National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

LET'S TALK

REDISTRIBUTING POWER TO ADVANCE HEALTH EQUITY

PART OF THE LET'S TALK SERIES

"Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the **empowerment** of communities, their ownership and control of their own endeavours and destinies."[1(p3)]

"The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of **power**, income, goods, and services, globally and nationally."[2(p1)]

"**Power**, after all, is the heart of the matter—and the science of health inequities can no more shy away from this question than can physicists ignore gravity or physicians ignore pain."[3(p169)]

THE FIELD OF PUBLIC HEALTH IS ROOTED IN REDISTRIBUTING POWER

Public health's foundations are in community health and organizing. The discipline has historically been a strong ally and organizer alongside housing reformers, social organizations, environmentalists, hygienists and labour movements.[4] As public health professionalized and developed, the field gravitated to a more biomedical and scientific view of diseases and wellness, yielding to the sentiment that public health should be apolitical. Over the years, the dominant narrative about health became that illness is a matter of science, germs and personal responsibility, therefore implicitly absolving corporations, governments and other structures for their roles in promoting or allowing an unequal distribution of power.[4]

Increasingly, however, public health leaders recognize that genuinely shifting "the loci of power and expertise, the structures of colonialism and medicine that continue to shape our systems"[5(p1)] toward communities is a key strategy for advancing health equity, building resilient health systems and sustainable societies, and enhancing well-being. It is also the role of public health practitioners to "resist current processes of depoliticization and strengthen the outward gaze on structural pathways from empowerment to health equity."[6(p1260)] In other words, public health must refocus its efforts on shifting power toward groups that have been marginalized by directing its energy to the political, economic and societal systems that can structurally drive health and well-being for all.

Public health's history also guides our work on power in more ways. Our focus on population and community health suggests a focus on collective power rather than on individual power. And our focus on equity and prevention suggests we focus on redistribution of power rather than just mitigating the impacts of power imbalance.

This document introduces the concept of power as it relates to health equity. It defines power and explains the relationship between power and oppression. It then explores a framework for understanding power to help practitioners recognize systems of power that influence public health practice. Specific strategies for redistributing power and advancing health equity are discussed, with a focus on building community power.

POWER IMBALANCE IS A FUNDAMENTAL CAUSE OF HEALTH INEQUITY

Health inequities are unfair and avoidable health differences between population groups arising from social, economic, demographic and geographic conditions.[7] As early public health practitioners understood, inequities are the result of an unequal distribution of resources needed for health, such as safe and affordable housing, good jobs with benefits, high-quality schools and clean and safe environments.

Access to many of these health-promoting resources is not the same among groups. Populations with whom this access has not been shared also face an unfair distribution of power: those with more power have better health outcomes and better access to social, economic and environmental health supports than those with less power.

Individual and group power have been linked to improved health,[8,9] and individual powerlessness has been linked to poorer health.[10,11] When communities that have been marginalized and civil society build power, health outcomes improve.[8,12] Conversely, when an unrepresentative few have more power in comparison to others in society, they can steer policy decisions, institutions and systems in ways — and create community conditions — that harm the health of some groups and maintain or increase inequity.[13–15]

Power imbalances are not accidental or unavoidable. Our society — and our public health practice — has been built upon multiple systems of oppression (e.g., White supremacy, colonization, nationalism, capitalism, patriarchy) that historically contributed to these imbalances and to this day actively ensure that wealth, status, land ownership and other resources remain in the hands of the powerful few.[16]

Health is inescapably political, as Bambra et al. point out, because "some social groups have more of it than others" and "because its social determinants are amenable to political interventions."[17(p187)] Although public health may desire to see itself as objective and apolitical, shifting back to working to redistribute power requires that public health move into political work. Remaining apolitical, although a safer choice, is a decision with consequences. Public health cannot be apolitical and, at the same time, claim that it is working to advance equity and social justice.

