EVENT SUMMARY

National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

“We are stronger together”: Dietitians in public health equity-focused work

ACKNOWLEDGEMENTS

Written in partnership by Eric Ng, Dalla Lana School of Public Health, University of Toronto and Dianne Oickle, Knowledge Translation Specialist, NCCDH. Special thanks to our internal reviewer Claire Betker, and to our external reviewers Kally Cheung*, Caroline Wai**, and Amy MacDonald**.

We are grateful to all participants who shared their experience, expertise, insights, and reflections during the conversation series.

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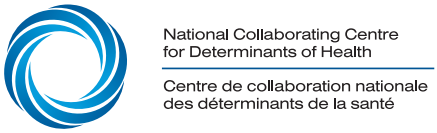

The National Collaborating Centre for Determinants of Health is hosted by St. Francis Xavier University. We are located in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaw People.

Please cite information contained in the document as follows: National Collaborating Centre for Determinants of Health & Ng, E. (2026). *"We are stronger together": Dietitians in public health equity-focused work.* Antigonish, NS: NCCDH, St. Francis Xavier University.

ISBN: 978-1-998022-95-3

Production of this document has been made possible through a financial contribution from the Public Health Agency of Canada through funding for the NCCDH. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.

This document is available electronically at www.nccdh.ca.

La version française est également disponible au www.ccnds.ca sous le titre *« L'union fait la force! » : Les diététistes dans le travail axé sur l'équité en santé publique.*

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Overview

Registered dietitians (RDs) working in public health are an essential part of the public health system in Canada. RDs work in a variety of roles and organizations, both in positions with a specific nutrition focus and in broader roles. As health care and health systems have evolved, the role of RDs in public health has also developed and matured — moving beyond a biomedical nutrition and dietetics focus to encompass social justice, health equity, and the structural and social determinants of health.

Dietitians have long recognized how equity issues intersect with the practice of dietetics, particularly in areas such as food insecurity, cultural food practices, diet-related disease prevention and weight discrimination. As attention to structural determinants (including racism and colonialism) and social justice has increased in public health over the past decade, RDs now have opportunities to lead efforts to improve population health through equity-focused roles that are not specific to RD licensing and qualifications. While these roles may not be nutrition-specific, RDs are well positioned to work directly on health equity and social justice issues because of the intersectoral, collaborative and community-driven nature of RD practice in public health.

For descriptions of equity-focused terms used in this document, refer to: *Appendix A: Glossary of Terms Relevant to the Core Competencies for Public Health in Canada*

To better understand how dietitians practice in equity-focused roles, the National Collaborating Centre for Determinants of Health and Dalla Lana School of Public Health at the University of Toronto collaborated to facilitate a conversation series with RDs across Canada. Three sessions were held in 2024 to bring together RDs working in public health roles with a specific focus on health equity. The series was designed to connect RDs working in equity-focused public health roles in Canada and to explore the role and capability of RDs to advance health equity and social justice.

This document begins by describing how the role of RDs in public health in Canada intersects with health equity and social justice. It then describes the conversation series and the core issues discussed by participants. Next, two main themes that emerged from the conversations are explored in more detail: the integral role of RDs in advancing population health equity and the diverse ways that RDs understand and integrate health equity into their practice. The final section considers how RDs across public health positions have both opportunity and responsibility to pursue health equity and social justice. The voices of participants are threaded throughout the document in the form of direct quotes.

This resource is intended to:

- reinforce that RDs in public health are qualified and capable of working in equity-focused positions;
- establish RDs as an integral part of multidisciplinary public health equity practice;
- support RDs working in public health nutrition-focused work to integrate health equity and social justice;
- inform program decisions, including staffing models and organizational capacity, that affect the positions of RDs in public health; and
- encourage health equity, social justice and anti-oppression approaches in all public health nutrition work.

