

Promoting Equity through the Practice of Health Impact Assessment



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Preface

Health Impact Assessment (HIA) is an important tool for understanding the health implications of proposed policies, plans, or projects on communities. Equity is a core value of HIA¹ and many practitioners have used HIA to advance equity in decision-making processes. Yet, as the field becomes more commonly known, there is a risk that the focus on equity will diminish without explicit attention, care, and guidance regarding its role in HIA practice.

This report serves as a primer to demonstrate:

1) how HIA practitioners and equity advocates can ensure that the practice of HIA maintains a strong focus on promoting equity; and 2) how HIA can be used as a tool to support equitable decision-making processes and outcomes. It describes the centrality of equity in HIA implementation in order to advance just and fair outcomes, and presents a set of principles for guidance in HIA practice. The primer also provides specific strategies for implementing each principle, identifies key challenges to this work, as well as suggestions for overcoming the challenges. Examples, including two detailed case studies, are incorporated to ground the document in real-life experiences. Our goal is to support equity as a vital pillar in the practice of HIA.

The authors, the Adler School Institute on Social Exclusion, Human Impact Partners, PolicyLink, and the San Francisco Department of Public Health's Program on Health, Equity, and Sustainability,* came together with the recognition that the focus on equity needed to be strengthened within HIA practice. We worked with a diverse Advisory Committee of equity advocates and HIA practitioners to develop the structure and content of this primer.

In the coming months, we envision developing more detailed information and tools to support the implementation of the principles and strategies contained in this document. We view this primer as one of the first steps in supporting the promotion of equity in HIAs and we are dedicated to ensuring that equity remains core to the practice.

* The views expressed herein do not necessarily reflect the official policies of the City and County of San Francisco, nor does mention of the San Francisco Department of Public Health imply its endorsement.



The HIA process provides opportunities for communities, especially those that endure health inequities, to ensure that decision-making processes reflect their health concerns and aspirations.

Introduction

Low-income people, communities of color, and other vulnerable populations face significant inequities in opportunity.⁴⁻⁵ Compared to white, middle- and upper-income communities, they have less economic, educational, and housing opportunity, and they have less access to health care, healthy foods, transportation, and other essential goods and services. These inequities largely result from historic and contemporary discrimination that occurs at the personal, institutional, and structural levels.⁶⁻⁷ While federal and state laws now prohibit many overtly discriminatory policies and practices, entrenched disparity-producing structures, including racism and classism, remain firmly intact.⁸⁻⁹ The non-participation of vulnerable populations—often due to lack of opportunity—in political decision-

making processes perpetuates these differences in opportunity.

Inequities in opportunity have been shown to lead to inequities in health, along the lines of race, ethnicity, income and education levels, and other variables.¹⁰ For example, people of color and low-income people experience poorer health outcomes than white, higher-income people.¹¹ African Americans are more likely to be born prematurely, suffer from asthma and obesity in childhood, and develop diabetes and cardiovascular disease in adulthood. And, an African American is also more likely to die at a younger age than her or his white counterparts. It is increasingly clear that these inequities cannot be addressed by health-care access alone.¹²

DEFINITIONS

Equity

Equity is just inclusion in a society in which a broad range of resources and opportunities are provided for all to participate and flourish. The goals of equity are to create conditions that allow all to reach their full potential, eliminating inequities on the basis of race, income, ability, geography, age, gender, immigration status, and sexual orientation, among others.²

Equity is distinct from equality. Equality provides each person or community with the same amount and type of resources, whereas equity recognizes that each person or community does not start at the same place and may need different types and amounts of resources to achieve similar outcomes. Some communities need more resources to experience the same outcomes as communities that have historically had access to more resources and opportunities. Equity requires that all people and communities have the conditions they need to achieve their full potential.

Issues of equity differ among communities. Each community must carefully consider the relevant issues, and ensure that representatives and leadership of the populations most vulnerable to those issues are prominently engaged in decision-making processes so that their experiences and aspirations influence the outcomes.

Health Equity

"Equity in health implies that ideally everyone should have a fair opportunity to attain their full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition, the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating opportunities for health and with bringing health differentials down to the lowest levels possible."³

DEFINITIONS

Vulnerable Populations

Populations who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.¹³

Health Inequities

Health inequities may be defined as disparities in health outcomes that emanate from unjust and unfair differences in social, economic, environmental, and political conditions. Groups that endure adverse health outcomes typically do so because they face greater obstacles to opportunity as a result of some aspect of their identity (e.g., race; ethnicity; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically subject to discrimination or exclusion).

Equity Advocates

Individuals and organizations that support, write, or speak in favor of, or fight alongside, vulnerable populations in pursuit of their rights, values, aspirations, concerns, and needs.

HIA Practitioners

Individuals who implement Health Impact Assessments (see definition, page 9). This includes practitioners in government agencies, academic and research institutions, community-based organizations, and nonprofit and for-profit organizations.

Addressing health inequities requires a more fair and just distribution of the social, economic, environmental, and political opportunities that yield good health outcomes. This requires ensuring that vulnerable populations play active and leading roles in public decision making that impacts their lives. And, addressing health inequities requires targeting resources to those communities that have the poorest health outcomes. While many health practitioners and advocates seek to employ these strategies to achieve health equity, the tools they have at their disposal to do so are limited.

Health Impact Assessment (HIA) is an important tool for advancing health and equity. HIAs help inform decision makers and other stakeholders about the likely health impacts associated with a proposed public decision (e.g., proposed policy, program, plan or project), and they provide information that serves as the basis of recommendations for ensuring that the decision improves health outcomes, especially for the most vulnerable. See page 9 for more information about HIA.

The role of HIA in advancing health and equity goes well beyond collecting and analyzing data on existing health inequities and predicting health impacts associated with policy or program decisions. The HIA process itself is also an important

instrument for building power in communities; for engaging community members in decisions that stand to affect their health and well-being; for integrating community knowledge, insights, and leadership into public decision-making processes; for building consensus around decisions; and for creating lasting relationships and collaborations across disparate constituencies. Significantly, the HIA process also provides opportunities for communities, especially those that endure health inequities, to ensure that decision-making processes reflect their health concerns and aspirations.¹⁴

HIA has been used extensively in Europe and Australia and, in the last 12 years, is an emerging practice in the United States. As HIA continues to grow here, it is critical to ensure that equity remains a salient value of the practice—to ensure that HIA remains true to its intent as a tool for promoting equity in decision-making processes, and the equitable distribution of positive health outcomes. Without explicit attention paid to equity in HIA, it will likely not be an effective tool for promoting the health and well-being of vulnerable communities, for narrowing health inequities, or for supporting the overall health of communities.

WHAT IS A HEALTH IMPACT ASSESSMENT?

Health Impact Assessment is a process to systematically analyze a proposed policy, plan, project, or program before it has been adopted, to see what the future health implications of the proposal may be and how equitably impacts are distributed across populations and communities.

Communities have used HIAs to understand the implications of transportation, land use, housing, labor, energy, and many other proposals for the health of vulnerable populations such as low-income people and communities of color. Where the potential for disparate impacts have been found, recommendations have been proposed to promote better health outcomes for disadvantaged communities.

