SOCIAL DETERMINANTS OF HEALTH AND INEQUITY

"There must exist a paradigm, a practical model for social change that includes an understanding of ways to transform consciousness that are linked to efforts to transform structures." - Bell Hooks

Connection to the Lens

At its inception, the Equity and Empowerment Lens (E & E Lens) was envisioned as a tool to help leaders and organizations examine the conditions under which equity grows or diminishes and take action to rectify the inequities that result from policies, procedures, and practices that benefit some while disadvantaging others. Understanding the social determinants of health is key to an effective Lens application process. In our day-to-day work, it may not be immediately apparent how various social determinants intersect with our programs and policies. A few Lens questions prompt us to think beyond conventional boundaries and institutional silos by asking us to consider developing new and innovative partnerships or strengthening current relationships with nonprofits and community partners. An example might include a health clinic developing a partnership with a nearby high school to tackle high rates of teen pregnancy, or a housing agency partnering with an economic justice organization to promote just and sustainable employment for its clients.

Background and Basics

The vision of the Multnomah County Health Department is "healthy people in healthy communities." But what is a healthy community? What conditions create healthy communities? Community members and those who work in communities have always understood that people who have peace, shelter, employment, access to education, and other basic needs tend to be healthier. Now, a large and expanding body of literature documents the health impacts of environmental, social, political, educational, and economic conditions, which together are referred to as the social determinants of health (SDOH). By improving each condition, and by working cross-sector on joint actions and goals, we can improve the livability of the community as a whole. When livability is improved for all, the community becomes healthier and we move a step closer to achieving health equity.

(Important note: for the purpose of this document, "health" is synonymous with positive outcomes in any sector.)

What are Social Determinants of Health?

According to the World Health Organization (WHO), social determinants of health are the conditions in which people are born, grow, live, work and age, the health care system being one of several. The social determinants are largely responsible for inequities, which are unfair, avoidable, and systemic differences in population outcomes. The social conditions (referred to as social determinants) resulting in inequities are shaped by (1) the distribution of money and other resources, and (2) the presence of fair/just decision-making processes leading to meaningful engagement of communities most affected by inequities. These social determinants are greatly influenced by policy choices at local, national, and global levels.

A report issued by the Robert Wood Johnson Foundation (2010) provides a compelling explanation of why we must pay close attention to these factors:

> *America leads the world in medical research and medical care, and for all we spend on health care, we should be the healthiest people on Earth. Yet on some of the most important indicators . . . we're not even in the top 25. . . It's time for America to lead again on health, and that means taking three steps. The first is to ensure that everyone can afford to see a doctor when they're sick. The second is to build preventative care . . . into every health care plan and make it available to people who otherwise won't go or can't go in for it. . . The third is to stop thinking of health as something we get at the doctor's office but instead as something that starts in our families, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe and in the water we drink. The more you see the problem of health this way, the more opportunities you have to improve it.*

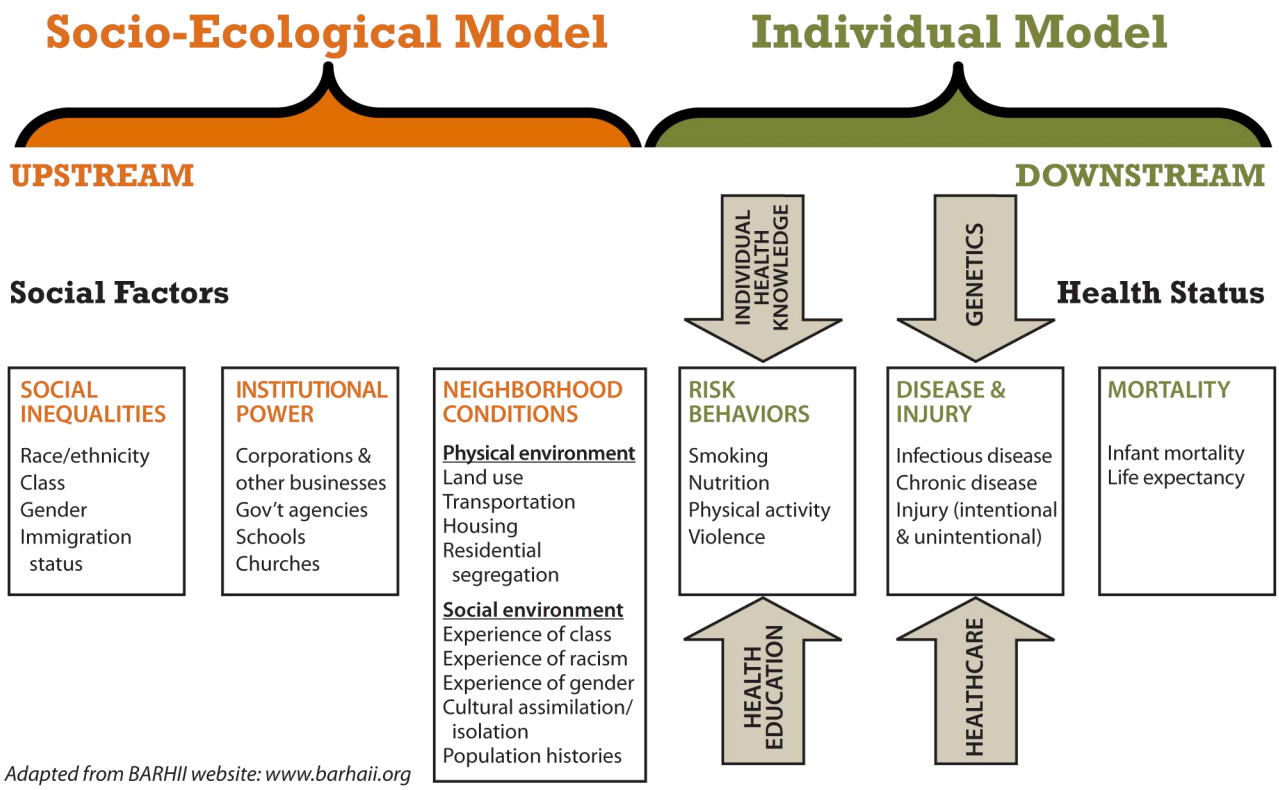
Taking these words to heart, we have adapted the following graphic from Bay Area Regional Health Inequities Initiative (BARHII) to depict how external, social factors (such as housing, institutional power, and racism, to name a few) and individual-related factors (in this example, risk behaviors, disease, and injury) work together to bring about positive or negative population health. Until recently, we have tended to focus on solutions and strategies that only target individual behaviors, as seen in the "risk behaviors" and "disease and injury" categories. However, in order to significantly improve outcomes at the population level and ultimately to eliminate root causes of inequities, we must recognize the external factors that also contribute to inequities experienced by populations and communities. These include neighborhood conditions, education, the role of institutional power in upholding unjust structures, processes, and decision-making, and how and why root causes exist in the first place. (see Concept Paper on *Hierachy and Root Causes*)

The socio-ecological model also connects health status to sustainability, climate health and equity (see Concept Paper on *Sustainability, Climate Health and Equity*), by examining how our social and economic sustainability exists within the resources and limitations of environmental sustainability. What affects our natural environment (clean air, food, and water) will greatly affect our social and economic environment. For instance, food shortages that result from increasing number of droughts due the climate change can result in higher prices in the markets, making it harder for low-income populations to access healthy, nutritious food.

SOCIAL DETERMINANTS FRAMEWORK

The following graphic illustrates another way to visualize the continuum of upstream, midstream, and downstream actions needed to eliminate the root causes of inequities, with a few sample strategies provided.

Balajee, Sonali S., et al., (2012). *Equity and Empowerment Lens (Racial Justice Focus)*. Portland, OR: Multnomah County.



Adapted from BARHII website: www.barhaii.org

Below we describe a number of social determinants that contribute to inequities. Following each is a brief, non-exhaustive list of questions to help frame each factor and suggest how to apply the principles of equity and empowerment within each area. You will notice that we have included questions about staff and organizational development in addition to questions about community members and clients. To make transformative change, it is important to work both internally and externally.

Socioeconomic Status

- Can families in the neighborhood afford basic needs? If not, how could this affect the conditions you/your organization are tracking (health indicators, educational benchmarks, homeownership, etc.)?
- How do your organizational processes exclude people based on socioeconomic status? What can you/your organization do to identify and eliminate barriers to just and fair decision-making and planning processes?

Wealth and Income Development

- Are economically sustainable jobs available for all communities, specifically communities of color, immigrants, and refugees? How can they prepare for better access to these jobs?
- Are green jobs available to all communities, specifically communities of color, immigrants, and refugees? How can they prepare for an access these jobs?
- How does your organization prioritize economic justice, in such area as workforce development, contracting and providing greater opportunities for income development for all?

Education

- Are all community members with whom you work able to obtain high quality education as children, as adults, and as elders? If not, why?
- What organizational, local, state, and federal policies, processes, and procedures assist communities in obtaining high quality education? What gaps still exist?
- How can you, your colleagues, and your organization help ensure that schools and places of learning provide culturally responsive education?