Key takeaways:

- RDs working in public health are well suited to health equity-focused roles, both in and outside of nutrition-focused roles.
- Relational approaches and connectedness among RDs, as well as organizational supports, are integral to equity-focused work.
- Opportunities for RDs to lead health equity work include topic-specific areas, organizational influence and advocacy.
- Challenges include pushback to RDs leading health equity work.
- RDs dedicated to public health nutrition and health equity practice are essential to achieving public health equity goals.

RDs, public health and health equity

An RD is "a professional who applies the science of food and nutrition to promote health, prevent and treat disease to optimize the health of individuals, groups, communities and populations."[1(p3)] In Canada, an RD is licensed by a provincial or territorial regulatory body[2] and has expertise and roots in human nutrition, food science, agriculture, food systems and interdisciplinary practice.[3]

RDs in Canada work across a wide range of settings and systems, including public health, community health, primary care, acute care, long-term care and the food industry.[4] Within public health, RDs fill a variety of positions outside of front-line nutrition program planning and delivery and the title of public health nutritionist/dietitian. As the nature of health care, including public health, evolves, RDs are increasingly represented in areas that extend beyond a biomedical nutrition and food science focus, including research, policy, communications, community engagement and other non-nutrition roles.[5]

When it comes to health equity, many RDs integrate equity considerations into dietetic practice by addressing areas such as food security, cultural food practices, weight stigma, Indigenous food sovereignty and the influence of income on eating patterns. In a survey of RDs in Canada,[7] respondents identified social justice as a core value of their profession and described incorporating it in their practice through strategies at intrapersonal (self-reflection), interpersonal (among RDs) and structural (system) levels. However, RDs working in public health often struggle with how to address structural and social determinants in their work.

From the National Collaborating Centre for Determinants of Health's *Glossary of essential health equity terms*[6]:

Health equity means that all people (individuals, groups and communities) have fair access to, and can act on, opportunities to reach their full health potential and are not disadvantaged by social, economic and environmental conditions, including socially constructed factors such as race, gender, sexuality, religion and social status. Achieving health equity requires acknowledging that some people have unequal starting places, and different strategies and resources are needed to correct the imbalance and make health possible. Health equity is achieved when disparities in health status between groups due to structural and social factors are reduced or eliminated.

Mainstream dietetics (with exceptions in some public and community health spaces) prioritizes downstream behavioural approaches,[8] while concepts like anti-oppression, transformation of health systems and political engagement are absent or remain peripheral.[4] Additionally, in some nutrition policy, there is often a disconnect between stated intentions to address equity issues and proposed actions that are consumer-oriented and attach equity-related considerations to targeted behavioural strategies.[9] Overall, this results in

a public health dietetic workforce that is likely underused and its potential underestimated in advancing health equity and improving the health status of communities and populations.[5]

RDs in public health are well positioned to work directly on health equity issues, both within and outside of formal nutrition-related roles. Dietetic practice, especially in community and public health spaces, is inherently intersectoral, collaborative, community-driven and evidence-informed. Moreover, RDs "have 'response ability' to redress structural and social injustice. Response ability refers to the combination of bearing responsibility (accountability) and having ability to respond (based on privilege, power, relationships, and learning)"[11(p159)] to issues of social justice and equity. Reinforcing this, the recently published *Core competencies for public health in Canada: Release 2.0* contains a number of competency statements that reflect social justice and health equity as foundational knowledge, skills and attitudes for all professions — including RDs — working in public health.[12]

"While the science of food and nutrition is a foundation of dietetic knowledge and practice, it does not comprise the entirety of [RD] knowledge and practice, nor is it mutually exclusive with the pursuit of social justice through advocacy."[10(p155)]

Core competencies for public health in Canada: Release 2.0[12]

Competency statements reflecting social justice and health equity include:

4.0 PROGRAM PLANNING, IMPLEMENTATION AND EVALUATION

4.4 Integrate anti-racist and anti-oppressive approaches into planning, practice, programs, services and policies.

4.8 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.

9.0 HEALTH EQUITY AND SOCIAL JUSTICE

9.1 Apply health equity and social justice objectives and principles in one's work.

9.5 Analyze how intersecting systems of power and oppression create experiences of privilege and disadvantage for different groups of people.

