National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

LET'S TALK

MOVING UPSTREAM

PART OF THE LET'S TALK SERIES

The purpose of this publication is to deepen understanding of what it means to "move upstream" — to address the non-medical root causes of health outcomes — and share examples to encourage public health and other sectors to put this approach into practice. The document is intended for public health, community organizations, health professionals, intersectoral partners in health initiatives, and anyone working with upstream concepts and strategies. This Let's Talk will challenge individuals and organizations to consider the focus of their current work and explore ways to shift it further upstream.

"It is when we look 'upstream' that we find the most effective … and equitable place for interventions for the public's health."[1(p4)]

THE UPSTREAM-DOWNSTREAM STORY

In the classic public health story credited to medical sociologist Irving Zola,[2] someone standing beside a stream sees a person float by, caught in the current and struggling to survive. Without thinking, they jump in to save that person. But once back on land, they see another person float by, and another, and another.... Tired from constantly jumping in and pulling people from the water to safety, they finally walk up toward the source of the stream to see *why* so many people end up in the water in the first place. They find that people are falling in — or being pushed — due to multiple factors that surround them but are out of their control.

The story illustrates the tension between the inclination to respond to immediate need and emergencies (help people caught in the current) and public health prevention, promotion and protection mandates (keep people from falling into the stream).

"The task becomes one of furiously swimming against the flow and finally being swept away when exhausted by the effort or through disillusionment with the lack of progress. So long as we continue to fight the battle downstream, and in such an ineffective manner, we are doomed to frustration, repeated failure, and perhaps ultimately to a sicker society."[2(p2)]

Building on the original analogy, we need to understand that not everyone has an equal chance of landing in the stream in the first place. Some people are actively pushed into the fast flowing current by experiences of stigma, discrimination and oppression, making it harder to stay afloat. Others experience unsupportive social, economic and environmental conditions that make the bank beside the stream much more slippery, forcing them to constantly struggle to stay out of the water. In addition to preventing people from falling in, public health must also recognize and focus efforts to change the circumstances surrounding those made most vulnerable to ending up in the water.

This document replaces the 2014 resource *Let's Talk: Moving upstream.*

"Determinants of health refer to the factors that influence the health of individuals, communities and populations"[3] — they represent the conditions of the water that surrounds us. It is imperative for public health to realize that "we need to measure and improve the water itself and not just move rocks upstream."[4]

"It's not just upstream, but it's the nature of the water itself that needs to be better measured and understood to be fixed."[4]

HOW IS UPSTREAM APPLIED?

As the term upstream has become increasingly recognized and used, interpretations and understandings of what **working upstream** is (and is not) have expanded.

Upstream-downstream terms are used as:

1. **A concept:** Upstream and downstream describe relative points of intervention for addressing the causes of poor health. Upstream interventions focus on changing the structural and social roots of health outcomes, challenging the dominance of behaviour change approaches typical of downstream interventions.
2. **A rationale:** Upstream represents the values and ethics for "why" (i.e., the reason) to work a certain way. It provides a foundational rationale for arguing for policies, strategies and programs that promote health equity, centred on how inequality, social norms and power differentials shape health.
3. **A way of thinking and working:** Upstream is a mindset, the way an individual or an organization approaches their work, allocates resources and takes action. An upstream way of working brings together partners across sectors and communities to support system-level strategies and change, and address the root causes of health outcomes.[5]

DEFINING ATTRIBUTES OF AN UPSTREAM APPROACH

The terms *upstream determinants, upstream influences, upstream strategies or interventions and upstream factors* are often used interchangeably. While there are nuances between these terms and the contexts in which they are used, it is important to recognize the core attributes of what is considered an upstream approach.

Core characteristics that make something upstream include:

- relationship to economic, political, social and physical environments;
- focus on non-medical factors that influence health outcomes;
- action mostly outside of the direct delivery of health care clinical services to treat illness and injury — and usually outside of the health sector altogether;
- contribution directly and/or indirectly to health outcomes, especially at community and population levels;
- impacts measured in terms of structural and social conditions broadly, with the consequences of upstream factors seen as downstream effects; and
- solutions or actions based on factors beyond individual choice or behavioural causes of health outcomes.[6]

Examples of each of these core characteristics are offered throughout this document.

