

Massachusetts Public Health Association

Health Equity Policy Framework

Approved by MPHA Board of Directors November 16, 2016



PURPOSE & BACKGROUND

This Health Equity Policy Framework is designed to provide a guide to the MPHA board, Policy Council, staff, and partners to operationalize our mission and vision to achieve health equity in Massachusetts.

This framework addresses five key areas:

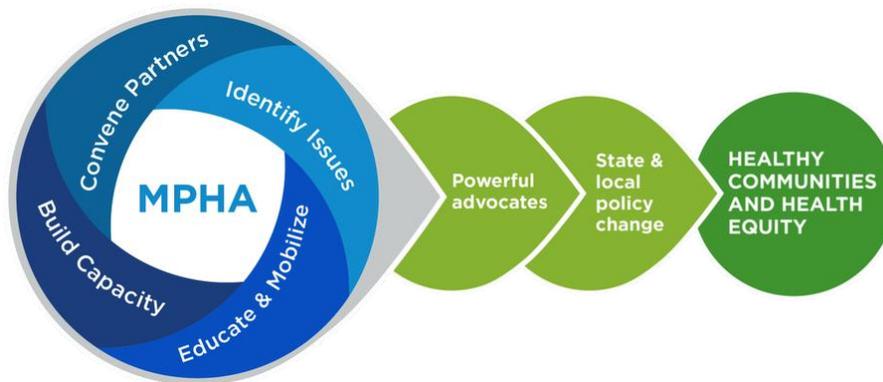
- Section 1: Definitions of Commonly-Used Terms
- Section 2: Framing
- Section 3: Policy Development
- Section 4: Community Partnerships
- Section 5: Organizational Leadership & Culture

Putting Our Mission Into Action

The goals of promoting health equity and racial justice are strong components of MPHA’s work and identity. Our mission statement is:

The Massachusetts Public Health Association is the champion for public health in the Commonwealth. We are the catalyst for change, eliminating health inequities and creating healthy communities for all.

This visual depicts our advocacy model, which is focused on state and local policy change:



To guide the development of a policy agenda, we have developed three overarching goals for our biennial agenda. These are:

- Combatting Institutional Racism
- Reducing Poverty
- Integrating Health into all Policies

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In mid-2016, a board “Committee on Race and Health” formed to advance the goal of addressing the impact of racism on our work.

The Health Equity Policy Framework is designed to support MPHA staff, board, and Policy Council members to operationalize these goals and enable us to act in more powerful ways to promote health equity and racial justice.

Racism, Poverty, and Health

We know that poverty – which affects all racial groups –and health are closely linked, and any strategy to promote health equity must focus on reducing poverty for everyone that experiences it. There are important strategies related to tax policy, housing, employment and labor law, and education policy which MPHA and our allies must tackle.

Our focus on health equity – including our focus on reducing poverty – cannot be race neutral. We recognize the ways in which racism shapes poverty: according to 2014 data from the Census Bureau, black and Hispanic individuals are more than twice as likely to be poor than white (non-Hispanic) individuals.¹ Pervasive racial inequities are embedded in many of the systems that influence income and wealth, including hiring practices, educational tracking, home mortgage lending.² Further, we recognize that racism impacts health independent of class, with people of color facing more discrimination and being less healthy than their white counterparts of the same income level or class.³ When we hold income constant, there are still large inequities based on race across multiple indicators for success, including education, jobs, incarceration, and housing.⁴

Facing History

As MPHA pursues policy changes to promote health equity, we must confront a long history of racial discrimination that has been embedded in our public policy. The Government Alliance on Race and Equity has highlighted some key moments in our nation’s history that must inform our current work:⁵

From the beginning of the formation of the United States, government played an instrumental role in creating and maintaining racial inequities. Through decisions about who could gain citizenship, who could vote, who could own property, who was property, and who could live where, governments at all levels have influenced distribution of advantage and disadvantage in American society. Early on in US history, rights were defined by whiteness. As an example, the first immigration law of the newly formed United States, the Naturalization Act of 1790, specified that only “whites” could become naturalized citizens.