9.6 Demonstrate knowledge of how to address discrimination, oppression and power imbalances that drive health inequities.

Bringing together equity-focused RDs in public health

Recognizing the diverse roles that RDs fill in public health, and their strength and capacity to advance health equity, the authors[a] collaborated to bring together RDs from across Canada working in public health with a focus on health equity to share knowledge, perspectives and opportunities in their work.

We have extensive experience in public health, dietetics, health equity, social justice, dietetic education, health policy and programming, research, and knowledge translation. We have practised as RDs in front-line public health, in both nutrition-focused and non-nutrition-focused positions, and were brought together through mutual connections working in health equity and social justice. Together, we are committed to strengthening the capacity of RDs to apply transferable skills and knowledge related to structural and social determinants of health — inherent in the practice of dietetics — to improve population health equity.

Conversation series

Over several months in 2024, we co-developed and co-facilitated a series of three conversations to learn how RDs engage in health equity and social justice work within public health practice and to explore opportunities to strengthen their roles in these areas.

The conversations were informally facilitated to foster a safe space for sharing and collaboration, with multiple opportunities for participants to connect directly with each other. The sessions included introductions, resource sharing, and opportunities for participants to describe their work and related equity experiences through interactive polls, small-group discussions and open-space networking. All sessions were held in English.

a The authors of the document are Dianne Oickle (National Collaborating Centre for Determinants of Health) and Eric Ng (Dalla Lana School of Public Health). From this point forward, we use "we" in place of "the authors" to reflect the personal, values-based and relational nature of this work.

The main goals for each conversation are outlined below.

CONVERSATION #1 – APRIL 2024

- Connect and support RDs working in public health units, authorities, organizations, etc. who have a health equity and social justice approach to their work.
- Understand the current state of RD practice in health equity-focused public health work.

CONVERSATION #2 – JUNE 2024

- Explore opportunities and barriers for RDs in public health to do health equity work.
- Discuss how RDs can contribute to social justice and equity in dietetics and public health.

CONVERSATION #3 – OCTOBER 2024

- Identify supports and resources needed to strengthen equity in RD practice in public health.
- Discuss how RDs can advance social justice and equity at individual, organizational and system levels.
- Explore how RDs can support each other in this work moving forward.

Each session was evaluated, and participant feedback — including key learnings and suggestions for future sessions — was used to shape subsequent conversations and inform this summary report.

Participants

Participants were invited if they were licensed RDs working in public health roles (nutrition-focused or otherwise) and health equity work was a central part of their position. In other words, responsibility for health equity was embedded within their roles, rather than a topic of interest. RDs were contacted across provinces and territories to reflect the diverse public health systems in Canada, and efforts were made to include Indigenous, Black and racialized dietitians. While we recognized that many RDs are involved in equity work in public health, the number of participants was limited to allow for deeper discussion and topic exploration.

Across the three conversations, all 25 invited participants attended at least one of the sessions, representing six provinces and one territory. Their diverse range of positions spanned local, regional, provincial/territorial and system levels, including:

- health equity regional or provincial coordinator/lead,
- policy officer/analyst,
- early years consultant,
- healthy communities program officer,
- provincial food and nutrition lead,
- government legislation and policy lead,
- front-line program delivery,
- management and formal leadership, and
- public health dietitian/nutritionist.

Conversation highlights

Each of the sessions explored distinct areas, intentionally capitalizing on common interests and the opportunity to broker and nurture connections among participants.

Conversation #1

Using a word cloud exercise to engage the group, we began the session by asking participants **What does health equity mean to you?** (see Figure 1).

FIGURE 1: PARTICIPANT RESPONSES TO WHAT DOES HEALTH EQUITY MEAN TO YOU?

Participants' responses focused on both structures and relationships. On one hand, concepts such as social justice, power, political, disruption, upstream and decolonization reflect a structural understanding of equity. On the other hand, a relational approach to equity work was characterized by unlearning, lived experiences, listening, curiosity, respect and resilience.

