

GEORGE WASHINGTON UNIVERSITY, MILKEN INSTITUTE SCHOOL OF PUBLIC HEALTH, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT (GWU) examined the national policy and funding environment for public health in the context of a changing health system and new administration (Levi, Heinrich & Mongeon, 2017).

NATIONAL COLLABORATIVE FOR HEALTH EQUITY (NCHE) served as the overall project coordinator to ensure alignment among the collaborating teams, facilitated cross-team sense-making, and led synthesizing findings across the other nine team scans to produce this report.

¹ See Appendix for expanded partner descriptions

² WKKF has made a commitment to invest in select geographic areas for at least a generation. Michigan, Mississippi, New Mexico, and New Orleans are WKKF's U.S.-based priority places.

³ For more information on each of the contributing teams' individual scan reports, please contact the respective corresponding author listed in the Acknowledgements.



PREVENTION INSTITUTE (PI) examined the national landscape and interviewed local grassroots, community-based, and base-building organizations to understand their perspectives on effective strategies and practices that governmental public health agencies could use to co-develop equitable partnerships with communities (Sims, Viera & Aboelata, 2018).

National Constituent Partners

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS (ASTHO) focused on the role state health officers and their agencies can play in advancing racial and health equity (Kershner, Rudolph & Cooney, 2017).

NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS (NACCHO) centered its portion of the environment scan on local health departments using a social justice framework (Hofrichter, 2017).

NATIONAL INDIAN HEALTH BOARD (NIHB) explored the definition and applications of what racial and health equity work looks like among sovereign Tribal nations co-located in the U.S. (Babbel, 2017).

Academic Research Partners in WKKF's Priority Places

MICHIGAN—UNIVERSITY OF MICHIGAN (UM) developed a case study for the scan focusing on the State of Michigan (Rubin et al., 2017).

MISSISSIPPI—UNIVERSITY OF MISSISSIPPI MEDICAL CENTER (UMMC) developed a case study for the scan focusing on the State of Mississippi (Beech et al., 2017).

NEW MEXICO—UNIVERSITY OF NEW MEXICO (UNM) developed a case study for the scan focusing on the State of New Mexico and Tribes co-located in the state (Sanchez-Youngman, Elias et al., 2018; Sanchez-Youngman, Sanchez et al., 2018).

NEW ORLEANS—TULANE UNIVERSITY AND INSTITUTE OF WOMEN AND ETHNIC STUDIES (TU-IWES) developed a case study for the scan focusing on the City of New Orleans Health Department (NOHD) and its key partners (Broussard et al., 2017).

Methods

The broad scope of this scan required a methodological approach that balanced the need for the findings to be generalizable to a national audience, yet specific enough to provide rich nuance and contextual distinctions. To address this need, a set of core questions was developed with input from each of the project teams. We were most interested in exploring:

1. **DEFINITIONS AND CONCEPTS**—racial equity, health equity and social determinants of health—e.g., how is health equity defined and does the health department use a common definition?
2. **PERCEIVED ROLE**—perceived and actual roles health departments are playing in advancing equity—e.g., do health departments see advancing racial equity among the social determinants of health as part of their responsibility?
3. **CURRENT INITIATIVES, PRACTICES & POLICIES**—the extent to which health departments are implementing racial and health equity strategies, programs, policies and practices
4. **PARTNERSHIPS & ENGAGEMENT**—the context and nature of the health departments' engagement with communities, community-based organizations and cross-sector partners external to the department
5. **BARRIERS & CHALLENGES**—understanding what barriers hinder the health department in advancing a racial and health equity agenda
6. **CONTEXT, FACILITATORS, AND SUCCESSES**—understanding what external and internal factors have facilitated successful equity strategies by health departments
7. **INTERNAL CAPACITIES**—exploring which internal capacities of the health department are vital to advancing a racial and health equity agenda
8. **LEADERSHIP**—understanding the extent to which and how leadership - internal and external to the health department - can play a role in advancing a racial and health equity agenda

With the exception of GWU—that is, due to their focus on federal policy and funding—each team was asked to cover the thematic essence of the core questions and given the flexibility to tailor the questions for their specific interviewees. The teams used triangulated scan methods that consisted of gathering archival data, reviewing relevant reports and policy statutes, drawing on previous studies, and collecting primary qualitative data through in-depth interviews and focus groups. NCHE also encouraged teams to conduct a validity check with their interviewees to ensure the findings were interpreted as intended. Data were collected and analyzed between June 2016–August 2018.



Public Health's Role in Health and Racial Equity

Our aim with this environmental scan was to explore the capacity of public health to advance racial and health equity with community engagement as a central strategy. The partners had to make decisions about whether to be prescriptive in defining core constructs such as health equity and racial equity and whether to explore the public health system broadly or narrow our focus to governmental public health agencies specifically. In the end, decisions were made to standardize core questions across the scans but also allow each team to tailor definitions and exact wording of questions to their particular contexts and interviewees. This flexibility allowed the overarching project to account for the diverse range of political environments our scan teams explored. We wanted interviewees to share their perspectives freely in environments where health or racial equity may not be politically viable or applicable if named, while allowing other teams to use these terms if they are in environments where health and racial equity are already embraced. That being said, having a clear understanding of the central tenets of health and racial equity is necessary for interpreting the scan findings. We outline these tenets below along with our rationale for focusing on governmental public health.

Conceptual Approach and Rationale: Defining Health & Racial Equity and the Role of Public Health

No single definition of health equity is accepted as the standard in the literature. Different definitions have been published by a number of renowned scholars and national and global public health institutions like Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO). The public health field has also not reached broad consensus on what related terms mean. All too often health disparities, health equity, and social determinants of health are used interchangeably yet they are not the same and their distinctions have meaningful implications for practice and measurement (Braveman, 2006; Grantmakers in Health, 2010). Braveman and her colleagues (2017) argue that it is not necessary for everyone to use a definition with the exact same words, but rather to agree on the critical elements that advance health equity. They distill these elements to be a conception of health that encompasses physical and mental health in addition to well-being and that "health equity means that everyone has a fair and just opportunity into a conception of health as possible which requires removing obstacles to health such as poverty and discrimination" and providing equal access to "the conditions and opportunities that support health" such as living wage jobs, quality education, and safe environments, especially for those who lack access and have worse health."

For the purpose of interpreting scan findings, we adopt Braveman et al.'s conception of health equity's critical elements. We also adhere to the notion that health equity is not just a desired outcome to achieve but also a continual process

to sustain. As Jones (2014) articulates, “we need to implement health equity as an assurance process involving active inputs, constant vigilance, and continuous correction.” She further notes that the Institute of Medicine identifies assurance as a core function of public health—underscoring the responsibility that health equity assurance is part of public health’s mission.

While this health equity framing was critical for interpreting scan findings, we also prioritized making sense of the scan using a racial equity lens. Racial equity was made an explicit priority for a variety of reasons, including the avoidable, pervasive inequities in health outcomes by race and their association with deeply entrenched historic and contemporary structural inequities and institutional racism (Davis et al., 2016; Iton, 2010; Jones, 2014; Williams, Priest & Anderson, 2016). Here a focus on the institutional or structural level is key because public health departments are vital institutions in our society. As Davis and colleagues (2016) document—the policies, practices and procedures *produced* by institutions—create the inequities we observe by race and socioeconomic status. Production happens when shared norms, values, and narratives steeped in history either reinforce inequities or are challenged to create movement towards equity.

Deciding to focus on racial equity, however, did not come without its tensions. We debated the differences between racial equity and health equity. Some team members pushed back on the idea that health equity is not inherently about racial equity. Those working with Tribes questioned whether a focus on race was appropriate. Others raised questions about whether racial equity would resonate with health departments in predominantly white areas where socio-economic inequalities are more of a concern. Would health departments feel that racial equity was under their purview? Are some in the field more focused on social determinants of health because it feels less fraught? In the end, we accepted our charge to focus on racial equity.

We also chose to narrow our focus on governmental public health as opposed to broadening to include the whole public health system. This was strategic and opportune. While public health cannot be fully accountable for racial and health equity, several recent publications coalesce around naming governmental public health agencies specifically as key institutions that are in prime position to advance equity (DeSalvo et al., 2017; Ferrer, 2015; Human Impact Partners, 2016; Liburd et al., 2016; Prentice, 2014; RESOLVE, 2014). During her time as Assistant Secretary for Health, DeSalvo and her colleagues (2017) built on the work of RESOLVE (2014) and the Public Health Leadership Forum to outline the role public health agencies can play as *Chief Health Strategists* that work across sectors and with communities to address broad determinants of health. Our teams debated the extent to which health departments should view themselves as needing to take the lead in all cases and agreed there is room for them to play a role. Several thought leaders in the field also remind us that there is precedent for governmental public health involvement. Public health agencies have a track record in social justice and uncovering the links between impoverished living conditions and their association with poor health; thus, there is a historic legacy to draw from to advance racial and health equity (Ferrer, 2015; Hofrichter, 2017; Iton, 2010; Prentice, 2014). Prentice (2014) further articulates, “[Expanded health equity practice] is . . . an argument that a public health department that uses its resources, perspectives, commitment, and savvy to challenge the structures of power that create and maintain social inequities and unhealthy living conditions is grounded in its own history.”



“Conceiving of American Indians as [racial] minorities, with funding and programs reinforcing this conceptual framework, undermines the very foundations of federal Indian law, which supports the ability of Tribes to operate as sovereign nations, identify and set priorities, and address the needs of Tribal citizens.”

— NIHB INTERVIEWEE
(Babbel, 2017)

4 While debated in the field, Braveman (2014) suggests when the term “health disparities” emerged in the U.S. literature it was used to describe the systematically worse health outcomes that are experienced by racially and economically oppressed populations. In this report we do not use the term disparities to describe any mere difference in health, but instead use the terms disparities and inequities interchangeably to refer to the systematic differences in outcomes stemming from oppression and privilege.