PUBLIC HEALTH MUST UNDERSTAND POWER TO ACHIEVE HEALTH EQUITY

POWER IS THE ABILITY TO ACHIEVE PURPOSE[18]

Although power can have negative connotations because it can be thought of as domination or *power over* others, there are other ways of thinking about power.[6,19–21] Individuals and collectives, including those most negatively impacted by inequities, can have *power to* achieve their goals. Public health can build *power with* those most impacted by inequity to advance equity and justice, starting from a place of humility and building trust (see also *Let's Talk: Community engagement*). And public health can support the realization of *power within* individuals and communities by helping them deepen their sense of self-worth, value and dignity as well as their capabilities to act collectively.

Community power is:

> the ability of communities most impacted by structural inequity to develop, sustain, and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision makers that change systems and advance health equity.[22(p29)]

Community-organizing groups often work with those most impacted by inequity to build community power. We define a community-organizing group as an organization that:

> brings people who identify as being part of a community together to solve problems that they themselves identify; helps a community identify common problems, mobilize resources, and develop and implement strategies to reach their collective goals; develops civic agency among individuals and communities to take control over their lives and environments; is committed to building a membership base and is accountable to that membership; and builds collective power to bring about structural change.[23]

POWER AND OPPRESSION

Public health's recent focus on racism and other forms of oppression has begun to advance health equity. Power and oppression are two sides of the same coin. A person or group lives within structures of oppression if other groups have the power to make decisions on their behalf and/or determine their actions.

Current racial, class, gender and ability structures, as well as other structures of oppression, are maintained by differences in power, and a redistribution of power can shift those structures to create a more equitable world:

- Class relations are defined by the power relationship between those who control resources and those who must sell their labour to earn a living. Those who control resources have economic power and power to control workplaces. Workers also have power, for example, to quit or, when they unionize, to strike. (For a longer analysis on labour and work and how they relate to health and equity, see this information brief on decent work.)
- Racial and ethnic relations are defined by the power relationship between groups of people who have been racialized differently, where groups of people who are deemed to be White are given access to power structures.

Racial relations also have a class component, since those who control resources typically have been White in Canada and in many other places. In this way, the struggles for racial and economic justice are deeply intertwined.

- Gender relations are defined by the power relationship between genders in society, in the family and in the workplace, with cisgender men typically holding more power than women and transgender people. Gender relations have both a class/economic component, with men historically being paid more and much of women's work being unpaid, and a racial component, with women of colour being expected by many in society to work outside the home though they may only have access to low-paying jobs.
- Relations between people with and people without disabilities are also defined by power. People with disabilities have less access to resources and to decision-making, and therefore less power, than non-disabled people.

These relations also have class, racial and gender dimensions that can exacerbate the power imbalance.

Although the power an individual or a group holds depends on the specific context, those who face multiple systems of oppression have less. In other words, intersectionality and power are tightly linked. (see also *Let's Talk: Intersectionality*).

Different social groups in society vie for state power so they can shape rules in their favour. The wealthy, for example, argue for relaxing limits on campaign donations to increase their influence with elected officials. However, the state can be used to promote equity by limiting the power of groups promoting policies and practices that lead to inequitable outcomes (e.g., limiting campaign donations by the wealthy and corporations) and by supporting the building of collective power among workers, people of colour, women and others.

Indigenous conceptions of power

Less has been published specifically about Indigenous conceptions of power. Harris et al. write:

> For Indigenous peoples, power comes from sovereignty, that is, custodianship of country as well as knowing (epistemology), being (ontology), and doing (axiology) regarding individual and collective obligations and accountabilities borne of that sovereignty. Governance in many Indigenous societies prior to colonization was based less on overt expressions of power (power over) and reflected a relational expression of power in which custodial responsibilities through reciprocity, mutual benefit, communal integrity and, importantly, endurance were vital. Governance systems aimed at ensuring the continuation of all life in harmony with the natural world.[48(p550)]

The concept of power and self-determination are interrelated, with both being about control over destiny. The National Coordinating Centre for Indigenous Health states that a crucial indicator of self-determination is "the degree to which Indigenous people are regaining control over their own lands and resources" and that "self-determination is not only a matter of having the authority to make decisions and laws, but also having a well-developed infrastructure for the implementation of decisions."[49(p49)]

The concept of decolonization is also related to power. For example, in the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, colonial power is referenced repeatedly, and equally the power of sexism and violence that has resulted from colonial power.[50]

