Resolution for Disability, Ableism, and Health Equity in Public Health Education and Health Promotion Practice

Call for integrating the role of disability and ableism in health education and health promotion practice.

Adopted by the SOPHE Board of Trustees
August 11, 2021

Whereas, the Society for Public Health Education (SOPHE) recognizes that the health and well-being of communities and the individuals within them is dependent not only on biological, but also social and environmental factors.

Whereas, the Centers for Disease Control and Prevention (CDC) reported that about 1 in 4 adults identified as having a disability. Based on 2019 data in the CDC's Disability and Health Data System, among adults 18 years of age or older living in the United States, DC, or the Territories who reported any disability, the age-adjusted prevalence was 26.7% (95% CI: 26.5-27.0) or an estimated 67.2 million people, which increased from 24.6% (95% CI: 24.4-24.9) or an estimated 62.6 million people in 2016 (Disability and Health Data System, 2016, 2019).

Whereas, disability occurs for many reasons, such as genetic or congenital causes, traumatic injuries, chronic illnesses, or simply due to aging (Carmona et al., 2010). Anyone of any race, ethnicity, education level, socioeconomic status, or age (Office of the Surgeon General [OSG], 2005) is, at best, temporarily able-bodied, can become disabled at any time, and thus disability can and does occur across the lifespan (Harpur, 2012).

Whereas, **disability**[1] can be considered from multiple perspectives: a functional approach, which "emphasizes the inability to perform important life activities"; a categorical or diagnostic approach, which focuses on "the underlying disease, trauma, or health impairment"; and a social approach, which recognizes "the barriers a person (with an underlying impairment or condition) experiences when interacting with the environment" (Drum, 2014, p. 3). This clarifies the very brief International Classification of Functioning, Disability and Health (ICF) definition of disability as "an umbrella term for **impairments**, activity limitations, or participation restrictions" (World Health Organization [WHO], 2001, p. 8). Further, to consider disability from a legal perspective, the Americans with Disabilities Act (ADA) as amended defines **disability with respect to an individual** as: "a physical or mental impairment that substantially limits one or more major life activities of such individual, a record of such an impairment, or being regarded as having such an impairment" (ADA Amendments Act, 2008), which are again, respectively, functional, categorical, and societal approaches (Carmona et al., 2010).

Whereas, disability can be experienced across a continuum (OSG, 2005); disability is not synonymous with chronic disease (Drum, 2014), nor is it an illness (OSG, 2005). Disability and health are not mutually exclusive and people with disabilities/ disabled people are frequently both healthy and well (Carmona et al., 2010).

---

[1] Terms in boldface are included in a glossary on page 9.

Whereas, the need to standardize, collect, analyze, and report health disparities data using consistent language, terminology, and definitions resulted in Section 4302 (Understanding health disparities: Data collection and analysis) of the Patient Protection and Affordable Care Act, which established data collection standards for demographic measures of race, ethnicity, sex, primary language, and disability status, that are required to be used, to the extent practicable, in all national population health surveys (Office of the Assistant Secretary for Planning and Evaluation, 2011).

Whereas, disability is a personal experience and some who experience it may choose to use person-first language while others may prefer identity or disability-first language (e.g., person with a disability or disabled person) (American Psychological Association [APA], 2020). Use of historic negative terminology (e.g., wheelchair-bound, confined to a wheelchair, crippled, crazy, etc.) perpetuates myths and stereotypes about the exclusivity of disability and health and wellness (Carmona et al., 2010). Equal access and equal opportunity for people with disabilities/ disabled people have been mandated by laws, regulations, court cases, and various programs, but improved quality of life cannot be mandated (OSG, 2005).

Whereas, "many persons with disabilities can, and do, lead normal, healthy lives *when they can access appropriate care to support their ongoing health and wellness needs*" ([emphasis in the original]; OSG, 2005, p. 4).

