Massachusetts Public Health Alliance

Health Equity Policy Framework

Approved by MPHA Board of Directors August 26, 2022

MASSACHUSETTS PUBLIC HEALTH ALLIANCE

PURPOSE & BACKGROUND

This Health Equity Policy Framework[1] is designed to provide a guide to the Massachusetts Public Health Alliance (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

MPHA envisions a Massachusetts of healthy, equitable, just, and thriving communities where racism, poverty, and zip code do not determine our health or lifespan.

Our Mission
MPHA is a catalyst for community-driven policy change that fosters conditions for people to achieve their full health potential where they live, work, and play. We advocate and organize in partnership to dismantle structural racism and address the other root causes of health inequities.

Our Commitments

- Humility – listening to those most impacted by inequity and being led by their priorities
- Trustworthiness – acknowledging and overcoming the legacy of mistrust in public health by acting with integrity and being accountable to community partners
- Shifting power – partnering with communities historically excluded from policy-making processes to win structural/systemic change
- Transformation – dismantling structural racism to drive measurable results for health equity across all communities in MA

[1] The Framework draws heavily on existing tools and resources from national experts, including Human Impact Partners, the Government Alliance on Race and Equity, 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.

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

- Dismantling Structural Racism
- Eliminating Poverty
- Integrating Health Equity into All Policies

In mid-2016, a board "Committee on Race and Health" formed to advance the goal of addressing the impact of racism on MPHA's work. The Racial Equity in Health Committee continues this effort by leading the board and staff in discussions on racial justice as well as by serving as a resource to assist all board committees with racial justice framing.

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. The Framework was revised and updated in early 2022.

Leading with Racism Explicitly, but not Exclusively

MPHA seeks to eliminate all forms of structural inequities that impact health. We lead with dismantling structural racism in these efforts. Our analysis and strategy to address structural racism is used as a framework to tackle the intersecting forms of oppression and discrimination that impact health, including classism, sexism, ageism, homophobia, transphobia, ableism, and xenophobia, among others.

> *We lead explicitly — though not exclusively — with race because racial inequities persist in every system across the country, without exception. We can't find one example of a system where there are no racial disparities in outcomes: Health, Education, Criminal Justice, Employment, and so on. Baked into the creation and ongoing policies of our government, media, and other institutions — unless otherwise countered — racism operates at individual, institutional, and structural levels and is therefore present in every system we examine.*
>
> *We also lead with race because when you look within other dimensions of identity — income, gender, sexuality, education, ability, age, citizenship, and geography — there are inequities based on race. Knowing this helps us take a more intersectional approach, while always naming the role that race plays in people's experiences and outcomes.*
>
> *Last, we lead with race because inflaming racial tension has been a deliberate political strategy by those seeking to maintain their own power. Through subtle, "dog-whistle" coded references and, more recently again, overt racist statements, wealthy special and corporate interests have successfully divided low-income people of color from low-income whites, preventing those groups from joining forces to build power. This has been detrimental to the physical, mental, social, and economic health of people of all races, including whites and must be countered if we are to advance equity.*

> *Advancing health equity requires addressing all areas of marginalization and understanding the interconnected nature of oppression. However, there is benefit to starting with race as we can harness tools, frameworks, and resources to address these inequities.*[2]

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 reducing poverty cannot be race neutral. We recognize the ways in which racism shapes poverty: according to 2020 data from the Census Bureau, Black residents are more than 2.5 times likely, and Latine[3] residents are more than twice as likely, as white[4] (non-Hispanic) residents to be poor.[5] Pervasive racial inequities are embedded in many of the systems that influence income and wealth, including hiring practices, educational tracking, and home mortgage lending.[6] Further, we recognize that

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[2] Human Impact Partners, *Health Equity Guide*, (updated July 2019).