HIAs are more specifically defined as “a systematic process that uses an array of data sources and analytic methods, and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program or project on the health of a population and the distribution of those effects within the population. Health Impact Assessment provides recommendations on monitoring and managing those effects.”¹⁵

The following steps guide the HIA process:

- **Screening.** Determines the need and value of an HIA.
- **Scoping.** Determines the project partners; health and social impacts requiring assessment; methodology for the analysis; and a work plan.
- **Assessment.** Provides an analysis of existing conditions; an assessment of the policy, plan, project, or program under study; and an evaluation of the potential impacts of the policy, plan, project, or program on existing conditions.
- **Recommendations.** Develops a set of recommendations for maximizing health outcomes.
- **Reporting.** Develops a report and communicates findings and recommendations.
- **Monitoring.** Tracks the impact of the HIA on the proposed policy, plan, project, or program and the impacts of the final policy, plan, project, or program on existing conditions.

Maximizing democracy and civic participation are important objectives of the HIA process.¹⁶

For more information on implementing an HIA, visit: <http://www.hiaguide.org>.



Only 8 percent of African Americans live in a census tract with a supermarket, compared to 31 percent of whites.²⁰

The Magnitude of the Problem: Inequity by the Numbers

While the nation is experiencing economic challenges as a whole, low-income people and communities of color as well as other disadvantaged communities have been hit harder. Lack of opportunity due to discrimination based on race, ethnic identity, socioeconomic status, gender, age, and physical ability, among other factors, continues to undermine access to jobs, basic goods and services such as housing and education, and the accumulation of wealth in the most vulnerable of U.S. populations.

Access to Opportunity, Basic Goods, and Services

Explicit and implicit discrimination on the basis of race and ethnicity remains salient in the United States and is a key factor underlying the significantly higher rates of unemployment and underemployment among African Americans and Latinos as compared to whites, even among those who are college educated.¹⁷ There are also wide disparities in educational attainment among races and ethnicities. In recent years, rising tuition costs that outstrip the pace of growth of grants and other financial resources have limited access to post-secondary education for such communities. These trends, and others like them, have adversely impacted educational opportunity for Latinos and African Americans and have harmful implications for employment opportunity. For instance, while 45 percent of jobs in 2018 are projected to require an associate's degree or higher,¹⁸ only 27 percent of African American workers, 26 percent of U.S.-born Latinos and 14 percent of Latino immigrants have an associate's degree, compared to 43 percent of white workers.¹⁹

People of color also lack access to basic goods and services. For example, only 8 percent of African Americans live in a census tract with a supermarket, compared to 31 percent of whites.²⁰ They do not fare much better with regard to transportation. While only 7 percent of white households do not own a car, 24 percent of African American, 17 percent of Latino and 13 percent of Asian American households lack access to a car.²¹ Those without a vehicle are often dependent on public transit to get to destinations required to support good health outcomes, such as hospitals, social services, jobs, and education. In many communities, public transit is unavailable, unreliable, or unaffordable, further hampering access.

Similarly, low-income people face significant barriers. According to Census Bureau figures, nearly 50 million people—including about one in five kids and one in eleven seniors—live below the poverty line. The new Supplemental Poverty Measure of the Census Bureau shows nearly half the people in the country live within 200 percent of the poverty line.²² Low-income children are more than twice as likely to drop out of high school compared to middle-income students and five times more likely to drop out than high-income students.²³ Despite the narrative that the United States is the land of opportunity, moving out of poverty is exceedingly difficult; 42 percent of children born to parents in the bottom fifth of the income distribution remain poor as adults.²⁴

Gender inequities are also prevalent in the United States. Median income among women is 78 percent that of men (\$36,040 vs. \$46,478).²⁵ The inequity is particularly pronounced for women of color, single women, mothers, and women with less education.

Political underrepresentation of women in the U.S. Congress is also pronounced. While the recent 2012 elections saw a record number of women elected to Congress, women make up less than 19 percent of the new 113th Congress.²⁶

These statistics reveal only part of the story about the numbers of, and types of barriers, faced by these populations. Additionally, disproportionate incarceration rates, environmental justice issues, threat of deportation and isolation from democratic processes, among numerous other systematic issues, create significant impediments for vulnerable populations to fully participate in social and economic opportunities required to maximize health and well-being, and to achieve their full potential.

Health Inequities

Inequities in opportunity and access to goods and services cited in the section above often translate into inequities in health outcomes.²⁷ For example,

infant mortality is higher among African Americans, American Indians, and Native Alaskans as compared to whites. Latinos, Asians, and African Americans have higher rates of diabetes than their white counterparts.²⁸ And, overall, African Americans die at a much younger age than whites.²⁹ Health disparities by race and ethnicity are evident in many other areas, including lung disease, hypertension, hepatitis B, and HIV/AIDS. African Americans, Latinos, and, to a lesser extent, Asian/Pacific Islanders have poorer health outcomes in all of these areas compared to whites.³⁰

There are also large health inequities among income groups. As income increases, regardless of racial and ethnic group, health outcomes improve.³¹ Significantly, research shows that race and income are independent factors in determining health outcomes. For example, African American and Latino families experience worse health outcomes compared to white families within the same income group.^{32 33}

Growing Awareness and Urgency among Advocates and Practitioners

The field of public health is changing in recognition of the role that social and environmental factors play in determining health outcomes. The *Social Determinants of Health (SDOH)* are defined by the World Health Organization as “the conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries.”³⁴ Studies have shown that only about 10 percent of health outcomes may be attributed to access to health care, and 20 percent to genetic predispositions. The remaining 70 percent are due to social and environmental factors, as well as behavioral variables³⁵ which are often socially and environmentally determined.

As a result of the growing appreciation for the role that social and physical environments play in determining health outcomes, health practitioners are seeking tools that aid consideration of health in policy arenas that shape those environments, such as transportation, land use, criminal justice, education, housing, and agriculture, which are typically outside of the realm of public health.

Community groups, advocates, and residents are also increasingly aware of the role played by social conditions in causing and exacerbating poor health outcomes, especially in vulnerable populations. The childhood obesity epidemic, in particular, has captured the attention and concern of many communities. Advocates are urgently working to address underlying social conditions such as lack of access to healthy foods, economic opportunity, housing, and transportation, as well as limited access to places to safely walk, bike, play, and be physically active. They are also actively working to ensure that low-income people, communities of color and other vulnerable populations are represented in decision-making processes related to these issues, and urging political representatives and officials to consider health implications as they make their decisions. As community advocates and public health practitioners strive to address the social determinants of health, they need tools and other resources to support their engagement in the policy arenas that shape these social factors. Health Impact Assessment is one such tool to which many are turning as they also seek to come to terms with America’s growing racial diversity.



*In 30 years, people of color will constitute
a majority of the U.S. population.*

Equity:

A Moral, Economic, and Health Imperative

Equity has long been a matter of social justice and morality. Today, as the country witnesses the emergence of a new racial and ethnic majority, equity is now, additionally, a health and economic imperative.

