

**Richmond Health Equity Partnership:
City of Richmond, Contra Costa Health Services,
West Contra Costa School District, Professor Jason Corburn**

Health Equity Reader

In response to questions at both the April Richmond Health Equity Partnership (RHEP) meeting and the May HiAP Subcommittee meeting, below please see an introduction to the concept of health equity. Please consider these definitions and references as providing a working vocabulary to support RHEP's work. We predict that through the process of developing a Health in All Policies, Full Service Community School strategies, Health Equity Report Card, Data & Training that we will develop a set of Health Equity Principles, rather than developing a single, static definition.

This document currently includes (in DRAFT form):

- Health Equity: An Introduction (p. 1)
- Selected Health Equity Readings (the basics p. 4; and p. 9)
- Deficit Thinking: An Introduction (and selected readings, p. 14)
- Resilience: An Introduction (and selected readings, p. 16)
- Theories of Change (to be added)

Share your expertise:

Please submit additional resources, references, frameworks etc. as this document is a first draft of what will be a living, online document that is accessible both the RHEP partners and the general public (email Gabino Arredondo at Gabino_Arredondo@ci.richmond.ca.us and Jen Loy at JenSLoy@gmail.com). Content, format, tone, etc. will also likely evolve as expertise is shared, knowledge is gained, and suggestions are incorporated.

Health Equity: An Introduction

What is health equity?

Health equity is achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices.ⁱ

What is the difference between **inequality** and **inequity**?

Inequality and **equality** are dimensional concepts, simply referring to measurable quantities.

Inequity and **equity**, on the other hand, are political concepts, expressing a moral commitment to social justice.ⁱⁱ

What is difference between **health inequality** and **health inequity**?

The WHO definition of health inequality and inequity was created in part by Paula Braveman, MD, Professor of Family and Community Medicine, and Director, Center on Social Disparities in Health, UCSF. In a paperⁱⁱⁱ she defines **equity in health**:

- as “the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage — that is, wealth, power, or prestige.”
- Inequities in health **systematically put groups of people who are already socially disadvantaged** (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) **at further disadvantage** with respect to their health; health is essential to wellbeing and to overcoming other effects of social disadvantage.
- Health inequities refer to those inequalities in health that are deemed to be **unfair** or stemming from some form of **injustice**.^{iv} And Braveman adds that health inequities result from an uneven distribution (of resources, services, wealth, etc.) **is unnecessary, unjust, unfair and avoidable**.
- As well, equity is an **ethical principle**; it also is consonant with and closely related to **human rights principles**.

In other words:

Health equity is not just about providing more services; it is also about how those services are developed, prioritized and delivered. What is needed to fundamentally address **health disparities** is a broad-based coordinated effort among many partners acting to address **root causes**. The root causes of health disparities are broadly based in inequalities in many aspects of life, including social and economic policies.

Other common phrases related to health equity:

- **Built Environment:** The human-made surroundings as a result of land use/place-making decisions; includes housing, buildings, infrastructure, roads, parks, transportation, etc.^v
- **Health Disparities:** The preventable difference in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged population. Although the term “disparities” often is interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen in a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location [educational attainment] all contribute to an individual’s ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations.^{vi}
- **Health in All Policies (HiAP):** Consider that policy and program decisions made by “non-health” agencies play a significant role in shaping community environments. HiAP, is a collaborative approach that has been used internationally to address just these kinds of issues. A HiAP approach recognizes that health and prevention are impacted by policies that are managed by non-health government and non-government entities, and that many strategies that improve health will also help to meet the policy objectives of other agencies. The World Health Organization, European Union, South Australia, Finland, and other Western nations are all exploring ways to implement HiAP.^{vii}

- **Root Causes of Health Disparities:** An important feature of health disparities as it is defined in the context of health equity and social justice is that the differences in health that certain populations experience are due to factors beyond individual control. The root causes of health disparities are systemic, institutionalized, and many decades or even centuries in the making. The relationships among the root causes of health disparities are multi-directional and cyclical, exacerbating one another and calling for intervention at every level.^{viii}
- **Social Determinants of Health** 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, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.^{ix}
- **PLEASE SHARE YOUR IDEAS:** What terms would you like to see identified? Can you suggest preferred sources? What does a useful glossary of terms look like to you?