Whereas, people with disabilities/disabled people are an unrecognized population experiencing health disparities (Krahn et al., 2015; Yee et al., 2018), whose needs are not addressed by most health and wellness programs (WHO, 2001). People with disabilities/disabled people encounter **discrimination** and prejudice in clinical and educational situations, which create barriers to obtaining appropriate care, information, and other needed resources (APA, 2017). In addition, the lack of appropriate programs and services and lack of information about those that exist contribute to health disparities among this population (OSG, 2005). Compared to people without disabilities/non-disabled people, people with disabilities/disabled people get fewer pap tests, mammograms, and PSA tests; have lower screening rates for diabetes, hypertension, and other chronic diseases; receive less preventive care; and have lower rates of exercise and higher rates of smoking, obesity, diabetes, hypertension, and cardiovascular disease (Krahn et al., 2015; Yee et al., 2018).

Whereas, **ableism** or **ableist** attitudes, beliefs, and policies persist due in part to inaccurate assumptions and fears about people with disabilities/disabled people, lack of representation, misrepresentation, lack of education, and/or lack of experiences interacting with people with disabilities/disabled people (Harpur, 2012; Levine & Breshears, 2019). Educators, faculty, students, and practitioners "must be afforded the opportunity to confront preconceived notions and implicit biases to properly address and mitigate the effects of such beliefs" (p. 147) and to remedy "issues of access, equity, equality, systemic oppression, and all facets of society which disproportionately disadvantage specific groups" which are matters of social justice (Levine & Breshears, p. 148).

Whereas, "contact has consistently been indicated as an effective method for mitigating negative attitudes" (Levine & Breshears, 2019, p. 148) and "the population at large must better understand the abilities of persons with disabilities, not solely their disabilities" (Carmona et al., 2010, pp. 230-231), training curricula and standards should incorporate inclusive education, positive representation, and increasing empathy, which are effective ways of reducing bias toward disadvantaged groups, including people with disabilities/disabled people (Levine & Breshears, 2019).

Whereas, people with disabilities/disabled people have many social identities (e.g., gender, age, race/ethnicity, disability status) and are part of diverse coexisting cultures, which is known as **multiculturalism** (APA, 2017). The **intersectionality** of these identities, which "are *not* separate, additive, dimensions of social stratification but are mutually defining, and reinforce one another in a myriad of ways" ([emphasis in the original]; p. 167) are associated with privilege or disadvantage (APA, 2017). Thus, the effect is compounded when discrimination, disability identity, and other **marginalized identities** (e.g., women, BIPOC, members of the sexual and gender diverse community) intersect (Levine & Breshears, 2019; Warner & Brown, 2011).

Whereas, it is important that disability should be understood as both a personal and a cultural identity (Andrews et al., 2019; Núñez G., 2009), with disability status having differential effects on both power and privilege (Bowleg, 2012) that make it necessary to fully support the problem-solving skills, self-advocacy, and self-efficacy of people with disabilities/disabled people (Wehmeyer & Little, 2013; Wehmeyer & Shogren, 2017).

Whereas, schools (preschool through graduate school) have a responsibility to educate students about such topics as disability and inclusivity (e.g., Jung et al., 2019), in order to shape the next generation's understanding of health, diversity, equity, and equality, educators at every level must integrate basic education on disability into course curricula and syllabi (Carmona et al., 2010; Levine & Breshears, 2019).

Whereas, multicultural competence trainings need to explicitly include disability identity (APA, 2017) and social justice issues so that trainees discover their own biases and "confront their own identities, privilege, and the systems they have been complicit in or subject to" (Levine & Breshears, 2019, p. 148).

Whereas, it is important to build a disability-competent public health workforce and leadership (Griffen & Havercamp, 2021) which the 10 Essential Public Health Services recommends as a way to "remove systemic and structural barriers that have resulted in health inequities [such as] poverty, racism, gender discrimination, ableism, and other forms of oppression" (Public Health National Center for Innovations, 2020). The objectives of Healthy People 2020 and Healthy People 2030 are, respectively, to increase the proportion of US MPH-granting public health schools offering disability-specific content and graduate-level studies in disability and health (Office of Disease Prevention and Health Promotion [ODPHP], 2015) and the proportion of state health departments offering programs aimed at improving health in people with disabilities (ODPHP, 2020). Public health workforce competencies including people with disabilities have been developed to align with and complements existing public health competencies from such organizations as the Association of Schools and Programs of Public Health (ASPPH), MPH Core Competencies, Public Health Accreditation Board (PHAB), Public Health Foundation Core Competencies for Public Health Professionals, Council on Linkages Between Public Health and Academia (Council on Linkages), and the 10 Essential Public Health Services (Association of University Centers on Disabilities, n.d.). Resources and trainings are available for practitioners of local public health education on disability inclusion (National Association of City and County Health Officials, n.d.).