¹ Institute for Research on Poverty. [Who is Poor?](#)

² The Aspen Institute Roundtable on Community Change: [Structural Racism and Community Building.](#)

³ Ibid.

⁴ Government Alliance on Race and Equity: [Advancing Racial Equity and Transforming Government: A Resource Guide to Put Ideas into Action](#)

⁵ Adapted from Government Alliance on Race and Equity: [Advancing Racial Equity and Transforming Government: A Resource Guide to Put Ideas into Action](#)

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Even legislation that on its surface appeared to be race neutral, providing benefits to all Americans, has often had racially disproportionate impact, as evidenced by the examples below.

- *The **National Housing Act of 1934** sought to support homeownership, but its implementation resulted in entrenched segregation and benefits largely only accrued to white families.*
- *The **National Labor Relations Act of 1935**, excluded agricultural and domestic employees, which excluded large numbers of African Americans who served in these occupations from labor protections.*
- *The **GI Bill of 1944** is credited for helping to build the middle class. But there were significant disparities in its impact. For instance, tuition benefits were theoretically offered to African American veterans, but largely could not be used where they were excluded from white colleges. Banks and mortgage agencies refused loans to African Americans, and when African Americans refused employment at wages below subsistence level, the Veterans Administration was notified and unemployment benefits were terminated. Of the 3,229 GI Bill guaranteed loans made in 1947 in Mississippi, only 2 loans were offered to African American veterans.*

In response to the many acts of government that created racial disparities and exclusion, both explicitly and in effect, the Civil Rights movement of the 1960s put pressure on government to address inequity. Following the victories achieved during the Civil Rights movement, many overtly discriminatory policies became illegal, but racial inequity nevertheless became embedded in policy that did not name race explicitly, yet still perpetuated racial inequalities.

Uses of this Framework

This Health Equity Policy Framework is designed to help MPHA be more intentional in addressing all forms of health inequities. The framework places special emphasis on racial inequities because we believe that racial inequities in health need focused and explicit attention.

We share the belief of the Government Alliance for Race and Equity that:

For us to advance racial equity, it is vital that we are able to talk about race. We have to both normalize conversations about race, and operationalize strategies for advancing racial equity. In addition, we must also address income and wealth inequality, and recognize the biases that exist based on gender, sexual orientation, ability and age, to name but a few. Focusing on race provides an opportunity to also address other ways in which groups of people are marginalized, providing the opportunity to introduce a framework, tools, and resources that can also be applied to other areas of marginalization. This is important, because to have maximum impact,

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focus and specificity are necessary. Strategies to achieve racial equity differ from those to achieve equity in other areas. “One-size-fits all” strategies are rarely successful.⁶

We also recognize that implicit bias impacts all of us, despite our best intentions, and that we must develop clear goals, strategies, and tools to operationalize our shared values if we are to avoid putting implicit bias into practice in our work in a way that reinforces racism and other forms of discrimination.

The Health Equity Policy Framework will guide MPHA’s work – both externally and internally – to combat the impacts of racism and other inequities on public health.

As we work to carry out our mission, we will use this Health Equity Framework to guide our actions. For instance, the Framework will be used to:

- Guide the development of new community partnerships
- Inform how we develop policy priorities
- Provide guidance on developing internal organizational practices, including hiring practices
- Guide our external communications
- Support MPHA to lead by example and to provide assistance to partner organizations working to embed health equity in their organizational practices

NOTE: The Framework draws heavily on existing tools and resources from national experts, including the Government Alliance on Race and Equity (GARE), the Anne E. Casey Foundation, and PolicyLink, among others. Where useful tools already exist, we seek to use or adapt those rather than creating new tools.

⁶ Ibid.

