Population Public Health

Winnipeg Regional Health Authority

This newsletter is intended to support the PPH January 2016 Standing Team Agenda item.

Why pay attention to the language we use?

Being intentional about our use of language is a practical way to further action to promote health equity. It helps us have safe conversations and avoid stigmatizing people or population groups. Shifts in language can facilitate shifts in attitudes, assumptions and behaviours, and help reframe complex issues.

Upcoming Events

Community Development Webinar
April 14th or 19th, 2016
9am – 10:30am

Staff Development Days
June 21 or 23, 2016
8:30-12 noon
Centre Culturel Franco-Manitobain, 340 Provencher Boul

The PPH January 2016 Standing Team Agenda is the National Collaborating Centre for Determinants of Health's "Let's Talk: Populations and the Power of Language." This document describes how public health practitioners and organizations use descriptive population terms to:

- Identify groups that are affected by the inequitable distribution of money, power and resources.
- Describe and evaluate public health initiatives that seek to improve the health outcomes of specific groups of people.
- Clarify program objectives, set eligibility criteria and allocate sufficient resources.

It suggests careful choice of language to alter discriminatory beliefs and practices and emphasizes:

- Diversity existing within population groups
- Advantage and disadvantage coexist
- Language influences power dynamics

What should we do?

What is considered appropriate language changes with the audience, the relationship, the purpose, and over time. Regardless of the setting, all language should aim to be respectful of people and their dignity.

In a community or individual setting it is best to avoid labeling and health jargon, and to focus on exploratory dialogue and listening. In conversation with community, we should be flexible and guided by the language they are using and prefer used.

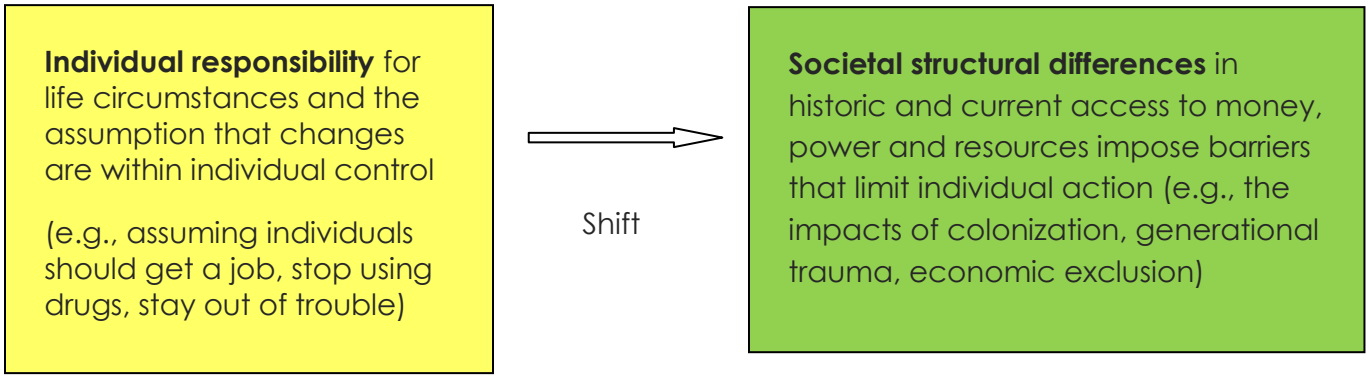
While we often get stuck on the appropriate term or word, it is equally important to pay attention to the context and sentences around what may be a contentious term to ensure that the intent and meaning of the term is communicated in a way that is clear, respectful, informed, and informative.

Our internal planning, programs and policy language

The purpose of this document is to support the use of language that promotes health equity in public health planning, program, and policy documents and discussions. The language suggested is for our internal use.

Within WRHA Public Health we suggest language that focuses us on systems and identifies situations or circumstances that result from the inequitable distribution of money, power and resources that impacts health outcomes. For example, *communities subjected to racism* or *racialized communities*. This represents a shift in perspective from individual to societal factors as in Figure 1.

Figure 1: How can language help us see things differently?



Our WRHA Public Health preferred <u>general terms</u> are:

- **Structurally disadvantaged people/populations/communities/groups**
- **Disadvantaged people/populations/communities/groups**
- **Populations limited by structural disadvantage**
- **Populations affected by structural disadvantage**

Using the term ***structurally disadvantaged*** can be useful to highlight the pre-existing structures and systems that drive health outcomes with certain audiences. The purpose is to recognize structures such as the conditions, circumstances, and determinants of health that influence opportunities for health. Since structures have been created though cumulative policy choices over time, they are not fixed and can be changed through different discourse and subsequent policy changes. The term supports our identification of solutions that modify the systems and structures –including institutions, policies and practices – that cause health inequities.

While language about health inequities often focuses on deficits it is important to recognize the many strengths of disadvantaged populations. Positive community and individual outcomes occur in spite of historical and current marginalization and oppression, but in a more fair society they would occur, and occur more frequently, because of the equal opportunities that come from equitable access to power, money and resources. A disproportionate burden of illness results from unequal opportunities to be healthy. Surveillance data, research and evidence can support our understanding of population health and illness. Recognizing and describing the context, history and current situation is an important part of using any language.

Principles of our language use

These principles are interrelated and not independent from each other.

1. Respect: individuals and collectives have the right to define their own identity; our responsibility is to respect that.
2. Humility: being self-reflective; being willing to be uncomfortable and to learn.
3. Courage: promoting health equity involves shifting our discourses to dismantle privilege and power.
4. Honesty: being willing to acknowledge that current structures of privilege and power benefit us.
5. Truth: not shying away from difficult conversations.
6. Wisdom: through integration of these seven principles we will learn and grow from experience.
7. Love/Kindness: recognizing the humanity in others as equal to your own; being kind to yourself and others.