Housing

- Can people of color, immigrants and refugees, and people living on low-income find housing in safe neighborhoods?
- How do policies protect (or not protect) renters from health hazards such as lead exposure and mold?
- What opportunities for quality home ownership exist for any population regardless of race/ethnicity and income?

Early Childhood Development

- Where do young children have the chance to learn and play in a safe environment? Where do they not, and why?
- How do children experience the negative effects of racial and other inequities in the community? According to what indicators?
- How can you / your organization support or sponsor community-capacity building efforts within the area of early childhood that are culturally specific and culturally responsive?

Transportation

- Do all people in the neighborhood have adequate access to public transportation?
- What transportation challenges do people face based upon income inequities? How do these challenges affect access to health care?
- How can current and new modes of public transportation better incorporate the voices of communities of color, immigrants, and refugees?

Access to Health Care

- Who has access to health services in the community? Who does not have access? Why or why not? What can be done to increase coverage for all residents to ensure health as a human right?
- How are health care organizations providing culturally responsive treatment and prevention services?
- How do health care organizations build capacity in communities to serve their own health needs?

Physical Environment/Land Use

- Is the physical environment safe for children?
- How do empty lots/abandoned areas in the neighborhood pose a threat to safety?

- Where geographically are certain populations more exposed to environmental toxins and pollution than others? What can be done to reduce such toxins and pollutants?
- What aspects of your program or project contribute to environmental pollution (transfer of resources and supplies, location in areas not conducive to public transit and multimodal forms of transport, etc.)? How can you mediate the negative impacts.

Respect and Dignity

- How does your organization demostrate respect for community members and promote deeper respect throughout the larger community?
- How do you know the community members with whom you work feel that they are respected in your organization and in the larger community?
- How does your organization demonstrate respect and value for staff who identify as members of communities most affected by inequities (paying particular attention to communities of color, immigrants, and refugees)
- How do you know they feel respected and valued in your department or organization?
- What policies, procedures, and practices in your organization protect the cultural values and ways of being that people from different communities bring?

Empowerment

- What barriers do empowerment exist in your organization or community?
- What strategies do you currently use to overpower staff and communities you work with?
- How do community members participate actively, as a community, in the broader society? Which community members participate, and why?
- What social and economic conditions change as a result of community action?
- How does your organization build community capacity to have agency over their lives?

Social Support/Social Networks

- How do community members provide support for their families and communities?
- How do high levels of stress affect community abilities to support each other?
- What robust, culturally specific networks support community members to lead healthy and fulfilling lives? How do these networks influence larger systems?

Public safety

- Do all neighborhoods have safe streets, yards, and buildings? Why or why not?
- How do unsafe neighborhoods negatively impact the overall health and success of community members you serve or staff working in your organization?
- Are children and teens exposed to violence in the neighborhoods? What are the demographics across income, race / ethnicity, age, gender, etc., of these children and teens?
- How do community members, most affected by inequities, relate to public safety officials?

Food Access, Safety and Security

- Do all communities have access to healthy and culturally specific food choices?

- What grocery stores exist in the neighborhood? Do communities of color, immigrants, and refugees have access to culturally specific stores and markets in their neighborhoods?
- Where is the distribution of local farmers markets? Of stores selling mostly processed and unhealthy foods? How does that correlate to the demographics in the area?

Access to Culturally-Responsive Activities and Services

- How can your organization actively value cultural heritage and integrate diverse cultural paradigms into organizational planning and decision-making?
- What safe places exist where culturally focused activities can take place?
- How are elders encouraged to pass on the knowledge and stories that are part of their heritage to the children of the community?

Race and Ethnicity

- What organizational processes exclude people based on racial and ethnic background? What might be some of the barriers to inclusion and meaningful engagement for these populations?
- Where is participation and involvement of communities of color, immigrants, and refugees working in your systems? How can your organization strengthen these processes?
- In regards to the other social determinants, how is your organization (1) tracking data based on race and ethnicity demographics; (2) making that data accessible to employees and staff; and (3) making decisions based upon that data.
- Where is our organization promoting culturally responsive policies and structures?

Recommendations for Lens Implementation and Application from an Social Determinant of Health Perspective

- Develop partnerships with programs doing equity work within other social sectors than the one(s) you work with currently. When working with individuals one-on-one or in small groups, it is sometimes challenging to consider how to integrate issues such as educational success, income development, and transportation. Perhaps your organization can develop a partnership with an organization working on one of these issues. Consider organizing a public forum highlighting the issue you are working with (for instance, overrepresentation in the community justice system), and integrate leaders from education or health who are also partnering with your organization.

- Ensure that messaging to people you serve is holistic and recognizes both the social and the individual influence on positive community outcomes. Population health clearly depends on both social and individual factors. Reflect on the messages you send to the people you serve. Is too much emphasis placed on the role of the individual in population health? Is it the other way around? Strive to communicate a balance and implement solutions accordingly.

- Prioritize and fund programs and partnership-building efforts that support cross-jurisdictional approaches. Organizations often prioritize direct services and individually based efforts to the detriment of successful partnership-building and collaborative strategies to eliminate duplication, share best practices and social technologies, and serve families and individuals in more holistic ways.

Individual Reflection Questions

- Think about your own experience and assets within housing, education, and other social determinants of health. How have such experiences and assets influenced the level of power you have or don't have in your organization or community?

- As you meet with community members you are working with or serve, consider how challenges or opportunities in other social determinant areas you are not directly working with might impact their situation. For instance, if you are working on improving library access for various communities you serve, what other social determinant areas (income/wealth development, education, transportation, etc.) could affect people's access? How does this knowledge move you to provide services differently or collaborate with external partners differently?

Balajee, Sonali S., et al., (2012). *Equity and Empowerment Lens (Racial Justice Focus)*. Portland, OR: Multnomah County.

HIERARCHY AND ROOT CAUSES

"For every effect there is a root cause. Find and address the root cause rather than try to fix the effect, as there is no end to the latter." - James Baldwin

Connection to the Lens

The Equity & Empowerment Lens (E & E Lens) embodies principles of social and racial justice. According to Krieger (2001) this framing "explicitly analyzes who benefits from - and who is harmed by - economic exploitation, oppression, discrimination, inequality and degradation of natural resources" (p.55). In order to eliminate the root causes of inequity, organizations must identify and eliminate oppression and discrimination in policies, practices, processes, structures, and relationships between colleagues, and between their structures and community members. Values and beliefs shape discrimination; the decision to create a more just society is, at heart, a choice about values. Values that support social justice and equity include honesty, inclusion, innovation, solidarity and humility. Using this Lens will help your organization address root causes, and specifically, how they relate to racial and ethnic inequities, how they contribute to maintaining the unjust effects of hierarchy, and how best to level the playing field for all residents of Multnomah County.

In line with national equity efforts that define the three main drivers of inequities – racism, class oppression, and gender inequity – the general version of the Lens (see *Lens At A Glance, page 28*) will focus specifically on how to identify policies, procedures, and practices that contribute to institutional racism, classism, and sexism. Below we will briefly review the definition and role of hierarchy in maintaining systems of oppression and reinforcing existing root causes.

Background and Basics

Hierarchy is the categorization of a group of people according to ability or economic, social, or professional status. The negative effects of hierarchy manifest when there is an established dominant group that tends to enjoy a disproportionate share of assets, resources, and other areas of positive social value (Pratto, Sidanius & Levin, 2006). (See Concept Paper *on Social Determinants of Health and Health Inequity for more information*). As a population in terms

of race/ethnicity, Whites/Caucasians comprise the dominant culture and possess the most direct access to the power and resources of society. As a result, the paradigms present in our institutions often reflect and empower the normative cultural values of the dominant group, and simultaneously disempower non-dominant groups who may not share these normative characteristics. Denying the value of non-dominant characteristics reinforces hierarchy. The consequence of hierarchy is an inequitable distribution of access to the resources necessary to thrive and meaningful inclusion and participation of all community members (Burke & Eichler, 2006).

Wallerstein argues that being powerless, or lacking "control over one's destiny," is a core social determinant of health and success (as cited in Symes, 1988).

> Living in an environment of physical and social disadvantage - being poor, low in the hierarchy, under poor working conditions or being unemployed, subject to discrimination, living in a neighborhood of concentrated disadvantage, lacking social capital, and at relative inequity to others - is a major risk factor for poor health (p.73).

Root causes of inequities stem from institutionalized practices shaped by dominant culture values, attitudes, and beliefs. These values and beliefs influence perspectives about the nature of problems and solutions, thus directly affecting decision-making and planning. Therefore, it is vital to integrate non-dominant culture perspectives to ensure more robust policy and decision-making processes based on equity and empowerment (Burke & Eichler, 2006). In order to achieve consistent, fair, and just decision-making, it is vital to focus on shifting cultural norms and strengthening organizational capacity to embody the values of inclusion, fairness, honesty, and empowerment within organizations. (See Concept Paper on *Empowerment Theory and Practice* for more information).

The labels that we place on people – black, white, poor, rich, gay, straight, old, young, disabled, etc. – can prevent people from being valued fairly and from receiving equal treatment. Treating someone differently, unfairly, and unjustly because of their actual or perceived identity is an "ism." The "isms" can be broadly defined as conduct, words or practices which advantage or disadvantage people because of their relationship to dominant culture (Burke and Eichler, 2006). The practice is just as damaging in less obvious and subtle forms as it is in obvious forms, and is still called an "ism" whether it is intentional or unintentional (DeAngelis, 2009). Some of the most common "isms" are racism, classism, sexism, ageism, heterosexism and disablism.