[3] The Framework uses the term Latine rather than Latinx, which cannot be pronounced or conjugated in Spanish, and rather than Hispanic, which is a linguistic category with strong connections to colonialism in Spain. Throughout the last half-century in the United States, different terms have arisen to represent residents who trace their roots to Spain or Latin America. The 1990s brought resistance to the term Hispanic, first introduced in the 1970s, due to the strong connection with colonialism and Spain, and a new term emerged— Latino—which was first used by the U.S. Census in 2000. While Hispanic and Latino are often used interchangeably, the terms have different meanings. Latino is an ethnic and cultural category referring to people from Latin America, including Central America, South America, and the Caribbean, whereas Hispanic is a linguistic category. In the early 2000s, Latinx emerged as non-gendered alternative to Hispanic and Latino. While this term was created with good intentions, Latinx is not designed for Spanish speakers since it is difficult to pronounce words that have replaced gendered vowels with an "x." As a result, Latine emerged as a gender-inclusive alternative. It is important to note that no broad umbrella term is adequate to represent a multi-continental diaspora. While MPHA will generally use the term Latine, we will enter spaces and relationships with humility and seek to use terminology that individuals and communities use to describe themselves. There's always nuance and debate about the most inclusive terminology, and MPHA's language will evolve as the world evolves around us. *See*, Why Latinx/e? *see, also,* Luis Noe-Bustamante, Lauren Mora, and Mark Hugo Lopez, *About One-in-Four U.S. Hispanics Have Heard of Latinx, but Just 3% Use It*, Pew Research Center (August 2020).

[4] The Framework follows the AP Style Guide in capitalizing Black and not capitalizing white. The AP describes its decision as follows: "There was clear desire and reason to capitalize Black. Most notably, people who are Black have strong historical and cultural commonalities, even if they are from different parts of the world and even if they now live in different parts of the world. That includes the shared experience of discrimination due solely to the color of one's skin. There is, at this time, less support for capitalizing white. White people generally do not share the same history and culture, or the experience of being discriminated against because of skin color." John Daniszewski, *Why We Will Lowercase White*, Associated Press Blog, July 2020.

[5] John Creamer, *Inequalities Persist Despite Decline in Poverty for All Major Race and Hispanic Origin Groups*, U.S. Census Bureau (September 2020).

[6] Keith Lawrence et al., *Structural Racism and Community Building*, The Aspen Institute Roundtable on Community Change (2004).

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.[7] When we hold income constant, there are still large inequities based on race across multiple indicators for success, including education, jobs, incarceration, and housing.[8]

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:

> *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.*
> *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.*

[7] Id.

[8] Julie Nelson, *Advancing Racial Equity and Transforming Government: A Resource Guide to Put Ideas into Action*, Government Alliance on Race and Equity (February 2015).

> *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.*[9]

Indeed, many seemingly "race neutral" policies enacted after the Civil Rights movement have perpetuated oppression and health inequity. These policies have been enacted and implemented by leaders in both major political parties. During the 1990s, the Clinton Administration enacted a wide range of policies that were rooted in stereotypes and have perpetuated racism and other discrimination including:

- the Violent Crime and Law Enforcement Act (known as the Crime Bill), which expanded policing and prisons contributing significantly to mass incarceration, sponsored by then-Senator Joe Biden
- the Defense of Marriage Act, which prohibited same-sex marriage
- the Illegal Immigration Reform and Immigrant Responsibility Act, which expanded deportations and restricted immigrants' due process rights[10]
- the Prison Litigation Reform Act, which severely curtailed incarcerated people's rights to bring lawsuits to remedy unhealthy and dangerous prison conditions[11]
- the Personal Responsibility and Work Opportunity Reconciliation Act, which dramatically reduced state aid to families living in poverty

The welfare reform debate and resulting legislation provides an illustrative example of a seemingly race neutral policy that was rooted in racist tropes and has perpetuated structural racism:

> *Federal policymakers created TANF in 1996 with the purported promise of helping families lift themselves out of poverty through work. But much of the debate around the 1996 law was centered (often implicitly, but sometimes explicitly) on Black mothers, who were portrayed as needing a "stick" to compel them to be more responsible and leave the program. TANF's harsh work requirements and arbitrary time limits disproportionally cut off Black and other families of color. Also, Black children are more likely than white children to live in states where benefits are the lowest and where the program reaches the fewest families in poverty. In the decade after policymakers remade the cash assistance system, it became much less effective at protecting children from deep poverty — that is, at lifting their incomes above half of the poverty line — and children's deep poverty rose, particularly among Black and Latinx children.*

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[9] Id.

[10] Donald Kerwin, *From IIRIRA to Trump: Connecting the Dots to the Current US Immigration Policy Crisis*, Journal on Migration and Human Security 6(3), 2018, pp. 192-204.