MOVING UPSTREAM TO ADDRESS THE DETERMINANTS OF HEALTH

"It is critical … to step out of the swirling current and walk upstream to explore the root source of the issues impacting the lives of [people]."[7(p815)]

The stream metaphor supports critical reflexivity about where current efforts are focused and whether they truly address what determines health (see Figure 1). It is also helpful for identifying a range of possible actions based on your current position in the stream (or system) and determining how to best direct your efforts to move further up the stream.

While changing health behaviours is important for improving both individual and population-level health outcomes, efforts often focus on changing behaviour in a downstream, individualized way. Instead, attention needs to shift upstream to the structural and social factors that determine the circumstances in which people live — conditions that shape access to opportunities and resources to be healthy. Without addressing these upstream drivers, downstream interventions are unable to produce sustainable and equitable improvements in health at both individual and population levels.

WORKING AT ALL LEVELS

Public health, in collaboration with and alongside other sectors, organizations, groups and community members, can influence health at downstream, midstream and upstream levels, as described in Table 1. Two practice examples follow to show how efforts can be directed and aligned across all three levels of the stream to promote health and reduce inequities.

Many downstream services can be strengthened by linking them to other systems and structures further upstream. For example, co-locating an income tax filing service at a community clinic or hospital complements the direct provision of clinical services and expands the focus to address socioeconomic factors.

FIGURE 1: MOVING UPSTREAM TO IMPROVE POPULATION HEALTH

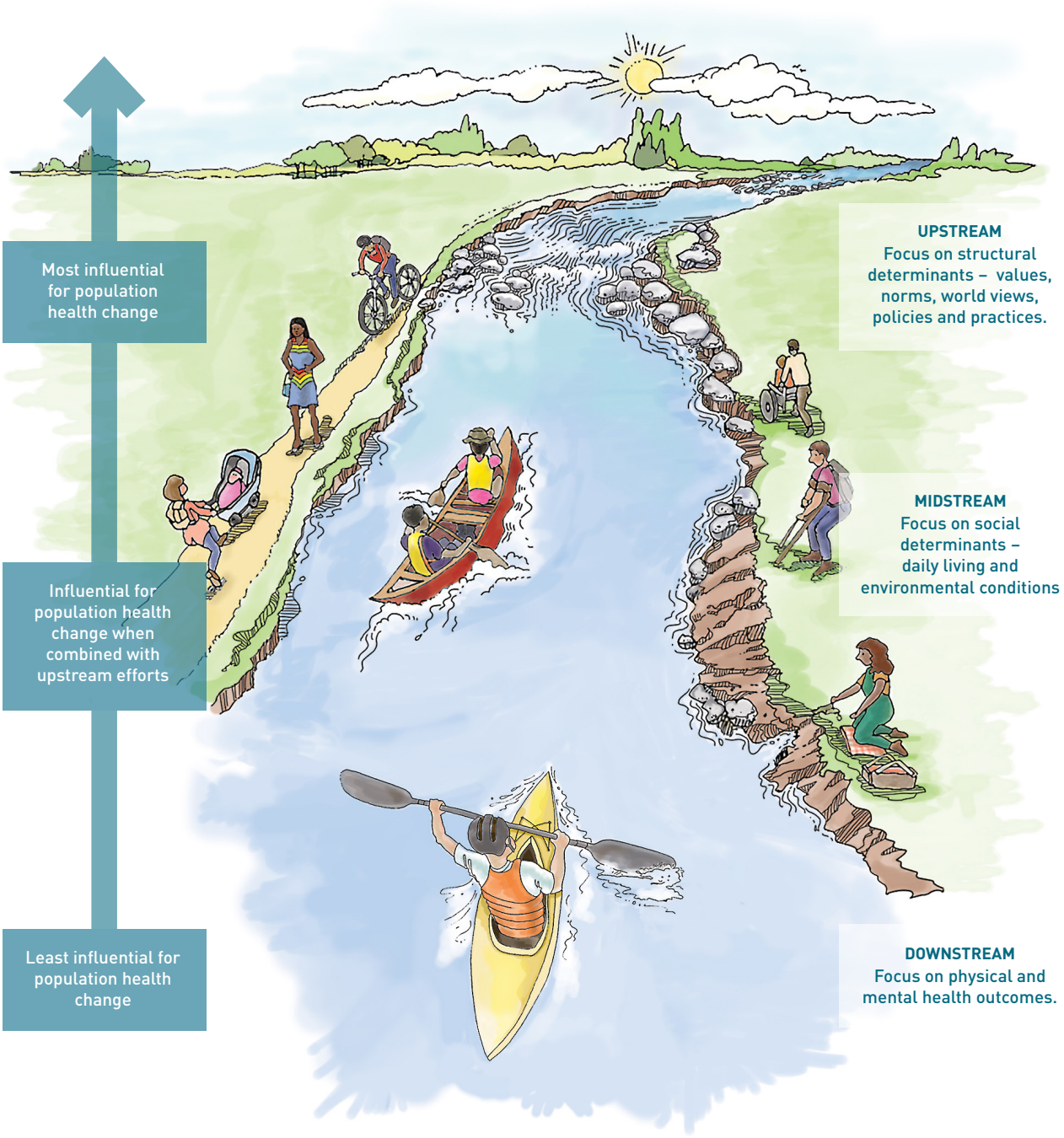
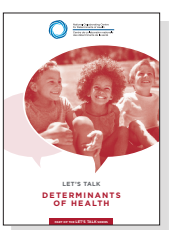