The United States is undergoing a major demographic change which has and will continue to have large impacts on the economic and political realities of the country. In 30 years, people of color will constitute a majority of the U.S. population. If the race- and ethnicity-based inequities that exist today are not addressed, the shift in the demographics will result in a decline in average national health outcomes, placing the nation's economic future at risk.³⁶ Recent studies suggest that greater economic inclusion is associated with robust and sustained economic growth over time. Given the demographic transition of the nation, the wide racial and ethnic disparities in health, educational, employment, income, and wealth that put the economic potential of the country at risk must be addressed.^{37 38 39} Equity is thus the superior model to support economic growth and success in the United States.⁴⁰

Today, 46 percent of the nation's children are of color.⁴¹ Evidence of the economic risk posed by existing race- and ethnicity-based health inequities is provided by experts who cite that today's children could be the first generation in the United States to experience shorter life spans and poorer health outcomes than their parents.⁴² If these children continue to endure inequitable outcomes, the nation's economic potential stands to be compromised.⁴³

Research has also shown that economic inequalities lead to poor health outcomes, not just for the low income but for all members of society. A 2012 study found that countries with the greatest levels of income inequity are unhealthier than those with more equal income distributions. It also found that more inequitable societies experienced poorer outcomes in general health, mental illness, drug use, obesity, teenage pregnancies, and homicides than more equitable societies, who also experienced higher social mobility and trust.⁴⁴ Greater economic and income equity will improve overall physical and mental health and well-being.



HIA supports community leadership and participation in decision-making processes.

Health Impact Assessment: A Tool for Equity

Health Impact Assessment can be a powerful tool for promoting health and equity in the following ways.

HIA offers a unifying framework: A health equity framework provides an effective tool for community groups and equity advocates working toward common goals and participating in decision-making processes. Health, broadly defined as it is in HIA practice, is a unifying principle that unites diverse interests. Health is a topic that every individual, family, and community cares about, and is an issue that is important to, and can engage, community members, elected officials, and other decision makers. HIA provides a systematic process for ensuring health equity is an outcome of decision-making processes.

HIA provides robust research and accompanying recommendations: The public health field has a strong and growing body of empirical evidence that supports community concerns and aspirations for good health. Health outcomes research often elucidates the overall inequities faced by low-income communities, communities of color, and other vulnerable populations and their associated health effects. As discussed earlier, inequities in health outcomes result from the systematic and unjust distribution of social, economic, political, and environmental conditions required for good health outcomes. When a policy, plan, project, or program is proposed, HIAs are useful for providing research to analyze

and forecast the distribution of health impacts across and within populations, engaging vulnerable populations in decision-making processes, and proposing recommendations that maximize health and equity for all. In addition, HIAs are useful for identifying institutions that can monitor a proposal's likely impacts over time and ensure accountability to health and equity over the long term.

HIA supports community leadership and participation in decision-making processes: Historically, vulnerable populations have been excluded from decision-making processes that impact their lives. HIA is an effective tool for supporting community participation and leadership in decision-making processes, thereby enabling adherence to democratic principles. By engaging in HIA, equity leaders can generate an evidence base that illuminates the health equity implications of a proposal, build community capacity, and support community involvement in decision-making processes that affect their lives.

HIA fosters accountability: HIA promotes accountability and transparency in decision making. Decision makers must have access to information regarding the health impacts of proposals, including the distribution of those impacts, in order to make informed and responsible decisions. Community groups must also have this information to ensure decision-maker accountability, especially to the most vulnerable.

Principles for Promoting Equity in HIA Practice

There is broad interest in ensuring that equity remains central to HIA practice and that HIAs are an effective tool for achieving equitable health outcomes. To assist practitioners in efforts to use HIA as a tool for advancing health equity, this primer provides a set of eight principles beginning with overarching principles that apply to the entire HIA process and then focusing on principles that guide specific HIA steps (noted on page 9).

- A. *Ensure community leadership, ownership, oversight, and participation early and throughout an HIA*** from communities of color, low-income communities, and other vulnerable groups. These populations will likely be most impacted by policies under consideration and have valuable expertise and insights that can inform decision making. It is critical to develop partnerships with, and engage, community representatives.
- B.** Use the HIA as a process to ***support authentic participation of vulnerable populations in the decision-making process*** on which the HIA focuses. This is critical because vulnerable communities are often excluded from decision-making processes that stand to impact them. If needed, the HIA process should help build capacity for disadvantaged communities to fully participate in the decision-making process.
- C. *Target the practice*** of HIA towards proposals that are identified by, or relevant to, vulnerable populations. Resources and capacity should be focused on issues faced by the most vulnerable segments of any community.
- D.** Ensure that a central goal of the HIA is to ***identify and understand the health implications for populations most vulnerable*** or at risk for poor health. HIA goals should reflect a focus on expanding opportunities for good health outcomes in vulnerable populations.
- E.** Ensure the HIA ***assesses the distribution of health impacts*** across populations wherever data are available. Populations may be defined by geography, race/ethnicity, income, gender, age, immigration status, and other measures. Vulnerable groups should be involved in defining these populations and in developing measures of vulnerability. Where data are unavailable, surveys, focus groups, community oral histories and experiences and other methods can be used to understand the distribution of impacts.
- F. *Identify recommendations that yield an equitable distribution of health benefits*** and maximize the conditions necessary for positive health outcomes among the most vulnerable populations and those who stand to be most adversely impacted by the decision that is being assessed. Identification of the distribution of impacts should be accompanied by recommendations for actions that yield equitable health outcomes.
- G.** Ensure that ***findings and recommendations of the HIA are well communicated*** to vulnerable populations most likely to be impacted by the decision being assessed. Culturally appropriate materials with non-

technical language and accessible summaries, distribution of findings via multiple mediums and platforms, and targeted outreach to sub-populations, such as vulnerable youth, are strategies that help ensure effective communication of findings and recommendations.

- H. After the decision on which the HIA is focused is made, ***ensure that the actual impacts of the decision are monitored***, and that resources and mechanisms are in place to address any adverse impacts that may arise.

If implemented with careful attention to these principles for promoting equity, HIAs can help transform how policy and other public decisions are made, who has a voice in those decisions, and how those decisions impact the health of vulnerable communities. Every day, policymakers and other public leaders make decisions that have implications for population health without acknowledgment or careful analysis of the potential impacts on our most vulnerable populations. To ensure these decisions reflect and address community health needs and aspirations, it is critical that vulnerable populations bring their knowledge and expertise to the decision-making process and have an active and affirmative voice in those decisions.

CASE STUDIES

Two detailed case studies illustrate how the principles of this primer can be incorporated to maximize equity through HIA practice.

Analyzing Paid Sick Days in San Francisco, California

In 2008, Human Impact Partners (HIP) and the San Francisco Department of Public Health (SFPDH) were approached by the Labor Project for Working Families and the California Work and Family Coalition (the Coalition) about conducting an HIA on the California Healthy Families, Healthy Workplaces Act, a bill that would entitle all workers in the state to accrue paid sick time that could be used for diagnosis, care, or treatment of health conditions of the employee or an employee's family member, or for leave related to domestic violence or sexual assault.