We then explored the connections between equity work and dietetics in public health, asking **Why are RDs well suited to do health equity work in public health?** Among the several reasons identified, food systems and food justice were described as central to dietetic practice, where food serves as an entry point to and rationale for equity work. Many participants emphasized that food is a human right, aligning with the human rights approach that drives equity work. RDs also highlighted how they bring a range of knowledge and skills essential to the work of health equity, including evidence-informed approaches, interdisciplinary collaboration, systems thinking and commitment to addressing the root causes of health.

Rather than focusing on what they do in practice, we asked participants **How do RDs do equity work in public health?** to bring out the values and principles behind their practice. Key strategies included collaboration with partner organizations, community engagement and knowledge translation. Participants again pointed to relational and interpersonal approaches of equity work, such as critical reflection, curiosity, continuous learning, and the importance of co-leading with communities and working with people with lived experience of inequities.

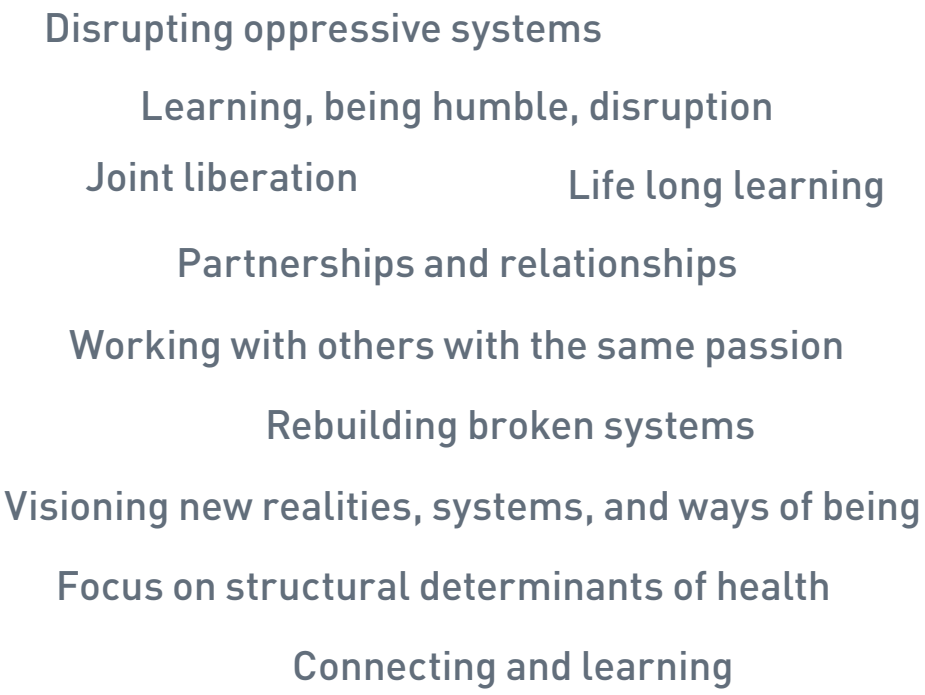
To close the first conversation, participants shared their thoughts on the discussions. RDs described health equity work as "pushing against the grain," requiring advocacy and persistence within their organizations as well as among partners and funders, which can feel isolating and deflating without adequate supports in place. They noted that health promotion and the public health role are still often framed around individual behaviour change and service provision (i.e., prone to lifestyle drift), rather than focused on structural changes related to the determinants of health. They also indicated that they have had to negotiate the perceived scope of dietetic practice within public health, where equity is often seen as "out of scope" or reflected in words but not actions.

At the same time, the group saw opportunities and responsibilities for RDs to do equity work in public health. They reinforced that equity is foundational to public health practice across all disciplines, and that RDs are well positioned to contribute with many transferable skills. The session concluded with participants appreciating the benefit of having a network to support each other in often challenging equity work.

Conversation #2

The second session built on the connections and sharing that happened in the initial conversation, seeking to strengthen the sense of connection among participants. We opened the session with the question **What do you love about doing equity work?** Responses reflected how equity concerns are closely integrated into participants' personal and professional identities (see Figure 2).