TABLE 1: APPLYING DOWNSTREAM, MIDSTREAM AND UPSTREAM APPROACHES[8]

DOWNSTREAM	MIDSTREAM	UPSTREAM
"Rescue people from the current by pulling them out of the water"	**"Help people out of the water before things get worse"**	**"Keep people from ending up in the water"**
EFFORTS AIM TO ...		
improve physical and mental health outcomes and respond to people's immediate health needs by focusing on **biomedical factors, behaviour change, and treatment of disease and injury**[3,9,10]	mitigate existing inequities, reduce vulnerability to risk, and promote health or modify behaviour by **changing the daily living and environmental conditions of people's lives**[3,9,10]	dismantle and change social and economic factors; challenge policies and practices (and those who shape them) at community, organizational and system levels; and shift underlying **values, norms, world views, policies and practices, and how institutions include and/or exclude people**[3,9,10]
ATTENTION IS ON ...		
• **physical and mental health outcomes** in communities and populations, including illness, disease, injury, physical and mental health challenges, chronic and acute conditions, and complications or consequences of an intervention or treatment[9] • **individual behaviours and biomedical and clinical risk factors** that contribute to health • **behavioural approaches** to health that include lifestyle changes, health choices, knowledge sharing, health education, skill development, risk reduction and direct service provision. This is where many public health (and other) services and strategies focus.	• **social determinants of health**, "the interrelated non-medical conditions of daily life in which people are born, grow up, live, work, play, learn, and age"[3] • **factors that shape health outcomes**, including available, affordable, accessible, decent, and sustainable: housing, income, working conditions, early childhood development, physical and natural environments, food, social networks and community, education, and health services. These factors determine the options people have and whether they are supported to be healthy or whether they experience harm.[9]	• **structural determinants of health**, "the written and unwritten rules that create, maintain, or eliminate ... durable and hierarchical patterns of advantage among socially constructed groups"[3] • **processes and conditions that shape the distribution of social determinants** • **factors that create inequities in power and resources**. These include values, beliefs, norms, world views, culture, governance, laws, policies, regulations, budgets and institutional practices, in addition to political, commercial and macroeconomic factors.[9] Systems of oppression — such as racism, colonialism, stigma, discrimination, capitalism, and societal inclusion and exclusion — also are key drivers of inequities.[3]
CHANGES GENERALLY OCCUR AT THE LEVEL OF ...		
mitigating the negative impacts of disadvantage on health at an individual or community level, and improving access to and providing health and social services[3]	directing or referring individuals who live with inequities to resources that support health at the regional, local, community or organizational level[10]	influencing factors that shape the conditions of people's lives and determine the environments they live in[10]

DOWNSTREAM	MIDSTREAM	UPSTREAM
INTERVENTIONS ARE ABOUT CHANGING THE ...		
effects and impacts of health and health inequities	**cause** of health and health inequities	**cause of the cause** of health and health inequities
EXAMPLES INCLUDE ...		
• mental health counselling (any age) • chronic disease prevention programs and early intervention programs • substance use cessation programs (smoking, alcohol, other) • communicable disease prevention campaigns • sexual health and sexually transmitted and blood-borne infection prevention programs • stress prevention programs • lifestyle and behaviour change programs (e.g., nutrition, physical activity, alcohol, smoking, substance use) • reproductive health services and clinics	• linking people with income assistance, social assistance or back-to-work programs • high school completion strategies • improving standards for housing conditions • affordable high-quality childcare • cultural competency training • collaboration to influence land use and transportation policies • working with employers and community organizers to change employment and working conditions • targeted vaccination clinics • harm reduction services • providing health materials in multiple languages	• advocating for living-wage policies, wage capping, rent control, progressive taxation and poverty reduction initiatives • prioritizing decolonizing and anti-racist strategies at all levels • implementing anti-stigma and anti-discrimination policies and practices at organizational and government levels • establishing anti-hate organizational policy and government legislation • developing gender- and sexuality-inclusive policies and procedures • respecting human rights • decriminalizing substance use • mandating decent work conditions for temporary foreign workers • citizen engagement in health system decision-making and resource allocation • restoring birth practices and land rights to Indigenous communities • expanding health care coverage to people with undocumented migrant status