Members of the coalition were focused on organizing and building leadership among low-income workers and advocating on their behalf. The coalition viewed the legislation as an opportunity to advance those goals and viewed the HIA as a way to incorporate public health expertise into the legislative process. The legislation would primarily help vulnerable populations as 79 percent of the lowest-paid workers, and over 50 percent of Hispanic workers in the state did not have paid sick days. Some categories of workers also had less access to paid sick days; 85 percent of restaurant workers, for example, could not take paid time off when they were ill. Given these statistics, an implicit goal of the HIA was to understand how the bill would impact these vulnerable populations.

During Scoping, HIP and SFPDH solicited input from partners about how the legislation might impact health, and which issues to prioritize. During Assessment, the HIA practitioners gathered statistics from administrative agencies and analyzed existing survey data to identify which populations had access to paid sick days and to better understand the impacts of paid sick days on health. HIP and SFPDH also worked with community-based organizations to conduct focus groups and collect additional survey data in an effort to engage vulnerable populations in both the HIA and the legislative process. For example, a Spanish-speaking group of domestic workers, who were members of Mujeres Unidas y Activas,

participated in a focus group in San Francisco and shared their experiences on how the lack of paid sick days affected their health and the health of their family members. Using quotes and stories from these focus groups, the HIA gave voice to the concerns of, and issues faced by, vulnerable populations.

The HIA found that ensuring that all workers have access to paid sick days would bring about many health benefits for both workers and other populations, and the HIA's primary recommendation was to pass the legislation.

Communications experts helped the HIA practitioners develop messages about how the legislation would impact the health of low-income populations, which would then impact the health of all Californians. The HIA practitioners participated in legislative hearings and in press conferences and interviews organized by the California Work and Family Coalition. As a result, HIA findings were covered in print media, online publications, local and national radio, and Spanish language television. Public health leaders also became spokespeople for paid sick days, bringing a new voice advocating for vulnerable workers to the dialogue.

The bill did not pass in 2008, primarily because there were budget implications for the state, which employed home health-care workers but did not provide them with paid sick days. As a result, in 2009 the HIA practitioners released an addendum to the HIA focused on the impacts of the legislation on home health-care workers, and the clients they served. Members of the National Paid Sick Days Coalition also asked the HIA practitioners to conduct similar analyses of paid sick days' bills being proposed at the federal level and in many states. Although an HIA was not conducted in Connecticut, advocates used health arguments contained in these HIAs to pass a bill, making it the first state to require that employers provide workers with paid sick days. Work in other states and at the federal level continues, and health arguments are a core component of the advocacy efforts. For more information on this case study visit, <http://www.humanimpact.org/doc-lib/finish/5/101>.

Creating a Healthy Corridor for All in St. Paul, Minnesota

The Healthy Corridor for All HIA was a community action research project led by ISIAH, PolicyLink, and TakeAction Minnesota, using the HIA framework to support a vision of a healthy transit corridor for all—including and especially for current residents who are low income, and people of color who have experienced disinvestment and historic discrimination.

In Minnesota, a new \$1 billion light rail line is being constructed to connect downtown Minneapolis with downtown St. Paul along the Central Corridor. It is estimated to spur an additional \$6 billion in public and private investment in local development. In St. Paul, the transit line passes through some of the region's most diverse and lowest-income communities. These include the nation's second largest Hmong population, a large Somali refugee population, and Rondo, a historic African American community that was devastated after Interstate 94 was built through the neighborhood in the 1950s by limiting land values, displacing community members and businesses, dividing the community, and increasing air pollution, among other impacts.

The new light rail line and subsequent land use changes raised hopes for community improvements, but also concerns about adverse community impacts, especially for low-income communities and communities of color. Based on this, PolicyLink, ISIAH, and the Hmong Organizing Program of TakeAction Minnesota (TAM's HOP) partnered to conduct an HIA of the rezoning ordinance that would lay the foundation for the implementation of transit-oriented development along the Central Corridor. The project partners dubbed the HIA, "Healthy Corridor for All" (HCA).

ISIAH and TAM's HOP worked closely with community groups to lead, organize, build capacity, and, in particular, support the participation of community partners, especially low-income people and communities of color, in the rezoning process and the HIA. PolicyLink conducted the research, identified policy recommendations, and provided technical assistance and capacity building support to community partners.

The project partners convened a leadership team of groups representing constituents along the Central Corridor—the Community Steering Committee (CSC). The CSC identified the focus for the HIA analysis, advised on research, prioritized and advocated for policy recommendations, and informed policymakers and their constituencies at every step in the HIA. The project partners also convened a Technical Advisory Panel (TAP) to provide technical support, expertise, and data resources. The project partners worked closely together, each with different, but complementary, roles and worked with the CSC and TAP to create a community-driven leadership team for the HIA.

The goals of HCA explicitly focused on equity, community empowerment, and equitable distribution of impacts and opportunities. Research on the community-prioritized indicators focused on distribution of impacts, specifically on the most vulnerable communities. Surveys and interviews helped bring to light the perspectives of Hmong immigrants, black leaders, and other leaders unable to formally devote time to the CSC or TAP. Trainings on zoning, land use, and the political decision-making process were held to support the capacity of community groups. Large community meetings were organized in churches during the HIA process to share information about the HIA and its findings with a broader community of leaders and residents, as well as with city council members, county commissioners, and other important decision makers.

The HIA produced a number of documents to share the findings with varied audiences: policy briefs for policymakers, a two-pager for community outreach, a 40-page summary for a broad audience using accessible language along with maps and graphs to depict the findings, and a 130-page online technical report providing the detailed methodology and full set of findings to ensure transparency and the credibility of the scientific process.* The publications featured photos of Central Corridor residents, including Hmong churches, Somali children, and black families, all taken by a local Chinese American photographer. A webpage was also developed to share the project materials. Project partners and CSC members presented the findings and recommendations of the HIA in a number of public forums and meetings with decision makers and key community leaders, to allow for an exchange of questions and to reach a broader audience.

The HIA supported the creation of a coalition of diverse interests, and increased community capacity to understand, engage, and influence land use policy. As a result of organizing and advocacy around the HIA recommendations, among a number of other factors, the City of St. Paul allocated millions of dollars towards the preservation and development of affordable housing near the transit stations. The HIA also provided research and data on community conditions that could be used for multiple assessment, advocacy, and planning purposes now and in the future. In addition, there has been a shift in the land use policy debate to include more community voices and health implications. For more information on the case study, visit www.policylink.org/HealthyCorridorforAllHIA.

* Shireen Malekafzali and Danielle Bergstrom, *Healthy Corridor for All: A Community Health Impact Assessment of Transit-Oriented Development Policy in Saint Paul, Minnesota* (Oakland, CA: PolicyLink, 2011). www.policylink.org/HealthyCorridorforAllHIA (last accessed January 31, 2013).

Key Strategies for Implementing Equity Principles in HIA Practice

The tables that follow provide examples of strategies to effectively implement the principles for promoting equity in HIA practice. Also provided are examples of HIAs in which such strategies were implemented. The lists of strategies and examples are not exhaustive, and are meant to be illustrative for those conducting and participating in HIAs in different contexts.

- A. Ensure community leadership, ownership, oversight, and participation early and throughout an HIA** from communities of color, low-income communities, and other vulnerable groups. These populations will likely be most impacted by policies under consideration and have valuable expertise and insights that can inform decision making. It is critical to develop partnerships with, and engage, community representatives.