Examples of Current Preferred WRHA Terms

There are no perfect words. Context is critical when using language. While not an exhaustive list, the illustrations below reflect ongoing learning and changing internal use of language.

Terms to avoid[1]	**Preferred systems-focused language**	**Comparable term** [2]
Vulnerable; Marginalized; Equities populations; At-risk; Hard to reach	Structurally disadvantaged	Structurally advantaged; Privileged
Poor people	People who experience poverty; Low income populations; Low income neighborhoods	High income; often the comparison group is the general/average population
The homeless; Homeless people	People who don't have homes; People who experience homelessness ; People who are homeless	People who are not homeless; people who are housed
Indians; Natives; Aboriginals	First Nations, Métis or Inuit peoples as appropriate; Indigenous; Aboriginal peoples may be used in specific legal and organizational contexts	Settlers; often the comparison group is the general/average population
Oriental; Using "the" before a group name (e.g., The Asians; The Filipinos); Ethnic minority; Visible minority	Context specific: may identify communities, people by origin (e.g., Filipino community; Filipino people) May also identify people of color; racialized communities	White
	Structurally advantaged; privileged; White people	
Homosexual	Sexual and gender minorities; LGBTTQ* (Lesbian, gay, bisexual, transgender, Two-Spirit and queer. The asterisk represents other minority gender identities and sexual orientations ex: questioning, intersex, pansexual, androgynous);	Straight, Cis-gender

[1] In general, we want to avoid terms that define people by their practices or characteristics in a way that subsumes their humanity (e.g. people who use drugs is preferred language; rather than drug users). This also happens when adjectives are used as nouns (e.g. Indigenous youth is preferred language; rather than young Aboriginals).

[2] Who is the assumed norm? Consider what is being implied as normative in language used and the power implications therein (e.g. 'people of colour' implies Caucasian as the norm). This aligns with the principle of Respect.

Creating safe learning conversations

Within WRHA Public Health we are working to continue and further our efforts to promote health equity. This requires critical self-reflection and the courage to change our behavior and practice. Staff people from structurally disadvantaged communities may fear repercussions if they identify and name when the "wrong thing" is either intentionally or inadvertently done or said. Since they may be the first or only ones to recognize a "wrong thing" they generally carry the disproportionate burden of deciding whether or not to confront an issue or statement. This may be more difficult depending on a staff's position within the organization. Initiating attention to a "wrong thing" may risk a negative reaction for criticizing others, challenging the group's status quo work culture or being seen as oversensitive. Additionally, disclosure of affiliation with a structurally disadvantaged or stigmatized group may risk personal stigmatization.

At the same time, people from structurally advantaged groups may be afraid to inadvertently do or say the "wrong thing," fearing hurting a co-worker's feelings, embarrassment or being seen as insensitive, ignorant or racist.

All of these fears may silence people and stop conversation. As a result of this silence, important learning, change, healing and team building opportunities may be missed. The responsibility for creating a safe learning environment/workplace for everyone is shared by all. It involves having honest, accountable and transformative conversations by clarifying intent, taking responsibility for mistakes and making amends, and figuring out how to improve on the situation going forward. All staff need to feel personally safe and contribute to a shared learning environment built on trust, forgiveness, appreciation and respect.

Examples from the Field

Healthy Sexuality and Harm Reduction (HSHR) Public Health Team

Working to support healthy sexuality requires nuanced and thoughtful approaches that help identify priority populations that are at higher risk for sexually transmissible and blood-borne infections (STBBIs) and at the same time work to build trust and understanding with communities. In their Strategic Planning Conceptual Framework, the HSHR team provides a definition of priority populations for internal use and planning purposes as: 'dynamic, socially constructed categories reinforced through surveillance and evidence. Although these categories can be stigmatizing, they can also be useful for planning targeted public health programs and services.'

The inclusion of the explanation is an important recognition of context and potential for stigmatization. The priority populations are described as: people from HIV-endemic countries; Indigenous peoples; men who have sex with men; people who use substances; people who are or have been in prison; people living with HIV; and structurally disadvantaged women and youth.

Mental Health Services

A key pillar of Manitoba's mental health strategic plan Rising to the Challenge (http://www.gov.mb.ca/healthyliving/mh/challenge.html) is a commitment to a recovery-oriented mental health system. In June 2015, the Mental Health Commission of Canada released the Guidelines for Recovery-Oriented Practice (http://www.mentalhealthcommission.ca/English/initiatives/RecoveryGuidelines) which describe the dimensions, principles and approaches of recovery-oriented practice. The WRHA Regional Mental Health program is also embarking on a transformation of its services toward a recovery–oriented system. All healthcare service providers have an important role in supporting recovery.

While the whole of recovery-oriented practice is built upon a culture and language of hope, one key shift is the focus on people living with mental health problems as individuals, not as "patients". "Recovery-oriented practice helps to highlight our shared humanity and avoids putting labels on people or defining them by a diagnosis" (Mental Health Commission of Canada, 2015). For this reason we avoid using terms such as "schizophrenic", and are encouraged to use phrases such as people living with a mental illness or people with lived experience.

Other ways in which language can be used to promote health equity from a mental health perspective include: focus on the strengths and abilities of each person rather than on deficits and limitations, recognize the diversity of every person's experience, background, and journey, believe in every person's capacity to recover, thrive and lead a meaningful and contributing life, embed a language of optimism and hope, use language that contributes to a positive sense of identity, support self-determination and choice, recognize that everyone's mental health and well-being is impacted by multiple intersecting factors such as biological, psychological, social, economic, as well as family context, cultural background, personal values and spiritual beliefs. Supporting recovery includes "removing barriers to full citizenship and creating a social context that fosters mental health and wellbeing" (Mental Health Commission of Canada, 2015).