For a more detailed description of the determinants of health, see *Let's Talk: Determinants of health*. This resource explores similar upstream and downstream concepts using a tree metaphor to illustrate the root causes of health outcomes and underlying drivers of health inequities.

EXAMPLE A – PROMOTING HEALTHY LIFESTYLES

You are part of a strategy to promote healthy eating and physical activity in your community. Leverage your knowledge and position to shift the focus further upstream. Table 2 outlines what efforts at each level of the stream might look.

TABLE 2: ACTIONS AT MULTIPLE LEVELS TO PROMOTE HEALTHY LIFESTYLES

DOWNSTREAM	MIDSTREAM	UPSTREAM
• Develop a social media campaign and resources on healthy eating and physical activity • Deliver community presentations on healthy lifestyle choices to prevent chronic disease • Offer free cooking sessions, support community gardens and promote free exercise programs for people with higher risk of developing diabetes • Connect families living on low incomes with food banks and other charitable food sources	• Promote access to locally grown food by working with local farmers • Support workplace policy development that allows flexible schedules to accommodate physical activity throughout the day • Analyze data on the location of grocery stores relative to neighborhoods living on a low income to identify ways to improve food access • Connect families living on low incomes with community food centres that combine practical supports like income tax clinics with food skills programming	• Support Indigenous communities in their efforts to restore cultural food hunting and harvesting practices • Work with community organizations to explore barriers to accessing healthy foods that are culturally appropriate and acceptable • Advocate for basic income to ensure families have sufficient resources to purchase healthy food and participate in physical activity options

EXAMPLE B – PROMOTING MENTAL HEALTH FOR CHILDREN AND YOUTH

You are working with community partners to promote the mental health of children and youth in your community. Leverage your knowledge and position to shift the focus further upstream. Table 3 identifies some potential strategies at each level of the stream.

TABLE 3: ACTIONS AT MULTIPLE LEVELS TO PROMOTE MENTAL HEALTH FOR CHILDREN AND YOUTH

DOWNSTREAM	MIDSTREAM	UPSTREAM
• Launch a media campaign on the importance of mental health and self-care • Deliver community presentations on emotional well-being and building healthy relationships • Increase the number of mental health counsellors for children and youth in schools and the community	• Work with partners to coordinate transportation and access to community and social services that support mental health for families living on low incomes • Seek subsidies to offset costs for mental health supports for children and youth • Connect parents with housing and employment supports to address the sources of stress affecting family mental health	• Develop policy within your organization for anti-racist approaches to care • Create guidelines for pronoun use and for recognizing gender and sexual diversity to ensure children and youth do not experience discrimination in your organization • Advocate for basic income to reduce income-related stress and ensure people have sufficient resources to support the health and well-being of their families

ARE WE *REALLY* UPSTREAM? POINTS OF TENSION

"We can fix health care. We can fix education, justice, community services, housing. We can fix those systems potentially and still not arrive at momentum towards stronger, healthier communities because we've failed to address really fundamental issues about the nature of our relationships with each other, the connections we have [to each other] and our connections to the natural world."[4]

Despite extensive evidence that the structural and social determinants of health exert the most influence on population health outcomes,[9] efforts to address them struggle to compete with a health system focus on individual responsibility and biomedical solutions. This focus limits the ability of public health and partners to shift thinking and action to address upstream factors.[5]

The complexity of upstream solutions may be used as rationale to avoid upstream efforts and reinforce a perception that "overcoming upstream influences ... require[s] sweeping changes that we often are not in a position to address."[12(p6)] As a result, several points of tension emerge that are important to acknowledge and understand in our efforts to swim or paddle against the current.

"What we do today will impact the future. If we are providing more services to children, for example, to prevent future need as adults, this is preventive. But we need to ask — are we impacting the symptoms or the causes? Why are they coming for services in the first place? That is the root of where we need to focus if we are working upstream."