Step: Throughout the HIA process

STRATEGIES

- 1. Conduct the HIA as a partnership among HIA practitioners, equity advocates, and a consortium of community leaders.** This will ensure community leadership and ownership of the HIA from its inception, and bring together public health and equity expertise.
- 2. Share financial resources for leadership and participation in HIAs among representatives of vulnerable communities, equity advocates, and HIA practitioners** (e.g., by identifying a shared budget, fundraising together, ensuring funds for community groups to participate, providing stipends to community members).
- 3. Establish an oversight committee composed of representatives of vulnerable communities and/or a combination of stakeholders that is empowered to make final decisions in each stage of the HIA.** When the oversight committee includes a combination of stakeholders, be aware of and address capacity and power issues to ensure that vulnerable populations are able to fully lead and participate. Equity advocates can help lead and facilitate the oversight committee processes.
- 4. Ensure meetings are scheduled and conducted to allow the full participation of and leadership by vulnerable populations.** This includes, but is not limited to: sharing the responsibility for facilitation; planning the meetings in partnership; scheduling meetings at places and times convenient for those populations; providing food and childcare; providing simultaneous translation services; setting ground rules and meeting formats so that those perceived to be ‘technical experts’ are not the only ones who feel empowered to speak.
- 5. Ensure HIA leadership and stakeholders include equity advocates and community representatives who will be able to communicate and translate the equity implications of the HIA findings in a robust and meaningful way.**

EXAMPLE

The Eastern Neighborhoods Community Health Impact Assessment (ENCHIA)⁴⁵ was conducted to assess the health impacts of rezoning and land use plans in three San Francisco neighborhoods. Convened by the San Francisco Department of Public Health (SFPDH), ENCHIA was guided by a multistakeholder community council of over 20 organizations whose interests were affected by development, including community planning, economic development, environmental justice, homelessness, open space, housing, low-wage workers, and small businesses. The council determined the content and focus of the HIA with SFPDH staffing the assessment process, gathering data, conducting research and producing group products. Staff produced materials for review in advance of each meeting, and in most instances, distributed a summary of key discussion points, findings, and next steps after each meeting. All products were reviewed and amended based on council deliberation. Given the time commitment required, council members representing nonprofit organizations were offered modest stipends for their participation. Meetings were held monthly at a location accessible by public transit and refreshments were provided. A project website posted meeting information and related materials.

- B.** Use the HIA as a process to **support authentic participation of vulnerable populations in the decision-making process** on which the HIA focuses. This is critical because vulnerable communities are often excluded from decision-making processes that stand to impact them. If needed, the HIA process should help build capacity for disadvantaged communities to fully participate in the decision-making process.

Step: Throughout the HIA process

STRATEGIES

- 1. Incorporate training on the political process and timeline for the targeted decision.**
- 2. Provide materials, training, and support for vulnerable populations to share their experiences and HIA findings and recommendations with decision makers during hearings, other meetings, and/or through other mechanisms (e.g., comment letters).** This may require HIA practitioners and equity advocates to dedicate time and resources to skills and leadership building.
- 3. Use available influence and power to ensure that decision-making processes are designed to allow authentic participation of vulnerable populations.**
- 4. When planning the HIA process, budget time and money for capacity-building activities including leadership development, coaching, and teaching research skills.** Equity advocates are excellent at building capacity within their own communities and should be given lead roles in these activities.
- 5. Ask community leaders to identify capacity-building needs and work with HIA practitioners, equity advocates, and other partners to carry out a capacity-building workplan.**
- 6. Identify the capacity-building needs of HIA practitioners and budget time and resources to build the practitioners' capacity in consultation with community leaders.**

EXAMPLES

In an HIA focused on oil development in Alaska's North Slope,⁴⁶ a partnership between community leaders of the Native American tribes and an HIA expert greatly increased the community's capacity, leverage, and power in a major federal decision regarding oil drilling. As part of the HIA process, a small tribal community formally participated as a "Cooperating Agency" in an Environmental Impact Statement (EIS) under the National Environmental Policy Act and thereby helped write the EIS, rather than simply offering comments which is the most common role communities have in such decision-making processes; see also the case study in "Guidance and Best Practices for Stakeholder Participation in HIA."⁴⁷

In the **Farmers' Field rapid HIA**⁴⁸ in Los Angeles, Human Impact Partners, the HIA practitioner, partnered with LA Community Action Network (LACAN), a community-based organization committed to promoting and defending the human rights of the low-income residents through community organizing and leadership development. LACAN received a significant part of the total funding for the HIA with which it brought together a panel of representatives of vulnerable populations who set the HIA scope, collected and analyzed survey data, assessed the impacts of the proposed NFL stadium with input from subject matter experts, and developed recommendations for mitigating negative impacts. Members of the panel then presented the HIA findings at press conferences, in meetings with the developer and key decision makers from the city, and in public hearings. Throughout the HIA process, these residents learned about: the connections between land use and the determinants of health; research, data collection and analysis; and how to use data to inform the decisions being made that would impact their lives.

- C. *Target the practice*** of HIA towards proposals that are identified by, or relevant to, vulnerable populations. Resources and capacity should be focused on issues faced by the most vulnerable segments of any community.

Step: Screening

STRATEGIES

1. After building trustful relationships with leadership representing vulnerable populations, HIA practitioners can facilitate the identification of salient issues in the community as well as proposals that impact those issues.
2. HIA practitioners can examine local health statistics, attend community meetings to share health issues of importance with vulnerable populations, and then identify community members (e.g., through community groups, places of worship, service providers) interested in addressing those issues.
3. Equity advocates can select an HIA topic relevant to the concerns of the vulnerable population with whom they work, and partner with HIA practitioners to conduct the HIA or build their own capacity to do so.
4. Equity advocates can seek out HIAs that are being considered (or are in process) to proactively share their expertise, concerns, and aspirations in an effort to incorporate these issues into the HIA process, as well as build relationships with HIA practitioners.

EXAMPLE

The opportunity to conduct an HIA on new labor standards for domestic workers arose from a multiyear history of partnerships between domestic worker advocacy organizations and the San Francisco Department of Public Health (SFPDH). When one community-based organization, Mujeres Unidas y Activas (MUA), helped introduce statewide legislation that would provide basic rights to domestic workers, SFPDH asked MUA to consider the value of an HIA in their legislative initiative. Recognizing the lack of good demographic and health data on the domestic worker population and the benefit of supportive public health voices in the legislative struggle, MUA and SFPDH agreed to conduct the **Domestic Workers HIA**.⁴⁹ MUA participated in the scoping and research for the HIA and used the findings both to shape the legislation and to advocate for its passage.

- D. Ensure that a central goal of the HIA is to **identify and understand the health implications for populations most vulnerable** or at risk for poor health. HIA goals should reflect a focus on expanding opportunities for good health outcomes in vulnerable populations.