While public health departments can play a pivotal role in advancing racial and health equity, they do not always need to be the lead and; at times, trying to take the lead could be detrimental to progress others have made. Racial and health equity practice requires well-established relationships based on mutual trust and shared leadership that can foster inside/outside strategies to advance equity over time (Beech et al., 2017; Hofrichter, 2017; Human Impact Partners, 2017; Prentice, 2014; Sims, Viera & Aboelata, 2018). In some cases, health departments are well-situated to leverage resources and broker constructive partnerships in service of equity. These kinds of health departments can serve as role models to push equity practice forward (Prentice, 2014). In other cases, it may be more strategic or appropriate for other organizations to lead (Sims, Viera & Aboelata, 2018). This does not mean public health departments have no responsibility of contributing or playing a role, but rather to recognize that agencies and communities have varying degrees of readiness and resources.

What We Learned About Conceptions of Equity and the Perceived Role of Public Health

Health and Racial Equity

We found that public health departments operate in historic, socio-cultural and political contexts that determine the extent to which equity framing and language is used and will resonate. Our partner teams observed wide variation in familiarity with equity-related concepts such as health and racial equity, health disparities⁴ or inequities, social and economic disparities, and social determinants of health. In some instances, teams found that health department staff used definitions published by public health authorities such as CDC or WHO while others created their own definitions based on working with the communities they serve. In other cases, health departments were well versed in health disparities outcomes but not the broader conceptions of equity and social determinants of health. Several of the teams found that many interviewees were not familiar with the terms “racial equity” or “health equity” even if they were working in areas that addressed the concepts. In other cases, the terminology was left out deliberately because it was not politically palatable or applicable to the context as in the case with Tribes.

Despite our best efforts to prioritize racial equity in the scan, it was at times difficult to unpack health equity from racial equity in the scan findings. Teams reported back that it was a challenge to interview some participants who were not already familiar with the concept of health or racial equity. In other cases, racial equity was described as inappropriate terminology. In Indian Country, for example, NIHB found that terminology around racial equity did not resonate and interviewees highlighted the tension between categorizing American Indians/Alaska Natives (AI/AN) as a racial minority group versus a political designation (Babbel, 2017). While the racial designation allows demographers to document the significant health disparities AI/ANs face as a racial group, the minority designation fails to capture the unique rights of federally recognized Tribes. Relegating diverse Tribal nations into an all-encompassing racial group hinders accurate data collection, masks the diversity of experiences across tribes, and dilutes, overlooks, or ignores AI/ANs priorities. In effect, interviewees shared that highlighting race for

Tribes reinforces structural inequities and diminishes sovereign rights. NIHB also found that there was a lack of consensus on how to conceptualize and measure equity within and across tribes. Participants debated the idea of whether health equity should be based upon comparisons made within one Tribe, across Tribes, or by comparing Tribes to non-AI/AN populations. While health and racial equity advocates may be eager to apply this framework to AI/ANs, it may be more fruitful to co-construct an equity agenda with Tribes and explore the benefit of developing new terminology that champions Tribal rights.

By contrast, the TU-IWES (New Orleans) team found that almost all interviewees referenced a longstanding racial hierarchy that has shaped society (Broussard et al., 2017). One participant expressed,

“Obviously, the big inequities in our society are racial inequities. There aren’t any other ways of dividing populations – age, gender, etc. that have as stark a disparity, in terms of poverty levels for instance, as race. It is by far the most stratifying characteristic and the area in which there needs to be the greatest level of improvement. We can’t deal with any inequalities unless we are dealing primarily with racial inequalities.”

This observation suggests that local context is key for understanding what terms will resonate when initiating an equity agenda. Some communities may be comfortable naming racism as an issue to tackle while others may need to consider alternative terminology and take time to incorporate discussions of race and oppression into the work.



Public Health’s Role

Across the scans, when interviewees articulated that public health had a role to play in advancing equity, they had differing worldviews on how and what types of actions agencies should take. Building on research by Raphael et al. (2014), the UNM team articulates three equity worldview types: functional, equality of opportunity, and structural (Sanchez-Youngman, Sanchez et al., 2018).

In New Mexico, while perspectives were varied among the public health staff, most ascribed to the *equality of opportunity* worldview (Sanchez-Youngman, Sanchez et al., 2018). They underscored the need for fairness and better access to quality health care and services for marginalized populations. One participant captures the sentiment:

“What it means is opportunity for people at all levels to have the ability to control and be in control and responsible for their own health. Some people have great opportunity to maintain and have control over their own health, and others have very limited opportunity. For a lot of reasons, the social determinants of health play a key role. I think we are the poorest state for childhood poverty. Those conditions in which people live disproportionately affect people’s ability to achieve health equity.”

RECOMMENDATION 1

Health departments must understand the cultural and political resonance of racial and health equity concepts with their communities and the extent to which clear definitions of terms and concepts will foster equity agenda development. For some Tribal health departments, this may mean avoiding the use of the term *racial equity* and working closely with the Tribe to articulate what alternative concepts resonate with an equity agenda that aligns with the Tribe’s needs.



PUBLIC HEALTH DEPARTMENT WORLDVIEWS ON EQUITY

FUNCTIONAL

The primary role of health departments is to collect data and target resources and programming toward priority populations. The focus is often in addressing the outcomes of inequality through the provision of services rather than addressing root causes. Social determinants of health are viewed as risk factors that modify individual level responses to environmental hazards or conditions.

EQUALITY OF OPPORTUNITY

Public health departments should offer targeted categorical services to marginalized populations and underrepresented communities because individuals should have equal opportunity for health regardless of race or socioeconomic status. Cross-sector solutions should center on increasing access to health care and improving the quality of services for those who need them most.

STRUCTURAL

Public health departments should collaborate with partners on community-driven initiatives and grassroots approaches that tackle inequities through community voice and action. Health inequities are viewed as a result of poverty, structural racism, patriarchal institutions, and oppression. Health and well-being are generated where people live, work, learn, and play.

Despite some interviewees sharing a similar worldview about their role, they still expressed frustration about the lack of solutions available for implementation. When solutions were discussed, they were often focused on providing services and resources for individuals to gain more control over their own health as opposed to interventions that target changing dynamics, policies, and contextual conditions.

In other cases, we found some interviewees expressed that they did not think public health departments should play a lead or significant role in advancing health and racial equity. While many championed equity as a core value of public health, several health departments are struggling to maintain their foundational and statutory responsibilities, much less address the social determinants of health and grapple with equity issues. As one NIHB participant explained, their Tribe is “simply trying to protect current resources, much less advance health equity” (Babbel, 2017). In these cases, public health staff do not feel that they are in position to tackle equity issues.

Exacerbating the problem, health departments operate in politicized environments with direct accountability to elected officials who may have agendas that support divestment from public services and conflict with health equity aims. Health department leaders navigating these environments often lack the skills to initiate and sustain conversations about equity within their agencies, in the larger political environment, and with potential partners. In Michigan, for example, local health department leaders suggested that staff buy-in on issues of race and poverty were heavily influenced by the conservatism of the environment where they worked. Local health department leaders noted a pervasive “pull yourself up by your bootstraps” mentality hindered discussions

around the social determinants of health and racial and social equity (Rubin et al., 2017). Most leaders expressed uncertainty about the political will of local officials to create changes, which limited leadership and staff's ability to take action. Several health officers in the state experienced pushback from more conservative or racially homogenous parts of the state that sometimes don't acknowledge or recognize disparities, particularly social disparities, and instead emphasize personal responsibility.

In New Orleans, more than one interviewee questioned the assumption that health equity, and by extension racial equity work, should be a priority of the City's health department (Broussard et al, 2017). While equity was never questioned as an ideal, some informants noted, "The extensive responsibilities for governmental public health—which include initiatives ranging from code enforcement to infectious disease prevention—are a challenge to fully addressing equity." When these issues were highlighted the barriers of "limited resources including time, staff and funding," were the reasons that entities like the New Orleans Health Department were often described as not being the primary lead, but as a facilitator in ending racial inequity. As one informant stated, "public health cannot solve, nor is it the role of public health to solve, the dilemma of how to best achieve racial equity. Public health professionals must play a facilitating role only. The solutions must happen within communities."

In Mississippi, many interviewees believed that health equity should be a central component of their mission but that "the state health department has not fully articulated an embracing of doing work around health equity" (Beech et al, 2017). High-level leadership is central to staff buy-in and ability to embed health equity into their work. One interviewee stated that "[Mississippi has] a long history of being engaged and involved in health equity work. We don't build upon that history. We don't talk about that history. We don't maximize that history in a way that shows that if any state or any place in this nation should be leading the charge in health equity, it should be this state. And there's no excuse for us not to be when our history is closely aligned with that. And so, I think for me, that's a leadership issue. There's a leadership gap." One participant described political support for equity in Mississippi as "non-existent".

RECOMMENDATION 2

Health departments should articulate a shared vision, worldview, and public narrative for how they see themselves advancing equity to galvanize staff and partners towards collective action on equity.





Inside, Outside & Across Strategies for Public Health Action on Equity

“ We do a lot of partnership work and community engagement and we are really good at engaging organizational representatives who many times help us to put together a racially diverse group, but that doesn't represent economic diversity. It has been said that we are good at engaging 'grass tops but not grassroots'...So, we know that we need to do a better job of engaging folks with the lived experience. And, we realize this, but it takes much more time and effort.”

— NEW ORLEANS INTERVIEWEE

(Broussard et al., 2017)

When tackling inequities, Baum (2007) encourages us to think of a *nutcracker*—that is, taking action that combines the dual effect of creating social movement among the grasstops and the grassroots. Iton (2010) further adds that equity interventions tend to fail when they focus on only one level by either building social capital with communities that are disconnected from meaningful structural intervention or by changing policies that do not resonate with and are not sustained by communities embracing them. At the core of the nutcracker effect is building with—and shifting more power to—communities most impacted by inequities and the unbalanced distribution of social, economic and political resources.