SECTION 1: DEFINITIONS OF COMMONLY-USED TERMS

In order to work toward our shared values, we must use common language in description of those values and in the strategies we use to advance them. Too often, conversations about equity and racism are unproductive because different people use the same terms to mean different things or use terms to mean a variety of things.

In order to work from a common understanding, MPHA adopts the following definitions of key terms:

Cultural Humility: A lifelong process of self-reflection, self-critique and commitment to understanding and respecting different points of view, and engaging with others humbly, authentically and from a place of learning.⁷

Health Disparities: Differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.⁸

Health Equity: The opportunity for everyone to attain his or her full health potential. No one is disadvantaged from achieving this potential because of his or her social position (e.g. class, socioeconomic status) or socially-assigned circumstance (e.g. race, gender, ethnicity, religion, sexual orientation, geography).⁹

Implicit Bias (or Hidden Bias): Implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness. Rather, implicit biases are not accessible through introspection.¹⁰

Inclusion: The action or state of including or of being included within a group or structure. More than simply diversity and numerical representation, inclusion involves authentic and empowered participation and a true sense of belonging.¹¹

Intersectionality: The premise that people possess multiple, layered identities, including race, gender, class, sexual orientation, ethnicity, and ability, among others. Intersectionality refers to the ways in which these identities intersect to affect individuals' realities and lived experiences, thereby shaping their perspectives, worldview, and relationships with others. Exposing these multiple identities can help clarify the ways in which a person can simultaneously experience privilege and oppression.¹²

⁷ Gallardo, M. E. (2013). [Developing cultural humility: embracing race, privilege and power](#).

⁸ National Institutes of Health. [Health Disparities](#).

⁹ Boston Public Health Commission: Speaking of Equity: Strengthening Common Language.

¹⁰ Kirwan Institute for the Study of Race and Ethnicity: [State of The Science: Implicit Bias Review 2015](#). Also see Banaji et al, Blind spot: The hidden bias of good people.

¹¹ Anne E. Casey Foundation. [Race Equity and Inclusion Action Guide](#).

¹² <http://www.intergroupresources.com/intersectionality/>

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Oppression: The systemic and pervasive nature of social inequality woven throughout social institutions as well as embedded within individual consciousness. Oppression fuses institutional and systemic discrimination, personal bias, bigotry and social prejudice in a complex web of relationships and structures that saturate most aspects of life in our society.¹³

Racial Justice: The systematic fair treatment of people of all races that results in equitable opportunities and outcomes for everyone. All people are able to achieve their full potential in life, regardless of race, ethnicity or the community in which they live. Racial justice — or racial equity — goes beyond “anti-racism.” It’s not just about what we are against, but also what we are for. A “racial justice” framework can move us from a reactive posture to a more powerful, proactive and even preventative approach.¹⁴

Racism: A form of oppression based on the socially-constructed concept of race that is used to the advantage of the dominant racial group (Whites) and the disadvantage of non-dominant racial groups.¹⁵

Internalized Racism: The private racial beliefs held by and within individuals. The way we absorb social messages about race and adopt them as personal beliefs, biases and prejudices are all within the realm of internalized racism. For people of color, **internalized oppression** can involve believing in negative messages about oneself or one’s racial group. For white people, **internalized privilege** can involve feeling a sense of superiority and entitlement, or holding negative beliefs about people of color.

Interpersonal Racism: Our private beliefs about race become public when we interact with others. When we act upon our prejudices or unconscious bias — whether intentionally, visibly, verbally or not — we engage in interpersonal racism. Interpersonal racism also can be willful and overt, taking the form of bigotry, hate speech or racial violence.