Step: Scoping

STRATEGIES

1. **Ensure vulnerable populations are part of the discussions in which the goals for the HIA are explicitly identified.** Equity advocates can also support the engagement of hard-to-reach populations to better understand their goals for the HIA.
2. **Explicitly include equity-related goals in the HIA workplan** (e.g., ensuring equitable distribution of benefits, promoting civic participation of vulnerable populations within the decision-making processes).
3. **Equity advocates can inform HIA practitioners about the communities most at risk and introduce leaders from these communities to share their stories and contribute to the HIA.**

EXAMPLES

The **Advanced Metering Infrastructure (smart meters) HIA**,⁵⁰ conducted in Chicago, was led by the National Center for Medical Legal Partnership (MLP). Smart metering technology allows utility companies to remotely and more easily shut off electricity to homes without visiting them, raising concerns regarding disproportionate impacts on low-income populations who may be more likely to be late in paying their bills and could easily have important heating or cooling systems shut off, creating health issues. MLP had a stated goal of “focus[ing] on ‘vulnerable populations’” as a subset of residential customers generally, because most utility proposals focus on the “average” customer. However, utility regulators or policymakers rarely possess information about subsets of residential customers who might respond differently from, or require, specific needs compared to, “average” customers. The report then goes on to define “vulnerable populations” and focuses the analysis on these populations.

The Institute on Social Exclusion at the Adler School of Professional Psychology partnered with residents of the Englewood community in Chicago to conduct an HIA focused on the mental health impacts of a proposed revision to the **federal policy guidance on employers’ use of arrest records in employment decisions**.⁵¹ The goals of the HIA included: “facilitat[ing] authentic community involvement, understanding, and voice in a public decision likely to impact collective mental health and well-being” as well as “promot[ing] the mental health and well-being of residents of the Greater Englewood community by...augmenting the tools and information that residents, public service providers, public officials, advocates and others who work in and on behalf of Greater Englewood residents have to ensure that public decisions promote community mental health and health equity.” While the focus of the HIA was the entire Englewood community, individuals with arrest records were a subset of the population targeted in the HIA due to their heightened vulnerability to poor health outcomes, such as diabetes and hypertension, but also depression and other forms of psychological distress. The Englewood community participation in the HIA allowed the implications of the federal policy to be grounded in community experience.

- E. Ensure the HIA **assesses the distribution of health impacts** across populations wherever data are available. Populations may be defined by geography, race/ethnicity, income, gender, age, immigration status, and other measures. Vulnerable groups should be involved in defining these populations and in developing measures of vulnerability. Where data are unavailable, surveys, focus groups, community oral histories and experiences and other methods can be used to understand the distribution of impacts.

Steps: Scoping, Assessment

STRATEGIES

1. **During the Scoping phase of the HIA, ensure that vulnerable populations have leadership in prioritizing the potential health issues related to the proposal, indicators or research questions for the HIA assessment, and methods and data sources for the HIA.**
2. **Use methods to analyze, describe, and display** (e.g., mapping) data stratified by vulnerability categories (e.g., age, race, income) when possible.
3. **Encourage agencies collecting data to inform the policy decision or the HIA to gather information that would allow for stratification into key population subgroups that can reveal inequities.** When stratified data are unavailable, the HIA can recommend that such data be collected in the future.
4. **Collect data from a sample of vulnerable populations using surveys, focus groups, and interviews, among other methods, to capture their unique circumstances.** Methods and approaches can be community friendly and engaging for community members.
5. **Authentically engage community members in data collection and analytic methods using community-oriented approaches,** (e.g., by using Community-Based Participatory Research methods).
6. **Equity advocates can lead data collection processes, surveys, interviews, and focus groups, given existing relationships they may hold with vulnerable communities.**
7. **HIA practitioners can work to increase their use of, and proficiency with, community-oriented data collection and analysis methods.**

EXAMPLES

In the Institute on Social Exclusion's **HIA on a proposed amendment to federal policy guidance on employer use of arrest records in employment decisions**⁵² (described in the previous example), equity was a focus throughout the Scoping and Assessment process. The HIA practitioners used a highly iterative process involving dialogue with community members to develop the Scope. In the Assessment, 254 surveys completed by Englewood residents were collected by the HIA team to gather information about a range of topics, including: demographics, psychological sense of community, collective efficacy, race-related stress, perceived discrimination, use of the informal economy, psychological distress, depression, life satisfaction, and well-being. In addition, five focus groups, organized by age and gender, were held with residents to discuss the HIA research questions and neighborhood resources.

In a more technical example, the San Francisco Department of Public Health conducted an **HIA of a potential road pricing policy**⁵³ that would charge \$3 during morning and afternoon rush hours to travel into or out of the congested northeast quadrant of San Francisco, California. In addition to assessing effects with respect to geographic equity on air and noise pollution, physical activity, and transportation-related injuries citywide and within the road pricing area under study, the HIA assessed equity impacts with respect to traffic-related health hazards and environmental exposures for children and youth, seniors, and low-income populations. The HIA used spatially assigned population and traffic data, ArcGIS mapping software, and traffic density as a general proxy for adverse environmental exposures and hazards of traffic.

- F. Identify recommendations that yield an equitable distribution of health benefits** and maximize the conditions necessary for positive health outcomes among the most vulnerable populations and those who stand to be most adversely impacted by the decision that is being assessed. Identification of the distribution of impacts should be accompanied by recommendations for actions that yield equitable health outcomes.

Step: Recommendations

STRATEGIES

- 1. Develop and prioritize recommendations that specifically mitigate potential negative impacts and target benefits for vulnerable populations.**
- 2. Equity leaders, vulnerable populations, and those who work with such populations can develop, pilot (where feasible), and prioritize recommendations in order to make sure the recommendations have the intended impact of promoting health equity.**
- 3. In addition to targeted recommendations, ensure that vulnerable populations have the institutional and other supports needed to benefit from recommendations that broadly focus on all populations and communities, regardless of vulnerability.**
- 4. Where gaps in data exist to assess potential impacts on vulnerable populations, recommend data collection to monitor the impacts of the policy decision and to inform future actions to address potential inequitable impacts.**
- 5. Recommend monitoring of the implementation of targeted policies to ensure vulnerable populations are benefiting appropriately.** Implementation of a policy often does not serve its intent in the absence of measures and processes for ensuring accountability.

EXAMPLES

The **rapid HIA on a dirty materials recovering facility**⁵⁴ outside of Albuquerque, New Mexico, initiated and overseen by residents of the impacted low-income area and conducted by the Bernalillo County Place Matters team, recommended that the special use permit request be denied by the county because the community in which the facility was proposed to be located already suffered significant environmental justice issues and health burdens that would be compounded by the facility in the event it was erected. While HIAs typically recommend mitigations for negative impacts, community members felt strongly that, because of past injustices, the recommendation to deny the permit was the only reasonable course of action and that nothing short of denial of the permit would address the health issues they faced.

In an **HIA on Farm to School legislation**⁵⁵ proposed in Oregon, two Community Advisory Committees helped draft and prioritize recommendations. Upstream Public Health, the HIA practitioner, held meetings throughout the state to share preliminary findings and receive feedback on the proposed recommendations. The recommendations addressed equity in two key ways. First, they suggested the policy language be changed to ensure Farm to School grants be preferentially given to schools serving low-income and racially diverse populations and schools in areas with limited food access. Second, the team developed recommendations related to implementing the legislation with strategies that involved equity by, for example, encouraging farm to school programs to support producers “utilizing labor practices that support worker health,” and using targeted food-purchasing strategies that support small-scale producers.