Tying the concepts of power, self-determination and decolonization to Indigenous public health programming within an urban environment, Dr. Sarah Funnel states that:

> Engagement occurs on a linear spectrum. It begins with informing and ends with collaboration, with the objective of reaching an ideal state of empowerment. To achieve this, public health entities must embrace authentic, empowering engagement. A similar spectrum exists that is more meaningful to Indigenous Peoples and which illustrates a range of authenticity, from inclusion, to reconciliation, to decolonization. On this spectrum, Indigenous inclusion is the most superficial; reconciliation is about relationships in which power is shared; and decolonization (self-determination) is about returning power to all Indigenous Peoples, including those living in urban environments.[51(p46)]

POWER AND POSITIONALITY

Although this *Let's Talk* is focused on collective power, power can also be considered at the individual level. Each of us has power, and how it manifests depends on context. We may be powerful in some contexts and less powerful in others. We need to be mindful that power structures also have the potential to shape interpersonal interactions; power imbalances and privilege play out in our daily lives and in our work settings. Ensuring our workplaces are equitable must include using policies and practices that level power imbalances. Public health practitioners, and others, must also understand their own positionality — the power they do or do not hold because of their multiple identities, including their named authority — and acknowledge the effect it may have on their perceptions and actions as well as on how they are perceived. We must also take into account how those with whom we work conceive of their own power or powerlessness (see also *Let's Talk: Community engagement for health equity*).

Public health institutions should also consider their own power. For example, public health agencies control their own programming and how decisions about that programming are made. Public health is also embedded in broader health systems, which wield tremendous power, but public health itself often has less power and control of resources within those systems.

CONVERSATION STARTER

Below is a working draft of a positionality statement for the National Collaborating Centre for Determinants of Health, in which we attempt to recognize the power the organization has. We welcome feedback about this draft, and we encourage organizations to consider writing and sharing their own positionality statements.

NCCDH POSITIONALITY STATEMENT

The National Collaborating Centre for Determinants of Health (NCCDH) recognizes that it holds a significant amount of power in various forms: (1) knowledge, as a currency and as a contributor to the dominant narratives in public health; (2) economic, through its funding structure as part of a federally-funded program since the NCCDH is funded by and reports to the Public Health Agency of Canada; and (3) access to various agenda-setting venues, such as conferences, private interagency meetings, etc.

In positioning itself, the NCCDH acknowledges that it is aware of its power and intends to use it to foster a more equitable world, by embracing values of humility, compassion, solidarity, accountability and justice in all of the work that it does. The NCCDH is committed to embracing diverse, anti-oppressive, intersectional and collaborative relationships and ways of knowing to support collective change, transformation and well-being.

The NCCDH espouses the notion that, as a holder of power, it will support the work of structurally disadvantaged communities as initiators, collaborators and equal partners. The NCCDH believes that public health must work to redistribute power to advance health equity.

PUBLIC HEALTH MUST WORK TO REDISTRIBUTE POWER TO ACHIEVE HEALTH EQUITY

Building on a deeper understanding of power, public health actors should adopt an approach that aims to shift power structures and systems while also addressing specific health and equity issues. To develop interventions that intentionally redistribute power, public health practitioners must take three steps:

1. Develop an understanding of power and be able to recognize how power and health equity outcomes are interrelated.
2. Use frameworks to analyze power dynamics that currently prevent policy, systems and structures from changing for a particular issue.
3. Develop and implement strategies and tactics stemming from that analysis that can change or resist those power dynamics, including:
    - building community power by supporting communities to develop and exercise collective control; and
    - limiting the power held by those that obstruct progress toward equity, by implementing approaches that oppose those power structures.

RECOGNIZING AND ANALYZING POWER TO DESIGN PUBLIC HEALTH ACTIONS

There is no one "correct" definition of power, and a number of frameworks have been developed to conceptualize it. The usefulness of any framework is based on whether public health practitioners can operationalize it into effective strategies to advance equity. The issue(s) of interest, the political context and constraints, existing relationships and partnerships, the available resources and other specifics will determine which frameworks and strategies are most useful in a particular situation.