To build and shift power in service of equity, Human Impact Partners (HIP, 2017) puts forth a valuable practice-based framework that outlines *inside* and *outside* strategies for public health agencies. Inside strategies are actions that are taken within the public health agency to build internal infrastructure that drives an equity agenda, such as improving organizational capacity, changing internal practices, and mobilizing data. Outside strategies are external to public health agencies themselves such as working with other government agencies, building community partnerships and championing transformative change. The framework accounts for what Prentice (2014) describes as, “. . . a long-term process that requires transformation of organizational culture and practice and the larger public understanding of what most influences health.” Strategies in the framework are interrelated, non-linear, and build on developing hard and soft skills that can be adapted to contextual needs.

The current scan builds on HIP's framework by providing rich examples of what public health departments face when employing these inside/outside strategies and by articulating a third category—that is, an *across* strategy that acknowledges the responsibility of role players and national resources external to public health agencies. When considering all three types of strategies, however, a major part of the work is developing a shared understanding of history, the origins of dominant narratives, and co-creating new narratives that support equity. According to Prentice (2014), public narratives are shared understandings or interpretations, grounded in common values and beliefs of why and how the world operates. They are important because “they shape public consciousness and thereby influence, often implicitly, decision-making.” Challenging and co-creating new narratives that support equity action needs to happen within health departments, with partners external to the health department, and in the broader public health field.

TACTICS FOR CREATING RACIAL AND HEALTH EQUITY NARRATIVES

- Emphasize social indicators of health and well-being beyond quantitative economic outcomes and pressure the media to rely on them, explaining distortions that result from relying on mainly economic measures.
- Focus attention on systems, social structure, and institutions as the source of inequalities to avoid blaming individuals.
- Question assumptions that inequity can be resolved through programmatic fixes; for example, that addressing the obesity epidemic primarily by educating about nutrition and exercise removes social responsibility from corporations for selling junk food.
- Pressure the media to examine structural causes of ill health; attend to the decisions about housing, land use, and transportation that generate inequity in health and who benefits.
- Express the distinction between mitigation or remediation of injustice vs. social change, to draw attention to social injustice and why it will continue without shifts in power and social transformation.
- Highlight contradictions in dominant narratives.
- Reveal the interests behind and make visible the true goals of the dominant narrative. Why, for example, are the needs of investors more important than the health and well-being of the population?
- Provide more adequate explanations for health outcomes.
- Challenge mass media on coverage and absence of coverage. For example, why is the local media narrative on stories about toxic contamination in the air or water about self-protection rather than investigation of systemic causes?
- Resist debating within the frame of the dominant narrative and challenge the interests that support it. Challenge, for example, the assumption of scarcity, the idea that markets act blindly without well-resourced interests influencing outcomes.
- Plan campaigns around specific aspects of a progressive narrative and undermining of dominant narrative.
- In health promotion: Provide information needed for collective social change, instead of exclusive reliance on self-protection and behavioral change. Focus on social responsibility.

(Hofrichter, 2017)

Inside Strategies

Health departments play a critical role in advancing equity through the way they leverage their internal resources to advance and embed racial equity in their work. A public health department's ability to maximize this role is influenced by a number of factors including: (1) the development of shared language and understanding of the root causes of inequity and a commitment to allocating resources to disrupt systemic inequality; (2) its formalized commitment to racial and health equity and values that is articulated in strategy documents and statutes; (3) whether it has strong leadership that is able to clearly communicate and gain buy-in for health equity; (4) the presence of effective and efficient systems for recruiting, hiring and retaining diverse staff; (5) staff with the skills and competencies necessary to advance health equity in their work; and (6) internal policies, processes, and decision-making structures that reinforce the work of staff.

“ We think general society doesn't remember the historical context for us. And again, this goes back to the historical trauma and all of the related policies that were in place and laws surrounding Tribal communities. And specifically, how we were aggregated, how we were categorized, how our healthcare in particular was organized. How it still is organized based on those existing policies that...impact our access issues. Impact our socio-economic issues. Impact our environmental issues. And then, vice versa because that history isn't well known, isn't understood, isn't acknowledged... then we get blamed.”

– NEW MEXICO INTERVIEWEE

(Sanchez-Youngman, Elias, et al., 2018)



Shared Definitions, Conceptions, and Narratives

An agenda for racial and health equity must be clearly defined, operationalized, and embraced in order to advance equity. This does not mean every health department needs to use the same definitions of equity, but rather to capture the essence of equity, as suggested by Braveman and colleagues (2017), and to clearly define equity and scope with its partners. Without a shared understanding of what is meant by equity, the ability for staff, leadership, and public health departments to advance racial and health equity will remain mostly unrealized. As discussed previously, across team reports, our interviewees expressed a lack of consensus around the definition of racial and health equity. Leaders found that undefined concepts hindered their efforts to communicate to staff the need to address equity in their work.

The psychological, emotional, and physical violence visited on African Americans and sympathetic Whites during [Jim Crow] obliterated gains during Reconstruction and set the stage for the erection of racist social, economic and political structures that have adversely impacted the health and well-being of African American Mississippians for generations. (Beech et al., 2017)

RECOMMENDATION 3

Health departments should work with communities and partners to create a shared understanding of the historic and contemporary imbalances in power that produce inequities as a foundational step in developing an equity agenda and also recognize that the process is iterative and may require intermittent reflection as partnerships grow, new actions are taken, and agendas expand.

For some health departments, using the terms health and/or racial equity are seen as controversial given the political climate and communities they serve. Some departments may choose to focus on non-racial aspects of equity such as income disparities or not acknowledge the issue of equity altogether. In other cases, staff within the department may be ready to take on health and racial equity issues but need support. These health departments may want to carefully craft an equity agenda that reflects the readiness and needs of the communities they serve. For some Tribes, this may mean eliminating the term racial equity completely (Babbal, 2017). In conservative states like Mississippi, that have an explicit history of racial discrimination and oppression, present day politics may continue to constrain how public resources are used—making movement on health equity occur unevenly (Beech et al., 2017). In states like Michigan, limiting worldviews held in racially homogeneous geographic contexts can impede efforts to move a racial equity agenda forward. Some constituents feel that economic equity is more appropriate and should be prioritized. For public health departments in these contexts, prioritizing shared understanding of historic and contemporary drivers of dominant narratives with community partners may be an important initial step.



Formalizing a Commitment to Equity

An organizational vision and mission grounded in a commitment to equity and values that prioritize external engagement and building power with communities are crucial components to building internal equity capacity for health departments. Formal strategic statements like a public health department's vision and mission serve as a guide to staff, can focus programmatic goals and decisions, and be used as a tool for communicating shared understanding of priorities. An interviewee, for example, described how through a prioritization process with community partners, the local board of health named elimination of structural racism as a priority (Sims, Viera & Aboelata, 2018). The inclusion of this root cause of poor health then helped to open the door to strategies and activities focused on eliminating racial bias across institutions and society, including: developing a community-level understanding of the historical forces involved in creating current inequities; using health equity data to illuminate how race-based policies and practices created opportunities for some and restricted possibilities for others; supporting organizational, institutional, and community leaders to work closely with community members to create awareness of how and why assumptions about racial and ethnic populations can impact their thinking, feeling, and actions; and using an equity-focused approach to develop policies that increase social and economic opportunities for racial and ethnic minorities.

Statutes are another way to formalize commitments to racial and health equity. According to ASTHO, state legislatures often set the parameters of a public health department's authority and the scope of public health programs (Kershner, Rudolph & Cooney, 2017). Including equity parameters in statutes and legislation can validate a health department's equity agenda and demonstrates commitment from the state beyond any individual agency.

RECOMMENDATION 4

Health departments should incorporate racial and health equity into formal strategic statements—such as vision, mission, and values—and in their jurisdiction's statutes to ensure that equity is part of a health department's mandate.



EXAMPLES OF STATE STATUTES THAT DEFINE OR REFERENCE EQUITY

- **COLORADO:** "Health equity" means achieving the highest level of health for all people and entails focused efforts to address avoidable inequalities by equalizing those conditions for health for all groups, especially for those that have experienced socioeconomic disadvantages or historical injustices. COLO. REV. STAT. ANN. § 25-4- 2202 (West 2017).
- **CALIFORNIA:** "Health equity" means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives. CAL. HEALTH & SAFETY CODE § 131019.5 (West 2017).
- **HAWAII:** "Health equity" means assuring equal opportunity for all people in the State to attain their full health potential. HAW. REV. STAT. ANN. § 321-1 (West 2017).
- **OREGON:** Does not have a statute that defines health equity explicitly, however, state law does reference health equity and cultural responsiveness as foundational capabilities necessary to protect and improve health and equitable health outcomes. OR. REV. STAT. § 431.137 (2017).
- **MINNESOTA:** In 2013, the Minnesota legislature directed the state health agency to produce a report on health equity in the state by February 1, 2014. Laws of Minnesota 2013, Chapter 108, Article 12, Section 102.

(Kershner, Rudolph & Cooney, 2017)



Leadership

Health departments with leaders who champion and create a compelling vision of racial equity that reverberates in the mission, vision, and values of the organization can be more effective in moving an equity agenda forward. Leadership that advances racial equity as an internal priority builds political will for the work and shows an internal commitment for staff to focus on health and racial equity. Furthermore, organizational climate—often influenced by effective leadership—can determine public health workforce attitudes and willingness to engage in activities that support new equity directions (Jung et al., 2012 as cited in Sanchez-Youngman, Sanchez et al., 2018). Effective leaders are able to reframe conversations away from a perceived oppositional relationship between state-mandated programs and organizational efforts to address racial and health disparities by uncovering linkages between the goals of both. These leaders leverage their resources to build staff capacity to understand and champion equity efforts by providing effective training and investing in organizational systems and processes that increase workforce capacity to do the work of equity. They model the importance of racial equity by creating accountability structures that clearly communicate how equity is connected to the work of staff and they encourage staff to build bridges with partners to help extend the limited capacity of health departments.

RECOMMENDATION 5

Train more health department leaders on the political skills it takes to navigate leading and collaborating on an equity agenda and creating culture change within and external to the department.