- G.** Ensure that *findings and recommendations of the HIA are well communicated* to vulnerable populations most likely to be impacted by the decision being assessed. Culturally appropriate materials with non-technical language and accessible summaries, distribution of findings via multiple mediums and platforms, and targeted outreach to sub-populations, such as vulnerable youth, are strategies that help ensure effective communication of findings and recommendations.

Step: Reporting

STRATEGIES

- 1. Develop a clear communications plan that has a strong emphasis on sharing findings and recommendations with vulnerable populations and those most impacted.**
- 2. Use appropriate communications methods for each population.** These might include: one-page summaries, webinars, videos, blogs, presentations, interactive workshops, digital stories, telenovelas, posters and/or earned media stories.
- 3. Use culturally appropriate material.**
- 4. Partner with representatives and leadership of vulnerable populations in the development and review of materials and communications strategies.**
- 5. Translate communication materials into languages used by vulnerable populations.**
- 6. Use non-technical language and accessible summaries.**
- 7. Distribute and/or present communications materials to vulnerable populations through channels they use (e.g., church meetings, Spanish-language television, community meetings, community leadership, Facebook).**
- 8. Ensure that the communications messenger is a leader from the impacted community.**

EXAMPLE

The **Second Street HIA**⁵⁶ in Bernalillo County, New Mexico, was released via a website (www.bcplacematters.com/2ndstreet/) that, in addition to the full HIA report, included short written summaries of various aspects of the HIA, maps and photographs of the area, accessible graphics showing important statistics and concepts, and videos in which residents tell their stories. The entire report, executive summary, and website were provided in both English and Spanish. The website was released to many stakeholders, including community members who were integral to its success in relation to the passage of the Bernalillo County Pedestrian and Bicycle Safety Action Plan. The website served as an empowerment tool for the community members whose stories were recognized as vital to the decision-making process.

- H. After the decision on which the HIA is focused is made, **ensure that the actual impacts of the decision are monitored**, and that resources and mechanisms are in place to address any adverse impacts that may arise.

Step: Monitoring

STRATEGIES

1. **Develop a monitoring plan that identifies health and equity indicators that can be tracked after the decision is made, names responsible parties for both tracking and acting on impacts of the decision, as well as identifies actions that can be taken if adverse impacts occur.** The plan must pay specific attention to tracking the impacts on vulnerable populations.
2. **While government agencies, community organizations, and others may be responsible for monitoring impacts, in all cases monitoring reports should be made publicly available and specifically communicated to vulnerable communities.** Findings from monitoring should be made available to all stakeholders simultaneously.
3. **Vulnerable communities can participate in the development of the monitoring plan.**
4. **Secure funding for community groups to participate in monitoring activities to the extent necessary.**

EXAMPLE

After completion of an **HIA on residential code enforcement policies**⁵⁷ in Marin County, California, the HIA leads—Legal Aid of Marin and Human Impact Partners—applied for additional funds to monitor the outcomes. While the final monitoring plan is still in development, a number of already identified indicators relate to impacts on vulnerable populations, including: average length of time before first inspection of health and safety complaint by code enforcement staff; average length of time before property-owner or property-manager repair is approved by code enforcement; perceptions of stress or fear among tenants due to interactions with property owners or property managers, or during inspections; and perceptions of institutional change among code enforcement staff. Residents will be involved in monitoring through: providing feedback based on personal experiences (e.g., in a focus group or survey); facilitation, coordination and promotion of those feedback sessions by promotoras (lay Latino community members who receive special training to provide basic health education); review of the final monitoring report; and participation in discussion of next steps based on the information gathered.

Addressing Common Challenges to Adhering to the Equity Principles

In emerging HIA practice in the United States, a number of challenges arise, especially in relation to promoting equity. For guidance regarding more general challenges faced by practitioners in conducting an HIA, please refer to resources such as *Health Impact Assessment: A Guide for Practice*.⁵⁸

Listed below are some of the challenges associated with efforts to focus on equity in HIA practice, accompanied by strategies for addressing those challenges.

Lack of Capacity

Inadequate capacity—with respect to time, skills, knowledge, relationships, and financial resources—can be a barrier to incorporating equity in HIA practice. HIA practitioners may lack knowledge and familiarity with equity issues facing communities, or they may lack relationships with vulnerable community stakeholders who can make important contributions to the HIA. Practitioners may also lack the adequate time and financial resources needed to partner with or engage vulnerable groups in the HIA process, particularly given short or often shifting timelines in legislative and policymaking processes. HIA practitioners may also lack training and experience in incorporating equity issues into the HIA process. Equity advocates may lack capacity with respect to skills, knowledge, time, financial, and other resources to engage in HIA and to help bring equity issues to the table. Vulnerable communities may also face their own internal challenges to participation in the HIA process including conflicts between the urgency of everyday needs and

immediate challenges, and the time required to participate in an HIA. HIAs can be time-intensive or may require steady engagement over a lengthy period of time, without yielding immediate or concrete solutions to pressing community needs. As a consequence, communities may not have the capacity to participate.

Importantly, the HIA process is fundamentally an opportunity to build capacity among HIA practitioners, equity advocates, and vulnerable populations to proactively address health and equity in decision-making processes—both for the decision that is the focus of an HIA, as well as for subsequent policy decisions. The following approaches are suggested strategies to begin building the required capacity among HIA practitioners, equity advocates, communities, and other stakeholders:

- Start with a small, time-specific HIA to build capacity and knowledge of HIAs and their potential benefits for vulnerable groups, and to build relationships between HIA practitioners and equity advocates. After an initial project has been completed, stakeholders should have increased capacity to tackle more complicated issues with HIAs. (Principles A, D, E, F)
- New and aspiring HIA practitioners in public health departments with limited time and resources could start to build HIA capacity by identifying and working with vulnerable populations on issues that overlap with their ongoing priority projects (e.g., injury prevention, climate change, physical activity). Another option is to reach out to colleagues in existing programs within the health

department who have strong relationships with members of vulnerable communities to facilitate the establishment of relationships and an understanding of their circumstances prior to embarking on an HIA. (Principle C)

- New HIA practitioners and equity advocates can spend time familiarizing themselves with existing HIAs that have incorporated a strong equity focus and may have policy implications for decisions being contemplated in their jurisdictions. This activity could serve as a launching pad for an HIA in their community.
- Other relevant strategies to overcome capacity challenges are listed in the Strategies section. (See A1, A2, B1, B2, B4, B5, B6, C1, C2, C3, C4, D3, E7)

Institutional Barriers

Often primarily due to political sensitivities, some organizations (e.g., government agencies) may not be willing or officially able to formally take a strong position in support of equity, including with respect to HIA findings and associated recommendations. This issue highlights the importance of selecting the right partner organizations in the HIA Screening step that can truly support the integration of equity in HIA practice and strongly communicate to decision makers and community members regarding HIA findings. (Principles A, G)

Nonetheless, agencies facing institutional barriers to speaking out regarding inequity often possess key data, technical capacity, and other resources that would support the integration of equity in an identified HIA. The following approaches are suggested as ways to support staff participation in equity-promoting HIAs from agencies facing such institutional barriers.