Selected Health Equity Readings

Health Equity: The Basics

There is a wide body of knowledge, literature, and even measurement and training tools related to health equity. *Unnatural Causes*, the acclaimed documentary series broadcast by PBS, offers a database of health equity materials that include fact sheets, videos, quizzes, training tools, journal articles and books, among other things. Below please see a few introductory readings from this and other key sources that consider health equity.

What is Health Equity? (Excerpted from the Unnatural Causes Action Toolkit)

http://www.unnaturalcauses.org/assets/uploads/file/What_Is_Health_Equity.pdf

Health equity concerns those differences in population health that can be traced to unequal economic and social conditions and are systemic and avoidable – and thus inherently unjust and unfair. Most of us can readily see how air pollution and toxic waste might harm health. But social structures can also get under the skin and disrupt our biology. Epidemiologist Sir Michael Marmot put it this way: “Real people have problems with their lives as well as with their organs. Those social problems affect their organs. In order to improve public health, we need to improve society.” Tackling health inequities requires widening our lens to bring into view the ways in which jobs, working conditions, education, housing, social inclusion, and even political power influence individual and community health. When societal resources are distributed unequally by class and by race, population health will be distributed unequally along those lines as well.

Unnatural Causes

http://www.unnaturalcauses.org/about_the_series.php

This acclaimed documentary series broadcast by PBS is now used by thousands of [organizations around the country](#) to tackle the root causes of our alarming socio-economic and racial inequities in health.

The four-hour series crisscrosses the nation uncovering startling new findings that suggest there is much more to our health than bad habits, health care, or unlucky genes. The social circumstances in which we are born, live, and work can actually get under our skin and disrupt our physiology as much as germs and viruses.

Unnatural Causes Episodes

http://www.unnaturalcauses.org/episode_descriptions.php?page=1

In Sickness and In Wealth (56 min.) How does the distribution of power, wealth and resources shape opportunities for health?

When the Bough Breaks (29 min.) Can racism become embedded in the body and affect birth outcomes?

Becoming American (29 min.) Latino immigrants arrive healthy, so why don't they stay that way?

Bad Sugar (29 min.) What are the connections between diabetes, oppression, and empowerment in two Native American communities?

Place Matters (29 min.) Why is your street address such a strong predictor of your health? (This episode is available as a **stand-alone DVD** with English, Lao, Hmong, Vietnamese, Mandarin and Cantonese audio, as well as English and Mandarin subtitles.)

Collateral Damage (29 min.) How do Marshall Islanders pay for globalization and U.S. military policy with their health?

Not Just a Paycheck (30 min.) Why do layoffs take such a huge toll in Michigan but cause hardly a ripple in Sweden?

Ask the Experts Forum #3: Myths About Health Inequities (From Unnatural Causes)

http://www.unnaturalcauses.org/assets/uploads/file/Ask_the_Experts_Forum3.pdf

William Dow, Tony Iton, Dennis Raphael, and David Williams discuss diet, universal health care, the economic costs of poor health, the “healthy immigrant effect,” and the difference between health disparities and health inequities.

Health Equity Quiz (From Unnatural Causes)

<http://www.unnaturalcauses.org/assets/uploads/file/quiz.pdf>

This quiz includes questions:

How does U.S. life expectancy compare to other countries?

Where did the U.S. rank in life expectancy 50 years ago?

What is the greatest difference in life expectancy observed between U.S. counties?

On average, which of the following is the best predictor of one's health?

A SAMPLE ANSWER: C. Whether or not you are wealthy. The single strongest predictor of health is our position on the class pyramid. Those at the top have the most power and resources, and on average live longer and healthier lives. Those on the bottom are exposed to many health threats over which they have little or no control – insecure and low-paying jobs, mounting debt, poor child care, poor quality housing, less access to healthy food, unreliable transportation, and noisy and violent living conditions – that increase their risk of chronic disease and early death. Even among smokers, poor smokers face a higher mortality risk than rich smokers. Those of us in the middle are still worse off than those at the top.^x

<http://www.unnaturalcauses.org/resources.php>

Welcome to our online collection of health equity resources

This database contains hundreds of articles, Web sites, video clips, charts, datasets, interviews, transcripts, and educational and outreach materials. *Check back often as we will continue to add resources on a regular basis.*

- Explore **all** resources by topic, related episode, type, or keyword using the tools to the left.
- Learn more about health equity concepts with our [Interactivities](#), [Case Studies](#), and [discussions with top scholars](#).