Institutional Racism. *The building this room is in, the policies and practices that dictate how we live our lives.* Institutional racism includes policies, practices and procedures that work better for white people than for people of color, often unintentionally or inadvertently. Institutional racism occurs within institutions and organizations such as schools, businesses, and government agencies that adopt and maintain policies that routinely produce inequitable outcomes for people of color and advantages for white people. For example, a school system that concentrates people of color in the most overcrowded schools, the least-challenging classes, and taught by the least-qualified teachers, resulting in higher dropout rates and disciplinary rates compared with those of white students.¹⁶

Structural Racism. *The skyline of buildings around us, all of which interact to dictate our outcomes.* Structural racism encompasses a history and current reality of institutional racism across all institutions, combining to create a system that negatively impacts communities of color. Structural racism is racial bias among interlocking institutions and across society, causing cumulative and compounding effects that systematically advantage white people and disadvantage people of color. This structural level of racism refers to the history, culture, ideology, and interactions of institutions

¹³ Adams, M., Bell, L.A., and Griffin, P (1997) [Teaching for Diversity and Social Justice: A Sourcebook.](#)

¹⁴ Anne E. Casey Foundation. [Race Equity and Inclusion Action Guide - Embracing Equity: 7 Steps to Advance and Embed Race Equity and Inclusion Within Your Organization.](#)

¹⁵ Boston Public Health Commission: Speaking of Race: Strengthening Common Language.

¹⁶ Ibid.

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and policies that work together to perpetuate inequity. An example is the racial disproportionality in the criminal justice system. The predominance of depictions of people of color as criminals in mainstream media, combined with racially inequitable policies and practices in education, policing, housing and others combine to produce this end result. And while some institutions play a primary responsibility for inequitable outcomes, such as school districts and disproportionate high school graduation rates, the reality is that there are many other institutions that also impact high school graduation rates, such as health care, criminal justice, human services, and more.¹⁷

Social Determinants of Health: The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.¹⁸

White Privilege. A right, advantage, or immunity granted to or experienced by White persons beyond the common advantage of all others; unconsciously or consciously, by virtue of their skin color in a racist society.¹⁹ It exists regardless of other, intersecting forms of discrimination that may negatively impact a group of people based on gender, class, religion, sexual orientation, etc. White privilege has been described as an invisible weightless knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools, and blank checks.²⁰

¹⁷ Ibid.

¹⁸ World Health Organization. [Social Determinants of Health Key Concepts](#).

¹⁹ Boston Public Health Commission: Speaking of Race: Strengthening Common Language.

²⁰ Peggy McIntosh: [White Privilege: Unpacking the Invisible Knapsack](#).

SECTION 2: FRAMING

Communicating about racism and other inequities – both internally and externally – can be challenging, due to fear, lack of tools, and widely held frames about race, class, and fairness.

MPHA commits to becoming a thought leader on the impacts of racism and other health inequities on public health outcomes, as well as in action to combat these inequities. We commit to being truth tellers about the personal, family, community, state and national cost of institutional racism on health, public health and health care costs.

In order to overcome barriers to effectively communicating about racism and other forms of inequities, we will use these principles:

- **Be race-explicit.** We will use race-explicit language and data to communicate about racial equity problems and proposed solutions. When working to address other forms of inequities, we will be explicit about who the problem impacts and how.
- **Frame structural and historical nature of the issue.** We will use language and examples that highlight the structural and historical nature of the problem and avoid framing that individualizes the problem. It is important that we talk about the past and current policy and legal structures that perpetuate inequities, recognizing that without a structural frame, many people including policymakers, will revert to an individual frame²¹
- **Provide hope and solutions.** The structural barriers to achieving health equity often seem overwhelming or even inevitable. MPHA must communicate hope, provide examples of important progress, and focus on how our members and partners can join to win policy changes that solve real problems.

The Center for Social Inclusion has created a useful “Talking About Race Toolkit”²² based on five years of research and testing. The sidebar at the right summarizes their approach.

²¹ Roundtable on Population Health Improvement: [Framing the Dialogue on Race and Ethnicity to Advance Health Equity: Proceedings of a Workshop](#).

²² Center for Social Inclusion: [Talking About Race Toolkit: Affirm, Counter, Transform](#).

It's more than just talk—you need to ACT.