In Table 1, we introduce the "three faces of power"[24] framework and outline actions for redistributing power. This framework is commonly used by practitioners focused on community power-building and, increasingly, by others in the public health sector. The subsequent sections discuss in more detail public health roles and interventions for building community power within each of these faces or forms of power.

TABLE 1: THE THREE FACES OF POWER AND WAYS TO SHIFT POWER TO COMMUNITY[25]

FACE OF POWER	DESCRIPTION	STRATEGIES THAT CAN BE USED TO REDISTRIBUTE POWER	EXAMPLES OF ACTIONS THAT BUILD COMMUNITY POWER	EXAMPLES OF ACTIONS THAT LIMIT THE POWER OF THOSE THAT OBSTRUCT PROGRESS TOWARD EQUITY
VISIBLE	Exercising influence in the political or public arena and among formal decision-making bodies to achieve a particular outcome	Organizing people and resources to influence public or formal decision-making processes through direct involvement and action, such as enacting administrative policy, designing and funding programs, voting on an issue, lobbying decision-makers or electing public officials to be decision-makers	• Advocating for the passage of a living wage policy that community members developed and support • Conducting a health impact assessment on a paid sick day policy that workers developed and support • Making voter registration information available where public health services are provided	• Advocating for limits on corporate lobbying broadly and about worker rights in particular • Conducting a health impact assessment on a policy that would limit the hiring of workers as contractors • Advocating for campaign finance reform that limits the influence of corporations in elections
HIDDEN	Organizing the decision-making environment, including who can access decision-making and what issues are being considered by decision-making bodies	Building durable, long-term civic infrastructure to affect the conditions that precede decision-making, such as developing and supporting networks of organizations that are aligned around shared goals and can shape public agendas	• Supporting community-organizing and leadership development efforts, for example, by providing trainings to community members about government agencies and how to engage with them • Forming coalitions among organizing, advocacy and other groups to build cross-race, cross-class, cross-issue networks	• Exposing ties between elected officials and corporate lobbyists • Publicly critiquing networks that advance racist and/or xenophobic ideas
INVISIBLE	Shaping information, beliefs and world views about social issues	Shaping public narratives to shift world views, values and behaviours: government, education, research, media, religious, political and social institutions do this by helping people make meaning of events and happenings in the world	• Developing transformative narratives that amplify values and beliefs such as interconnectedness, belonging and sustainability	• Exposing narratives that glorify individualism, free markets, anti-government sentiments and racism • Research and critical scholarship on current narratives and world views and their impact on health

VISIBLE POWER:

Public Health Interventions in Decision-making

Public health practitioners regularly engage in making decisions about public health programs and initiatives, and they use data, research, communications, advocacy and lobbying to educate policy-makers and influence their decisions.[25] These are all ways we use the first face of power in this framework. However, our influence and interventions have not always advanced equity, and at times, both our actions and inactions maintained or deepened inequities.[26]

Building community power and advancing equity can be accomplished by intervening in public decision-making alongside those facing inequities. For decisions related to the social, economic and environmental factors that influence health — typically outside the direct control of public health practitioners — this can mean understanding the priorities of those facing inequities by deeply engaging them and supporting their ability to impact decisions related to those priorities.

Public health practitioners can play multiple roles, for example, engaging in the same activities listed above to influence decisions but with a focus on community priorities and building the capacity of members of the community to use public health research and data to advocate on their own behalf. In this face of power, visible power, public health's role is to listen deeply and lift and amplify community voices to the organizational and authoritative power holders (e.g., a public health nurse gathers narrative evidence about inequities the people they work with face and reports it to the decision-making table in their organization).

Through the lens of this first face, limiting the power of wealthy individuals and corporations that work to maintain the status quo includes working with others to advocate and/or lobby for policies that, for example, tax those individuals and corporations in order to reduce their ability to use their wealth to influence decisions, and reform electoral rules to reduce their influence, including restricting campaign donations. Another example of using this face of power is a health promoter working with city council to develop municipal policies that promote health and change those policies that may harm health in their community.

HIDDEN POWER:

Public Health Interventions in Building Infrastructure and Agenda-Setting

Public health frequently plays the role of convener, bringing together coalitions, for example, to identify community priorities and address them. These coalitions often develop a set of interventions, advancing a proactive agenda that may include introducing new policy concepts.[25] These activities are examples of public health's use of the second face of power — hidden power.