FIGURE 2: PARTICIPANT RESPONSES TO *WHAT DO YOU LOVE ABOUT DOING EQUITY WORK?*



In small groups, participants discussed both opportunities and barriers for RDs in public health to do health equity work. **Opportunities** included topical areas such as school programs, chronic disease prevention, weight bias and body diversity. Other opportunities involved increasing awareness of and engagement with Indigenous health, and advocating through professional associations, such as developing position statements related to health equity. Participants also identified education and training for RDs, leadership opportunities, partnerships, modification of current public health strategies, and the value of reflective practice.

Barriers included the perception among some RDs who do not see their role in interrupting the systems that cause inequities, and the difficulty of trying to change the same system we are all living and working in. Participants also pointed to the tendency of public health and government to focus on services instead of policy, political priorities, limited budget and resources, and broader societal forces such as capitalism. Additional barriers included inadequate organizational enablers and supports, personal and professional biases, and lack of public awareness and value placed on equity. One participant noted, "It feels as though the public doesn't know what we do."

Participants were then asked **How can RDs bring social justice and equity into their work?** Their suggestions have been grouped into four main strategies:

- **Weave it in instead of adding it on –** by raising awareness, normalizing and prioritizing health equity considerations in all aspects of the work, and identifying tasks within roles and scope of practice that can benefit from applying an equity lens.
- **Apply it to the work –** by assessing and reporting on the existence and impact of health inequities; applying an equity lens to development of healthy public policies and health impact assessments; collaborating with public health teams to share work and learnings (e.g., around Indigenous health, 2SLGBTQIA+ health, racialized communities, newcomers and refugees, income policy, commercial determinants of health, climate change); and advocating to leadership and government at every opportunity.
- **Demonstrate reflexivity and commitment –** by strengthening personal reflective practice, reflecting on positionality and power, engaging in continued learning and discussion, and "understanding that the opportunity and responsibility to bring social justice and equity into your work starts with you."
- **Centre community voice –** by engaging directly and meaningfully with community, making spaces for community voices, and leveraging stories from community members and front-line public health practitioners who see the reality of inequities.

The group concluded the session by reinforcing the benefit of having a network of connections and expressing interest in another opportunity to meet.

Conversation #3

In the third session, we focused on the actions required to advance social justice and equity as dietitians working within the public health system. We asked participants **What do you need to do equity work in your practice?** (see Figure 3 for the resulting word cloud).

FIGURE 3: PARTICIPANT RESPONSES TO *WHAT DO YOU NEED TO DO EQUITY WORK IN YOUR PRACTICE?*

RDs emphasized that organizational support is essential for equity work. Also important are building relationships with communities and having a community of practitioners to regularly connect with. Participants noted existing barriers to equity work as well, such as defined timelines, limited scope, and ongoing need for funding and resources.

Two participants shared examples of work they have been involved in to advance equity:

- **Community capacity building –** One RD described coordinating and disseminating community development funds to grassroots organizations working with communities experiencing marginalization and racialization. This included both the joys of working with diverse communities and the challenges of limited funding. Community organizations rely on these competitive yet short-term grants, but more sustained and secure funding is lacking to address systemic inequities.
- **Position paper development –** RDs discussed the challenges in naming the health impacts of racism and colonialism embedded in public health research and practice, and pushback encountered when questioning the status quo and institutionalized constructs such as weight bias and the misuse of body mass index (BMI). Development of a position paper was identified as one way RDs have countered these challenges, with key messages including the importance of support and collaboration among RDs (and all public health professionals) and explicit acknowledgement that confronting deeply rooted structures like BMI and colonialism is inherently political.

Both examples reinforced the supports and challenges faced by RDs doing equity work in public health. Further challenges included navigating complex bureaucratic structures within organizations (including government) while simultaneously advocating for social change. Although equity work is mandated in public health, budgetary decisions and constraints and lack of political will for change create ambiguities and limits to this work. RDs often have to "make the case" for equity work within their roles in public health and as dietitians.