Whereas, health information is not always communicated using plain language or is communicated via modalities which do not meet the needs of people with and without disabilities (ODPHP, 2010; Health Literacy, n.d.).

Whereas, the challenge is to "ensure that disability is understood within the context of health and wellness by providers, educators, policymakers and the public" (OSG, 2005, p. 8).

Therefore, be it resolved, the Society for Public Health Education, Inc. (SOPHE) shall:

Engage in the following internal activities (for SOPHE, SOPHE Chapters, and Members):

(1)   Provide opportunities for professional education for member educators, faculty, students, and practitioners that:
   a) Support the development of the knowledge and skills of those within the SOPHE network through ongoing training and collaboration to:
      i.   increase knowledge related to the functional models of disability, the use of preferred and inclusive language and terminology, the multicultural and intersecting identities that people with disabilities/disabled people have, and the public health workforce competencies to include people with disability;
      ii.   communicate with people with disabilities/disabled people using inclusive, plain language and accessibility features through oral, print, and other modes of communication;
      iii. utilize accessibility features and plain language to ensure that products made available through the SOPHE network are accessible to anyone who wants them in the ways in which they access material by requiring an accessibility check before dissemination and including information about how to request accommodations prior to events/meetings/presentations.
   b) Include people with disabilities/disabled people in outreach and education work by collaborating with organizations that value diversity, person-centeredness, self-advocacy, and self-determination.
   c) Promote public health education and health promotion programs and practices that are inclusive of and accessible to people with disabilities/disabled people through SOPHE events and activities, including sessions at the national meetings, dedicated webinars, journal articles, and other modes of dissemination.
   d) Demonstrate the integration of disability content in public health and health education activities, education, and programming including using disability status as a demographic descriptor.
   e) Recognize disability, ableism, and able-bodied privilege, in the same manner as has been done with race, racism, and white privilege (see Breny, 2020; Sue et al., 2019).
(2)   Support members to incorporate acquired knowledge and skills about disability within their own work that:
   a) Promotes development of new or modified educational materials and standards for training programs, courses, and preschool through graduate school curricula.
   b) Includes diverse educational content that represents people with disabilities/disabled people accurately, appropriately, and positively.
   c) Incorporates disability as personal and cultural identities within multicultural competence and intersectionality frameworks.
   d) Integrates disability, ableism, and health equity content in undergraduate and graduate-level studies of public health and health education.
   e) Enables expansion of state health department programs aimed at improving health in people with disabilities/disabled people.
   f) Fosters training opportunities among health educators and state health department personnel to increase knowledge and skills to serve people with disabilities/disabled people and develop inclusive, accessible initiatives and programs.
(3)   Collaborate across the SOPHE network of communities of practice, committees, and task forces to develop resources and learning opportunities that encourage educators, faculty, students, and practitioners to question their own preconceived notions and implicit biases; properly address and mitigate the effects of such beliefs; confront their

own identities, privilege, and systemic biases; and commit to becoming agents of social justice.

(4) Champion practitioners who expand practice efforts to address the needs of people with disabilities/disabled people, to include: removing barriers that prevent access to appropriate care and resources; developing barrier-free health and wellness programs that support and promote wellness and prevent chronic illness; reducing health inequities by providing sufficient accessible communication using plain language about available services for wellness promotion; and ensuring that accessibility to health promotion activities is sufficiently broad that no one is excluded from full participation in such activities or membership in target populations and communities.

(5) Emphasize environments (spaces, places, and people) which are inclusive, non-discriminatory, and accessible and that:
   a) Integrate accessibility as part of the planning for SOPHE national meetings by requiring submissions, materials, products, and presenters for any SOPHE national business to be accessible, by requiring an accessibility check before dissemination, and by including information about how to request accommodations prior to SOPHE national business.
   b) Utilize universal design principles to assure meeting spaces, both built and virtual, are accessible to all; provide multiple modes of accommodations and accessible communications that meet the needs of diverse audiences and communities, which may include CART, ASL interpretation, and closed captioning; and require conference presentations and posters to meet Section 508 compliance and other accessibility requirements.