These activities can be conducted with an explicit focus on equity and on building the power of those most impacted by inequity. Community- and labour-organizing groups can be key partners and allies, and their members can have a strong voice in coalition decision-making, including taking the role of final decision-maker. Public health practitioners can also organize themselves and work in allyship with those facing inequities to advance an equity agenda. This includes public health practitioners building coalitions or communities of practice within their own organizations.

In this face of power, public health's main roles are to actively look for and remove barriers to community participation, priority-setting and decision-making; proactively build coalitions of diverse groups that can advance equity agendas built around community priorities; and partner with others to restrict lobbying and other access to decision-makers by wealthy individuals and corporations, to reduce their ability to influence rules and regulations in ways that harm health.

INVISIBLE POWER:

Public Health Interventions in Changing Dominant Narratives

The shift within public health over the last several decades to increasingly focus on the importance of the social, economic and environmental factors that impact health — the determinants of health — can be thought of as an intervention related to the third face of power. Using research, communications, policy advocacy and other public health tools, practitioners have actively, though not uniformly, worked to shift people's mindsets from an individualistic view of the causes of health and illness to a social and political view.[25] Public narratives — "collections of deeply rooted stories in our collective consciousness that transmit values and ideas about how the world works"[27] — have been shifting because of these efforts.

Public health can work to intentionally shift additional public narratives and world views to further advance health equity. This is an important strategy because most dominant narratives are embedded in the psyche of almost all people in society, from policy-makers to practitioners to even the people harmed by these ideas and resulting policies. Table 2 identifies some of these widespread dominant narratives and negative impacts. Transforming dominant narratives is critical because it influences what is thought of as common sense and opens more possibilities for making the policy and structural changes required for equity.

Critical academic scholarship and advocacy can unmask negative dominant narratives and their impacts on health. For example, Friel et al.[28] developed a power analysis tool and applied it to seven Australian policy debates related to the determinants of health. They found that "socially created rules and mandates, especially associated with neoliberalism, racism, sexism and biomedicalism, guide and constrain policy decision-makers' choices, through setting the expectations about how the game should be played and who has power in the game."[28(p10)] Another key finding from their study was:

> Forms of invisible structural power, enabled by expert power, were used to limit normative social views of "health" to individualised biomedical or behavioural conceptions. Thus "health" became conceptually equivalent to use or availability of biomedical interventions to avoid illness, or exercise of individual choices, and behaviours to maintain healthy behaviours. An important effect of this is the constraining of responsibility and leadership for health equity to the health sector, thus embedding an institutional path dependency that is difficult to rectify. In addition, adoption of the biomedical view of health as the norm serves to maintain the economic power of those who deliver the therapies, medications or behavioural programs that ostensibly cultivate "health."[28(p10)]

A transformative narrative is not just a response to the currently dominant and harmful narrative but should also promote the values and beliefs that would create an equitable world. To be effective in shifting dominant narratives, public health practitioners must have core competencies in communication and a solid understanding of how mental models and world views are created through social discourse and through public health programs and actions.

Furthermore, to increase its effectiveness at communicating narratives, it is important to ensure that public health has channels to do so (e.g., advocating for policies that restrict consolidation and deregulation of the media). An example of using the third face of power could be a public health group comprised of many disciplines coming together to create new transformative narratives around issues such as substance use and to design a way to communicate these new narratives consistently.

TABLE 2: EXAMPLES OF DOMINANT NARRATIVES THAT IMPACT HEALTH EQUITY

DOMINANT NARRATIVES	EXAMPLES OF POTENTIAL IMPACTS FOR HEALTH EQUITY
Health is a matter of individual responsibility.	People who use drugs are thought to be undeserving of health or social services.
Individual liberty should be a top priority.	People believe that it is their right to not wear a mask to protect others from COVID-19.
Free markets and neoliberal economic policies are the best policies.	People believe that the free market can solve climate change and minimize the role of government in doing so. People believe that the free market can provide sufficient and adequate housing for all. People believe that housing is a commodity and not a human right. People believe that the free market can provide the best cost for prescription drugs through increased competition.
There is a scarcity of resources, and we must decide where to best use them.	People believe that providing support to some populations means taking from another population. For example, providing primary care to people experiencing homelessness or using substances takes away from providing services to the general population.
Racism is a thing of the past.	People believe that interpersonal racism has decreased and that racism is therefore outdated, and they don't see the impacts of structural racism.
Health is physical (or biological).	People undervalue mental and spiritual health because they perceive health as mainly a biological phenomenon.