[11] Human Rights Watch, *No Equal Justice: The Prison Litigation Reform Act in the United States* (2009).

Since this Framework was originally adopted in 2016, we have witnessed powerful policies and social movements deeply rooted in racism and white supremacy. The 2016 election was the first presidential election after the 2013 Supreme Court decision *Shelby v. Holder*, which eliminated key provisions of the Voting Rights Act and ushered in a new era of attacks on voting rights that specifically make it harder for Black Americans to vote. The election turned on the ugly rhetoric of xenophobia, racism, and sexism, with an explicit focus on demonizing and scapegoating immigrants and ushered in a new era of racist policymaking, which exacerbated racial disparities and fueled racist violence. Political leaders, including President Donald Trump, used the COVID-19 pandemic to scapegoat Asian Americans, leading to an increase in discrimination and violence. At the state level, the murder of George Floyd by Minneapolis police in 2020, together with the murders of Ahmaud Arbery, Breonna Taylor, and many others, exposed a long and brutal history of sanctioned violence against Black people

In a country where economic inequality is so closely tied to racial inequality, and where people of color are systematically underinvested in and disenfranchised, a policy that is on its face neutral automatically harms communities of color. Numerous state and federal pandemic response policies which were race neutral on their face had predictable and devastating impacts which reinforced and exacerbated racial inequities. In Massachusetts, for instance, the state's early COVID vaccination strategy was rooted in "mass vax" sites. Most of these sites were long distances from communities where many residents of color live, were difficult to access without a car or high-speed internet and did nothing to address the earned mistrust many residents of color experience in relation to the public health and healthcare systems – all in the face of clear and significant racial inequities in the impact of COVID on communities of color. The constant attacks on democratic institutions and the near collapse of social safety net systems demonstrate the urgency of broad reforms that center equity.

Uses of this Framework

This Health Equity Policy Framework is designed to help MPHA be more intentional in addressing all forms of health inequities.

We recognize that white supremacy culture and implicit bias impact 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 reinforcing systems of oppression in our work.

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 Policy 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 practice

SECTION 1: DEFINITIONS OF COMMONLY-USED TERMS

In order to work toward our shared values, we must use common language to describe those values and 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:

Community power: Power at its best is the ability of communities most impacted by structural inequity to develop, sustain, and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision makers that change systems and advance health equity. Community power building is the set of strategies that these communities use to act. It is particularly critical for underserved, underrepresented, and historically marginalized communities who have been excluded from decision-making on the policies and practices that impact their health and the health of their communities.[12]

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.[13]

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.[14]

Health Equity: The opportunity for everyone to attain their 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).[15]

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.[16]

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[12] Manuel Pastor et al., *A Primer on Community Power, Place, and Structural Change*, USC Equity Research Institute (September 2020).

[13] Gallardo, Miguel E., *Developing Cultural Humility: Embracing Race, Privilege and Power* (2013).

[14] National Institutes of Health, *Health Disparities* (2002).

[15] Boston Public Health Commission, *Health of Boston 2016-17*.

[16] Cheryl Staats et al., *State of the Science: Implicit Bias Review 2015*, Kirwan Institute for the Study of Race and Ethnicity (2015),

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.[17]

Intersectionality: The premise that people possess multiple, layered identities, including race, gender, class, sexual orientation, ethnicity, and ability, among others. Intersectionality, a term originally coined by Kimberlé Crenshaw in 1989, 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. "Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects."[18, 19]

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.[20]

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.[21]

Racism: A form of oppression based on the socially-constructed concept of race that is used to the advantage of the dominant racial group (white people) and the disadvantage of non-dominant racial groups.[22]

> **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.
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> **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.
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> **Institutional Racism:** *The building this room is in, the policies and practices that dictate how we live*

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[17] Anne E. Casey Foundation, *Race Equity and Inclusion Action Guide* (January 2015).

[18] Columbia Law School, *Kimberle Crenshaw on Intersectionality, More than Two Decades Later* (June 2017).

[19] African American Policy Forum, *Intersectionality Primer*.

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

[21] 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.

[22] Boston Public Health Commission, *Health of Boston 2016-17*.

