# Language We Use To Promote Health Equity

## 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.

## Background

The National Collaborating Centre for Determinants of Health published the concept review and discussion guide: "Let's Talk: Populations and the Power of Language" available here: http://nccdh.ca/resources/entry/lets-talk-populations. 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

## 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.

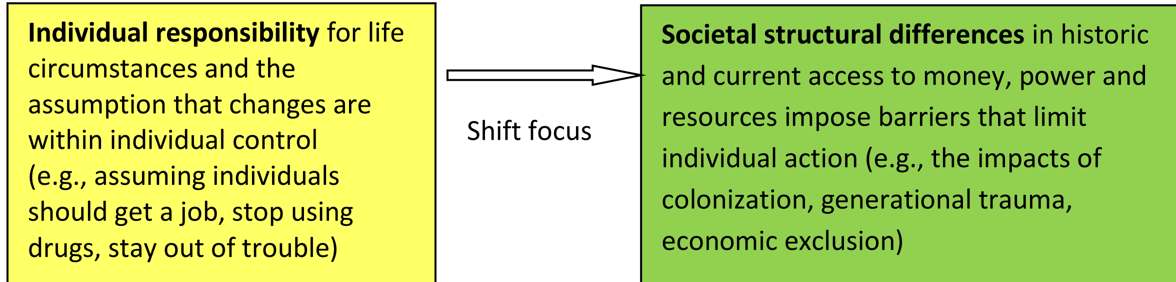
## Our internal planning, programs and policy language

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 general terms 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; using 'the' before a group name (e.g., The gays) | Sexual minorities; LGBTQ people (Lesbian, gay, bisexual, two-spirit and queer.) | Straight |
| Conflating transsexual/ transgender/transvestite | Gender minorities; gender-diverse people; trans people. | 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.

Prepared by: Dr. Marcia Anderson DeCoteau, Kim Bailey, Dr. Sande Harlos, & Hannah Moffatt