Deshpal Grewal[13], Community Health Specialist

PRESSING INDIVIDUAL NEEDS

Without question, efforts to address individual and family-level social and economic needs are necessary. However, mitigating the impact of social and economic factors on the lives of individuals is *not* the same as working upstream. For example, no-cost recreational programs, homelessness shelters and food vouchers for families living on low incomes sit toward the downstream end of potential actions. While these approaches represent a relative step upstream from treating injury and disease, for instance, they still focus on individual behaviours and circumstances,[11] which is inadequate in the pursuit of community, population and societal health.[14]

UNIVERSALITY OR UPSTREAM?

Universal, population-level or community-level interventions are not automatically upstream, especially if they don't address structural and social determinants of health. Efforts to prevent disease in a population through lifestyle or behaviour change, for example, represent a focus on downstream risk behaviours rather than addressing the underlying causes of those behaviours.[7]

BETTER THAN NOTHING?

Faced with tensions and uncertainty about where and how to address the upstream drivers of health inequities, there may be resistance rationalized by budget pressures and perceived lack of resources, with downstream actions justified as being "better than nothing."[15] However, if we revert to downstream actions, this may cause harm by entrenching downstream thinking and benefitting those who are already in advantaged positions, effectively increasing the gap between those less and more likely to be healthy.[16]

Water moves all the time
No one strategy, policy or initiative is inherently or permanently placed upstream (or anywhere in particular along the stream). It is the way that policies intersect and interact that determines where their impact is felt, and how far up the stream that impact will reach.

"Even comprehensive interventions that address families' needs still cannot fully address upstream drivers."[11(p782)]

Upstream work is inherently complex. Therefore, we need to embrace that complexity by doing what we can from wherever we are positioned along the stream.

HOW TO MOVE UPSTREAM FROM WHERE YOU ARE

"It is important to identify the points at which the flow may be controlled, stemmed and redirected: the 'floodgates' that the most powerful actors in society may open or close.... Many of these [flows of causal factors] are shaped by political and legal superstructures and frameworks."[1(p5)]

It may seem that upstream action is out of reach, structural factors are beyond our control, we don't make policy, and we need to wait for "the system" to change. But remember — it is not *only* political parties and people in formal leadership positions who determine the ability to work upstream. While we may not be able to control high-level political forces, for example, we *can* change policy, practices, norms and values in our own organizations and communities. We can use our position and voice to communicate and advocate for the change we want to see.[17] If you can't practice advocacy in your current position, work through professional and partner organizations to advocate for system change. At the very least, we can shift our own perspectives, practices and values that determine how we approach our own work and life.

We *are* the system. Every one of us can do something to shift the focus of our current efforts to be more upstream.

We need action at all levels of the stream to create a healthier society. The question of how far up the stream we go reflects the type of change desired and the opportunities available to support it. Sometimes we need to work midstream or downstream to address immediate needs, but from here we can

shift our gaze up the stream to strengthen the impact. Any movement upstream we can make from our current position — doing what we can with what we have — will strengthen our agency and contribution to transforming the health of society.[17]

> Shifting upstream is about preventing people from getting pushed or slipping off the bank along the stream so they don't end up in the water.

TALK ABOUT POWER

Learn about visible, hidden and invisible sources of power that impact health, and how individual and community powerlessness leads to poor health outcomes. "Power imbalances are not accidental or unavoidable."[18(p3)] Nor are they natural or inevitable — they are deliberately maintained to perpetuate inequities in access to power and resources and ultimately to what is needed to be healthy. Power imbalances create and maintain systems of oppression that deny some people what they need to be healthy and thrive. These imbalances do not need to be accepted as is. Reflect on your power and positionality (the privilege associated with your identities) and how these shape your perceptions and actions, as well as how you are perceived by others (critical reflexivity).[18]

> You can paddle hard in a boat with other people paddling with you and get further upstream, faster and stronger.

CHALLENGE ASSUMPTIONS (YOUR OWN AND OTHERS') ABOUT THE CAUSES OF HEALTH OUTCOMES

Think and talk about settings, conditions of daily life, power and fairness, rather than behaviour and lifestyle. Ask yourself how a health promotion strategy or recommendation might be harder to follow for someone experiencing racism or stigma based on gender and sexual identity, or for someone who does not have a safe home, or paid sick time, or access to resources due to a disability. Then focus on addressing the barriers instead of individual behaviours.