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.[23]

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 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. [24]

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.[25]

[23] Id.

[24] Id.

[25] World Health Organization, *Social Determinants of Health: Key Concepts* (May 2013).

Trauma:

Individual Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as overwhelming or life-changing and that has profound effects on the individual's psychological development or well-being, often involving a physiological, social, and/or spiritual impact.

Intergenerational (or Historical) Trauma: Cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences. Intergenerational trauma is connected to events and experiences disproportionately perpetrated against Native Americans, Black Americans, and other people of color, including genocide, slavery, massacres, prohibition/destruction of cultural practices, discrimination/systemic prejudice, and forced relocation, among others.[26]

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.[27] 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.[28]

White Supremacy Culture: The explicit to subtle ways that the norms, preferences, and fears of white European descended people overwhelmingly shape how we organize our work and institutions, see ourselves and others, interact with one another and with time, and make decisions. Tema Okun describes characteristics of white supremacy culture, including perfectionism, defensiveness, quantity over quality, worship of the written word, fear of open conflict, paternalism, and right to comfort, among others.[29]

[26] Linda Henderson-Smith, *Intergenerational Trauma and Its Impacts*, National Council for Mental Wellbeing (June 2021)

[27] Boston Public Health Commission, *Health of Boston 2016-17.*

[28] Peggy McIntosh, *White Privilege: Unpacking the Invisible Knapsack* (1988).

[29] Cuyahoga Arts & Culture, *White Dominant Culture & Something Different: A Worksheet* (2019).

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 disrupters and truth tellers about the personal, family, community, state, and national cost of institutional racism on health. We commit to using MPHA's institutional weight and political capital to disrupt institutional racism, structural racism, and white supremacy culture.

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

- **Be explicit about racism.** We will use explicit language and data to communicate about the impact of structural racism and proposed solutions, stressing that racism, not race, is the problem. 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 frame[30]

- **Support narrative change**. We will support narratives that tell stories about the impact of structural inequities on communities, including amplifying voices from communities most impacted by inequities to tell their own stories and identify their own solutions.

- **Provide hope and solutions – and an urgency for change.** 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. In doing so, we will communicate the urgency of making these changes, as structural inequities impact the daily lives of our communities. We support study and research, but we need action now.

[30] Roundtable on Population Health Improvement, *Framing the Dialogue on Race and Ethnicity to Advance Health Equity: Proceedings of a Workshop*, National Academies Press (October 2016).

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 include[31]:

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 this particular decision?***
   Are there potential negative impacts or unintended consequences? Are there strategies to mitigate the unintended consequences?[32] How does this proposal address or recognize the cumulative impacts of racial and other inequities over time and across intersecting issues?

4. ***How have affected community members or leaders been engaged in the development or vetting of the proposal?***
   What methods were used to engage affected community members? 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? What mechanisms are built in to ensure accountability to the stated goals of the proposal?***

[31] Adapted from Government Alliance of Race and Equity, *Racial Equity Toolkit: An Opportunity to Operationalize Equity* (October 2015); Voices for Racial Justice, *Racial Equity Impact Assessment Tool* (October 2015).

[32] 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.

Is there adequate funding, required community engagement, enforcement mechanisms, data collection, and public reporting to track progress? How will the public be able to tell if this policy was successful? (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.)

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 this particular decision? Are there strategies to mitigate the unintended consequences?
- Do affected community members support the policy? [33]

[33] Government Alliance of Race and Equity, *Racial Equity Toolkit: An Opportunity to Operationalize Equity* (October 2015).

SECTION 4: COMMUNITY PARTNERSHIPS

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. People most impacted by health inequities have historically been shut out of decision-making processes that impact their own lives and neighborhoods. So, while winning concrete policy changes is extremely important to MPHA, it is even more important for us to support a shift in who has the power to identify the problems and solutions and to drive that change. To counter this historic and contemporary imbalance of power, we seek to support grassroots organizations led by or accountable to people of color, low-income people, and others directly impacted by health inequities.

To accomplish these goals, we build relationships with local partners to identify problems, develop solutions, support or 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 developed[34]:

Mutuality

- Relationships between MPHA and local partners must be based in mutual benefit and mutual self-interest. MPHA's self-interest is advancing our mission and values.
- 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 grassroots organizations led by or accountable to residents most impacted by health inequities, 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

[34] Principles adapted from "MPHA's Field Program: Organizing for Policy Change & Heath 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.