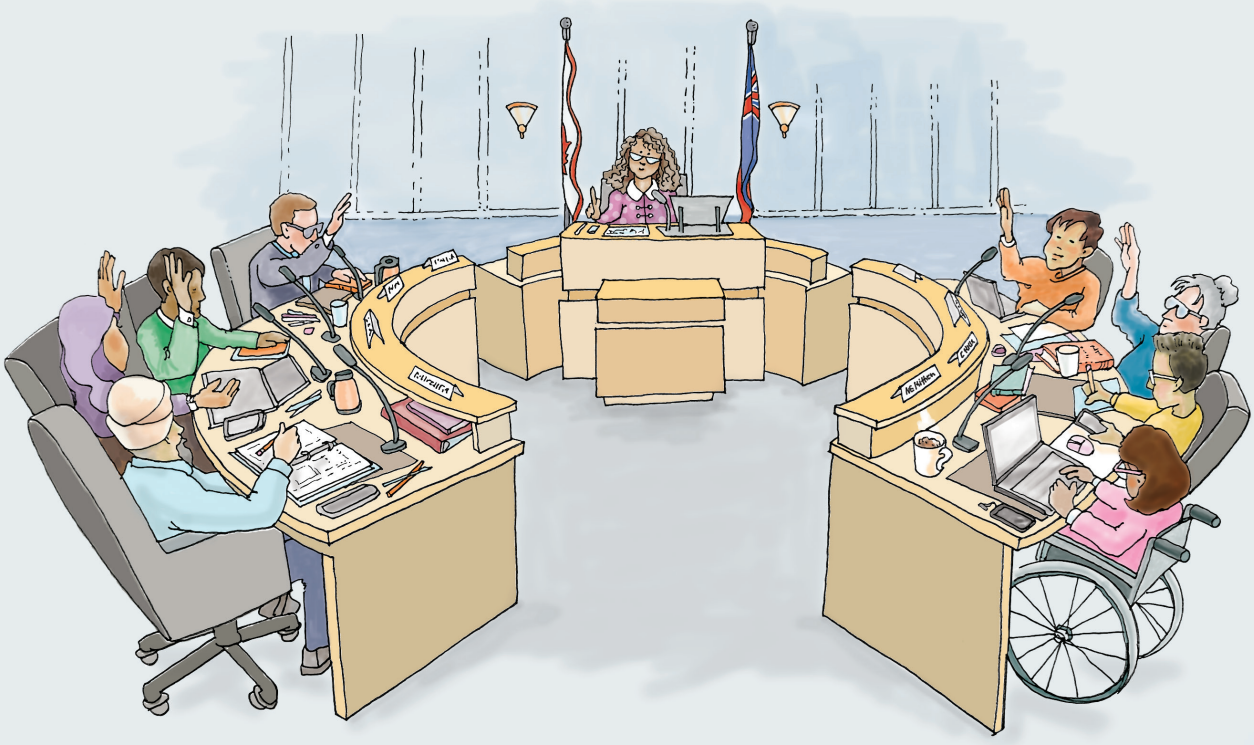
CASE STUDY: HOUSING, HEALTH AND POWER

Conducting a thorough power analysis using a framework like the three faces of power is useful for developing strategies and guiding actions to advance equity.

Housing stability, quality, safety and affordability impact health in a variety of ways,[29] and public health in Canada[30] and the United States[31] has engaged in housing policy as a social determinant of health. Let us look at housing policy through a power lens.