The E & E Lens is designed to help organizations identify and eliminate root causes, including institutional racism (also known as structural racism or systemic racism). Institutional racism is "the network of institutional structures, policies, and practices that create advantages for White people and discrimination, oppression, and disadvantage for racialized people [communities of color, immigrants, and refugees]" (Lopes and Thomas, 2006, p.270). Such racial discrimination

can occur by governments, corporations, religions, educational institutions or other large organizations with the power to influence the lives of many individuals. The following research studies highlight the racist impact of practices, whether directly or indirectly driven by institutional policies. In a 2004 study, researchers Bertrand and Mullainathan discovered widespread discrimination in the workplace against job applicants whose names were perceived as "sounding black." These applicants were 50% less likely than candidates perceived as having "white-sounding names" to receive callbacks for interviews. In another study, a sociologist at Princeton University sent matched pairs of applicants to apply for jobs in Milwaukee and New York City, and found that black applicants received callbacks or job offers at half the rate of equally qualified whites (Bonikowski, Pager, & Western, 2009). In both examples, the negative influence of hierarchy manifests in the categorization of job applicants who were perceived to be a member of a non-dominant group. The result was decreased employment opportunities for this group and thus the perpetuation of inequities.

As organizations work to identify and eliminate policies and practices that support racism, classism, disablism and other forms of discrimination, it is also vital to identify factors that contribute to keeping them in place. Not only does hierarchy play a significant role in the perpetuation of racist policies and practices in organizations, but the experience being a member of a non-dominant group can also decrease positive mental health (See Concept Paper on *Positive Mental Health & Equity*). In a surprising learning, researchers in the famous Whitehall Study discovered that social standing within an institution was connected to health risk factors. While the researchers had originally assumed that executives at the top of the hierarchy experienced increased health risks as a result of high stress, what they discovered instead was the opposite. With each employment grade level decrease, the risk factors increased. Sir Michael Marmot, who was featured in the health equity PBS documentary series Unnatural Causes, and has done extensive research on the influence of social standing on health outcomes, described the results more specifically in an interview for the film:

> The higher the grade, the better the health. The lower the grade, the higher the mortality rate and the shorter the life expectancy, in this remarkably graded phenomenon. So if you were second from the top, you had worse health than if you were at the top; if you were third from the top, you had worse than if you were second from the top – all the way from top to bottom (Unnatural Causes, p.2).

Not only did this study reveal the negative health effects of social stratification, but also established hierarchy as a critical determinant and root cause. Although none of the participants lived in poverty (another potential health risk factor), simply experiencing lower levels of social and professional status within a workplace hierarchy significantly impacted health outcomes. Marmot explained that people at lower levels of the hierarchy experienced less autonomy, control and empowerment, also associated with decreased health. These findings align with research reviewed for the Concept Paper on *Empowerment Theory and Practice* and

a comprehensive study of major world economies that revealed societies with higher rates of homicide, infant mortality, obesity, teen pregnancy, depression and incarceration also tend to have greater social inequality (Hofrichter, 2006).

Hierarchy can have direct, insidious effects on the health and well being of our communities. As institutions we must recognize the existence of hierarchies and construct policies, practices, and procedures that mitigate the negative impacts on people. The *In Wealth and In Sickness* section of Unnatural Causes describes how society is constructed very much like a ladder. Some natural stratification occurs in society. However, we can decrease the space between the rungs by making positive changes to our structures, policies, and environments. Creating and maintaining empowering spaces that recognize, celebrate, and utilize multiple cultural ways of being is essential. Not only does this intentional practice embody the spirit of equity and inclusion, but it can also reduce the harmful results of social stratification and hierarchy.

It is also important to understand that one's place in the hierarchy shifts by time and place; we all find ourselves in different levels within hierarchies by gender, class, age, ability, religion, language, ethnic background and sexual orientation, to name just a few. We must recognize the existence of multiple and shifting identities within communities and ourselves. We must recognize that the experiences of women of color are different from those of men of color based on sexism, and are also different from the experiences of White women based on racism. Finally, we must recognize that hierarchies can exist within hierarchies. Within the gender hierarchy, some groups of men can have more dominance over other men based on income and race/ethnicity. Within the race/ethnic hierarchy, heterosexual men and women of color can be dominant over individuals who do not fall into normative definitions of sexual identity.

What keeps hierarchy in place?

The tie between hierarchy and the five faces of oppression

Hierarchy is a key characteristic of organizational structure and functioning. When hierarchical structures are oppressive, however, the gap between health and success of those at lower social status levels compared to their counterparts at higher levels is significant.

Organizations and decision-making bodies have the power to either create the opportunities or reify the constraints that can lead to population success or decline. Systemic limitations and everyday practices can inhibit the ability of individuals and groups to develop and exercise their capacities, and express their needs, thoughts, and feelings. (Young, 2011)

> In this extended structural sense oppression refers to the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms-- in short, the normal processes of everyday life. (p.41)

When applying a Lens, it is critical to become familiar with *how* people are negatively affected and oppressed within structures. Young's framework (2011) outlining the five faces of oppression is a great way for Lens participants to understand *how* populations are affected by the root causes of inequities, and how to facilitate improved systemic solutions that dismantle existing oppression and lead to greater equity and racial justice. Young states that no singular oppression is more fundamental than any other. The areas below simply function as a tool for determining how individuals and groups experience oppression, and do not comprise a full theory of oppression.

- **Exploitation:** This occurs when institutional conditions hinder the capacity of employees to develop themselves and support the development of others. When populations are being exploited, larger gaps exist between workers and employees who can accumulate more, and those who suffer from poverty, material deprivation, and a loss of control. For example, when an organization lacks focus on ensuring greater representation of communities of color in leadership roles, compared to seeing and accepting such representation only in lower levels of the organization, it contributes to exploitation. As noted by Sandra Hinson (2008), "the wage and wealth gap between the wealthy owners and managers, on the one hand, and the masses of working people, on the other, is an indication of the degree of exploitation that exists in society."

- **Marginalization:** Young (2011) suggests this form of oppression is perhaps the most dangerous. People who are marginalized are those who the system of labor cannot or will not employ. In addition to material deprivation, marginalized populations experience exclusion "from useful participation in social life" (Young, p.50) and then are often demonized and for their lack of participation. So much of society's recognized activities occur via social coordination and cooperation. Social structures and processes that exclude people from participating are unjust, and can lead to deprivation of the cultural conditions necessary to thrive. By not engaging communities most affected by inequities in planning and decision-making, and those specifically often excluded in labor (people living with disabilities, for instance), an organization exhibits marginalization.

- **Powerlessness:** Powerlessness is experienced when people in societies do not regularly and meaningfully participate in making decisions that affect their working, social, and political lives -- their daily lives. (*National Association for City and County Health Officials*) In a workplace, those who experience powerlessness have little or no autonomy around work tasks, cannot exercise their creativity or judgment fully, and overall do not command respect compared to others (Young, 2011). Structures and policies that contribute to powerlessness can further prohibit individuals from attaining higher positions and create poor working and living conditions (that can lead to decreased spiritual, mental, physical health) (See Concept Paper on *Relational Worldview*).

- **Cultural imperialism:** Cultural imperialism is the manifestation of negative hierarchy. When policies, processes, and structures value a dominant group's (the group that as a population has the most power and control over decision-making and processes affecting others) experience and culture, and establish it as the norm, cultural imperialism takes place. People who experience this form of oppression are made invisible, and labeled by stereotypes, affecting their capacity to thrive and actively participate in political and social decision-making. Organizational structures and practices that fail to recognize, hold up, and utilize a variety of perspectives (such as cyclical, relational, systemic, feminist, holistic, to name a few) in addition to dominant perspectives perpetuate cultural imperialism and oppression.

- **Violence:** Systematic violence manifests when certain groups "live with the knowledge that they must fear random, unprovoked attacks on their persons or property, which have no motive but to damage, humiliate, or destroy the person" (Young, p.61). For groups living with such fear, they share the daily knowledge with their group members that they are more susceptible to violation based solely on their group identity. While the particular acts of violence are horrible to encounter or witness; what makes this violence also a form of oppression is the social context that normalizes these acts. Organizational structures, communications, policies and practices condoning such violence (and it is critical to mention that 'violence' is comprised of both acts on the physical as well as mental and emotional) must reform via analysis, new recommendation-setting, and actual change. To combat violence, major changes in social and cultural norms, stereotypes, and policies supporting violence must happen.