Unnatural Causes has also assembled ten key items that were influential in the development of this series. These resources and links will provide information about the key concepts covered in the series and this Web site.

[Backgrounders on Health Equity Topics \(pdf\)](#)

UNNATURAL CAUSES

This document by California Newsreel provides an overview of how social concerns such as income, jobs, education, housing, and racism relate to health outcomes and inequities. The short pieces in this document are taken from the topic introductions in the Health Equity database on the UNNATURAL CAUSES Web site

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[Closing the Gap in a Generation](#)

FINAL REPORT from Commission on the Social Determinants of Health

A project of the World Health Organization (WHO), the Commission on Social Determinants of Health (CSDH) supports countries and global health partners to address the social factors leading to ill health and inequities. It draws the attention of society to the social determinants of health that are known to be among the worst causes of poor health and inequalities between and within countries. The determinants include unemployment, unsafe workplaces, urban slums, globalization and lack of access to health systems.

The Unnatural Causes website also contains final reports from the different knowledge networks, as well as additional background articles and resources.

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The Web site also contains final reports from the different knowledge networks, as well as additional background articles and resources.

Commission for a Healthier America

WEB SITE

The Robert Wood Johnson Foundation Commission to Build a Healthier America looks beyond the medical care system to investigate how factors such as education, environment, income, housing and personal health choices impact the health of all Americans and ultimately provide better opportunities for Americans in every community to grow up and stay healthy. Even with decades of effort to improve America's health care system, too many Americans still die earlier than they should, and too many are suffering from conditions that can be prevented.

The RWJF Commission released a report in February 2008, [Overcoming Obstacles to Health](#), that provides a profile of the current state of health in America.

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Library of Resources on Social Determinants of Health

WEB SITE created and maintained by Dennis Raphael

A great collection of resources on the issues surrounding SDOH, health equity, and the politics of creating real change in the social factors that most affect health outcomes.

See especially Raphael's "Public policies and the problematic USA population health profile," and "The Politics of Population Health: Why the Welfare State is the Key Social Determinant of Health."

Race, Ethnicity, and Health

BOOK edited by Thomas A. LaVeist

This public health reader brings together the best peer reviewed research literature from the leading scholars and faculty in this growing field. This original and much-needed resource will be invaluable to graduate students and researchers alike. The book provides a historical and political context for the study of health, race, and ethnicity, with key findings on disparities in access, use, and quality. This volume also examines the role of health care providers in health disparities and discusses the issue of matching patients and doctors by race.

Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the U.S. (pdf)

REPORT from The John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health, 2007

An overview of how socioeconomic status affects health, though consideration of neighborhood, employment conditions, personal behaviors, health care, race and stress. Includes policy implications. The MacArthur Network on SES and Health brings together many of the world's top researchers on socioeconomic factors in health. Many of these experts were interviewed for UNNATURAL CAUSES.

Beyond the Basics of Health Equity

Social Determinants of Health: The Canadian Facts

Juha Mikkonen and Dennis Raphael

The primary factors that shape the health of Canadians are not medical treatments or lifestyle choices but rather the living conditions they experience. This report considers 14 social determinants of health and outlines why they are important; how Canada is doing in addressing them; and what can be done to improve their quality. The purpose of the document is to provide promote greater awareness of the social determinants of health and the development and implementation of public policies that improve their quality.

Tackling Health Inequities Through Public Health Practice: Theory to Action

BOOK edited by Richard Hofrichter and Rajiv Bhatia

Social justice has always been a core value driving public health. Today, much of the etiology of avoidable disease is rooted in inequitable social conditions brought on by disparities in wealth and power and reproduced through ongoing forms of oppression, exploitation, and marginalization.

Tackling Health Inequities raises questions and provides a starting point for health practitioners ready to reorient public health practice to address the fundamental causes of health inequities. This reorientation involves restructuring the organization, culture and daily work of public health. Tackling Health Inequities is meant to inspire readers to imagine or envision public health practice and their role in ways that question contemporary thinking and assumptions, as emerging trends, social conditions, and policies generate increasing inequities in health.

The Biology of Disadvantage: Socioeconomic Status and Health

JOURNAL Nancy E. Adler and Judith Stewart, eds. *Annals of the New York Academy of Science*

How does socioeconomic status get under the skin? This book summarizes the decade of research by the MacArthur Foundation Research Network on Socioeconomic Status and Health “exploring the pathways and mechanisms that contribute to the gradient relationship between socioeconomic status and health.”