AFFIRM

1. Start with the heart. The health of our children, families, and loved ones depends on the environments in which we live.

2. Tell us how we got here in simple terms. For decades, low income communities of color have been the dumping grounds for environmental hazards.

COUNTER

3. Explain “shared fate” in racially-explicit terms. People of all races want to live in clean environments with decent housing, good jobs, and high-quality schools.

4. Take on race directly. Having access to neighborhoods that support success shouldn't be determined by your race.

TRANSFORM

5. Reframe winners and losers. Corporations that contaminate our environments need to be held accountable. For our collective good, we need to value the quality of all of our neighborhoods above the profits for a few.

6. End with heart and a solution. Join me in supporting legislation that will bring accountability to corporations. They need to pay their fair share so that all of us can have healthy environments in our communities.

Center for Social Inclusion: Talking About Race Toolkit, adapted by GARE.

SECTION 3: POLICY DEVELOPMENT

When considering adopting new policy priorities, MPHA should use a Racial Equity Assessment Tool to evaluate the potential positive and negative impacts on racial equity. Other equity goals can also be evaluated through this framework, but the impact on racial equity should always be explicitly addressed.

When using data, we recognize that aggregate statewide or national data typically masks the impacts of racial and other inequities. When available, data should always be broken down by race/ethnicity or other demographic variables to understand the nature of the inequity and to track progress.

Key questions for such an assessment include²³:

1. *What is the policy under consideration?*

What are the desired results and outcomes? How would the proposed policy change existing racial and other inequities? How does the proposed policy address historic or contemporary inequities?

2. *What are the racial and other equity impacts of this particular decision?*

Who is most impacted (neighborhoods, regions, racial/ethnic groups, income groups)?

3. *Who will benefit from or be burdened by the particular decision?*

Are there potential negative impacts or unintended consequences? Are there strategies to mitigate the unintended consequences?²⁴

4. *Have affected community members or leaders been engaged in the development or vetting of the proposal?*

What has your engagement process told you about the factors that produce or perpetuate racial inequity related to this proposal? What has your engagement process told you about how the proposed policy will be perceived by affected groups? (See Section 4 on Community Partnerships for more details about MPHA's goals and principles for community engagement.)

5. *Can the policy be successfully implemented and evaluated for impact?*

Is there adequate funding, required community engagement, enforcement mechanisms, data collection, and public reporting to track progress? (Data collection can include a combination of quantitative and qualitative data gathered from public agencies and other formal sources, as well as collected informally through relationships and knowledge of community members.)

²³ Modified from Government Alliance of Race and Equity: [Racial Equity Toolkit: An Opportunity to Operationalize Equity](#) and Voices for Racial Justice: [Racial Equity Impact Assessment](#).

²⁴ We recognize that data on the health equity impacts of many decisions may not be readily available and that additional research may be required. MPHA will use the best information available to inform our decisions. We may recommend a health impact assessment and/or equity analyses be conducted on issues for which the impact is unclear.

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SECTION 5: POLICY DEVELOPMENT

We recognize that sometimes unanticipated internal or external demands require quick consideration and action. We subscribe to the assertion by GARE that “While it is often tempting to say that there is insufficient time to do a full and complete application of a racial equity tool, it is important to acknowledge that even with a short time frame, asking a few questions relating to racial equity can have a meaningful impact.” In such cases, we will use an abbreviated tool suggested by GARE for “quick turnaround” decisions, answering three questions:

- What are the racial equity impacts of this particular decision?
- Who will benefit from or be burdened by the particular decision?
- Are there strategies to mitigate the unintended consequences?²⁵

²⁵ Government Alliance of Race and Equity: [Racial Equity Toolkit: An Opportunity to Operationalize Equity](#).

SECTION 4: COMMUNITY PARTNERSHIPS

MPHA is proud of a more than ten year commitment to meaningful organizing and engagement with local community leaders and residents. We believe that this truly makes our reach statewide and sets us apart from many Boston-based advocacy organizations – and contributes to an influence on policy that is outsized to the budget and staff size of MPHA.