Exploitation, marginalization, powerlessness, cultural imperialism, and violence manifest in different ways, visible and invisible, direct and indirect, intentional and not intentional. However, we must understand that when any of these conditions are present within our organization we are perpetuating long-standing oppression. Moving toward equity and racial justice requires that we recognize how our policies, procedures and practices play into each of these conditions and take active steps to dismantle structures that do not promote the well being of all people. Different groups and individuals within those groups can experience combinations of these five oppressions in varying ways. As Hinson (2008) states:

> Most, if not all, working people experience exploitation. Racism runs through each of these kinds of oppression, intensifying the experience of exploitation, powerlessness, cultural dominance and everyday violence. Gay men as a group experience cultural dominance [imperialism] and the threat of violence, but they may not necessarily experience other forms of oppression based on their class and occupational status. White professional women experience cultural dominance [imperialism], fear of sexual violence, and a degree of powerlessness-- especially if they constantly have to prove themselves worthy of their status. (p.85)

The Equity & Empowerment Lens (E & E Lens) asks users to take a passionate stance to promote equity and social justice. To that end, the Lens asks us to reflect deeply and honestly about who is affected by a particular policy or program, and how. (See the *Lens At A Glance, Questions #3 and 4, p.30*) Young's framework on the five faces of oppression provides a robust framework for articulating the detrimental impact of root causes as they appear in institutional structures and practices. As presented in the E & E Lens, the five faces of oppression is also a tool for organizations to initiate conversations, strategic planning, and decision-making that truly reflects a vision for equity and racial justice. Lens solutions call for immense transformation and challenge organizations to eliminate the negative impacts of hierarchy and other root causes of inequity.

Recommendations for Lens Implementation and application from an Empowerment Perspective

- **Acknowledge the existence of institutional hierarchy.** Change does not happen amidst denial. We know that the further down the hierarchy an individual or group exists the more they experience stress.
- **Make a commitment to examining how institutional hierarchy functions**, and mitigate the negative impacts.
- **Recognize when viewpoints from the dominant paradigm are privileged** and/or more readily adopted than viewpoints from non-dominant paradigms. Using a racial justice focus, integrate non-white paradigms into the work.
- **Intentionally include perspectives from multiple paradigms** in every discussion and decision-making process.
- **Adapt your structure and timeline** to integrate communities who value greater collaboration and deeper dialogue processes.
- **Examine where and how multiple areas of oppression exist in relation to the experiences of people affected (the existence of intersectionality)**. When looking at the impact of a program on racial and ethnic populations, think also about how the program is affecting women and children of color, immigrants and refugees. Ask yourself how are people who identify as LGBTIQ who are also members of communities of color, immigrant, and refugee populations being affected?
- **Engage and value the perspectives of employees** from all levels or professional classes, top to bottom.

Individual Reflections Questions

- Communities most affected by health inequities are most often from non-dominant cultures. What can you or your colleagues do to improve inclusion of non-dominant cultures' viewpoints in goal setting, implementing, and evaluating your work?
  - In relation to racial justice, how can communities of color, immigrants, and refugees be further included into all aspects of the work?

- What is your organizational structure? What hierarchies exist within that organizational structure, and how do they play out in the daily interactions between workers of different levels?

- How do you, specifically, and your organization, generally, perpetuate negative hierarchies? Think about specific examples, and explore how you could shift policies, practices, or procedures to increase the empowerment of all people.

- What types of stressors might your staff be experiencing? What can you do to mitigate the external stressors in your workplace? Are responsibilities assigned inequitably? If so, can responsibilities be redistributed to allow for more equity within your group?

RELATIONAL WORLDVIEW

"Humankind has not woven the web of life. We are but one thread within it. Whatever we do to teh web, we do to ourselves. All things are bound together. All things connect." - Chief Seattle Duwamish

Lead Author: Terry L. Cross, MSW, ACSW, LCSW (Seneca Nation of Indians) Terry Cross is an enrolled member of the Seneca Nation of Indians and is the developer, founder, and executive director of the National Indian Child Welfare Association.

Connection to the Lens

The Equity & Empowerment Lens (E & E Lens) purposefully includes the relational worldview as a foundational model for this work because it supports the World Health Organization's holistic definition of health, and also speaks to models of population health and success deeply espoused by several communities of color in addition to Native/Indigenous populations. The four quadrants of the relational worldview, based on context, spirit, body, and mind embody the principles that guide the Lens. They speak to the collective nature of health across various sectors, and to the power of a respectful relationship between self and others, and self and surroundings. The relational attributes of this paradigm support and highlight the inclusion of both social and individual determinants of health, the significance of social supports/networks as well as respect, dignity, social determinants, and the importance of all three areas of sustainability (environmental, economic, and social).

Background and Basics

The relational worldview provides a way to help us understand the holistic scope of resources that lead to positive population health and overall outcomes. This includes the necessary mental, physical, spiritual, and contextual resources that, when considered as a whole, can lead to positive health. The model embodies key Lens values such as balance, inclusion, and empowerment. (See Concept Paper on *Empowerment Theory and Practice*). It also speaks to the intersection of the various social and individual areas (environment, economic, mental, physical, spiritual, etc.) that come together to either negatively or positively

affect population success. Additionally, the model was deliberately included to represent a worldview founded on concepts and processes supported by many communities of color.

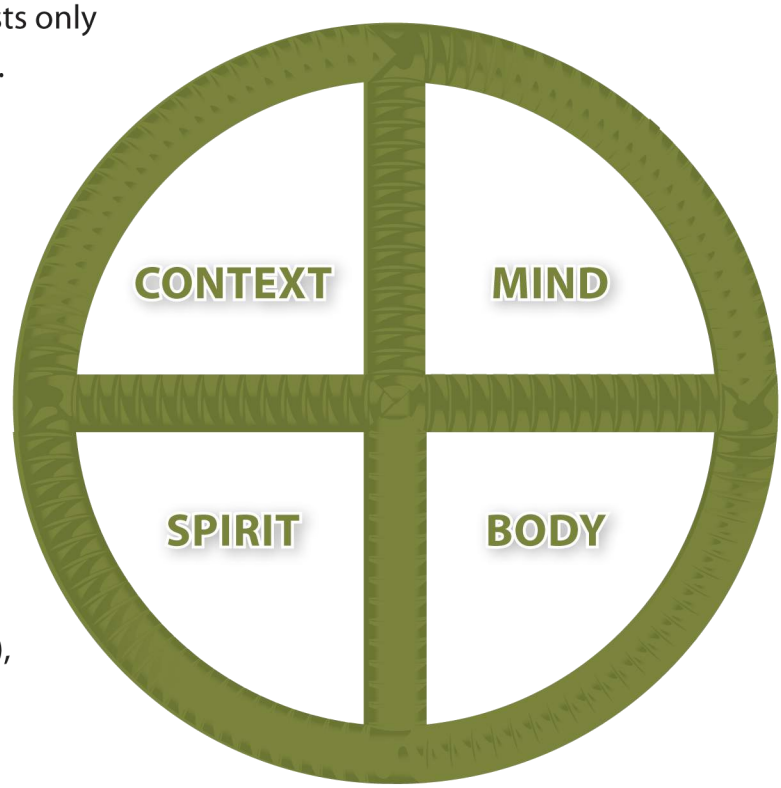
The National Indian Child Welfare Association (NICWA) developed the relational worldview model we share here. It is a reflection of the Native thought process and concept of balance as the basis for health, whether that is an individual, family or an organization. The relational worldview does not just apply to indigenous population health, but is also a model of health in many communities of color who prioritize the importance of a balanced relationship between land, resources, people, spiritual faith, and power.

In today's society, there are two predominant worldviews - linear and relational. The linear worldview is rooted in European and mainstream American thought. It is logical, time-oriented and systematic, and has at its core the cause-and-effect relationship. In contrast, the relational worldview sees life as a harmonious relationship where health is achieved by maintaining balance between the many interrelating factors in one's circle of life.

The relational worldview, sometimes called the cyclical worldview, is a holistic model of health, grounded in indigenous teachings and realities, that has served as an exemplar and set of practices to ensure the sustainability of their populations and accompanying ecosystems for thousands of years. It is intuitive, non-time oriented and fluid. The balance and harmony in relationships between multiple variables, including spiritual forces, make up the core of the thought system. Every event is understood in relation to all other events regardless of time, space, or physical existence. Health exists only when things are in balance or harmony.

The individual relational worldview model can be best illustrated with a four-quadrant circle.

The four quadrants represent four major forces that together must come in balance. One quadrant does not exist without the other three, and all quadrants work in a symbiotic manner. These quadrants represent context, mind (mental), body, (physical), and spirit (spiritual).



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- Context includes culture, community, family, peers, work, school, socioeconomic conditions, and social history.
- Mind includes our cognitive processes, such as thoughts, memories, knowledge, and emotional processes such as feelings, defenses, and self-esteem.
- Body includes all physical aspects, such as genetic inheritance, gender, and condition, as well as sleep, nutrition and substance abuse.
- Spirit includes both positive and negative learned teachings and practices as well as positive and negative metaphysical or innate forces. For the purposes of the Lens, 'spiritual' is being defined by its late Latin root, 'espiritus' or 'spirare,' meaning 'to breathe into.' Essentially, the spiritual quadrant has to do with that which brings passion, breath, or purpose into people's lives.

In the relational worldview these four quadrants are in constant flux and change. We are not the same person at 4pm that we were at 7am. Our level of sleep is different, our nutrition is different and our context is different. Thus, behavior will be different, feeling will be different and our context is likely different. The system constantly balances and re-balances itself. If we are able to stay in balance, we are said to be healthy, but sometimes balance is temporarily lost.