The Status Syndrome: How Social Standing Affects Our Health and Longevity

BOOK by Sir Michael Marmot, 2004

Marmot, advisor to the World Health Organization and one of the premiere scholars on social determinant of health, presents the results of his own 30 year study into the effects of class on health, together with a comprehensive overview of current theory and research. He highlights how a sense of autonomy and control over our lives can be a key factor in our ability to live long, thriving lives.

“Where you live may signal life expectancy”

By Angela Hill, Oakland Tribune Posted: 04/17/2008

http://www.contracostatimes.com/ci_8966052

“Social inequity is health inequity,” [Tony] Iton said. “Education policy is health policy. Transportation policy is health policy. All these things are connected, and we need to harmonize these strategies across the board because — right now — years of life are lost due to social conditions.”

“Life and Death from Unnatural Causes”

Certain groups of people in Alameda County are getting sick and dying prematurely from “unnatural causes.” In Alameda County, access to proven health protective resources like clean air, healthy food, and recreational space, as well as opportunities for high quality education, living wage employment, and decent housing, is highly dependent on the neighborhood in which one lives. These inequities cluster and accumulate over people’s lives and over time successfully conspire to diminish the ultimate quality and length of life in these neighborhoods. Some of the social inequities that are associated with poor health are:

- A retail salesperson would need to work nearly 100 hours per week to afford fair market rent for a 2- bedroom apartment.

- Households earning less than \$20,000 per year spend over half of their income on transportation.
- A teacher of poorer students in Oakland Unified School District makes \$14,000 less than a teacher of wealthier students in Piedmont Unified School District.
- West Oakland residents breathe air that contains 3 times more diesel particles than in the rest of the Bay area.
- African Americans are sentenced to prison for drug offenses at a rate 34 times that for Whites even though they use illicit drugs at about the same rate.
- Latinos are 5 times as likely as Whites to lack health insurance.

A Few Key Academic Articles

“Social conditions as fundamental causes of disease

Link and Phelan

http://hsb.sagepub.com/content/51/1_suppl/S28.full

Link and Phelan (1995) developed the theory of fundamental causes to explain why the association between socioeconomic status (SES) and mortality has persisted despite radical changes in the diseases and risk factors that are presumed to explain it. They proposed that the enduring association results because SES embodies an array of resources, such as money, knowledge, prestige, power, and beneficial social connections that protect health no matter what mechanisms are relevant at any given time. In this article, we explicate the theory, review key findings, discuss refinements and limits to the theory, and discuss implications for health policies that might reduce health inequalities. We advocate policies that encourage medical and other health-promoting advances while at the same time breaking or weakening the link between these advances and socioeconomic resources. This can be accomplished either by reducing disparities in socioeconomic resources themselves or by developing interventions that, by their nature, are more equally distributed across SES groups.^{xi}

More Link and Phelan: Link, B. G., & Phelan, J. 1995. “Social conditions as fundamental causes of disease.” *Journal of Health and Social Behavior*. Spec No, 80-94.

“Health inequalities among British civil servants: the Whitehall II study”

Marmot, Michael, et al

<http://www.ncbi.nlm.nih.gov/pubmed/1674771>

The Whitehall study of British civil servants begun in 1967, showed a steep inverse association between social class, as assessed by grade of employment, and mortality from a wide range of diseases. Between 1985 and 1988 we investigated the degree and causes of the social gradient in morbidity in a new cohort of 10,314 civil servants (6900 men, 3414 women) aged 35-55 (the Whitehall II study). Participants were asked to answer a self-administered questionnaire and attend a screening examination. In the 20 years separating the two studies there has been no diminution in social class difference in morbidity: we found an inverse association between employment grade and prevalence of angina, electrocardiogram evidence of ischaemia, and symptoms of chronic bronchitis. Self-perceived health status and symptoms were worse in subjects in lower status jobs. There were clear employment-grade differences in health-risk behaviours including smoking, diet, and exercise, in economic circumstances, in possible effects of early-life environment as reflected by height, in social circumstances at work (eg, monotonous work characterised by low control and low satisfaction), and in social supports. Healthy

behaviours should be encouraged across the whole of society; more attention should be paid to the social environments, job design, and the consequences of income inequality.^{xii}

“A glossary for health inequalities.”