The group closed this final session in the conversation series by appreciating the time spent together and voicing a collective desire to support and connect with one other moving forward.

Collective learnings

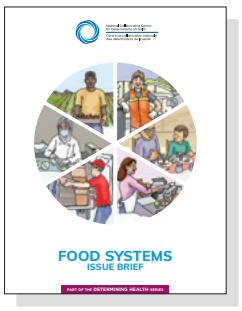
After each session, we met to debrief and reflect on our own experiences and thoughts about what the group discussed, in addition to reviewing evaluations and recorded materials from the sessions. The following themes (finalized in Spring 2025) represent our collective learnings from the conversation series.

RDs are well suited for equity-focused roles in public health

"Because RDs use evidence-based practices, need to get to the root of the problem, understanding why people may not be eating optimally, and this dissection lends itself well to understanding health equity principles which go way beyond individual change behaviour."

Participant

Both within and outside of public health nutrition-focused roles, conversation participants were unwavering in their conviction that RDs working in public health have the knowledge, skills and capacity to do equity-focused work. Within public health nutrition roles, food represents an entry point for addressing the structural and social determinants of health. Food sovereignty, food systems, food justice and food access often fall within the scope and role of RDs, providing opportunities that intersect with determinants of health to influence the health of individuals, communities and populations.



For more information on how food systems impact health, see *Determining Health: Food systems issue brief*

To learn more about food justice as a public health priority, see *Determining Health: Food justice practice brief*

"Food is a human right — we all need it, we engage with it daily.... That fundamental need and right brings an equity lens."

Participant

The right to food[13,14] — rather than just promoting healthy eating as a lifestyle choice — was consistently supported by participants during the sessions. RDs working outside of public health nutrition-focused roles, such as positions in health equity, policy, consulting, healthy communities, management and government, discussed being well situated to combine the expertise around food and nutrition inherent to dietetics with system-level knowledge and skills for broader change.

"Because our work is connected to food and land, which is foundational to what has been a tool for disconnection and oppression, and can also support reconnection and liberation for all."

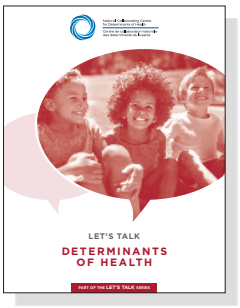
Participant

"Food [is] a lens in which we understand the world (worldview) — connected with systems of power and ... with one another (relational)."

Participant

RDs understand health equity and its application to practice in different ways

When participants were asked "What does health equity mean to you?" (see Figure 1), they described both what the term health equity means (e.g., upstream, lived experience, intersectionality) and what knowledge, skills and approaches are needed to do health equity work (e.g., listening, curiosity, respect, pushing boundaries). They did not distinguish between the "what" and the "how" of health equity work, perhaps because it is difficult to tease out the differences if the connection to values and social justice is not clear. This demonstrates ongoing tension in public health about how health equity is understood and put into practice.



For an overview of the social, ecological and structural determinants of health, see *Let's Talk: Determinants of health*

"Often, little of our work is directly related to food and nutrition but more about the structural and social determinants of health."

Participant

"The most common public health work is still very saviourist [belief that people need to be saved] and inequitable, like creating tools and resources around the food guide."

Participant

Several responses to this question aligned with but were not specific to social justice (e.g., listening, connection, resilience, curiosity, respect). One participant commented in the lead-up to one of the sessions that their work is "definitely related to health equity, but not really to social justice." While both interesting and puzzling, this division is not surprising. Many public health practitioners make a clear distinction between the two concepts. Health equity is viewed as a clearer concept that is more quantifiable, comfortable and neutral, and easier to talk about because it is focused on the distribution of resources (including access to services) and material factors that determine health. Social justice, on the other hand, is associated with deeply embedded structural issues that are less clear, less measurable, more uncomfortable, political, divisive, likely to produce strong reactions, relational, values-based and linked to societal "isms" over which individuals have no control — and therefore not actionable.[15] "What we are left with, then, is a concept of equity that is detached from structural and societal considerations of social justice."[15(p641)]

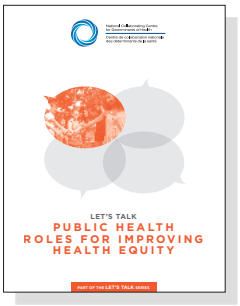
"Still has focus on 'service provision,' how health systems identify 'health equity' still lacks upstream approaches."