In the linear worldview, the person owns or is the problem. In the relational worldview, the problem is circumstantial and resides in the relationship between factors. The person is not said to have a problem but is said to be out of harmony. Once harmony is restored, the problem is gone. In the linear model, we are taught to treat the person, and in the relational worldview, we are taught to treat the balance or imbalance.

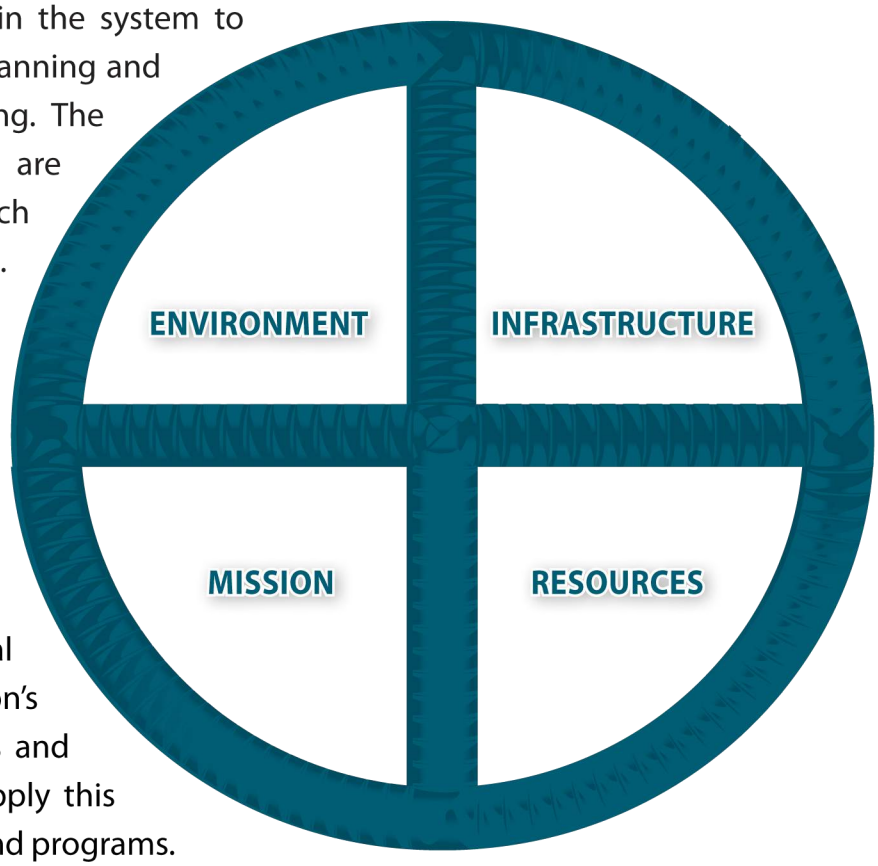
Change can occur by addressing one quadrant. However, the belief is that by attending to one, the change agent is actually opening a portal to all the others because they exist interdependently. It is the consideration of the interdependence of the relationships among all factors that give understanding. It is the constant change and interplay between various forces that accounts for resilience. We can count on the system's natural tendency to seek harmony, and we can promote resilience by contributing to the balance.

The glue that holds the four quadrants together is the presence and practice of being in respectful, inclusive relationship to one another, to an individual's and a community's purpose in life, and to the environment.

Relational Worldview Applied to Organizations

The relational worldview is a model and paradigm that we can apply to different structures, programs, and policies. The model can be applied to the individual and population perspective

depicted above, and can also be translated to the level of the organization, or a system. In this application, the 'context' applies to the 'environment' of the organization. The 'mind' applies to the infrastructure necessary in the system to do the work, such as strategic planning and culturally proficient programming. The 'body' refers to resources that are vital to get the work done, such as fiscal and human resources. And 'spirit' corresponds to the mission, purpose, and vision of an organization, or that which drives the work, and sets purposeful goals.



In addition to consciously integrating the relational worldview into our organization's work with community members and participants, it is vital to also apply this model within our departments and programs. By doing so, we adhere to the guiding principle of equity stating that in order to reach our outcomes, we must intentionally focus our equity-related efforts on both the internal and external to bring about systemic, sustained change.

Recommendations for Lens Implementation and Application from an Relational Worldview Perspective

- When addressing how a policy positively and negatively affects populations experiencing inequities, paying particular attention to communities of color, immigrants and refugees, and consider analyses of such impacts across a population's or an individual's mental, physical, spiritual, and contextual spheres.
  - **Mental:** How is the population's mental health positively or negatively affected by the policy/program/practice? (their thoughts, emotional processes, etc?) (See Concept Paper on *Positive Mental Health*)
  - **Physical:** How is their physical health affected, and by what (sleep, nutrition, ailments, genetic inheritances, sexual health, etc.)?
  - **Spiritual:** Does the population or individual feel a sense of passion and purpose in what they are doing and in how they are living their lives?

- **Context:** What contextual factors in the population's social history, economic realities, culture, work environment, educational experiences (early childhood included), etc., add to positive or negative effects on health and success? (See Concept Paper on *Social Determinants of Health*)

When creating actions/strategies, what can you include that improves relationships:

- Person to person? Person to organization?
- Person to their own talents and purpose?
- What are a few strategies that increase the sense of value or respect that people you work with (colleagues, community partners) feel in relation to working with you?
- What are a few strategies in programming that support connecting the contextual to mental, physical, or spiritual factors?
- What are key barriers to identifying areas of change and creating recommendations in a non-siloed, relational manner?

Individual Reflections Questions

- How do you identify with both the linear and relational worldview?
- How does that worldview or model manifest in what you value in relationship with colleagues, community partners, family?
- In the work you do with community members, how does including the realm of context (education, culture, family, peers, socio-economic factors) affect any recommendations for positive change or treatment?
- When looking at the health and retention of the communities of color, immigrants and refugees within your organization, how does considering the mental, spiritual, and contextual spheres have a positive effect on internal organizational processes and evaluation?

EMPOWERMENT THEORY AND PRACTICE

An empowered organization is one in which individuals have the knowledge, skill, desire, and opportunity to personally succeed in a way that leads to collective organizational success." - Stephen Covey

Lead Author: Noelle Wiggins, EdD, MSPH, is the founder and manager of the Community Capacitation Center at the Multnomah County Health Department and Adjunct Assistant Professor of Community Health at Portland State University.

Connection to the Lens

Working in a way that promotes the empowerment of individuals, organizations and communities most affected by inequities is a practical method for achieving health equity. The Equity & Empowerment Lens (E & E Lens) itself uses and integrates empowering strategies for employees and community members leading to more diverse representation in the resulting recommendations, and most importantly, the inclusion of community voice most affected by inequities. A key resource for the Moving into Action section is the Empowerment Assessment Tool (see Appendix D) that provides concrete examples of empowering strategies to integrate into recommendations.

We can create empowering strategies simply by improving our individual interactions with one another and consciously activating an equity-based inquiry within our thinking. Ask yourself, how can we avoid hierarchy that creates oppression? (See Concept Paper on *Hierarchy and Root Causes*) How can we be more culturally humble in how we approach and partner with communities of color, immigrants, and refugees? Individual actions make up the relationships that contribute to the strength, resiliency, and effectiveness of organizations.

Background and Basics

Over the last 30 years, it has become increasingly clear that persistent variance in the health status of different communities are the result of environmental, social, and economic conditions. A number of public health researchers have proposed

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that the common thread running through all these adverse social conditions is powerlessness. On average, in any relationship between two groups of people, those who have more control and power have better health, while those who have less control and power (vis à vis the other group) have worse health. If powerlessness is the root cause of health inequities, then it follows that the solution is empowerment.

The idea and practice of empowerment grew out of the work of community organizers such as Saul Alinsky, who proposed that oppressed people needed to build "power coalitions" to counter-balance the power of institutions. Although Alinsky focused mostly on governmental institutions, empowerment theory and practice applies to all types of institutions and structures. Many civil rights, international solidarity, and other transformative social movements around the world have worked to eliminate unjust power structures (see Concept Paper on *Hierarchy and Root Causes*) Similarly, much of the current equity work focuses on examining and eliminating the root causes of inequity.

The concept of empowerment entered the social sciences fields via community psychology in the 1980s. Empowerment was introduced as an alternative to the paternalistic philosophy and practice that had guided social services since the nineteenth century. Subsequently, the concept has been used within occupational and stress research and public health.

In the media and in public discourse, the term "empowerment" is often misused to refer to purely individual-level changes, or to imply that one person can "empower" another. In public health, on the other hand, empowerment is viewed as "a process of promoting participation of people, organizations, and communities towards the goal of increased individual and community control, political efficacy, improved quality of community life and social justice" (Wallerstein, 1992, p. 197-205). In public health, empowerment is something you do for yourself with your community, although outsiders to a given community can play a role in creating the environmental and institutional conditions where empowerment becomes more possible. Empowerment is both a process and an outcome.

This Lens is different from other equity lens in that it explicitly addresses the connection between equity and empowerment. Equity is an ideal, a goal. Community empowerment (to distinguish it from individual empowerment) is the vehicle for achieving equity in process and outcome (Wiggins, Johnson, Farquhar, Michael, Rios & López, 2009).