(6) Explore opportunities to coordinate with NCHEC and other credentialing bodies to provide continuing education credits for completion of professional training as described in internal activity 1.

(7) Promote the use of standardized measurements as prescribed by Section 4302 of the ACA, including disability status, and prioritize efforts to increase evidence-based programs and practices which are inclusive of improving health in people with disabilities/disabled people.

(8) Support building a diverse and skilled workforce that ensures inclusive participation of all by recruiting professionals, practitioners, and students with diverse backgrounds, including disability status, and by increasing the presence of people with disabilities/disabled people in public health education and health promotion positions of leadership.

(9) Share this resolution with all members of the Coalition of National Health Education Organizations (CNHEO), encouraging them to: advocate to address systemic issues that lead to discriminatory behavior in education, research, and practice; use universal design principles, accommodations, and accessible communications in their meetings; and ensure that people with disabilities/disabled people have sufficient accessible information using plain language and equal opportunities to participate in barrier-free and appropriate health promotion activities.

Engage in the following external activities:
(10) Consistent with the spirit and the letter of the Americans with Disabilities Act as amended, actively work to mitigate the barriers that people with disabilities/disabled people experience when interacting with the environment, so as to increase equal opportunity and equal access and improve the quality of life for people with disabilities/disabled people.

(11) Promote the integration of disability content in public health and health education that is inclusive, appropriate, accurate, and accessible by:

a) Addressing discrimination in the broader society and working to remedy issues of access, inequity, inequality, injustice, disadvantage, or systemic oppression.
b) Supporting leadership, governmental, and other disability advocacy efforts toward achieving health equity.

(12) Use culturally competent evidence-based practices that promote and maintain the health of people with disabilities/disabled people.

References

ADA Amendments Act of 2008, 42 U.S.C.A. § 12101 et seq., Pub. L. No. 110-325 (2008).
https://www.congress.gov/110/plaws/publ325/PLAW-110publ325.pdf

American Psychological Association. (2017). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. American Psychological Association. http://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association. (2020). *Publication manual of the American Psychological Association: The official guide to APA style* (7th ed.). American Psychological Association. https://apastyle.apa.org/style-grammar-guidelines/bias-free-language/disability

Andrews, E. E., Forber-Pratt, A. J., Mona, L. R., Lund, E. M., Pilarski, C. R., & Balter, R. (2019). #SaytheWord: A disability culture commentary on the erasure of "disability". *Rehabilitation Psychology, 64*(2), 111–118. https://doi.org/10.1037/rep0000258

Association of University Centers on Disabilities. (n.d.). *Disability in Public Health: Including People with Disabilities: Public Health Workforce Competencies.* https://disabilityinpublichealth.org/

Bowleg, L. (2012). The problem with the phrase women and minorities: Intersectionality-an important theoretical framework for public health. *American Journal of Public Health, 102*(7), 1267–73. https://dx.doi.org/10.2105/AJPH.2012.300750

Breny, J. M. (2020). Continuing the journey toward health equity: Becoming antiracist in health promotion research and practice. *Health Education and Behavior, 47*(5), 665–670. https://dx.doi.org/10.1177/1090198120954393

Carmona, R. H., Giannini, M., Bergmark, B., & Cabe, J. (2010). The Surgeon General's call to action to improve the health and wellness of persons with disabilities: Historical review, rationale, and implications 5 years after publication. *Disability and Health Journal, 3*(4), 229-232. https://dx.doi.org/10.1016/j.dhjo.2010.07.004

Disability and Health Data System. (2016; 2019)*. Disability estimates: Disability status and types* [online]. Centers for Disease Control and Prevention. Retrieved July 12, 2021 from https://dhds.cdc.gov

Drum, C. E. (2014). The dynamics of disability and chronic conditions. *Disability and Health Journal, 7*(1), 2–5. https://dx.doi.org/10.1016/j.dhjo.2013.10.001