Our teams found that some health officers see their role as serving as champions and strategists for health equity and catalysts for change (Kershner, Rudolph & Cooney, 2017; Rubin et al., 2017; Sims, Viera & Aboelata, 2018). They see the importance of working with other departments and sectors to create comprehensive solutions as key to their work. This is also reflected by Bliss et al. (2016) who suggest that convening and partnering were strategic actions taken by the Minnesota state health officer to advance equity. They further share that building towards a common vision with partners makes for more meaningful action and that special attention ought to be paid to who is making decisions, who has voice and is being listened to by policymakers, and what narratives prevail.



If you really want to work with a community, your staff has to look like that community and be able to relate to that community. So that means you need to hire people from those communities.”

– ASTHO INTERVIEWEE

(Kershner, Rudolph & Cooney, 2017)

Ability to Recruit and Retain Workforce

Funding and resources undergird every discussion about organizational capacity. We found nearly universal agreement that a lack of sufficient funding and limitations imposed by the current public health infrastructure made engaging in work outside of mandated services very difficult. In Michigan, concerns about job security in a financially volatile environment posed barriers for staff to push the boundaries necessary for an equity agenda (Rubin et al., 2017). In one example, it was only when staff were reassured of their job safety and importance to the team, that they began to seek out more conversations about racial and social diversity in the community.

Ensuring workforce diversity, representation, and inclusion can be a vital component of an internal equity strategy. ASTHO found that “half of all state and territorial health officers interviewed said explicitly that a representative workforce was important to having cultural competency in their health equity work” (Kershner, Rudolph & Cooney, 2017). Yet, NACCHO found that while many local health departments stress the importance of diversity, few specifically consider and implement recruitment practices that focus on hiring members of the community or individuals who reflect the makeup of local communities (Hofrichter, 2017).

We did find examples of public health departments being innovative and changing their approach to human resources to be more inclusive and diversify staffing. In Michigan, one local health department created a Health Equity Council to assess every program using a health equity lens to examine hiring practices, administrative oversight, and potential outcomes in the community (Rubin et al., 2017). Each assessment was finalized in a report with opportunities for improvement. Some departments are assuring that advertisements for any new office position are posted in all local ethnic newspapers and media outlets to encourage diversity in hiring. A participant in New Orleans further shares, “The make-up of [public health] staff and leaders is so important – we need more diversity in the thinking and leadership roles . . . we need more strategic recruitment and mechanisms to enable the workforce to have the tough conversations about history . . . our historic inequities have become normalized and people are still not talking about or acknowledging it. This is starting to change as people call others, including our local, state, and national leaders, out” (Broussard et al., 2017).

RECOMMENDATION 6

Health departments should make diversity, equity, and inclusion a part of their internal equity strategy and be transparent about how diversity, equity, and inclusion are incorporated into staff recruitment, hiring, and retention practices.



Competencies and Skills

Equity efforts require staff with the skills and competencies to understand the root causes of inequity as well as the skills to partner effectively and collect, use, and share information to create bi-directional feedback loops.

WORKSHOPS & TRAINING

Workshops and trainings can be a tactic for advancing an equity agenda on the individual and organizational level and it may be important to do both. On the individual level, staff members, organizational leaders, and community members need safe spaces to explore their own mindsets and experiences with issues of race, racism, oppression, and structural inequities. Individuals play a role in shaping agendas, establishing and maintaining relationships, and developing strategies that can be inclusive or exclusive based on their worldviews, expertise, and life experiences. At the organizational level, health departments can commit to offering organization-wide workshops or trainings that create a shared understanding of the historical and contemporary causes of inequity. An interviewee from New Orleans shares,



“We fund clinics, hospitals, and other agencies to provide direct services. And, you always have to take into consideration the individual biases of the person delivering services . . . And, they may not even be aware of them. And that’s one of the reasons that we try to give [service providers and staff] training. There’s a training that we do periodically called ‘Undoing Racism’ because people need to be aware of their own prejudices and biases” (Broussard et al., 2017).

Workshops and trainings must not only provide the safe spaces for people to deal with their own issues related to bias and racism, but also provide the conceptual language and actionable tools that develop the accountability structures necessary to implement equity efforts.

Our scans found wide variation in capacity, awareness, and training within health departments on health inequities. Reasons for this variation were attributed to competing priorities, limited resources and an overall lack of readiness to make programmatic changes. Furthermore, health officials also expressed concern about the extent to which trainings translated into meaningful changes in how staff approached their work (Rubin et al., 2017). One explanation is that, while many departments focus on cultural competency, few emphasize structural competency—that is, the ways that structures of power and legacies of racism, class, and gender inequity affect health outcomes (Hofrichter, 2017). This was reinforced across scans as different local and state health departments report that one-time or infrequent cultural competency and cultural diversity trainings were held; however, few offered trainings that address public health’s role in attacking the root causes of inequality. A participant in New Mexico shared,

“They have a really good training website at the Department level, but again, it’s really about internal stuff, and it’s not about necessarily transforming our public health practice, or even making people aware of inequity and our desire bring about health and racial equity as a Department” (Sanchez-Youngman, Sanchez et al., 2017).

RECOMMENDATION 7

Health departments should ensure staff understand the historic and contemporary root causes of inequity as well as possess the skills and competencies to partner effectively and collect, use, and share information with other agencies and communities.

While staff do not need to become experts in the systems of oppression, it is essential that staff possess skills and competencies around how to use public health resources to influence programs, policies, and internal practices in order to disrupt the reproduction of racial and health inequities (Hofrichter, 2017). Skills and competencies include but are not limited to a rooted understanding of historic inequities, valuing and practicing principles of community based participatory action, a cross-disciplinary orientation, along with specific public health technical skills. While trainings and workshops can be one step for a health department to take, it is not sufficient to just offer trainings alone. Other aligned tactics are needed to ensure uptake and application of new lessons by staff. Sanctioned strategies, approaches, and new practices that support equity approaches should be valued and acknowledged by leadership and supported by the department.



DATA & KNOWLEDGE

The use of public health data, and evidence-driven methodologies such as health impact assessments, are valuable resources in building organizational capacity to advance inside and outside strategies. Internally, self-assessment data on staff skills and competencies can provide insights to public health leadership on where to invest equity training resources. Workforce skills and competencies in data and epidemiology can also be a valuable asset to communities in advancing equity. Sims, Viera & Aboelata (2018) suggest public health plays a uniquely valuable role and helps to “shift the narrative” when it uses its expertise and data to educate non-health sectors and policymakers about the role of structural factors and community conditions in creating and perpetuating racial and health inequities. In addition to shifting the focus toward community conditions and underlying systems, several interviewees emphasized that public health is well positioned to describe how residents of communities that experience inequities face multiple, intersecting challenges to health and safety. An interviewee, for example, described how powerful it was when a local health officer came to speak to leaders about striking health disparities that stemmed from industrial pollution in a largely African American zip code. “The zip code study stunned people—industry couldn’t minimize it. It’s important that public health leaders step up in that way, use data to describe the environmental pollution crisis, and its effects on morbidity and mortality.” The data, in this instance, provided an opening for negotiations between the community and industry leaders.

Public health departments are seen as data authorities and can use this cultural capital to identify data-driven policies and programs that redistribute resources to communities. (Sims, Viera & Aboelata, 2018)

Furthermore, health departments across this scan are collecting data that can be useful in understanding racial and health equity issues in their communities and provides evidence for policy action. In New Mexico, one interviewee talked about how they use data to advance health equity policies “during the [legislative] session, [the Office of Policy and Accountability (OPA)] engages in bill analysis, it’s an opportunity to provide relevant health information to legislators that can inform their decisions” (Sanchez-Youngman, Sanchez et al., 2018). For many, there is a desire to implement more actionable strategies and approaches that advance equity; yet, the capacity of public health departments to use data in service of equity effectively varies. Well-resourced public health departments possessed extensive data and GIS systems and skilled staff were able to collect, analyze, interpret, and disseminate useful equity related data. We found that others were able to leverage partnerships to access needed data. It was not enough, however, to have data collection and analytic capacity. Community Health Needs Assessments (CHNA) were noted as an underutilized resource that did not always build in racial equity measures and were not adequately leveraged for advancing health and racial equity priorities. As a health officer in Michigan notes,

“ We will be helping to educate lawmakers and other policymakers about what the data shows us... helping to leverage the evidence base to the extent it exists on some strategies to address some of those issues. So, we talk very openly about where we have issues and what we know about those issues. I see that as probably the biggest role [public health can play].”

(Kershner, Rudolph & Cooney, 2017)



“That is the issue I’ve found [with doing surveys like CHNA], we do a nice assessment and create a nice product but don’t know what to do with that data beyond assessing and using that data to write grants” (Rubin et al., 2017).

Exacerbating the problem, many Tribal and small local health departments do not have enough financing and/or capacity to collect population health data in a consistent or ongoing manner. Barriers in access and capacity to collect Tribal health data can be attributed to multiple data collection and reporting factors (e.g. sample size) that influence both the validity and statistical significance of AI/AN data. For health departments, this makes establishing AI/AN equity goals and priorities difficult and presents a challenge for Tribes to demonstrate need to funders. An NIHB participant shares,

“One of the challenges [Tribal communities face is] how do you get Tribe specific data? Because there [are] some things that are just impossible to find out. You have to peel them out of the state data or peel them out of national data and then say AI/AN, and what does that have to do with the [specific Tribe]? So, it’s very difficult to actually know what’s going on in the community in terms of measuring effects of health inequities, so we’re working on that through the Tribal health assessment and the Tribal health improvement process that we’re in the middle of right now” (Babbel, 2017).

RECOMMENDATION 8

Health departments must work with communities and partners to acknowledge when to wield the power of data by providing evidence that can make the case for action and when to yield to the information a community knows about itself. Health departments should also share in and be transparent about the data inquiry process.

In an equity centered public health practice, developing and distributing disparities data may be necessary but it is not sufficient. To make headway on building power with communities, co-ownership of efforts in the knowledge generation process—to collect, analyze, disseminate, and validate data/information—can help to build valuable capacity and skills within communities and departments. That is, bringing community residents into the data-gathering process means empowering residents to shape the scope of inquiry, collecting data in a culturally effective way, and sharing data in ways that serve the priorities of the community as well as those of the institution gathering the data (Sims, Viera & Aboelata, 2018). We must also recognize that data is a specific type of information and that other ways of knowing such as lived experiences and oral histories are also vital sources of information that ought to be deemed as credible because they expand our understanding of what is happening in a community.