"Understanding and applying upstream concepts is not easy, and it involves more than just adding more knowledge. It requires us — especially those of us occupying social locations of privilege — to take time and effort to learn and deepen our understanding of oppressive systems and structures and consider how they shape us as individuals and the work that we do. This will position us to better align our work with upstream thinking and to identify (and call out, if possible) when the alignment is low."

Dr. Lindsay McLaren[15], Professor

WATCH FOR AND RESIST LIFESTYLE DRIFT

Lifestyle drift represents the "tendency for policy to start off recognizing the need for action on the upstream … determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors."[19(p148)] This happens because it is more direct, streamlined and (in some ways) easier to implement behavioural health promotion strategies that target individual risk factors and lifestyles downstream, where the solutions are less

complex and the impacts are more immediately identifiable.[20,21] However, the pull of lifestyle drift (and reliance on behavioural health promotion) will result in little impact on population-level health and may increase inequities because it weakens efforts to take on upstream structural conditions that determine health.[22]

Ask "*Why?*" at least five times when someone comes to you for help.
For example, someone has depression:

- Why? Because they have a lot of stress.
- Why? Because they lost their job.
- Why? Because they couldn't go to work.
- Why? Because they were sick.
- Why (did this get them fired)? Because they don't have paid sick days.

ENGAGE COMMUNITY MEMBERS IN DECISION-MAKING AND PRIORITIZING

Community self-determination is essential to promote trust, build relationships, and expand on the knowledge and lived expertise of community members about what upstream means to them.[23] Encourage community members to connect their personal circumstances to unequal structures of power, privilege and oppression that shape interpersonal interactions and circumstances of daily life.[18] Develop relationships with and support community-organizing groups to identify health priorities and upstream actions that will make the most impact for them.[24] Sharing power with communities and committing to meaningfully engage community members in prioritization and decision-making[25] is, by nature, an upstream strategy.

CHANGE HOW YOU MEASURE UPSTREAM IMPACT

Beyond statistics, disease rates and population numbers, variables for measuring upstream factors also include economic, social and ecological conditions and the built environment. Assessing the impact of upstream efforts is difficult when data are too focused on numerical and empirical indicators. Measuring the conditions of daily life (social and ecological factors that include transportation, exposure to toxins, air quality, employment, urban and rural design, and social supports) is essential to demonstrate the impact of upstream action.[5] In addition, the value of qualitative indicators cannot be overstated — impact on quality of life, wellness, individual and collective capacity, and relationships formed are significant indicators that can be used to measure upstream impact.

In 2019, Engage Nova Scotia and its partners conducted the Nova Scotia Quality of Life Survey, which is set to be relaunched in 2025. Centred around eight domains of well-being, the survey included over 200 questions exploring topics such as trust in others and institutions, confidence in democracy, experiences of loneliness and discrimination, job satisfaction, and connection to nature. Engage Nova Scotia also offers a Wellbeing Mapping Tool for viewing survey data by community area and a Wellbeing Analysis Tool that shows differences by location, topic and/or demographic. This initiative represents a shift to collect data that measure impact further upstream, including changes to the structural and social conditions that shape health outcomes.

MIND THE DISRUPTION

For more information about Engage Nova Scotia see Season 3 of the NCCDH podcast Mind the Disruption.

How do you know that your actions are further upstream?

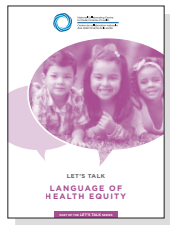
Make sure your efforts include attention to upstream factors and measure upstream influences on health. Indicators (quantitative and qualitative) include changes in:

- relationships built (individual and organizational);
- sectors engaged (health and non-health);
- social, ecological and structural influences on health;
- quality of life and sense of well-being; and
- experiences of racism, stigma, discrimination, and inclusion or exclusion.

If efforts are not addressing these structural and social factors (also described in Tables 1-3), then they are more downstream.

USE LANGUAGE THAT IS PERSON-FIRST, SYSTEM-FOCUSED AND ASSET-BASED

The words and terminology we use reflect individual and institutional values and beliefs about the roots of health. In turn, language also influences how we view people who live with inequities and how we understand our role to address social and structural determinants.[26] Use terms that bring attention to systemic causes instead of those that reinforce individual responsibility and blame for negative health outcomes. For example, refer to *people marginalized by oppression* instead of *marginalized people*. Many commonly used terms reinforce stigma and perpetuate the very systems that create inequities in the first place, including language we use in daily life and terms embedded in our organizational practices and documents.