Griffen, A., & Havercamp, S. (2021). Preparing a disability-competent workforce. In D. J. Lollar, W. Horner-Johnson, & K. Froehlich-Grobe (Eds.), *Public health perspectives on disability: Science, social justice, ethics, and beyond* (2nd ed., pp. 341-366). Springer. https://dx.doi.org/10.1007/978-1-0716-0888-3

Harpur, P. (2012). From disability to ability: Changing the phrasing of the debate. *Disability & Society, 27*(3), 325-337, at pp. 333-334. https://dx.doi.org/10.1080/09687599.2012.654985

Health Literacy. (n.d.). *Plain language materials and resources*. Centers for Disease Control and Prevention. Retrieved April 19, 2021 from https://www.cdc.gov/healthliteracy/developmaterials/plainlanguage.html

Jung, L. A., Frey, N., Fisher, D., & Kroener, J. (2019). Establish a culture of equity and inclusion. In *Your students, my students, our students: Rethinking equitable and inclusive classrooms* (pp. 13-32). Association for Supervision & Curriculum Development. http://www.ascd.org/publications/books/119019/chapters/Establish-a-Culture-of-Equity-and-Inclusion.aspx

Krahn, G. L., Walker, D. K., & Correa-De-Araujo, R. (2015). Persons with disabilities as an unrecognized health disparity population. *American Journal of Public Health, 105*(S2), S198-S206. https://dx.doi.org/10.2105/AJPH.2014.302182

Levine, A., & Breshears, B. (2019). Discrimination at every turn: An intersectional ecological

lens for rehabilitation. *Rehabilitation Psychology, 64*(2), 146-153. http://dx.doi.org/10.1037/rep0000266

National Center for County and City Health Officials. (n.d.). *NACCHO: Health and Disability*. https://www.naccho.org/programs/community-health/disability

Núñez G., G. R. (2009). Culture and disabilities. In C. E. Drum, G. L. Krahn, & H. Bersani, Jr. (Eds.), *Disability and public health* (pp. 65-78). American Public Health Association. https://dx.doi.org/10.2105/9780875531915ch05

Office of Disease Prevention and Health Promotion. (2010). *National action plan to improve health literacy: Summary*. U.S. Department of Health and Human Services. https://health.gov/sites/default/files/2019-09/Health_Lit_Action_Plan_Summary.pdf

Office of Disease Prevention and Health Promotion. (2015). *Healthy People 2020: Topics & objectives; Disabilities and health* (DH-3 Revised). U.S. Department of Health and Human Services. https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health/objectives

Office of Disease Prevention and Health Promotion. (2020). *Healthy People 2030: People with disabilities objectives; Public health infrastructure* (DH-R02). U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/browse-objectives/people-disabilities

Office of the Assistant Secretary for Planning and Evaluation. (2011, October 31). *HHS implementation guidance on data collection standards for race, ethnicity, sex, primary language, and disability status*. U.S. Department of Health and Human Services. http://aspe.hhs.gov/datacncl/standards/ACA/4302

Office of the Surgeon General. (2005). *The Surgeon General's call to action to improve the health and wellness of persons with disabilities*. US Dept of Health and Human Services. https://www.ncbi.nlm.nih.gov/books/NBK44667/

Public Health National Center for Innovations. (2020). *Ten Essential Public Health Services*. Centers for Disease Control and Prevention. https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

Sue, D. W., Alsaidi, S., Awad, M. N., Glaeser, E., Calle, C. Z., & Mendez, N. (2019). Disarming racial microaggressions: Microintervention strategies for targets, white allies, and bystanders. *The American Psychologist*, *74*(1), 128–142. https://dx.doi.org/10.1037/amp0000296

Warner, D. F., & Brown, T. H. (2011). Understanding how race/ethnicity and gender define age-trajectories of disability: An intersectionality approach. *Social Science & Medicine, 72*, 1236-1248. http://dx.doi.org/10.1016/j.socscimed.2011.02.034

Wehmeyer, M. L., & Little, T. D. (2013). Self-determination. In M. L. Wehmeyer (Ed.), *The Oxford handbook of positive psychology and disability* (pp. 116-136). Oxford University Press. https://dx.doi.org/10.1093/oxfordhb/9780195398786.013.013.0010