Participant

Within dietetics, RDs believe that food and nutrition form the basis for equity work. At the same time, there is a steadfast conviction that RDs can engage in equity work towards social transformation without necessarily invoking biomedical nutrition expertise.[16] In the conversation series, participants felt strongly that "everything is related to health equity" and that equity can be woven into their work across different roles rather than added on as an extra task. They affirmed that every RD can do something within their scope of practice, even when broader systemic barriers work against system-level change.

Opportunities identified by RDs to integrate equity into practice:

- Strengthen understanding of health equity concepts and actions.
- Develop relationships and partnerships with organizations and groups across sectors, beyond those specifically focused on health or nutrition (e.g., basic income and living wage coalitions, affordable housing organizations, disability networks).
- Lead or partner with other professional networks and associations on social justice advocacy.
- Support positions on social justice issues or develop role papers for RDs on these issues.
- Support and collaborate with RDs across the sector working on similar health or policy issues.
- Broaden the scope of dietetic practice to integrate and normalize a health equity focus in public health strategies.
- Build relationships and engage meaningfully (e.g., co-lead, partner) with communities facing structural and social health inequities.
- Reorient current interventions from service delivery towards structural solutions to reduce health inequities.
- Bring an equity lens to all areas RDs traditionally work in (e.g., health promotion, school nutrition, food insecurity, chronic disease prevention).



This NCCDH resource outlines four key public health roles to guide equity-focused practice: *Let's Talk: Public health roles for improving health equity*.

When considering barriers, one RD described equity work as "pushing against the grain." Although equity has been part of mainstream public health discourse since the release of the 2008 World Health Organization report on social determinants of health,[16] "true" equity work focused on systemic change remains on the margins. Those engaged in it often feeling isolated and unsupported. Participants widely agreed that resources allotted to equity work are insufficient and that decision-makers in public health view it as optional or an add-on. This is reinforced by predetermined public health mandates and funding streams that prioritize health protection, health education and disease prevention. In addition, support for equity work often seems peripheral: the language of equity is used in mission statements and organizational plans but not integrated structurally into policies and funding that would enable actualization of equity-focused strategies and interventions.[15]

"It feels as though the public doesn't know what we do.... How do we expect the public to know what we're doing when we don't involve them?"

Participant

This contradiction points to the challenge of doing equity work within government organizations. As civil servants, RDs are working to change the structure and function of their organizations from within the system, which is shaped by rigid internal policies and resistant to change. As a result, equity work requires navigating internal bureaucracies and advocating for changes at the margins (sometimes outside of mainstream public health functions). For some RDs, this may contribute to fears of being treated differently by their employers and losing their jobs when they push for important changes.

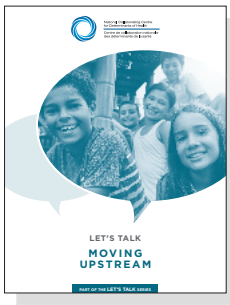
"It can feel relentless and deflating.... [This reinforces the] importance of colleagues supporting each other in this work."

Participant

Considerations and next steps

As attention to health equity continues to grow in professional dialogue and across public health, it is important to recognize the multiple ways the concept is understood and used. Drawing on conceptual framings of "upstream,"[17] health equity can be considered as an issue, a solution and an approach.

- An issue – Health equity, as a concept and term, highlights fairness and justice and draws attention to the structural and social factors that create relative advantage and disadvantage at all levels of society.
- A solution – Health equity is the reason for working a certain way, "a foundational rationale for arguing for policies, strategies, and programs that promote health equity, centered on how inequality, social norms and power differentials shape health."[18(p3)]
- An approach – Health equity is an essential value and ethical approach for public health, a strategy to address health disparities created by structural and social factors that shape the conditions of daily life and, in turn, health outcomes.