For more information about health equity language and essential health equity terms, see

Glossary of essential health equity terms

Let's Talk: Language of health equity

DRAW ON THE CORE COMPETENCIES FOR PUBLIC HEALTH IN CANADA

The skill and ability to "pursue upstream actions that address systemic factors influencing health outcomes, such as political, social, economic and environmental factors, while supporting downstream actions to meet the immediate public health needs of individuals, families and communities" is considered an essential competency for public health at all levels.[27(p11)] Work toward achieving this competency by improving knowledge and skills related to working upstream, partnership building, leadership, advocacy, relationship development, consensus building, community organizing and intersectoral collaboration.

Do you have a practice example of working upstream? We welcome your thoughts, ideas and stories! Email us at nccdh@stfx.ca.

DISCUSSION QUESTIONS

Use these questions in conversation with colleagues, partners and networks at organizational and individual meetings to consider the current focus of your work and how to shift it upstream.

- Reflect on your own beliefs about what causes health outcomes. How do your own values and world views influence how you see the roots of health? How does your own positionality affect how you interpret where strategies and efforts fit along the stream?
- Think about when you first heard the upstream-downstream story. What factors were part of your early discussions about this analogy? How has your understanding of downstream, midstream and upstream changed?
- Draw a map of your current work portfolio. Where along the stream does most of your work sit? How strongly is lifestyle drift pulling it downstream? How can you shift what is in your current scope to be further upstream?
- Identify initiatives in your community that are taking action on structural and social determinants of health. How can your public health team collaborate with and support these initiatives to impact upstream drivers of health?
- How are the concepts of downstream, midstream and upstream being used in your context? Are they being applied in ways that reflect their relationship to determinants of health, or is there a disconnect between how they're used and how things are currently done?
- Develop some key messages that describe where your work sits along the stream. How would you describe the nature of your work to a family member? A co-worker? A community partner? How would you respond to resistance to shifting away from individual behaviour-based strategies in favour of approaches that address socioeconomic and societal conditions?