Wehmeyer, M. L., & Shogren, K. A. (2017). Problem solving and self-advocacy. In K. A. Shogren, M. L. Wehmeyer, & N. N. Singh (Eds.), *Handbook of positive psychology in intellectual and developmental disabilities: Translating research into practice* (pp. 217-229). Springer. https://dx.doi.org/10.1007/978-3-319-59066-0_15

World Health Organization. (2001). *International Classification of Functioning, Disability and Health: ICF*. https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health

Yee, S., Breslin, M. L., Goode, T. D., Havercamp, S. M., Horner-Johnson, W., Iezzoni, L. I., & Krahn, G. (2018). *Compounded disparities: Health equity at the intersection of disability, race, and ethnicity*. Disability Rights Education and Defense Fund. https://dredf.org/2018/01/19/compounded-disparities-health-equity-intersection-disability-race-ethnicity/

Recommended Citation:

Society for Public Health Education. (2021). *Resolution for Disability, Ableism, and Health Equity in Public Health Education and Health Promotion Practice.* URL:

Note: To update and expand upon the [2002 SOPHE Resolution on Eliminating Health Disparities Based on Disability Status](#), this document was developed by (listed alphabetically): Rose Ewald, Tara Lutz, and other contributors.

GLOSSARY

Ableism: the term for personal biases and systemic discrimination which describes a "network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical and therefore essential and fully human" archetype against which disability "is cast as a diminished state of being human" (Harpur, 2012, pp. 329-330).

Ableist: describes the "prejudice, discrimination and discounting of persons with disabilities" (National Center on Birth Defects and Developmental Disabilities, 2018), including "discriminatory or abusive conduct towards people based upon their physical or cognitive abilities" (Harpur, 2012, pp. 329-330).

Disability as a stereotype: "reflects the notion that the person with a different ability is the opposite of 'able'; as an adjective, the label **disabled** implies that a person is in a category separate from the able-bodied population" (Harpur, 2012, pp. 329-330).

Disability with respect to an individual: "a physical or mental impairment that substantially limits one or more major life activities of such individual" (a functional approach); "a record of such an impairment" (a categorical approach); or "being regarded as having such an impairment" (a societal approach) (ADA Amendments Act of 2008; Carmona et al., 2010, pp. 230-231).

Discrimination: "can be equated with societal inequity, inequality, or injustice" in that "the experiences and opportunities of individuals with disabilities are not the same as those without" (Warner & Brown, 2011, p. 1237).

Functioning and disability as components of health (WHO, 2001): "a dynamic interaction between health conditions (diseases, disorders, injuries, traumas, etc.) and contextual factors [which] include both personal and environmental factors" (p. 8).

    Functioning: "an umbrella term for body functions, body structures, activities and participation [that] denotes the positive aspects of the interaction" (p. 8).

    Disability: "an umbrella term for impairments, activity limitations or participation restrictions [that] denotes the negative aspects of the interaction" (p. 8).

    Environmental factors: "the facilitating or hindering impact of features of the physical, social and attitudinal world [which] interact with all the components of functioning and disability" (p. 8).

Impairments: "problems of body functions and structures associated with health conditions? (WHO, 2001, p. 4).

Intersectionality: mutually defining dimensions of social stratification (e.g., race/ethnicity, gender, age, and dis/ability status) which "are *not* separate, additive, dimensions but … reinforce one another in a myriad of ways" ([emphasis in the original]; APA, 2017, p. 167).

Marginalized Identities: people who are members of non-dominant social groups, "e.g., members of the LGBTQIA community, people of color, women, etc." (Levine & Breshears, 2019, p. 147).

Multicultural Competence: "a recognition that each individual is unique and situated within a different societal context that needs to be recognized and acknowledged" (APA, 2017, p. 43); "the difference between teaching students about various cultures they encounter, and working with students to confront their own identities, privilege, and the systems they have been complicit in or subject to" (Levine & Breshears, 2019, p. 148).

Multiculturalism: "the coexistence of diverse cultures that reflect varying reference group identities" (APA, 2017, p. 167).