The word "empowerment" can be threatening, since it may suggest that some people will have to give up power so that others can have more. In some cases this will be true. But the concept of empowerment as used here is based on the idea that power is not a finite commodity.

There is enough to go around, as long as some people don't take too much. Ron Labonte has called empowerment a "fascinating dynamic of power given and taken all at once, a dialectical dance . . ." (Bernstein, Wallerstein, Braithwaite, Gutierrez, Labonte & Zimmerman, 1994, p.285)

How can we create conditions in our organizations that promote the empowerment of individuals and communities? One way is to begin thinking about power as something we exercise with others, rather than over others. Hierarchy serves the function of maintaining organization within our structures (See Concept Paper on *Hierarchy and Root Causes*). However, when the 'power over' orientation leads to unfair and unjust policies and practices, we need to reset and reprogram our organizations using 'power with' actions and processes. In order to actualize equity, empowerment needs to occur at three levels (individual, organization and community). If we only focus on individual empowerment (by, for example, building a client's skills to advocate for a particular issue), the outcome will be increased self-efficacy for that individual. However, when we support the empowerment of groups and communities, we move more systemically towards equity. The underlying conditions that cause health inequities won't change unless empowerment occurs at all three levels.

Practicing cultural humility and using culturally responsive communication strategies are two ways to support empowerment at the individual level. Cultural humility is vital to identifying and eliminating social injustices, and is defined as maintaining a lifelong commitment to self-reflection and openness to learning, focusing on understanding one's own assumptions and beliefs in practice (Tervalon & Murray-Garcia, 1998). Culturally responsive communication recognizes and values multiple identities, ways of being, and communication styles. One strategy to strengthen organizational empowerment is to authentically engage employees who experience inequities in the organization's decision-making processes. Organizational empowerment can be either vertical (increasing democratic processes within the organization) or horizontal (increasing the organization's empowerment through the support of other organizations). At the community level, promoting empowerment means building capacity within communities. Public agencies can do this by providing information, acting as a convener to bring community groups together with other organizations (such as universities), using and teaching empowering strategies (such as popular education), and building skills and leadership within communities (for example, by training Community Health Workers).

Recommendations for Lens Implementation and Application from an Empowerment Perspective

- When applying the Equity and Empowerment Lens (E & E Lens), it is important to "walk our talk" around empowerment. This means involving people most affected by racial/ethnic and

other inequities and using practices that promote trust and safety, so that all participants feel comfortable sharing their perspectives and opinions.

- Create conditions that promote participation by a wide range of people. This may mean reducing workloads; providing childcare, interpretation, and/or transportation; and using culturally responsive frameworks and communication styles.
- On an on-going basis, seek to determine whether or not staff and community members feel valued, respected and included in decision-making. Surveys, focus groups, and employee-supervisor meetings are just a few ways to obtain this input.
- Utilize The Empowerment Assessment Tool (Appendix 4) to help promote empowering behaviors and processess in an explicit way.

Individual Reflection Questions

- Empowerment begins in our one-on-one interactions. Thinking about our interactions with community partners, we can ask ourselves a series of questions:
  - How can I avoid hierarchy that creates oppression? (See Concept Paper on *Hierarchy and Root Causes*)
  - How can I approach and partner with communities of color, immigrants, and refugees in ways that reflect cultural humility?

- Individual actions shape relationships that contribute to the strength, resiliency, and effectiveness of organizations. Consider:
  - What are the implications of acting in a hierarchical or disempowering fashion on the quality of your partnerships?
  - Every time you sit with a co-worker, think about the implications of your interaction considering your position in the hierarchy, and what you need to do in order to avoid oppression. *Know that it is possible that the answers to your question may not match the answers of the person with whom you are interacting.*
  - Ask yourself: What barriers to empowerment exist in your organization or community, especially as they relate to the exclusion and unjust treatment of racial and ethnic communities?
  - How can you eliminate these barriers?

THE LENS AS A QUALITY IMPROVEMENT TOOL AND PROCESS

"There are two primary choices in life: to accept conditions as they exist, or accept the responsibility for changing them." - Denis Waitley

Lead Author: Dr. Robert Johnson, MD is a Quality Manager with the Community Epidemiology Services group. He acts as Deputy Director for Community Health Services and is a retired Captain in the US Public Health Service.

Connection to the Lens

At its core, the Equity and Empowerment Lens (E & E Lens) is a reflective quality improvement tool and set of processes designed to change the way we do business, leading to improved outcomes for all members of our community and the elimination of root causes of inequities. In order to approach quality improvement in our Lens application and integrate inclusion and empowerment, we refer to 'customers' in this work as 'participants' and 'community members.' This shifts our focus from primarily business transactions involving people as consumers in relation to their providers/educators/etc., to viewing change as a relational process that occurs through the following actions:

- Supporting respectful and empowering relationships between community members and their providers, or employee to employee; and
- Analyzing and amending power structures to decrease negative effects of hierarchy and further inclusion of communities most affected by inequities.

The E & E Lens provides a space for analysis on how well a policy, program, or practice:

- Meets the needs of the community it serves (internal and external to the organization) by incorporating culturally responsive and empowering strategies;
- Makes decisions and conducts planning processes that integrate staff and community voice (paying particular attention to communities most affected by inequities); and
- Institutionalizes empowering strategies and outcomes leading to greater equity.

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During the process of Lens application and analysis, we identify goals to accomplish and then further specify how to measure equity related improvements. Lastly, we plan, try, observe, and integrate the "Model for Improvement" adopted by the Health Department. The Lens, at its core, functions as a quality improvement tool because it assesses how well a program or policy addresses the root causes of inequities, identifies actions, and integrates results.

Background and Basics

Quality improvement has its roots in the business, manufacturing and economic fields, focusing on efficiency and customer-satisfaction. Industry quality improvement efforts have a long history in the United States and around the world with icons like W. Edwards Deming, Walter Shewhart, and J.M. Juran leading the movement.

According to Deming, to comprehend the workings of a system and thus be able to improve its efficacy, we must see the system as a dynamic entity unto itself. This recognition helps us understand the interdependencies and interrelationships among all components and increases the accuracy of our predictions about the impact of changes throughout the system. Deming offered practical approaches to improving quality and productivity that shifted the focus of managers from trying to change people to instead examining and changing processes and systems. The goal of the resulting redesign was improved output and reduced cost.

The integration of quality improvement in public health has been occurring in one form or another for decades. Early efforts focused on building organizational capacity (such as staff training, leadership development, strategic planning) but in the early 1990's the focus shifted to performance measurement. Currently, organizations utilize quality improvement in a variety of ways. The "balanced scorecard" has become a tool for programs to measure their success and performance in multiple areas such as customer satisfaction, financial indicators, business processes, learning and growth. Other processes such as Value Stream Mapping and Cause and Effect diagramming have become common strategies to examine organizational practice. Future quality improvement efforts look to integrate such tools and processes to act in a more proactive and thorough manner across departmental levels (Leonard, 2010).

According to researchers in the field, quality improvement is the "Continuous and ongoing effort to achieve measurable improvements in efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community" (Riley, Moran, Corso, Beitsch, Bialek, Cofsky, 2010, p. 6). Tying the Lens application process to quality improvement efforts has proven very successful during educational sessions on the Lens. Quality improvement presents the need for a clear focus on implementing recommendations that eliminate inequities and lead

to more successful population outcomes (health, education, transportation, etc.) and greater community satisfaction.

To make the work of quality improvement accessible and focused on basic, key components that lead to organizational learning and transformation, we must begin by repeatedly asking ourselves and colleagues key questions outlined by the Community Health Services Program Performance and Quality Improvement Workbook (2011): What are we trying to do? How well are we doing it? Could we do it better? Are we making people/communities better by doing what we are doing?

Recommendations for Lens Implementation and Application from a Quality Improvement Perspective

The Lens is only as useful and beneficial as the quality of the processes used to implement it and then institutionalize resulting recommendations/actions.

- **Be clear about roles.** The effectiveness of a Lens application depends upon the capacity of the people using it. Encourage your team (management and staff) to:
  1. apply the Lens to their own work,
  2. make resulting improvements to the work, and
  3. improve professional development according to the principles of the Lens.

- **Apply quality improvement processes to your own work and leadership strategies**. Leaders can best support system-wide change by using the tools themselves, and by creating the conditions necessary to implement equity-based recommendations and deepening professional development.

- **Share information and complete assessment in groups**. Quality improvement researchers recommend cross-organizational and cross-occupational communities of practice that share knowledge about the quality agenda (Bartunek, 2011). This calls for leaders to have a strong message about the importance of the Lens application and integration, and offer opportunities for staff to share, work through, evaluate, and disseminate information and outcomes.

Individual Reflection Questions

- What do you and other staff need in order to create a conducive environment to apply, implement and integrate the Lens?

- Where do opportunities to improve the quality of your work to identify and the root causes of inequities experienced by our communities?

- If you/your organization didn't address these inequities, how will this impact your program/policy/processes?