VISIBLE POWER

Municipalities typically develop housing plans and set housing policies. The city councillors making those decisions often get campaign contributions from housing developers, and the contributions of housing developers support the election of city councillors who agree with their views.[32] Some policy decisions that would lead to better health outcomes, such as the passage of affordable housing policies in cities that are facing a housing crisis, are opposed by many housing developers because those policies would reduce their profits. City councillors face pressure from housing developers — their donors — to not pass those policies.[33,34] In other words, housing developers, who have significant financial resources, have more power to influence elections than community members who would benefit from policies that increase housing affordability, quality and safety but who do not have similar financial resources with which to influence elections. Those populations can organize themselves and build community power to advance the housing policies that would lead to health equity. ACORN Canada, for example, organizes residents in Toronto and elsewhere around housing issues.[35]



HIDDEN POWER

Canadian corporations engaged in housing — builders, renovators, land developers, trade contractors, lending institutions, insurance providers, etc. — work together through industry associations. One function of these associations is coordinating advocacy and lobbying efforts to influence federal, provincial and local policies related to housing. At the federal level, for example, the Canadian Home Builders' Association has approximately 9,000 members[36] and has lobbied recently on tax and financing issues.[37] Provincial chapters in Ontario,[38] Manitoba[39] and elsewhere also lobby on a variety of issues, including mortgage and tax policy.[40]

At the local level, additional home builders' associations exist (e.g., HAVAN in Vancouver has over 1,100 members,[41] and the Building Industry and Land Development Association in Toronto has over 1,300 members[42]), and they also conduct advocacy and lobbying on behalf of their members (e.g., on development approval processes).[43,44] These coordinated efforts are likely to influence legislation and policy already being considered (visible power) as well as potentially change what legislation and policy will be considered (hidden power). Although progressive housing organizations like ACORN Canada also exist, they are less well funded and smaller, and they have less financial power to shift the political agenda.

INVISIBLE POWER

There are a number of dominant world views and narratives that maintain current inequities related to housing. Many people in Canada believe that:

- Private ownership of land and housing is natural, and people and companies should be allowed to buy and sell land and housing for profit.
- People who are unhoused are personally responsible for their situation.
- Some neighbourhoods lack opportunity because the people living in them have chosen not to invest in their neighbourhood, and they could just move to a different neighbourhood if they wanted to.
- Government "interference" in the housing market (e.g., building additional affordable housing or taxing the profits of developers) is unnecessary, especially if it could negatively impact their home values.

These world views and narratives have significant impacts: a lack of affordable housing in many communities in Canada, significant unhoused populations and segregated communities that differ greatly in their access to opportunity. These dominant world views run counter to world views that would lead to increased equity, including Indigenous world views in which the concept of land ownership is abhorrent.[45] Housing advocates in the United States are lifting a different set of narratives, such as a Homes Guarantee,[46] and using messaging such as:

- "Everyone should have a safe, stable place to call home."
- "All children deserve a roof over their head and a safe place to live."
- "Like air to breathe and food to eat, safe shelter is a basic human need."[47(p1)]

KEY MESSAGES

- Power, specifically collective power, is at the root of the history of public health.
- Power impacts health equity and individual and collective health at a structural level, which puts it in the purview of public health.
- Power can be harnessed or redistributed through a variety of means, many of them accessible to public health practitioners.

REFLECTIVE QUESTIONS

To reflect on opportunities for building collective power, public health can consider the following questions:

- Who is making the visible decisions we want to influence in the short run? Who influences those people, bodies or organizations? What relationships do we have to decision-makers and those that influence them? What public health assets (e.g., evidence) can be mobilized to influence the decisions? How can we communicate our evidence, experience and perspective in a way that they will hear?
- What hidden infrastructure is influencing the decision-making agenda? What infrastructure can we build in the intermediate term to support an equity agenda? Who do we need to be working with and how can we build deep and trusting relationships with them? How can public health's convening capacity and perceived objectivity be used to support building power with communities most impacted by inequity?
- What dominant public narratives are influencing the decisions that impact health, making a particular viewpoint seem like common sense? What are transformative narratives centred on equity that could make a different set of options seem like common sense in the long term? How can we use public health communications, research, campaigns, programs, advocacy and other activities to disseminate these narratives?
- What power do I hold as an individual? What power does my institution hold? And what power does the system I work within hold? How can that power be used to advance equity?

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