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."
- Where strong grassroots leadership exists on policy campaigns related to MPHA priority issues, we will seek to provide support and mobilize our resources in solidarity rather than leading directly. This includes mobilizing support from our networks and other partners, when strategic.
- 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.
- At times, the leaders of local organizations rooted in communities of color and low-income neighborhoods are not representative of the community being served. MPHA will collaborate with these organizations when our mission and values are aligned, including having an explicit commitment to disrupting structural racism. When collaborating, we will seek to understand the ways in which community members inform, lead, or govern the priorities and strategies of our partner organizations. In our partnership, we will encourage and support them to develop stronger mechanisms of accountability to the people they serve. We will seek to do so with integrity and humility, recognizing MPHA's own imperfections and areas for future growth.
- 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 engagement from community residents and leaders in the work of advocacy and organizing.
- We work primarily with community leaders and organizations rather than engaging in grassroots organizing, 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.[35]

Power & Decision Making

- We will create opportunities for formal shared decision-making power.
- We will strive for clarity and transparency about decision-making power in our relationships with local partners. We will be transparent about when decision-making power is formally shared and when ultimate decision-making power rests with MPHA.
- 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. We will be intentional about building sustainable and mutually beneficial relationships with partners.
- We recognize that we will make mistakes. We will welcome feedback from partners and will practice humility when partners seek to hold MPHA accountable.

We recognize that partnerships and coalitions are complex and imperfect. Some embody our values strongly, while others are contradictory to our values. Like MPHA, many coalitions are striving to more effectively live out genuinely held values related to racial justice and health equity. In considering the degree to which coalitions and partnerships are aligned with MPHA's values, we will ask ourselves the following questions and use the answers to guide our relationships with each partnership. Note that the answers to these questions do not dictate any particular outcome or decision but will be used to help staff navigate complex relationships while adhering to MPHA's values and commitment to dismantling structural racism.

- Has the coalition/partnership explicitly named a commitment to health equity and racial justice?
- In what ways are organizations led by or accountable to people most impacted by health inequities playing a leadership role in the coalition/partnership? Do decision-making processes place value on the voices and priorities of those most impacted?
- Are decision-making processes transparent? Do decision-making processes hide ways in which power is hoarded by some?
- Where there is imperfect alignment, is MPHA able to play a meaningful role in shifting the practices of the coalition/partnership? Considerations include:
    - Is there a genuine desire among the coalition/partnership leaders to engage in work to more powerfully advance racial justice?
    - Will coalition/partnership leaders continue to engage in conversations about racial justice, even when they are difficult or fraught?

[35] Adapted from Pioneer Valley Planning Commission: Fair Housing Equity Assessment.

    - Does MPHA's continued participation harm or undermine other coalitions/partnerships?
- Do we have grassroots or other allies within the coalition/partnership? What is their perspective on MPHA's participation or role? What is the perspective of MPHA partners or allies outside the coalition/partnership?
- What does MPHA gain from participation that helps us advance our mission? Does the coalition/partnership have the power – or the potential power – to win victories that will advance the MPHA mission?
- What does MPHA gain or lose by stepping away from the coalition/partnership?

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 Foundation,[36] or the organizational self-assessment from Equity in the Center in order to identify strengths, areas for growth, and to track progress.[37]

Organizational Leadership and Staffing

- We will make racial diversity of the MPHA board and staff an explicit goal.
- All board members and staff should be committed to continued education on racial justice, including an openness and commitment to self-study as well as formal discussions and trainings. Other leaders, including the MPHA Policy Council, are encouraged to also participate in such discussion and training. MPHA new board member and staff orientation will include information about MPHA's commitment to racial justice and the Health Equity Policy Framework.
- We will continue to 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.

[36] Annie E. Casey Foundation: Race Matters: Organizational Self-Assessment.

[37] https://equityinthecenter.org/wp-content/uploads/2021/11/eic_aww-pub_wip_final-112021.pdf

    - Practices to support the success and leadership of board members and staff of color.
- 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 backgrounds 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 grassroots community organizations led by or accountable to people most impacted by health inequities.
    - 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.