SUSTAINABILITY, CLIMATE HEALTH, AND EQUITY

"The history of this country is one of struggles to achieve equity, justice and opportunity. Each generation has faced this political challenge. In this moment we are confronted with the real possibility of climate change stealing the American ideal of opportunity from not just the low-income American, not just Indigenous Peoples, not just the person-of-color in America, but all Americans (WEACT)."

Lead Author: Kari Lyons-Eubanks is a Policy Analyst for Multnomah County Environmental Health Services and focuses on ensuring that climate-related policies consider health equity and the health impacts of environmental justice programs. Tim Lynch has a BA in Political Science and serves as the Energy & Climate Coordinator of the Multnomah County Office of Sustainability. Tim draws on over ten years of sustainability and public policy experience to advance innovative climate change and energy initiatives in the community.

Connection to the Lens

The Equity & Empowerment Lens (E & E Lens) utilizes the framework of people, place, power, and process to envision and implement cross-sector solutions that will build and sustain the resources and conditions necessary for existing and future populations to thrive. Research shows that communities of color, immigrants, refugees, and people living on low-income bear the brunt of current and future climate-affected events and situations. To achieve equity in our sustainability and climate change work, we must increase the sense of control communities of color and low-income populations have within their social, economic, and political settings. Simultaneously, we must transform our institutions to create the space for meaningful community engagement in decision-making and resource allocation processes (See Concept Paper on *Empowerment Theory and Practice*). An E & E Lens application is the first step in a larger commitment to institutional transformation. In order to eliminate root causes of social injustices, organizations must identify and eliminate oppression and discrimination as they appear in policies, programs, practices, and structures.

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Background and Basics

The mission of Multnomah County's Office of Sustainability is that all residents of Multnomah County have the right to a sustainable and healthy environment. Sustainable development meets the needs of the present without compromising the ability of future generations to sustain their own needs. Global trends in the environment also impact our local community. For example, according to many local climate projections our summers are likely to have hotter average temperatures and an increased number of extreme heat events than in years past. Several consecutive days of temperatures of 90 degrees Fahrenheit or higher and elevated nighttime lows in the 60s and 70s pose a risk to populations without access to air conditioning, well-insulated homes or cooling centers. Combined with the urban heat island effect – urban areas that retain heat due to a higher quantity of buildings and paved surfaces and less vegetation – that already impacts certain communities, Multnomah County's population as a whole will be at increased risk of heat related illness and mortality as the global climate changes. Communities with the fewest resources to prepare will disproportionately feel the burden of these shifts. Climate health is one of the most significant sustainability challenges and transformative issues of the 21st century (Costello, A. et al., 2009). As we see manifestations of climate change, ranging from temperature and precipitation to air quality, and increases in frequency and duration of natural hazards – we see the serious and far-reaching implications for present and future generations.

Policies and projects that have sustainability and climate change at the core of their purpose strive to (Multnomah County Office of Sustainability):

- Create a future where communities, commerce and nature thrive together in harmony.
- Use resources efficiently by recognizing the interconnections among community well being, land use, building, transportation, affordable housing, food systems, the natural environment, and public health and by adopting a holistic long term view of our investments which includes social and environmental costs.
- Ensure that ecosystem impacts and the costs of protecting the environment do not unfairly burden any one geographic or socioeconomic sector.
- Ensure healthy communities by celebrating diversity and considering the impacts of the root causes of public health in policies and programs, such as providing safe neighborhoods, advocating for a living wage, and ensuring access to education for all.
- Consider the public health co-benefits of our efforts so that we improve the health of all people while creating a healthy environment, ecosystem and economy.

Sustainability is often tied to three distinct goals:

- To live in a way that is environmentally sustainable or viable over the long term;
- To live in a way that is economically sustainable, maintaining living standards over the long-term; and

- To live in a way that is socially sustainable, now and in the future (Dillard, J., Dujon, V. & King, M. C., 2009).

The works starts with us as people and with our social processes. The economy supports the social realm, both of which depend upon the constraints of environmental resources.

Sustainability efforts are now shifting away from an exclusive focus on environmental stewardship, and towards an understanding of the deep interconnections between people, place, power, and process in relation to environmental impacts. Our social structures, institutions, and processes are greatly influenced by economic conditions, drivers, and opportunities. When environmental conditions are positive, healthy and in balance, we sustain beneficial social and economic conditions for all people.

Why is climate change such a pressing issue requiring critical transformative change? To bring home the sense of urgency, consider the following major negative health impacts:

- **Asthma, respiratory allergies, and airway diseases** will increase as people are exposed to more allergens like pollen, air pollution, and dust.
- **Cancer** will likely increase as people are exposed to more and stronger ultraviolet radiation from the sun.
- **Cardiovascular disease and stroke** will increase due to heat stress, airborne particles, and changing ecology of infectious agents connected to cardiovascular disease.
- **Heat and weather-related morbidity and mortality** will increase as extreme weather, including extremely hot days, storms, and flooding becomes more common. Effects will include heatstroke, injuries, and epidemics following weather events (e.g., cholera after flooding).
- Malnutrition and exposure to toxins will cause **impaired human development**, especially in fetuses and children.
- **Mental illness and stress-related disorders** will result from property damage and social disruption related to climate change.
- **Waterborne, vector-borne, and zoonotic** disease will increase as warmer temperatures expand the areas hospitable to these organisms (WHO, 2009).

Communities of color, immigrants, and refugees are already experiencing disproportionately high rates of the negative health impacts listed here. Certain groups will bear the brunt of climate change-related ill health because of their present demographic, social, or geographic

situation and their experiences of intergenerational and historical inequities. Worldwide, people living with low-incomes and communities of color will disproportionately suffer from morbidity and mortality related to extreme heat waves, dirty air, water scarcity, and urban heat island effects. They will also be disproportionately affected by higher food and electricity costs and by potential job losses and economic shifts. Low-income communities and communities of color, who already live in the most polluted areas, are the first in line for the negative impacts of climate change. Humans are particularly vulnerable, and low-income women, women of color, and immigrants will be most impacted by severe weather events, heat waves, and increases in disease rates that will characterize the Earth's changing climate (NIH, 2010).

In order to integrate equity and a racial justice lens into the work of sustainability, we must consider a few key barriers and integrate recommendations into policy, practice, and programming:

Key Barriers:

- **Not using or underutilizing existing data on disparate impacts.** We must have policies that prioritize the use of data and build the capacity of staff to effectively integrate data into their practice.
- **Lack of meaningful engagement and fair treatment** of communities most affected by racial, ethnic, and overall inequities. Given the nature of unrealistic timelines, organizational pressure, and lack of capacity to engage communities in a culturally responsive manner those most affected by inequities often feel disconnected from the process and observe decisions being made without them at the table.
- **Lack of understanding about the human right to clean air, water, land, and fair treatment**; when we acknowledge this right, integrating and compiling data on disparate impacts and engaging populations negatively affected by climate change becomes a necessary part of the process.

National sustainability and climate change work has traditionally been led by and designed for the interests and needs of the mainstream – often middle-class, white America. As a result, communities of color and low-income communities have struggled to find a place in the movement, despite a strong desire and willingness to engage meaningfully. Roger Kim of the Asian Pacific Environmental Network, in an interview from Everybody's Movement said, "[Our members] have seen huge transformation, most of it negative and polluting and the degradation of their communities back home has been quite dramatic…The lack of power and voice is the same, whether it's here in Richmond [California] or in Laos or in southern China or Beijing. The root cause is powerlessness (Park, 2009). (See Concept Paper on *Empowerment Theory and Practice* and *Hierarchy and Root Causes*)".

Various polls support the need for meaningful engagement by all communities in climate and sustainability work. For example, specifically with regard to climate change: Sixty-one percent

of African American voters, 55 percent of Latino voters, and 57 percent of all voters of color considered global warming to be "extremely serious" or "very serious" compared to 39 percent of whites and 43 percent of all voters. In order to address the urgent need recognized by the majority of communities of color, we must transform this movement into one for all people. Creating a sustainable, healthy environment requires participation from every community.

What is the solution? Grounding the climate change movement in the principles of environmental justice and equity is vital. (See Appendix 3 for the Principles of Environmental Justice on page 112). Deepening our understanding of the intersection between race, class and power dynamics will improve collaboration efforts and help us understand who benefits from resource allocation and who does not; who has a voice at the table and who does not, and why. Integrating the scientific, data driven approach to climate change and sustainability through a social and racial justice lens will engender more balanced and meaningful participation and perspectives.

Recommendations for Lens Implementation and Application from a Sustainability Perspective

The Equity & Empowerment Lens (E & E Lens) serves as a guide for organizations to critically reflect upon their policies, procedures and practices to identify and prioritize actions that will enhance equity and racial justice within their institution. When applying specific Lens questions to your climate-related or sustainability project, engaging the communities most affected by climate change and environmental concerns is an important first step. We must also take action on their recommendations, and finance the institutionalization of culturally responsive ways of practice.

Key strategies might include:

- **Build community capacity**. Strengthening outreach and providing culturally responsive education that integrates the social determinants is essential. This may mean deeper efforts in addition to sending out a flyer in multiple languages. Consider instead a more systemic approach like providing financial resources for environmental work to culturally specific organizations with established community relationships.