PARTNERSHIP DEVELOPMENT

Staff competencies and skills in partnership development are also a key asset for carrying out an equity agenda. Partnerships can come in the form of working with other government agencies outside of health, collaborating with other service providers and community-based organizations, or working with community residents and base-building organizations. Each requiring a slightly different approach and skillset. We go into further detail about related strategies in the next section.

Outside Strategies and Tactics

Public health actors are influenced by and simultaneously influence larger structural forces. They operate in politicized environments with direct accountability to mayors, county commissioners, governors, and Tribal leadership who may have agendas that either take priority over or directly conflict with racial and health equity efforts. Yet, advancing racial and health equity requires action by more than the health department alone and the use of equity promoting values and practices in establishing and maintaining partnerships matters. A growing number of health departments acknowledge the importance of partnerships with other agencies to address determinants within and outside of the health services sector such as access to affordable housing, safe places to be physically active, equitable education and employment opportunities, and availability of healthy food retail options (Levi, Heinrich & Mongeon, 2017; Rubin et al., 2017). Across our scans, we found health departments exploring and implementing partnerships with human services agencies in other sectors, local colleges and universities, school districts, law enforcement, funders and community-based nonprofits as an approach to improve overall health. In Michigan, for example, interagency partnerships and dual service infrastructures are being created to improve coordination and seamless referrals between agencies (Rubin et al., 2017). Local health departments there are also working with local farmers' markets through WIC to promote healthy eating and support the Double Up Food Bucks program that leverages Supplemental Nutrition Assistance Program (SNAP) dollars toward fresh produce. Establishing committed partnerships with community-based and base-building organizations can also be a crucial component of an effective equity agenda. Aligning with community-driven and base-building efforts can lend health departments the necessary distance to tackle potential politically controversial issues related to equity, the degrees of freedom needed to connect to broader social movements outside of health, and the ability to bring to bear a wider array of resources than could be accessed alone.

Equity Values and Practices for Partnerships

In the spirit of "cracking the nut" of health equity, simultaneous partnership development with the grassroots and the grassroots is imperative in moving an equity agenda forward (Baum, 2007). Partnerships provide opportunities to build deeper relationships, strengthen resilience, and ensure the sustainability of collective equity efforts. Partnerships may more easily traverse political risk by building a base that can create openings to participate in activities or advance the health department's health equity mission in ways that may not have otherwise been politically viable (Hofrichter, 2017). Community and base-building partners, for example, can lead on advocacy efforts that push an equity agenda forward while also helping the health department comply with lobbying restrictions. Health departments, on the other hand, can wield their positions in communities to convene a broad cross-section of stakeholders and lend credibility to evidence that makes the case for taking equity actions.

“ [Equity] is not something the local health department can go in alone, once you get into it. It's such a big topic you need collaboration of entities across the board working on that.”

– MICHIGAN INTERVIEWEE

(Rubin et al., 2017)



In partnerships that are formed to advance equity, the approach, values held by participants, and power dynamics matter. To avoid reinforcing imbalances in power, equity-focused partnerships should seek to be transformational as opposed to transactional (Hofrichter, 2017; Sanchez-Youngman, Sanchez et al., 2018; Sims, Viera & Aboelata, 2018). Transformational partnerships: (1) bring intentionality to equity, (2) raise awareness of power dynamics, and (3) use processes and practices that build and balance power. Across the scans we found more examples of transactional relationships where the health department determines the scope of work and community partners report out on contracted deliverables (Sanchez-Youngman, Sanchez et al., 2018; Sims, Viera & Aboelata). By contrast, transformational partnerships go beyond seeking input; they are a long-term social change process based on trust, transparency and mutual reciprocity that takes time to evolve (Beech et al., 2017; Hofrichter, 2017). In addition to tackling disparities content issues, the transformational partnership itself is an act towards advancing equity.

BRINGING INTENTIONALITY TO EQUITY PARTNERSHIPS

In the context of governmental public health, a critical precursor to advancing racial and health equity is the intentional broadening of the departments' focus beyond an individual-level programmatic approach that has come to characterize public health practice in the last half-century, towards a systems-level orientation. Systemic change—a fundamental change in policies, processes, relationships, and power structures as well as deeply held values and norms—is required to address the structural factors that have caused inequities in health and safety to be produced. This intentionality in systems-level change that advances equity and shifts power to combat structural racism, bias, and oppression are front and center in transformational partnerships (Sims, Viera & Aboelata, 2018).

Partnerships that bring intentionality are explicit in articulating equity related strategies and aligned actions. EquityNewOrleans, provides an example of this kind of intentionality in action. The initiative, supported by the W.K. Kellogg Foundation in partnership with the Foundation for Louisiana, aims to address economic, racial, or geographic disparities in New Orleans by embedding equity—just and fair inclusion—in all City decision-making and development of future policies, programs, and services (Broussard et al., 2017). To accomplish this aim, several strategic actions will be taken including establishing an Equity Office, incorporating equity into municipal statutes, incorporating equity into budget decisions, and ensuring equity is part of agencies' strategic plans, among many others.

Recent efforts in King County, WA provide another example of an intentional focus on equity. King County Health Department (KCHD) assisted in institutionalizing equity principles such as diversity, equity, social justice, and inclusion throughout the County's strategic plan (Hofrichter, 2017; Sims, Viera & Aboelata, 2018). In 2010, KCHD and other local government agencies sought the input of several thousand residents and county employees to create the County's Strategic Plan. KCHD's data and mapping, depicting how disparities were correlated with place and race, were critical to launching King County's equity work. Based on community input, the plan included an *Equity and Social Justice* guiding principle that shapes the County's decisions, organizational practices, and community engagement. This guiding principle allows for analysis of the systemic causes of inequities in the County—such as housing and education policies—and encourages the prioritization of departmental resources aimed at reducing inequities.

In both the New Orleans and King County examples, government agencies established equity as a strategic priority that should be integrated into its policies, practices, and approaches; thus, addressing structural racism, discrimination and bias is now part of their mandate (Sims, Viera & Aboelata, 2018). This level of intentionality opened up opportunities for the health department and its partners to take explicit actions that build towards equity in its practice with community and integrate equity values into the formal policies that guide decision-making within governmental institutions.



RAISING AWARENESS OF POWER DYNAMICS

Building transformational equity partnerships requires a tremendous amount of self-awareness and reflection. A foundational step in building transformational partnerships is developing a shared narrative on the historic and contemporary social production of inequities, challenging problematic dominant narratives, and co-creating new narratives that reflect a community's understanding of its own story (Hofrichter, 2017). By sharing understanding of the root causes of inequity, structural and institutional barriers can be named—raising a collective awareness about where in the community racial and health inequities are reproduced. Health departments may find themselves being viewed as part of the problem. A participant interviewed by Prevention Institute observed tensions between community organizers and the need for public health departments to produce measurable results on, in many cases, singular health issues which can ignore broader community priorities and reinforce oppressive dynamics (Sims, Viera & Aboelata, 2018). Furthermore, the mere presence of institutional partners can limit who shows up and what is voiced. The racial mix and representation of participants can also impact what gets said as exemplified in this quote by an interviewee in Mississippi:

“[Racial equity] doesn’t always come up in mixed groups, where we have White and Black staff and partners working together, because of that [dis]comfort and that unease. I think the notion that there’s blame that’s associated with somebody in the room in 2017, that had nothing to do with these systems being created, but in the confines of never being a White person in all-White conversation, but as a Black person in all-Black conversations, it always comes up. And sometimes it has a crippling effect, and sometimes it’s even in the context of our own community doing more to combat these systems that are perpetuated, and how long are we going to be able to wrestle with the history and be paralyzed by that.” (Beech et al., 2017).

While health departments should forge partnerships with communities, departments must also possess the self-awareness to judge when to step away to create a safe space for community partners to name sensitive issues related to race, oppression, and imbalances in power (Sims, Viera & Aboelata, 2018). All partners may be well served to routinely raise questions about who is at the table, who is missing, what may or may not be raised as an issue depending on who is present, and the extent to which the agenda reflects the community's needs. Building trust with partners takes time, the process is iterative, and is essential for progress (Beech et al., 2017; Hofrichter, 2017; Sims, Viera & Aboelata, 2018). Moments of conflict may be inevitable but, if shared values, supportive practices, and power balancing processes are put in place, tensions can be leveraged into learning and growing opportunities (Sims, Viera & Aboelata, 2018).

RECOMMENDATION 9

Health departments should be intentional about a focus on equity and seek to form diverse partnerships that can coalesce around a broad equity agenda. These partnerships should also be explicit in addressing systems and structural level changes that undo racial and social power imbalances.



EQUITY PARTNERSHIPS IN ACTION: CUYAHOGA COUNTY, OH

In Cuyahoga County, Ohio, the Cuyahoga County Board of Health has taken a multi-sector approach to partnership—collaborating with community organizations, local government, and health care to strengthen collective capacity to advance health equity. Through participation in the Center for Achieving Equity—a local nonprofit established to empower leaders and communities to identify and address the conditions that shape health and opportunities—the Board's staff, along with their community and governmental partners, were able to open a dialogue on how systemic and institutionalized racism and unfair public and organizational policies have produced inequities in health. For the Board of Health, participation in the Center has marked a strategic shift from prevention approaches centered on behavior modification and access to health care to those focused on socio-economic factors, institutional decision-making, and policies that can improve community conditions. The Board of Health also serves as the backbone organization for the Health Improvement Partnership (HIP)-Cuyahoga which is a consortium of over 100 community partners joining forces to improve health for all Cuyahoga residents. Charged with developing the County's *Community Health Improvement Plan*, HIP-Cuyahoga successfully named the "elimination of structural racism" as a priority goal.