Kawachi I, Subramanian S V, Almeida-Filho N.

<http://jech.bmj.com/cgi/content/abstract/56/9/647>

In this glossary, the authors address eight key questions pertinent to health inequalities: (1) What is the distinction between health inequality and health inequity?; (2) Should we assess health inequalities themselves, or social group inequalities in health?; (3) Do health inequalities mainly reflect the effects of poverty, or are they generated by the socioeconomic gradient?; (4) Are health inequalities mediated by material deprivation or by psychosocial mechanisms?; (5) Is there an effect of relative income on health, separate from the effects of absolute income?; (6) Do health inequalities between places simply reflect health inequalities between social groups or, more significantly, do they suggest a contextual effect of place?; (7) What is the contribution of the lifecourse to health inequalities?; (8) What kinds of inequality should we study?^{xiii}

“Defining Equity in Health”

P Braveman, S Gruskin

<http://jech.bmj.com/content/57/4/254.short>

For the purposes of measurement and operationalisation, equity in health is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health; health is an essential to wellbeing and to overcoming other effects of social disadvantage. Equity is an ethical principle; it also is consonant with and closely related to human rights principles. The proposed definition of equity supports operationalisation of the right to the highest attainable standard of health as indicated by the health status of the most socially advantaged group. Assessing health equity requires comparing health and its social determinants between more and less advantaged social groups. These comparisons are essential to assess whether national and international policies are leading toward or away from greater social justice in health.^{xiv}

More Braveman: Braveman P, Gruskin S. Defining equity in health. *Journal of Epidemiology and Community Health* 2003;57:254-258.

<http://jech.bmj.com/cgi/content/abstract/57/4/254;>

Braveman P. Monitoring Equity in Health and Healthcare: A Conceptual Framework. *Journal of Health, Population and Nutrition* 2003 Sep;21(3):181-192.

[http://www.icddrb.org/images/jhpn2103_monitoring-equity.pdf;](http://www.icddrb.org/images/jhpn2103_monitoring-equity.pdf)

Braveman P. Health Disparities and Health Equity: Concepts and Measurement *Annual Review of Public Health* 2006;27:167- 194

<http://arjournals.annualreviews.org/doi/abs/10.1146/annurev.publhealth.27.021405.102103?journalCode=publhealth>

“Confronting the Challenges in Reconnecting Urban Planning and Public Health”

Jason Corburn

<http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.94.4.541>

Although public health and urban planning emerged with the common goal of preventing urban outbreaks of infectious disease, there is little overlap between the fields today. The separation of the fields has contributed to uncoordinated efforts to address the health of urban populations and a general failure to recognize the links between, for example, the built environment and health disparities facing low-income populations and people of color. Doctor Corburn reviews the historic connections and lack thereof between urban planning and public health, highlight some challenges facing efforts to recouple the fields, and suggest that insights from ecosocial theory and environmental justice offer a preliminary framework for reconnecting the fields around a social justice agenda.^{xv}

Deficit Thinking: An Introduction and Selected Readings

What is deficit thinking?

Deficit thinking posits that individuals or entire communities are unsuccessful, and/or suffer the effects of social and health equity do so because of internal deficiencies. This model does not consider the root causes of failures at school, health disparities, etc. As well, the deficit thinking paradigm does not seek assets (either of the individual or community), missing opportunities to identify protective factors that lead to resilience (see following section) or identify “what works.” when individuals succeed or when communities are safe and healthy despite assumptions of failure.

When thinking about school leadership and changing school environments, identifying and replacing deficit thinking is particularly important.

“Displacing deficit thinking in school district leadership. Education and Urban Society” Skrla, L. and Scheurich, J.J

The deficit thinking paradigm, as a whole, posits that students who fail in school do so because of alleged internal deficiencies (such as cognitive and/or motivational limitations) or shortcomings socially linked to the youngster—such as familial deficits and dysfunctions The popular “at-risk” construct, now entrenched in educational circles, views poor and working class children and their families (typically of color) as predominantly responsible for school failure.