- **Develop mechanisms for meaningful public engagement.** This means exploring the definition of meaningful engagement and engaging key stakeholders in project development and implementation. It goes beyond public comment to public participation and voice.
- **Protect and empower vulnerable individuals and communities from economic impacts.** Review the economic implications of your project on communities of color, immigrants, and refugees and analyze the distribution of resources to determine whether these groups benefit equally from your decisions.
- **Build development capacity** and better integrate environmental justice into existing funding streams. For example, encourage creative funding strategies and partnerships that bring financial resources to community-driven organizations working directly with community leaders and participants on environmental and racial justice.

Individual Reflection Questions

- Who benefits most from the project? Who is most impacted? Who bears the most negative environmental consequences as a result of the project policy, program, or process?

- How does your program engage communities most affected by the program in an empowering way?

- How does your project integrate the community into funding decisions and planning?

- What financial resources will you provide to build capacity in communities of color, immigrant or refugee communities?

- What public health benefits or adverse health impacts may occur as it relates to this project?

- What is the impact of your project on greenhouse gas production?

- How does your work integrate principles of environmental justice? See Appendix 3.

- If your policy, decision, project involves the use of land or space, how is any prior historical or spiritual connection to the area or land and the populations who hold such connections considered in decision-making, planning, or any siting?

POSITIVE MENTAL HEALTH AND EQUITY

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Connection to the Lens

The connection between health, economics, and social well being is well-documented and researched. Forward-thinking, equitable, and broad policy changes can help directly counter the trends that lead to social inequities. We must initiate policy, practice, and program changes to eliminate the root causes of the socio-economic inequities that decrease positive mental health. Applying Lens questions and suggested processes to policies, decisions, resource allocation issues, programs and practices will enable your organization to make the necessary adjustments to increase equity and racial justice. This Lens specifically includes positive mental health as a major concept paper due to the clear ability of inequity to block positive mental health, and the importance of positive mental health as a key resource in supporting both individual physical and overall social health outcomes.

Background and Basics

The development of post-World War II policies directed the field of mental health towards treatment in the medical model, and away from the cultivation of positive mental health (Seligman, 2002). As we begin to understand ourselves and our communities within a relational worldview (See Concept Paper on *Relational Worldview)*, knowledge of this historic shift creates an opportunity to redirect attention to the critical importance of positive mental health. Bringing positive mental health into the picture requires understanding three main concepts.

First, mental health must be distinguished from mental illness. Positive mental health and mental illness exist on correlating but psychometrically separate axes (Keys, 2002). Curing mental illness does not necessarily lead to positive mental health. We promote and protect positive mental health by making sure people

have the material resources they need, have a sense of control over their lives, and have the ability to participate in important decision-making in community governance. The World Health Organization (WHO) recommends formally separating policies for treatment of mental illness and policies for the promotion of positive mental health (WHO, 2004).

Second, mental health is a social indicator. Cultivating positive mental health requires both social and individual level interventions (WHO, 2009). Positive mental health serves as a resource and is linked to higher overall physical health, greater longevity, increased positive social choices such as lowered criminal activity, drug use, and alcohol use, and increased productivity and job performance. Positive mental health is also a multi-directional pathway, impacting educational attainment, civic engagement, and community participation (Keys, 2002; WHO, 2009). Although the pathways are complex and multi-layered, the robust associations between positive mental health and physical health, positive health behavior choices, positive work life experiences, and positive social engagement are clear.

Finally, lack of equity is one of the key barriers to positive mental health (WHO, 2009). Positive mental health decreases, and the chances for development of mental illness increases, in a social system with high levels of inequality in social and economic resources. Status competition and insecurity is heightened across all income groups in conditions of inequality. As Layard (2005) notes about happiness, the more we are able to distribute income among populations the higher our collective levels of happiness will be. In contrast, inequality leads to lower health outcomes. Those who experience discrimination from belonging to a social group outside the dominant norm (for example discrimination against race, ethnicity, sexual orientation, age or disability) combined with distributional inequality (or poverty) also experience inequities in health, defined as systematic, unjust, and avoidable differences in health outcomes (Hofrichter, 2006).

The Commission on the Social Determinants of Health (2008) (See Concept Paper on *Social Determinants of Health and Inequity*) identifies the key factors which will reduce the impact of social stratification on health: 1) alleviating poverty, 2) empowering individual agency (or control over one's life), and 3) empowering political voice, or participation in decision-making. In addition, the World Health Organization (2009) emphasizes that addressing the gap between the rich and the poor is critical to each of these factors. Cultivating positive mental health requires that we utilize poverty alleviation strategies, incorporate empowering practices to promote health, and and create the space for authentic voice and participation in policy and decision-making. The WHO also identifies positive mental health as the primary resource for generating the solutions to address social and environmental concerns. Nurturing positive mental health in our communities is fundamental to accessing the creativity, ingenuity, and contribution of all people. Positive mental health is tightly linked to and should be as strongly considered as physical health.

The deep inequities in this realm are evident in the increased levels of mental illness and stress-related diseases experienced by communities of color. Several key federal reports, including one from the United States Surgeon General (2001), have emphasized the connection between race, culture, ethnicity and mental health inequities. The Coalition of Communities of Color (2010) report echoes the work at the federal level and more specifically highlights the need to integrate the mental health of young people of color into the work of the County and beyond. The report states that mental health stressors that can lead to mental health distress in the form of attempted suicide include "various forms of self-recrimination, self-hatred and fear and worry about the future" (p.11). While data on the mental health inequities at the local level for young people of color is not extensive, the report makes the connection between future diminished economic opportunities and decreased positive mental health for youth of color in this County, and urges all practitioners to pay strict attention to improving positive future opportunities for youth of color.

The Coalition of Communities of Color (2010) released a second report specific to the Native American/American Indian population and states that:

> We are becoming aware that the physical toll of living with racism and its daily indignities harms several essential bodily functions such as blood pressure, maternal health, hormonal balance (with high rates of the stress hormone, cortisol, understood to be pronounced among communities of color), and mental health. Nowhere is the toll of racism higher than the experience of Native American youth [in the United States] who are likely to commit suicide at levels that are 70 percent higher than among the general population (p. 73). The connection between the effects of institutional racism in the form of unfair and unjust policies and decisions affecting communities of color, immigrants, and refugees can further exacerbate social inequities experienced by these populations. According to the United States Surgeon General "racial and ethnic minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health"(2001, p.3).

Positive mental health is a resource and a pathway to obtain what one needs to thrive, meaningfully participate, and engage. Not only do physical health and positive mental health affect personal well being, but also discrimination and health inequity are tied to other social experiences that reduce the overall productivity in a community, including:

- Higher unemployment rates;
- High dropout rates;
- Greater experiences of chronic illness; and
- Experiences of racism (and other '-isms') at the individual, organizational, and community levels.

Positive mental health also links to social sustainability. If an individual and community are flourishing, and protective factors are promoting the realization of potential, then we improve

social processes and community livability. Likewise, if we enhance social sustainability, economic and environmental conditions also strengthen. The presence of positive mental health in an organization or community is a key indicator of the ability to achieve success.

Finally, positive mental health contributes to increased productivity, work satisfaction, and economic empowerment. The cost of low productivity, lawsuits around discrimination and disrespectful behavior, and overall drains of low team morale could be mitigated by more empowering behaviors and practices leading to positive mental health (See Concept Paper on *Empowerment Theory and Practice*). Empowering strategies within a community itself can build the necessary bonds to improve social cohesion, a key social determinant of positive population outcomes.

Recommendations for Lens Implementation and Application from a Positive Mental Health Perspective

Remember that positive mental health is supported by three factors:

- alleviating poverty;
- empowering individual agency (or control over one's life); and
- empowering political voice, or participation in decision-making.

Create inclusive employee decision-making processes in the workplace to focus on empowering individual agency. This brings a fuller range of skills and perspectives to problem-solving while supporting positive mental health and productivity.

Create, foster, promote, and evaluate inclusive and respectful employee-to-employee and supervisor-to-employee relations. Such positive connections are critical to success in the day-to-day within a workplace, and further positive mental health (See Concept Paper on *Hierachy and Root Causes)*.

Utilize empowering strategies. When working with community members and clients, think about how your programming or services factor in their positive mental health needs via empowering strategies such as client-led positive mental health discussions and diagnoses, and an overall integration of the cultivation of positive mental health strategies in interactions (See Concept Paper on *Empowerment Theory and Practice)*.

Incorporate community-based models of positive mental health when working with communities of color, internal and external to your organization (such as the holistic, balanced approach set forth in the *Relational Worldview* Concept Paper) in data-gathering, discussions, treatments, and/or policy changes.

Elevate the issue of positive mental health within your organization and in client and community relations, as a major resource and a pathway towards equity and empowerment.

Individual Reflection Questions

- Where do you see positive mental health occurring in your organization? What factors contribute to these examples of positive mental health?

- How can you celebrate what is working in your organization? How can you learn from and share these moments?

- How can you promote interactions leading to positive mental health with coworkers, community members, and clients?

- How can you further integrate culturally responsive actions, behaviors, and training in your work to promote positive mental health with communities of color, immigrants, and refugees?