SECTION 1: Introduction

Imagine a roaring river in the mountains. You and a friend are observing the peaceful scene when a person appears in the middle of the rapids calling for help. You have to save him!

You jump into the river and pull him safely to the bank. Not long after, a few more people appear in the water calling for help. Then a whole crowd is in the rapids, calling desperately for help. They are going to drown if you and your friend do not save them.

Your intuition tells you to run upstream and see why so many people are falling into the river. Your friend, frustrated, confused, and concerned about the people that urgently need to be saved, can't seem to understand why you would do such a thing. But you know that you cannot keep up with the throngs of near-drowning people.

When you reach the top of the rapids, you clearly see why so many people are falling in. There is an old, decrepit bridge that people are trying to cross, not realizing that it is unsafe. They will continue to fall in by the dozens and drown downstream if you do not fix the bridge or put up a fence to prevent them from trying to cross.

The stream parable, which is frequently recited in relation to prevention, illustrates a major contributor to the current health crisis in our country. For too long, too much attention and effort has focused downstream, leading to excessive health care spending and relatively poor health outcomes. Since public health is traditionally a field grounded in prevention, public health professionals generally appreciate the need for moving upstream to improve the public's health, even as they encounter barriers and resistance to upstream health interventions. Public health professionals promote healthy behaviors; ensure

access to prenatal care; advocate for clean air; and ensure safe water and food, among many other upstream preventive health strategies. In a sense, they build fences and mend bridges. However, there is more to the story…

As you look farther upstream, you notice bridges in various states of repair along the river. Some are strong, made of sturdy components. Others are weak and debilitated, with missing boards or flimsy railings. It doesn't surprise you that most of the people falling in the river are crossing the poorly made bridges, while those individuals that live near or travel across the strong bridges are protected. Of course, all of the bridges could use more reinforcement, but it's easy to see which bridges need the most attention.

The health profile of the United States reflects persistent inequities in health. It is becoming increasingly evident that we must look *farther* upstream to identify and address the underlying conditions that create such inequities if we expect meaningful changes in health outcomes. These underlying conditions are often referred to as *social determinants of health*, and include things like education, early childhood conditions, income, housing and neighborhood conditions, and workplace characteristics (Marmot & Wilkinson, 2005). The conditions in which we live and work are the primary determinants of health; investments in these areas will help to improve health outcomes for everyone (Marmot & Wilkinson, 2005). Importantly, however, differences in these underlying conditions are the root causes of inequities in health (Graham, 2004).

In the stream parable, certain groups of people are more likely to fall into the river than others. They do not fall in because of individual weakness or intrinsic flaws. Rather, some people are privileged to live in communities with strong bridges, usually made of high quality materials that protect them from falling into the river and promote their safe passage across. Members of other groups, often characterized by gender, race, socioeconomic status, sexual orientation, gender identity, age, or disability status, are

more likely to live in communities with poorer quality bridges. So while we need to move upstream to prevent people from falling in, instead of directing the majority of our efforts to pulling people out, we also need to ensure that *all* of our communities have strong bridges.

Purpose

The purpose of this guide is to provide a resource to assist the Delaware Division of Public Health (DPH) and its partners in moving farther upstream to address the underlying causes of health inequities in Delaware's communities. By raising awareness of the social determinants of health and sharing strategies and lessons learned, the goal is to enhance our collective capacity to foster optimal health for all Delawareans.

Specifically, this guide was created to support DPH in the implementation of its health equity strategy. The guide's development was influenced by several national efforts to promote population health and achieve equity in health, including the U.S. Department of Health and Human Services' (DHHS) *Action Plan to Reduce Racial and Ethnic Health Disparities,* the National Partnership for Action's *National Stakeholder Strategy for Achieving Health Equity* (http://minorityhealth.hhs.gov/npa/) and *Healthy People 2020* (http://www.healthypeople.gov/2020/default.aspx). The guide is also aligned with the Patient Protection and Affordable Care Act and related efforts to transform the health care system in Delaware (http://dhss.delaware.gov/dhss/dhcc/cmmi/).

While informed by scholarly literature, this guide relies heavily on technical reports, websites, and other practical tools and resources. Much of the material provided in the guide is publicly available and/or reproduced with permission. References and web links for additional information are provided as appropriate.

It is important to note that efforts to achieve health equity through community change and improvements in social determinants are emergent in the scholarly literature. Terms like "best practices" and "evidence-based practices" are difficult to interpret and apply when working with communities. This is because community-based and community-oriented work is, by definition, unique to each community. Public health practice must embrace the preferences of the targeted population or community in addition to taking into account the needs, assets, and resources of that community.

Figure 1 is a model of evidence-based practice developed by Satterfield and colleagues (2009). It illustrates the complexity of research translation in public health practice by putting decision-making at the intersection of research, community characteristics, and available resources. This model is particularly relevant to efforts to promote health equity, given the heightened attention to community empowerment

and social context in a health equity approach, which is described in greater detail later in this guide. Because of the complexity involved in making informed decisions to achieve health equity, this guide is a compilation of promising approaches, informed by the literature, that are meant to be adapted for community needs, assets, preferences, and available resources. It reflects the dynamic nature of the social and environmental context that can vary by place and by time.

Figure 1. Domains that influence evidence-based decision making in public health

Source: Satterfield JM, et al., 2009. Retrieved from http://www.cdc.gov/pcd/issues/2012/11_0324.htm.

The contents of this guide are based on priority professional development needs that were identified when DPH developed its health equity strategy. Although the guide is not comprehensive, it provides a foundational understanding of important concepts related to health equity. It also includes links to supplemental resources and tools where appropriate. Each section includes a glossary of terms, which serves to promote a common language. Feedback on the guide, including updates or areas needing greater attention or detail, should be addressed to:

Delaware Division of Public Health
Office of Health Equity
417 Federal St.
Dover, DE 19901
http://www.dhss.delaware.gov/dhss/dph/mh/healthequity.html

References and Additional Resources

Graham, H. Social determinants and their unequal distribution: Clarifying policy understandings. *The Milbank Quarterly, 2004, 82*(1), 101-124.

Jacobs, J.A., Jones, E., Gabella, B.A., Spring, B. & Brownson, R.C. (2012). Tools for implementing an evidence-based approach in public health practice. *Prev Chronic Dis*, 9, 110324. Retrieved from http://www.cdc.gov/pcd/issues/2012/11_0324.htm

Marmot, M. & Wilkinson, R. (Eds.). (2005). *Social Determinants of Health (2nd ed.)*. Oxford: Oxford University Press.

Satterfield JM, Spring B, Brownson RC, Mullen EJ, Newhouse RP, Walker BB, et al. Toward a transdisciplinary model of evidence-based practice. *Milbank Q* 2009, 87(2), 368-90.