REFERENCES

1. Coggon J, Gostin LO. Global health with justice: controlling the floodgates of the upstream determinants of health through evidence-based law. Public Health Ethics. 2020 Apr;13(1):4–9. doi: 10.1093/phe/phaa011.
2. McKinlay JB. A case for refocusing upstream: the political economy of illness [Internet]. Eagle (ID): Interdisciplinary Association for Population Health Science; 2019 Nov 18 [cited 2025 Aug 27]. 10 p. (IAPHS Occasional Classics; no. 1). Available from: https://iaphs.org/wp-content/uploads/2019/11/IAPHS-McKinlay-Article.pdf
3. National Collaborating Centre for Determinants of Health. Glossary of essential health equity terms [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; [updated 2024 Dec; cited 2025 Aug 27]. Available from: https://nccdh.ca/learn/glossary
4. National Collaborating Centre for Determinants of Health. Disrupting for well-being with Engage Nova Scotia (part 1). Mind the disruption [audio on the Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; 2025 Mar 25 [cited 2025 Aug 27]. Podcast: 37 min. Available from: https://nccdh.ca/learn/podcast/disrupting-for-well-being-with-engage-nova-scotia-part-1
5. McMahon NE. Framing action to reduce health inequalities: what is argued for through use of the 'upstream–downstream' metaphor? J Public Health (Oxf). 2021 Sep;44(3):671–8. doi: 10.1093/pubmed/fdab157.
6. Distelhorst KS, Graor CH, Hansen DM. Upstream factors in population health: a concept analysis to advance nursing theory. ANS Adv Nurs Sci. 2021 Jul-Sep;44(3):210–23. doi: 10.1097/ANS.0000000000000362.
7. Mitchell LK, Chopp D. Medical-legal partnerships reinvigorate systems lawyering using an upstream approach. J Law Med Ethics. 2023 Winter;51(4):810–6. doi: 10.1017/jme.2023.162.
8. Solar O, Irwin A. A conceptual framework for action on the social determinants of health [Internet]. Geneva (Switzerland): World Health Organization; 2010 [cited 2025 Aug 27]. 75 p. Available from: https://apps.who.int/iris/handle/10665/44489.
9. National Collaborating Centre for Determinants of Health. Let's talk: determinants of health [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; 2024 [cited 2025 Aug 27]. 15 p. Available from: https://nccdh.ca/images/uploads/NCCDH_Lets_Talk_Determinants_of_health_EN_FV.pdf
10. Public Health Agency of Canada. A vision to transform Canada's public health system [Internet]. Ottawa (ON): PHAC; 2021 Dec [cited 2025 Aug 27]. 128 p. (Chief Public Health Officer of Canada's report on the state of public health in Canada; 2021). Available from: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/state-public-health-canada-2021/cpho-report-eng.pdf
11. Dopp AR, Lantz PM. Moving upstream to improve children's mental health through community and policy change. Adm Policy Ment Health. 2020 Sep;47(5):779–87. doi: 10.1007/s10488-019-01001-5.
12. Albino J, Tiwari T. Behavior change for caries prevention: understanding inconsistent results. JDR Clin Trans Res. 2020 Jan;5(1):6–9. doi: 10.1177/2380084419878180.
13. Grewal, Deshpal (Fraser Health Authority). Online small group conversation with: Dianne Oickle (National Collaborating Centre for Determinants of Health). 2025 Jan 28.
14. Lantz PM. The medicalization of population health: who will stay upstream? Milbank Q. 2019 Mar;97(1):36–9. doi: 10.1111/1468-0009.12363.
15. McLaren, Lindsay (Department of Community Health Sciences, University of Calgary). Conversation with: Dianne Oickle (National Collaborating Centre for Determinants of Health). 2024 Oct 2.
16. Hernandez EM, Vuolo M, Frizzell LC, Kelly BC. Moving upstream: the effect of tobacco clean air restrictions on educational inequalities in smoking among young adults. Demography. 2019 Oct;56(5):1693–721. doi: 10.1007/s13524-019-00805-2.
17. National Collaborating Centre for Determinants of Health. A different kind of health equity: Creating conditions for action on the structural determinants of health 2025 environmental scan. [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; Forthcoming 2025.
18. National Collaborating Centre for Determinants of Health. Let's talk: redistributing power to advance health equity [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; 2023 [cited 2025 Aug 27]. 19 p. Available from: https://nccdh.ca/images/uploads/NCCDH_Lets_Talk_Redistributing_Power_to_Advance_Health_Equity_EN.pdf
19. Popay J, Whitehead M, Hunter DJ. Injustice is killing people on a large scale—but what is to be done about it? J Public Health (Oxf). 2010 Jun;32(2):148–9. doi: 10.1093/pubmed/fdq029.
20. Baum F, Fisher M. Why behavioural health promotion endures despite its failure to reduce health inequities. In: Cohn S, editor. From health behaviours to health practices: critical perspectives [Internet]. Chichester (UK): Wiley-Blackwell; 2014 [cited 2025 Aug 27]. p. 57–68. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1002/9781118898345.ch6
21. Carey G, Malbon E, Crammond B, Pescud M, Baker P. Can the sociology of social problems help us to understand and manage 'lifestyle drift'? Health Promot Int. 2017 Aug;32(4):755–61. doi: 10.1093/heapro/dav116.

22. Williams O, Wiltshire G, Gibson K. Health inequalities: how and why physical education can help and hinder the equity agenda. In: Stirrup J, Hooper O, editors. Critical pedagogies in physical education, physical activity and health. New York (NY): Routledge; 2021. p. 170–83.
23. Williams CM, El-Bayoumi J. Optimizing upstream health in the community-oriented integrative domain. Health Equity. 2018;2(1):313–5. doi: 10.1089/heq.2018.0041.
24. National Collaborating Centre for Determinants of Health. Let's talk: community organizing [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; 2025 [cited 2025 Aug 27]. 14 p. Available from: https://nccdh.ca/images/uploads/NCCDH_Let's_Talk_Community_organizing_EN.pdf
25. National Collaborating Centre for Determinants of Health. Let's talk: community engagement for health equity [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; 2021 [cited 2025 Aug 27]. 13 p. Available from: https://nccdh.ca/images/uploads/comments/Lets-Talk-Community-Engagement-EN.pdf
26. National Collaborating Centre for Determinants of Health. Let's talk: language of health equity [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; 2023 [cited 2025 Aug 27]. 12 p. Available from: https://nccdh.ca/images/uploads/NCCDH_Lets_Talk_Health_Equity_Language_EN.pdf
27. National Collaborating Centres for Public Health. Core competencies for public health in Canada: release 2.0 [Internet]. [place unknown]: NCCPH; 2025 [cited 2025 Sep 21]. 36 p. Available from: https://nccph.s3.amazonaws.com/uploads/2025/10/NCCPH_Core-Competencies-for-Public-Health-in-Canada_Release-2.0-1.pdf

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