(Sims, Viera & Aboelata, 2018)

PARTNERSHIP PRACTICES THAT SUPPORT BUILDING AND SHARING POWER

In addition to intentionality and raising awareness of power dynamics, developing transformational partnerships requires adhering to organizational practices that build trust, participation, and co-ownership. Transformational practices are iterative participatory processes that employ transparent decision-making and resource allocation, value co-creation and open access to data/information, and balance needs among partners' agendas (Beech et al., 2017; Hofrichter, 2017; Sims, Viera & Aboelata, 2018). When data collection and sharing is accountable, inclusive and transparent, for example, it can provide a means to serve the priorities of the community as well as those of institutional partners who already have a mandate to collect and track data. Community involvement throughout the evidence gathering process—that is, from determining scope of inquiry, data collection, analysis, all the way through dissemination—builds the research capacity of communities, ensures the relevance of the information, and broadens data utility. In effect, this approach transforms the way knowledge is produced by extending the capacity of institutional and community partners and sharing the power over the process.

Transformational practices can build power across networks of partners that can be leveraged to create movements. Networks provide looser bonds beyond partnerships to develop a shared exploration of the relationship of the roots of inequity to specific interests, structures, and processes of decision-making that cumulatively generate social and economic inequalities in housing, transportation, education, jobs, etc., that lead to health outcome disparities. Networks can provide a space for creating relationships among institutions and entities that formerly did not act in concert, so that sub-networks can emerge that provide shared leadership opportunities and effective division of labor.

Participants in New Mexico, for example, describe how they use Tribal networks to work within healthcare organizations, external government bureaucracies, and health care organizations to combat structural racism, create regulatory policy reform, and to advocate for health services that meet the needs and cultural practices of American Indian populations (Sanchez-Youngman, Elias et al., 2018). Tribal leaders discuss building alliances with white officials in city and state government to strategically obtain positions of power in the public and private sector to create organizational and structural changes to advance health equity for Tribal communities.

Networks can also expand influence and exchange valuable resources beyond a partnership's service region. In another example from New Mexico, one of the local health councils underwent *Undoing Racism* training and has subsequently built internal capacity to also train others nationally (Sanchez-Youngman, Sanchez et al., 2018). This has led this particular health council to develop "people powered" capacity to participate in environmental health justice initiatives, partner with Place Matters⁵ on equity initiatives, and leverage their network to

advocate for policy change locally and in collaboration with Tribes. In the Midwest, the *Building Networks* initiative, was developed to align public health agencies with community organizers across several states with the intention that coming together would strengthen the capacity of each to advance an equity agenda (Hofrichter, 2017). The networks aimed to co-create a clear social justice-based narrative for a variety of audiences and achieved varying degrees of connections that are ongoing. As Hofrichter explains, “While the health practitioners and organizers selected issues as a means towards broader social change, the work began with the understanding that the goals could not be achieved one issue or policy at a time.” In other words, the formation of the network organized around the idea of creating a social movement was an act towards equity in and of itself.



Connecting to Social Movements

Policy development is most productive when agencies have legitimate and broad political support (Sanchez-Youngman, Sanchez et al., 2018). Some health departments have learned how to participate in non-health campaigns and broader social movements to garner the political support needed to advance an equity agenda (Hofrichter, 2017). In this scenario, it can be a win-win for public health to attract grassroots champions while also providing evidence that quantifies the impact of broader social issues on a tangible outcome that resonates such as health. Further, these social movements influence the national discourse on equity which helps to reshape the contours of the political culture and narratives about race and equity in ways that can reduce the political risk to health departments. The economic justice movement, for example, has been making headway with fair wage campaigns such as “Fight for 15” to raise the minimum wage to \$15 per hour. Public health departments such as Illinois’ Cook County Health Department are doing their part by working with local community organizers to support fair wage policy change (Hofrichter, 2017). To deepen equity impact, departments can find allies and alignment in the environmental, racial, criminal, and immigrant justice movements among many others.

In the U.S., social movements from the abolitionist and the labor movement to civil rights and the women’s movement have been responsible for major advances in the public’s health. (Hofrichter, 2017)



RECOMMENDATION 10

Health departments should seek to form transformational partnerships that acknowledge, self-examine, and rebalance power dynamics among participants. Within these partnerships, the practices and processes that support the partnership must be iterative, participatory, and transparent to build necessary trust and shared accountability among partners.

RECOMMENDATION 11

Health departments and their partners can leverage their impact if they connect to social movements beyond specific health issues. This can provide cross-cutting equity policy issues with a broader coalition of constituents and be a win-win for diverse yet aligned equity agendas.

⁵ Place Matters, now known as Collaboratives for Health Equity (CHE), is an initiative formerly lead by the Joint Center for Political and Economic Studies. CHE is a national network of teams working to advance health equity in cities and counties, led by the National Collaborative for Health Equity.



Networking Across Strategies

Building A Public Health Equity Movement

A consistent and dominant theme that emerged across the teams' scans was that to be in position to advance racial and health equity public health itself needs a movement—that is, the viability of governmental public health and public health departments playing a role in advancing equity are intricately intertwined. Taking the broader health system into view, public health funding is disproportionately imbalanced compared to health care, accounting for just 3% of overall health spending (Levi, Heinrich & Mongeon, 2017). Centers for Medicare and Medicaid Services, for example, estimates that per capita spending on core public health functions is \$108.92, comprised of federal (\$22.66), state (\$31.26), and local (\$55.00) sources compared to the \$9,990 spent per capita for health care services (Levi, Heinrich & Mongeon, 2017). Trust for America's Health also reports that state spending has been flat for almost a decade and wide variation exists between different states and local jurisdictions within states (Segal & Martin, 2017). Public health agencies themselves are vulnerable entities much like the communities they provide safety net services for.

Public health agencies continually face budget cuts that threaten their ability to fulfill their duties and provide services. In 2012, the Louisiana state legislature passed a plan to cut Medicaid funding by \$523 million, with funding to the public healthcare system cut by \$329 million (Broussard et al., 2017). That year, the administration also announced that the Louisiana State University Hospital System—which replaced the Charity System serving low income residents after Hurricane Katrina—would lay off 1,500 employees and reduce inpatient services in early 2013. Since then, the hospitals have endured even more funding cuts, and 9 of the 10 public hospitals entered public-private partnerships in order to stay open. In 2017, statewide mid-year budget cuts in Mississippi reduced appropriations to the Mississippi State Department of Health (MSDH) by 14 percent (Beech et al., 2017). It was expected that the following budget would be cut by an additional 18 percent. This resulted in the reorganization of the MSDH—closing six public health district offices and restructuring the Office of Health Disparity Elimination.

In addition to financial challenges, deficits in infrastructure can pose problems. Many Tribes, for example, do not have a specific Tribal health department; therefore, Tribal health administrations and health services are left to fulfill public health duties, frequently with insufficient resources to administer foundational public health services (Babbel, 2017). Indian Health Services (IHS) is also underfunded, forcing the agency to have a narrow focus on managing chronic diseases and urgent and emergent health issues. As a result, Tribal public health has been even more under-resourced, pushing Tribes to compete against each other for the limited resources that are available. Not only are Tribes forced to compete against one another, but IHS and other agencies that serve Tribes are pitted against each other as well. One interviewee observed that this practice creates further chasms between well-resourced Tribes and agencies, and those

that are not. The lack of development and investment in critical public health infrastructure over the years, combined with IHS' focus on primary health care services has led to misinformation and ignorance about what public health is and the role it plays in the healthcare system.

Similarly, divestment in public health agencies and infrastructure undermines what they can produce and leaves little room for departments to imagine a racial and health equity agenda. As one Mississippi participant shared,

“. . . [I] think that it's a real travesty that those conversations have become so politically fraught and because there's also a climate of budget cutting that I think folks are really challenged and really nervous to speak openly and honestly and candidly about the racial piece" (Beech et al., 2017).

The origins of these funding and infrastructure imbalances are tied to the structural distribution of power and resources in a pattern that mirrors what happens to communities that face inequities. As public goods and services are increasingly privatized, policy decisions are made out of the public eye and incentives are for profit rather than the greater common good. In effect, public health becomes devalued and the influence of agencies diminishes. Thus, governmental health departments have a stake in an equity agenda because their own fate is linked to advancing more equitable and democratic society.

Public health departments must acknowledge that advancing equity is essentially about transforming power—a political act. Hofrichter (2017) describes the aim of transforming power as a “fully developed realization of democracy;” that is, “reshaping governance, governing systems and politics across all issues, so no one class or network of groups dominates . . . it entails rearranging institutional power.” He further articulates that this degree of social change is no easy undertaking, is a long-term process, and is well beyond the scope of a single health department let alone the entire governmental public health sector. Despite this, for the vitality of the field and the nation's health, public health is in position to build a movement—a public health equity movement.

Health departments have a stake in an equity agenda because their own fate is linked to advancing a more equitable and democratic society.

At the grassroots level, addressing power imbalances entails constituency base building among public health agencies internally but also with institutional allies and communities. Public Health Awakened, started by Human Impact Partners in response to the Trump administration, is a promising example of a growing grassroots public health workforce constituency (Hofrichter, 2017). With over 900 members representing 37 states plus the District of Columbia, the network has organized and used its collective power to address a variety of racial and health equity issues. In the wake of the Trump administration's first travel ban by executive order, for example, the network published and quickly disseminated, *Public Health Actions for Immigrant Rights: A Short Guide to Protecting Undocumented Residents and Their Families for the Benefit of Public Health and All Society* (as cited in Hofrichter, 2017). Public Health Awakened provides the field with a built-in constituency that can be activated in service of equity and public health base-building.



By modeling deep partnership, public health can begin to develop aligned systems, coordinated strategies, and networked organizations and resources. This network of partners, thought leaders, and funders can build national political will for racial and health equity at the grassroots. Public health serves as a key node that can strategically align with other social movements, attract progressive funders and thought leaders to the table, and amplify the work of allied institutions and networks that value health and racial equity.