We recognize that at the root of health inequities is an imbalance of power in who has the ability to shape the decisions that impact health. To counter this historic and contemporary imbalance, we seek to support organized people with the ability to shape decisions for their own communities. Our long term goal is to develop more power within and together with low income communities and communities of color, so that policies at the state and local level support health equity and address the racial and class discrimination embedded in many of our public policies.

To accomplish these goals, we build relationships with local partners to identify problems, develop solutions, lead policy campaigns, and implement successful measures. Local partners are community-based organizations, community leaders, or community residents working locally or regionally to advance health equity.

MPHA re-commits to principles that have guided the development of mutually-beneficial and long-standing relationships with local partners, while seeking to go further in explicitly addressing health equity in the development of relationships and operations of policy campaigns. We will embrace the following principles, some historic and others newly-developed²⁶:

Mutuality

- Relationships between MPHA and local partners must be based in mutual benefit and mutual self-interest.
- We are committed to sustaining long-term relationships with local partners, not simply “one-off” actions.
- We value community knowledge and expertise as equally valuable as academic research and data. We seek to “ground truth” data and research in the experience of local partners.
- With insights from our partners and allies, blended with our observations and analysis, we seek to align MPHA’s health equity priorities with those of community-led organizations where they exist.
- We will work to understand the specific equity dimensions of a given issue and ensure that the equity dimension is clearly understood between MPHA and local partners. When collecting

²⁶ Principles borrowed and adapted from “MPHA’s Field Program: Organizing for Policy Change & Health Equity;” PolicyLink: [Getting Equity Advocacy Results \(GEAR\) Toolkit](#); Annie E. Casey Foundation. [Race Equity and Inclusion Action Guide - Embracing Equity: 7 Steps to Advance and Embed Race Equity and Inclusion Within Your Organization](#); Government Alliance on Race and Equity: [Racial Equity Toolkit: An Opportunity to Operationalize Equity](#); and Voices for Racial Justice (MN): [Authentic Community Engagement: A Key To Racial Equity](#).

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anecdotal evidence or qualitative data, we will seek to understand the specific racial equity impacts of a problem or proposed solution.

- We commit to supporting effective implementation of policies to ensure that successful policy campaigns lead to tangible benefits in low income communities and communities of color, recognizing that too often benefits have bypassed these communities.

Building Collaborations

- We seek to bolster existing collaborations and build new collaborations with local partners in low income communities and communities of color. Partnerships should include local public health leaders, as well as other organizations that are focused on related social determinants of health, even if they do not frame their work as “public health.”
- In any given policy campaign, we will review data on the impact of the specific issue and ensure that we are engaged with local partners most impacted by the issue at hand.
- MPHA seeks to support and collaborate with leaders of color and leaders in low income communities with the goal of building strong relationships with those organizations.
- In communities of color and low-income neighborhoods where local organizations’ leadership is not representative of the community it is serving, MPHA will collaborate with them while also seeking to build agreement on our values for leadership that represents the community being served.
- Throughout the policy development and campaign process, we will ask ourselves which impacted people or communities are not included and seek to engage new partners in our campaigns.

Organizing & Advocacy

- We believe that issues must be “deeply felt” by local partners in order to generate grassroots and grassroots engagement in the work of advocacy and organizing.
- We have a grassroots rather than grassroots focus, recognizing the existing organizations within communities have members or constituencies of grassroots residents. We seek to engage these grassroots constituencies through existing organizations and local leadership.
- We will acknowledge common reasons why people of color and low income people are under-represented in policy campaigns and leadership of community organizations, including historic and contemporary discrimination, language and cultural barriers, lack of resources including time, lack of exposure and knowledge about public policy, and past experiences of trust being breached. We will seek to invest the appropriate time and personalized attention to overcome these barriers, and strive to not reinforce common barriers.²⁷

²⁷ Adapted from Pioneer Valley Planning Commission: [Fair Housing Equity Assessment](#).