Valencia argued, further, that such deficit thinking is deeply embedded in educational thought and practice and that it pervades schools that serve children from low-income homes and children of color. That is, even though virtually every u.s. school has a mission statement containing some form of the aphorism “all children can learn,” actual practices and programs in these same schools are suffused with deficit views of the educability of children of color and children from low-income homes. The result of this pervasive deficit approach is that students from low-income homes and students of color routinely and overwhelmingly are tracked into low-level classes, identified for special education, segregated based on their home languages, subjected to more and harsher disciplinary actions, pushed out of the system and labeled “dropouts,” underidentified as “gifted and talented,” immersed in negative and “subtractive” school climates, and sorted into a plethora of “remedial,” “compensatory,” or “special” programs.^{xvi xvii}

“Deconstructing deficit thinking: Working with educators to create more equitable learning environments”

Garcia, S.B. and Guerra, P.L.

Studies of comprehensive school reform suggest that such efforts often fail because of educators’ unwillingness to examine the root causes of underachievement and of failure among students from low-income and racially or ethnically diverse backgrounds and because of their tendency to locate the problem within students, families, and communities. Reform efforts are undermined by educators’ deficit views and by their beliefs about the children who become the targets of reform.^{xviii} They believe that the students and the families are at fault because, from their perspective, “these children” enter school without the necessary prerequisite knowledge and skills and that so-called uncaring parents neither value nor support their child’s education.^{xix}

Because these educators do not view themselves as part of the problem, there is little willingness to look for solutions within the educational system itself.^{xx}

Additional Selected Readings:

“Deficit thinking”

<http://www.learnnc.org/lp/pages/990>

Contemporary deficit thinking falls into three distinct categories: neohereditarianism, the culture of poverty paradigm and the theses of cultural and environmental deficits. Each category represents a modern form of thought that has roots as far back as the 17th century. Each also has a long history of being suited to a particular historical period’s socially acceptable ways of talking about race, immigration and education.

“Challenging Deficit Thinking”

<http://www.english.iup.edu/hcs/Rural%20Literacy%20Readings/Challenging%20Deficit%20Thinking.pdf>

Valencia, R. R. Dismantling Contemporary Deficit Thinking: Educational Thought and Practice (The Critical Educator)

Valencia, R. R. & Black, M. S. (2002). “ Mexican Americans don’t value education!” – On the basis of the myth, mythmaking, and debunking. *Journal of Latinos and Education*, 1(2), 81-103.

Valencia, R. R. . *The Evolution of Deficit Thinking: Educational Thought and Practice* (Stanford Series on Education and Public Policy)

Resilience: An Introduction and Selected Readings

What is Resilience: In a succinct distillation, Cohen and Schuchter^{xxi} define resilience as the **ability to withstand negative external stressors** and it is determined by psychosocial and environmental factors. On the psychosocial level, they offer, resilience refers to how people respond to stress^{xxii} and is conceptualized as normal development under difficult or adverse conditions.^{xxiii} On the environmental level, resilience entails adaptation and accommodating change gracefully and without catastrophic failure.^{xxiv}

Resilience can be defined as both the “the capacity of a child to deal effectively with stress and pressure, to cope with everyday challenges, to rebound from disappointments, mistakes, trauma, and adversity, to develop clear and realistic goals, to solve problems, to interact comfortably with others, and to treat oneself and others with respect and dignity”, *and* as the “ability to meet life’s challenges with thoughtfulness, confidence, purpose, responsibility, empathy, and hope”. Resilience can be understood as a process or an ability (not a personality trait); it can be measured at the individual or community level; and resilience can be supported by both psychosocial and environmental factors.

Potentially, an understanding of what makes residents and communities “resilient” can inform and influence the design of policy and interventions that seek to support and maintain that which makes residents and their neighborhoods “resilient.”

Selected Readings

“The construct of resilience: Implications for interventions and social policies”

Luthr and Cicchetti

The focus of this article is on the interface between research on resilience—a construct representing positive adaptation despite adversity—and the applications of this work to the development of interventions and social policies. Salient defining features of research on resilience are delineated, as are various advantages, limitations, and precautions linked with the application of the resilience framework to developing interventions. For future applied efforts within this tradition, a series of guiding principles are presented along with exemplars of existing programs based on the resilience paradigm. The article concludes with discussions of directions for future work in this area, with emphases on an enhanced interface between science and practice, and a broadened scope of resilience-based interventions in terms of the types of populations, and the types of adjustment domains, that are encompassed.^{xxv}

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Theories of Change: An Introduction and Selected Readings

[Import resources provided by Professor Jason Corburn]

DRAFT

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