Given the current vulnerable financial state of governmental public health, however, major advances cannot come from the bottom up alone. Forward thinking influential institutions and funders outside of governmental public health need to wield, share, and help to build power to advance equity (Ranghelli, Choi & Petegorsky, 2018). Governmental public health agencies and communities should not have to shoulder the entire burden of movement building nor would an internal grassroots strategy solely be comprehensive enough to enact lasting change. Outside actors that acknowledge the political risk of equity movement building can also wield influence using movement building strategies that build momentum from the outside. Health departments, for example, need support in adapting existing resources and programs to ensure racial and health equity is part of their mandate. Funders can influence dynamics between health departments and their partners by requiring an equitable portion of the financial resources go directly into communities and being open to measurement that incorporates different forms of knowledge generation. These kinds of new approaches and funding arrangements can disrupt power dynamics and shift what issues are considered credible and worthy, with who and how public health initiatives are funded, and what gets legitimized as measures of success.

RECOMMENDATION 12

Forward thinking funders and thought leaders need to wield their influence to advocate for the value of public health, push for systems change strategies, and support both health departments that can serve as incubators for demonstrating new equity strategies, and bring external resources to those that face opposition to equity.



Conclusion

Racial and health disparities are pervasive and, in too many cases, continue to widen. Our most vulnerable communities bear the brunt of these disparities due to imbalances in social, economic and political power. Governmental public health has a historic legacy to build upon in playing a role in aligning and strategizing with external social justice movements in the service of improving population health.

To address inequities in health, public health and allies must recognize that to do so is a political act that entails disrupting the deeply entrenched structures of power. The burden of political risk can be mitigated by employing inside, outside, and across movement building strategies that challenge problematic narratives by co-creating new ones and developing transformational alliances to leverage collective actions rooted in mutual reciprocity that reflects communities' voices and needs.

Internally public health departments need leaders with a galvanizing vision of health equity that is grounded in the policies, programs and culture of departments. There is a need for shared language around racial and health equity that is grounded in a systemic understanding of oppression and its impact on health outcomes, while providing the flexibility and nuance necessary to understand specific historical, geographic and cultural differences.

Public health departments need staff with the skills and experiences necessary to execute efforts to address the social determinants of health and effectively liaison with communities, other departments, and advocacy groups because public health cannot do this work alone. We need systems of shared accountability where public health departments are in relationship with other stakeholders to expand the reach and resources available to advance equity. Public health departments have an important opportunity to leverage their many strengths and mitigate their structural weaknesses through strategic and diverse partnerships.

Public health departments can identify, produce and share data that informs practitioners and communities about the systems, processes, and policies that produce health inequities and ways to disrupt them. When politically viable, health departments can use their social capital to bring unlikely partners together, and advocate on behalf of efforts that center equity and justice. Public health departments can counteract their weaknesses by moving toward a model of shared accountability whereby various players outside of public health departments are meaningfully engaged in developing and executing effective campaigns, programs, and partnerships that advance equity.

Health departments can broker strategic partnerships with grassroots organizations, advocacy groups, complementary departments, political leaders, and funders to create an ecosystem that supports health equity. Various opportunities exist to do so from low-risk knowledge sharing efforts such as public forums, symposiums, and presentations, to strengthening relationships with complementary departments through cross-training and joint programming, all the way up to advocating on behalf of public and private policies that reinvest resources into historically disinvested communities. Every health department



has a role to play. Simultaneously, forward-thinking institutions and funders are needed to push the field towards equity from the outside in. Funders can incentivize collective action and systemic approaches to addressing the social determinants of health. Other institutions can create opportunities to align their goals with health equity and use the media and other campaigns to lift up the role of public health in advancing equity. Change will not occur from the top-down, but will require bi-directional and complementary efforts.

The future of public health and the vitality of our communities are intertwined with progressing towards a more racially equitable and democratic society. This vision will be facilitated by nimble, interconnected, cross-sector networks bound by shared values and common goals to change the public discourse about racial and health equity and make connections among seemingly disparate issues to ensure all people have access to the resources they need to thrive.



Recommendations

- **RECOMMENDATION 1:** Health departments must understand the cultural and political resonance of racial and health equity concepts with their communities and the extent to which clear definitions of terms and concepts will foster equity agenda development. For some Tribal health departments, this may mean avoiding the use of the term *racial equity* and working closely with the Tribe to articulate what alternative concepts resonate with an equity agenda that aligns with the Tribe's needs.
- **RECOMMENDATION 2:** Health departments should articulate a shared vision, worldview, and public narrative for how they see themselves advancing equity to galvanize staff and partners towards collective action on equity.
- **RECOMMENDATION 3:** Health departments should work with communities and partners to create a shared understanding of the historic and contemporary imbalances in power that produce inequities as a foundational step in developing an equity agenda and also recognize that the process is iterative and may require intermittent reflection as partnerships grow, new actions are taken, and agendas expand.
- **RECOMMENDATION 4:** Health departments should incorporate racial and health equity into formal strategic statements—such as vision, mission, and values—and in their jurisdiction's statutes to ensure that equity is part of a health department's mandate.
- **RECOMMENDATION 5:** Train more health department leaders on the political skills it takes to navigate leading and collaborating on an equity agenda and creating culture change within and external to the department.
- **RECOMMENDATION 6:** Health departments should make diversity, equity, and inclusion a part of their internal equity strategy and be transparent about how diversity, equity, and inclusion are incorporated into staff recruitment, hiring, and retention practices.
- **RECOMMENDATION 7:** Health departments should ensure staff understand the historic and contemporary root causes of inequity as well as possess the skills and competencies to partner effectively and collect, use, and share information with other agencies and communities.
- **RECOMMENDATION 8:** Health departments must work with communities and partners to acknowledge when to wield the power of data by providing evidence that can make the case for action and when to yield to the information a community knows about itself. Health departments should also share in and be transparent about the data inquiry process.
- **RECOMMENDATION 9:** Health departments should be intentional about their focus on equity and seek to form diverse partnerships that can coalesce around a broad equity agenda. These partnerships should also be explicit in addressing systems and structural level changes that undo racial and social power imbalances.
- **RECOMMENDATION 10:** Health departments should seek to form transformational partnerships that acknowledge, self-examine, and rebalance power dynamics among participants. Within these partnerships, the practices and processes that support the partnership must be iterative, participatory, and transparent to build necessary trust and shared accountability among partners.
- **RECOMMENDATION 11:** Health departments and their partners can leverage their impact if they connect to social movements beyond specific health issues. This can provide cross-cutting equity policy issues with a broader coalition of constituents and be a *win-win* for diverse yet aligned equity agendas.
- **RECOMMENDATION 12:** Forward thinking funders and thought leaders need to wield their influence to advocate for the value of public health, push for systems change strategies, and support both health departments that can serve as incubators for demonstrating new equity strategies, and bring external resources to those that face opposition to equity.



References

- Baum, F. (2007). Cracking the nut of health equity: top down and bottom up pressure for action on the social determinants of health. *Promotion & Education* (14), 90-95.
- Bliss, D., Mishra, M., Ayers, J. & Valdes Lupi, M. (2016). Cross sectoral collaboration: The state health official's role in elevating and promoting health equity in all policies in Minnesota. *Journal of Public Health Management and Practice*, 22 (1Supp), S87-S93.
- Braveman, P. (2006). Health disparities and health equity: concepts and measurement. *Annual Review of Public Health*, 27, 167-194.
- Braveman, P. (2014). What are health disparities and health equity? We need to be clear. *Public Health Reports*, 129 (Suppl 2), 5-8.
- Braveman, P., Arkin, E., Orleans, T., Proctor, D. & Plough, A. (2017). *What is health equity? And what difference does a definition make?* Princeton, NJ: Robert Wood Johnson Foundation.
- Davis, R., Savannah, S., Harding, M., Macaysa, A. & Fujie Parks, L. (2016). *Countering the production of health inequities: An emerging systems framework to achieve an equitable culture of health.* Oakland, CA: Prevention Institute.
- DeSalvo, K.B., Wang, C., Harris, A., Auerbach, J., Koo, D. & O'Carroll, P. (2017). Public Health 3.0: A Call to Action to Create a 21st Century Public Health Infrastructure. *Preventing Chronic Disease*, 14, E78.
- Ferrer, B. (2016). Building health equity: A community-driven approach to confront racism, promote racial healing, and sustain equitable opportunities for optimal health. *Journal of Public Health Management and Practice*, 22 (1 Supp), S110-S111.
- Grantmakers in Health (2010). *What's in a name? Untangling health disparities, the social determinants of health, and health equity.* Issue Focus. Retrieved from url: http://www.gih.org/files/usrdoc/Issue_Focus_Whats_In_a_Name_3-22-10.pdf.
- Human Impact Partners. (2016). *14 inside and outside strategies to advance health equity within local public health practice.* Oakland, CA: Human Impact Partners.
- Iton, A. (2010). Tackling the root causes of health disparities through community capacity building. In R. Hofrichter & Bhatia, R. (Eds.) *Tackling health inequities through public health practice: theory to action* (2nd Edition) (pp.115-136). New York, NY: Oxford University Press.
- Jones, C. (2014). Systems of power, axes of inequity: parallels, intersections, braiding the strands. *Medical Care*, 52, S71-S75.
- Prentice, B. (2014). *Expanding the boundaries: health equity and public health practice.* Washington, DC: National Association for City and County Health Officials.
- Ranghelli, L., Choi, J. & Petegorsky, D. (2018). *Power moves: Your essential philanthropy assessment guide for equity and justice.* Washington, DC: National Committee for Responsive Philanthropy. Retrieved from url: <https://www.ncrp.org/initiatives/philamplify/power-moves-philanthropy>
- Raphael, D., Brassolotto, J. & Baldeo, N. (2014). Ideological and organizational components of differing public health strategies for addressing the social determinants of health. *Health Promotion International*, 30 (4), 855-867.
- RESOLVE. (2014). *The high achieving governmental health department in 2020 as the community chief health strategist.* Public Health Leadership Forum. Retrieved from url: <https://www.resolve.org/site-healthleadershipforum/files/2014/05/The-High-Achieving-Governmental-Health-Department-as-the-Chief-Health-Strategist-by-2020-Final1.pdf>
- Segal, L.M. & Martin, A. (2017). A funding crisis for public health and safety: State-by-state public health funding and key facts. Trust for America's Health. Retrieved from url: <https://www.tfah.org/wp-content/uploads/archive/assets/files/TFAH-2017-InvestInAmericaRpt-FnIRv10.3.pdf>
- Williams, D.R., Priest, N. & Anderson, N. (2016). Understanding associations between race, socioeconomic status, and health: patterns and prospects. *Health Psychology*, 35(4), 407-411.