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Power & Decision Making

- We will strive for clarity and transparency about decision-making power in our relationships with local partners. We will be clear when we are seeking input but ultimate decision-making power rests with MPHA and when decision-making power is formally shared.
- We will create opportunities for formal shared decision-making power.
- We will seek to provide ongoing opportunities for local partners in the process of identifying problems, designing solutions, developing strategy, and implementing policy victories.
- We will seek to avoid making last minute calls for help because we suddenly need “real people” to testify, speak to press, etc. outside of an existing relationship with a local partner.

SECTION 5: ORGANIZATIONAL LEADERSHIP & CULTURE

MPHA recognizes that we must intentionally combat racism and other forms of discrimination within our organization as well as in our external advocacy and organizing work. To this end, we adopt the following principles:

Organizational Learning and Culture

- We recognize that combatting health inequities – including addressing organizational barriers and building organizational capacity – is a difficult and long term effort that requires ongoing commitment and resources. This will require recognizing the historical legacy of structural racism and white privilege and increasing our understanding of how these inequities impact our field, our work, and our organization today.
- We seek to create a culture of learning for the organization and all MPHA leaders and staff. This includes learning from other organizations that have been engaged in similar health equity work locally as well as taking advantage of national best practices.
- We seek to actively build an organizational culture that encourages and rewards experimentation and innovation as we work to develop stronger practices to combat health inequities and racial discrimination.
- We will periodically conduct an organizational self-assessment, such as the Race Matters Organizational Self-Assessment created by the Annie E. Casey Foundation²⁸, in order to identify strengths, areas for growth, and to track progress.

Organizational Leadership and Staffing

- We will make racial diversity of the MPHA board and staff an explicit goal.
- All board members and staff should attend a multi-day anti-racism training. Other leaders, including the MPHA Policy Council, are encouraged to also attend such training.
- We will develop tools and structures to support the recruitment and retention of a diverse board and staff, including:
 - Procedures for building diverse candidate pools for board and staff openings.
 - Screening and interview tools that limit the impact of implicit bias in reviewing applications.
 - Identification of barriers to recruiting and retaining diverse board and staff members.
 - Practices to support the success and leadership of board members and staff of color.

²⁸ Annie E. Casey Foundation: [Race Matters: Organizational Self-Assessment](#).

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SECTION 5: ORGANIZATIONAL LEADERSHIP & CULTURE

- Activities that facilitate discussion about the impact of racism on health will be included regularly in board and committee meetings, with the goals of advancing individual and collective learning and vocabulary.
- We will consider the equity impacts of relying on unpaid interns in limiting entry points into the field for those who are not able to volunteer their time, and we will consider opportunities to apply for funding that will allow us to invest in learning opportunities for young people of color and people from low/moderate income background seeking to enter the field.

Policy Council

- The MPHA Policy Council will be responsible for recommending organizational policy priorities and positions to the MPHA board for approval, considering requests for MPHA's support (or opposition) to other policies, and serving as a table for exploring emerging policy issues that impact health equity.
- The MPHA Policy Council is rooted in our belief that:
 - To select meaningful policy priorities, we need input from local, regional, and statewide leaders.
 - Communities of color and low income communities most impacted by health inequities must be represented in MPHA's decision-making by leaders of community-based organizations.
 - Engagement from community-based and statewide leaders in decision-making processes leads to greater engagement in the work of advocacy and organizing.
 - We must be explicit in our aims to address racism in MPHA's policy work and seek to actively counter the unintentional impacts of racism on our work.
 - We must work from a common language, set of goals, and framework to pursue health equity, combat institutional racism, and reduce poverty.
- We will identify and seek to provide the resources needed – including staffing, technology, technical assistance, financial, and other – to support active and meaningful engagement of current and future Policy Council members.