- HIA practitioners can partner with equity advocates and other community partners who, through an HIA process consistent with this primer, would be empowered to strongly communicate and promote HIA findings and recommendations. (Principles A through H)
- Public health department and other government agency staff are responsible for responding to requests from the public for data and information regarding their areas of expertise. While some political climates may not support

the participation of public agency staff as co-authors, or technical partners, or being acknowledged on an HIA, public agency staff in such circumstances can still support the conduct of an equity-oriented HIA by providing data, information, and other resources to the project.

- Institutional leadership can support increased consideration of equity in HIA by identifying or pursuing funding and additional resources to explicitly support such work, and thus expanding the purview of their agency—ideally consistent with defined goals regarding reducing inequities.
- Institutional leaders can take risks within their agencies to adopt a stronger stance on equity. Data on health disparities, inequities, as well as social determinants of health can support this stance. Goals related to elimination of health inequities from Healthy People 2020, the Centers for Disease Control and Prevention, and the World Health Organization provide additional rationale.

Data Gaps

HIA practitioners often face challenges in gaining access to the data required to identify and analyze health impacts—including data on vulnerable groups (e.g., by income, immigrant status), particularly at a geographic level appropriate for stratified analyses of the policy under consideration. This results in an important data gap regarding research findings and information on existing and potential future health issues specific to vulnerable populations. Approaches to addressing these data shortcomings include:

- HIA practitioners can be creative and open to working across disciplines, professions, and with equity advocates to identify new data sources, methods, and research to address data gaps for equity issues. (Principle E)
- Advocate for the appropriate collection of data that effectively demonstrates the specific circumstances of vulnerable populations. (Principle E)
- Other relevant strategies to overcome data-related challenges are listed in the Strategies section. (See E3, E4, E5, E6, F4)

Power Inequalities

Those with privilege—whether it is based on race, class, gender, age, or other factors—often hold power in decision making and are not open to sharing it. Decisions made in situations where power is inequitably distributed often lead to inequitable outcomes. When firmly based in its core values and championed by strong leadership from vulnerable populations, HIA can address power inequities in decision-making processes. However, when HIA is controlled by those without an interest in sharing power and/or who have real or perceived benefit from maintaining the status quo, HIA can be appropriated as a technocratic tool that serves those in power and does not address equity.

Approaches to addressing inequitable power dynamics in the HIA process include:

- Make certain to facilitate the HIA with clear ground rules to ensure the full participation of vulnerable populations, including a transparent decision-making process for each step of the HIA up to and through approval on the final materials. (Principle A)
- Clearly establish roles and decision-making power in the HIA Screening and Scoping stages to support the strong engagement and leadership of vulnerable populations.
- Diversify the field of HIA practitioners through capacity building and collaboration with equity advocates and vulnerable communities. This will develop a broader base of HIA capacity, knowledge, skills, and demand to help ensure health and equity impacts are considered in decision-making processes and are not mainstreamed or bureaucratized to support the status quo. (Principles A through H)
- Use existing laws and policies that require a consideration of health and may offer specific opportunities for disadvantaged groups to participate in the decision-making process (e.g., the National Environmental Policy Act).⁵⁹
- Other relevant strategies to overcome power inequality challenges are listed in the Strategies section. (See A1, A2, A3, A5, B2, B3, B5, B6)

Distrust and Perceptions of Bias

In the context of the aforementioned power inequalities, HIA practitioners and equity advocates often confront issues of trust, and allegations of bias, when working to conduct HIAs that incorporate equity issues. At the beginning of an HIA process, equity advocates or vulnerable populations, on the one hand, and government or academic institutions, on the other, may distrust one another based on historic interactions and/or concerns about the other's agenda. Similar issues can also arise towards the end of an HIA process among decision makers who distrust HIA findings generated from processes that include vulnerable populations or equity advocates. Such decision makers may, therefore, call the process and its outcomes biased.

Approaches to addressing historic distrust between equity advocates/vulnerable populations and government/academic institutions who may be involved in implementing an HIA—in addition to the aforementioned principles and strategies—include:

- Work to understand the roots of historic distrust and proactively address those issues in new collaborations so they do not impact the collaborative process, and are not repeated. One formal mechanism to promote trust is to develop “Principles of Collaboration,” to ensure HIA partners and stakeholders have a common agreement regarding the HIA process.⁶⁰ These could be established in the HIA Scoping stage.
- Create materials that appropriately frame the HIA within the historic context and experiences of vulnerable populations.
- Other relevant strategies to overcome distrust and perception of bias challenges are listed in the Strategies section. (See A1, A2, C1, D1, D2, G1, G3, G4, G5)

Approaches to addressing perceptions of bias by decision makers can include:

- Engage a diverse group of impacted stakeholders in an HIA process that fosters broad inclusion and consensus to ensure that results take into account a wide range of interests and concerns—including vulnerable

communities as well as stakeholders representing groups that typically have more access to political power. Engaging decision makers in this process directly can sometimes be an effective strategy to reduce their distrust. (Principle A)

- Ensure that public testimony includes a diversity of “expert” opinions—for example, from community members to medical doctors—to support HIA findings including equity impacts on health. (Principle G)
- Make an informed decision about how (not whether) to include equity in communication about the HIA findings. Some considerations include the following: Should equity impacts be the lead message regarding the findings and recommendations, or should they have less priority in messaging? What language will best resonate with the intended audience(s)? While HIAs seeking to promote equity should clearly state HIA findings specific to the distribution of policy impacts on vulnerable populations and their associated recommendations in HIA

communications, responses to these questions will likely vary based on the HIA findings and the intended audience(s) to ensure clear and effective communication. (Principle G)

- In the HIA, or in testimonies and other communication methods, cite established local or national public health initiatives that affirm equity as a core goal of public health (e.g., Healthy People 2020, from the U.S. Department of Health and Human Services, provides a vision, mission, and four overarching goals and associated objectives for achieving better health in the United States by the year 2020, and includes the goal to: “Achieve health equity, eliminate disparities, and improve the health of all groups”).
- Clearly document the HIA research methodology and ensure that any assumptions or limitations are fully described. Strong research methodology makes it more difficult to challenge the results with allegations of bias. (Principle E)

Conclusion

There is strong and growing evidence regarding the health inequities faced by vulnerable populations that result from inequities in access to social, political, and economic opportunities that protect and promote health. The continued exclusion of vulnerable populations from political decision-making processes further perpetuates these inequities.

This primer has been written for equity advocates and HIA practitioners to encourage and support their efforts to ensure that equity retains its role as a core value in the growing practice of HIA in the United States. As detailed throughout, HIA is a tool with the potential to support decision-making processes that yield more equitable health outcomes. However, this potential will not be realized without a deliberate focus on equity in HIA processes, as well as within the expanding field of HIA in the United States. This primer has provided principles and concrete strategies to promote equity within HIA practice, as well as to encourage an expanded discourse on the value and importance of equity within the practice.

Without explicit attention to equity within HIA practice, we risk perpetuating and exacerbating the health inequities that have resulted in gross disparities in health outcomes by race, income, and other factors of vulnerability. As we continue to build awareness of the critical issue of promoting equity through HIA, we hope that others will join us in working to ensure the future of HIA in the United States is firmly grounded in equity.

Notes

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