ENVIRONMENT SCAN REPORTS

- Babbel, B. (2017). *Building the public health capacity to advance equity in Indian Country.* Washington, DC: National Indian Health Board.
- Beech, B.M., Bruce, M.A., Gamble, A., Crump, M.E. & Hamilton, G.E. (2017). *Challenges and requirements for building public health department capacity to advance health equity: the Mississippi case.* Jackson, MS: University of Mississippi.
- Broussard, D., Richardson, L., Wallace, M. & Theall, K. (2017). *"Do we want to feel exclusive or like a true community?": increasing public health capacity to address equity in New Orleans.* New Orleans, LA: Tulane University and Institute of Women and Ethnic Studies.
- Kershner, D., Rudolph, C. & Cooney, M. (2018). *Leadership approaches to health equity: how state and territorial health officials are advancing health equity in the 21st century.* Arlington, VA: Association of State and Territorial Health Officials.
- Levi, J., Heinrich, J., Mongeon, M. (2017). *Building governmental public health capacity to advance equity: a scan of the funding environment.* Washington, DC: George Washington University.
- Hofrichter, R. (2017). *Advancing health equity in local public health practice: challenges and possibilities.* Washington, DC: National Association of County and City Health Officials.
- Rubin, S., Kushion, M., Jacobson, P. & Meadows, P.D. (2017). *National Collaborative for Health Equity Scan: Michigan.* Ann Arbor, MI: University of Michigan.
- Sanchez-Youngman, S., Sanchez, V. & Elias, M. (2018). *Insider perspectives on the integration of health equity into public health practice in New Mexico.* Albuquerque, NM: University of New Mexico.
- Sanchez-Youngman, S., Elias, M., Lasansee, S. & Sanchez, V. *Supplement: American Indian perspectives on the integration of health equity into public health practice in New Mexico.* Albuquerque, NM: University of New Mexico.
- Sims, J., Viera, S., Aboelata, M.J. (2018). *Partnering for health equity: grassroots organizations on collaborating with public health agencies.* Oakland, CA: Prevention Institute. Retrieved from url: <https://www.preventioninstitute.org/publications/partnering-health-equity-grassroots-organizations-collaborating-public-health-agencies>

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Appendix

Environmental Scan Partner Descriptions⁶

National Core Partners

GEORGE WASHINGTON UNIVERSITY, MILKEN INSTITUTE SCHOOL OF PUBLIC HEALTH, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT (GWU) examined the policy and funding environment for public health in the context of a changing health system and new administration (Levi, Heinrich & Mongeon, 2017). GWU focused on federal policy, public and private funding, and national research priorities – with particular focus on opportunities to support public health in an evolving political and fiscal environment. The final report provides an overview of the public and philanthropic investments in public health, with special regard to advancing *accountable health* approaches that address social determinants of health using a public health frame.

NATIONAL COLLABORATIVE FOR HEALTH EQUITY (NCHE) served as the overall project coordinator to ensure alignment among the collaborating teams, facilitated cross-team sense-making, and led synthesizing findings across the other nine team scans to produce this report.

PREVENTION INSTITUTE (PI) examined the national landscape and interviewed local grassroots, community-based, and base-building organizations to understand their perspectives on effective strategies and practices that governmental public health agencies could use to co-develop equitable partnerships with communities (Sims, Viera & Abuelata, 2018). PI focused on elevating opportunities and strategies that can be employed in service of equity by leveraging an agency's infrastructure, established partnerships, credibility, and resources. Findings are organized by three principles for equity transformation: (1) bringing intentionality to health equity efforts, (2) valuing community experience and capacity, and (3) aligning health department functions with equity goals. Their scan unearths how the political environment, capacities of partnering organizations, funding allocation, and partner dynamics can both positively and negatively impact the degree to which communities and public health agencies can partner to advance equity.

National Constituent Partners

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS (ASTHO) focused on the role state health officers and their agencies can play in advancing racial and health equity (Kershner, Rudolph & Cooney, 2017). ASTHO explored how state leaders conceptualize and approach equity while also specifying issues particular to their states and perspectives on current initiatives, challenges, and opportunities. In addition, the report provides a scan on statutes that include equity and legislative policy approaches.

NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS (NACCHO) centered its portion of the environment scan on local health departments (Hofrichter, 2017). The report uses a social justice framework to provide a rich review of the historic and structural causes for racial and health inequities. NACCHO outlines leading champions, puts forth potential strategies, and outlines roles that local public health departments can play to shift power dynamics and connect health equity initiatives to broader social equity movements.

NATIONAL INDIAN HEALTH BOARD (NIHB) explored the definition and applications of what racial and health equity work looks like among sovereign Tribal nations co-located in the U.S. (Babbal, 2017). The scan uncovers the opportunities and barriers for Tribes to play an elevated role in advancing racial and health equity while also illustrating how the concept of race does not resonate with and is potentially damaging for Tribes. Notably, the American Indian and Alaskan Native (AI/AN) designation is critical for documenting health inequities; however, the distinct government-to-government political status that should be afforded to federally recognized Tribal members is often overlooked and misunderstood. NIHB's report summarizes the need to uphold the federal trust responsibility to be upheld; increase cultural and systems alignment with local, state, and funder agencies; raise public health systems capacities; and expand partnerships and cross-sector wellness initiatives.

⁶ For more information on each of the contributing teams' individual scan reports, please contact the respective corresponding author listed in the Acknowledgements.

Academic Research Partners in WKKF's Priority Places

MICHIGAN - UNIVERSITY OF MICHIGAN (UM) developed a case study for the scan focusing on the State of Michigan (Rubin et al., 2017). Michigan's public health structure is decentralized, where 45 local health departments and 3 Tribal health departments are controlled by their respective jurisdictions, and the state health agency serves the entire state. UM provides a review of governmental public health history in the state and centered much of their scan on the varying capacities of local health departments across Michigan, including one of the three Tribal health departments. The team also explored the provision of state-level equity resources and the relationship between and the state and local health departments. Key observations included the need for common equity language and concepts, increased training and aligned resources, broadening the focus on equity among the social determinants of health as opposed to narrowly concentrating on health disparities outcomes, and acknowledging the need for tailored approaches across the state.

MISSISSIPPI - UNIVERSITY OF MISSISSIPPI MEDICAL CENTER (UMMC) developed a case study for the scan focusing on the State of Mississippi (Beech et al., 2017). Mississippi's public health structure is centralized where the state health agency (MSDH) serves Mississippians through county health departments organized into three restructured regions as a result of 2017 budget cuts—i.e., northern, central, and southern. They argue that racial health disparities in states like Mississippi are often embedded in historical and sociopolitical contexts that maintain the racial subordination of African Americans. UMMC reviewed the historic and contextual factors for inequities and adopted an anti-racism praxis that aims to eradicate or minimize racism by reviewing targeted evidence, planning, implementation and relationship-building to achieve health equity. Among the key findings included observations that health equity is not an explicit goal of MSDH or many of its partners; however, new campaigns offer opportunities to elevate equitable health goals; the mission, strategy and programming led by the Office of Health Disparities Elimination needs to be better integrated with the rest of the agency; community engaged partnerships have been a fruitful strategy; recruiting and retaining a skilled workforce with health equity competencies has been a major barrier; and a state-wide equity agenda has gained little to no traction, but successes have been achieved at the local level.

NEW MEXICO - UNIVERSITY OF NEW MEXICO (UNM) developed a case study for the scan focusing on the State of New Mexico and Tribes co-located in the state (Sanchez-Youngman, Elias et al., 2018; Sanchez-Youngman, Sanchez et al., 2018). Tribes included in the scan were a sample of five pueblos and members of the Navajo Nation. The State of New Mexico's public health structure is centralized, with five public health regions and over 50 public health offices that deliver services. New Mexico has a system of county and Tribal based health councils that serve as a liaison between the health department and local communities. Using a qualitative approach, the UNM team explored how historic, organizational, and capacity factors mediate the relationship between the health councils, Tribes, and the health department and the degree to which they have embraced an equity agenda. Interviewee views on organizational features were categorized into six themes: health disparities data, assurance of core services, policy and public outreach, shifting toward health equity approach, workforce development, and partnerships/collaborations. UNM found that regional staff ascribed more importance to partnerships and downstream implications in comparison to central staff. They also found that worldview orientation and public health councils were key factors in local public health equity practices. For Tribes, sovereign nation rights was a top equity theme.

NEW ORLEANS - TULANE UNIVERSITY AND INSTITUTE OF WOMEN AND ETHNIC STUDIES (TU-IWES) developed a case study for the scan focusing on the City of New Orleans Health Department (NOHD) and its key partners (Broussard et al., 2017). Using the Social Ecological Model (SEM) as a guiding frame, the findings are organized by SEM's theoretical concentric constructs—Policy, Community, Organizational/Institutional, Interpersonal/Relational, and Individual. TU-IWES provides a review of historic and contemporary contextual factors that produce inequities and accounting of how New Orleans' public health system has evolved. NOHD is a nationally accredited local health department and, beginning in 2016, began to implement an agency-wide health equity agenda that plays a vital role in the City's overarching equity strategy, *EquityNewOrleans*. Other key findings included debate about the degree to which health equity should be centered as part of the health department's responsibility; the need for deeper community engagement, to acknowledge and address power dynamics, and political leaders to act on the equity agenda; improving NOHD's internal and external communications; and ensuring public health leaders are from diverse backgrounds, skilled, and competent in health equity strategies—especially those that deal with racism.