To learn more about working upstream to influence health equity, see *Let's Talk: Moving upstream*

"Once you develop awareness of the impact of health equity, you can't turn it off."

Participant

Drawing on all three framings of health equity is necessary to confront the complex public health challenges of our time. Climate change, dis/misinformation, austerity, deepening inequality, increasing intolerance, hate speech, openly discriminatory views and ongoing colonialism embedded within societal structures represent challenges that impact all areas of public health, including dietetics.

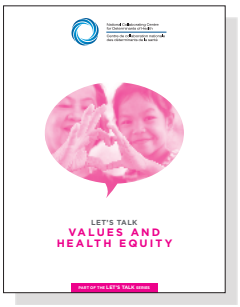
RDs working in public health roles with a distinct equity focus are passionate, capable and determined. Health equity is not just an aspiration — their passion for social justice and health equity is an identity "facilitated by a consistent integration of ethics in education, behaviors of leaders and mentors, and social interactions."[19(p241)] In other words, health equity and social justice are not only deeply interconnected but also integral to one's identity and sense of self — they are both values and solutions.

Although values may not appear explicitly in provincial and territorial mandates for public health program and service delivery, they are woven throughout the Core Competencies for Public Health in Canada, which outline the essential knowledge, attitudes and skills required across all levels of public health.[12]

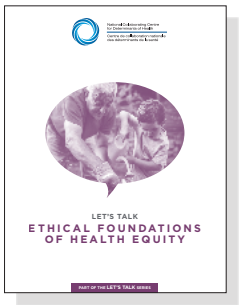
Core competencies for public health in Canada: Release 2.0[12]

Essential values for effective public health practice … include a commitment to health equity and social justice, respect, humility, accountability, transparency, cultural safety and evidence-informed approaches … rooted in an understanding of the determinants of health; historical and ongoing power imbalances; intersectionality; and strategies to promote population health and well-being and advance health equity.(p6)

Specific equity-focused competency statements are reproduced on page 5 of this document.



To learn more about values as drivers of health equity, see *Let's Talk: Values and health equity*



This NCCDH resource focuses on justice as the ethical basis of health equity: *Let's Talk: Ethical foundations of health equity*

"We experience similar challenges and there is opportunity to continue to collaborate. We are stronger together."

Participant

RDs working in health equity-focused positions and programs would benefit from working more closely together — simply put, they need each other. When asked in post-session evaluations "What is the main thing you learned?", RDs highlighted that connecting with others doing equity-focused work across the country was the most helpful. As a profession in small numbers within public health spread across a large country like Canada, relationships and collaboration were seen as the most essential part of building capacity to address health equity.

As described earlier in this document, relationships are what brought us together to do this work in the first place, what brought RDs to participate in the conversation series, and what will sustain this work moving forward. Connection was simultaneously a driver, a need and a benefit of the conversation series. The relational nature of this work, therefore, is both foundational and valuable in and of itself.

"Importance of collaborating with others so we can find the stories that will influence decision makers/ those in positions of power in the systems."

Participant

Regardless of our roles or positions, RDs are called on in public health "to transform health and social systems towards social justice."[4(p12)]

We challenge the false dichotomy that it is necessary to choose between health equity and dietetics positions. Opportunities and responsibilities exist for RDs to do health equity work, no matter what their job titles are. RDs are capable and well positioned to make major contributions to health equity efforts to advance population and public health. This is not to detract from the importance of public health nutrition-focused roles, which are being systematically eliminated from the public health landscape. In fact, **positioning RDs in equity-focused roles can only strengthen the importance of dietetics and nutrition within public health**. RDs working across positions and roles in public health, both nutrition and non-nutrition specific, can shift not only how they work but also the structures within which they practise.[11]

"We have a responsibility as a profession, and as individual practitioners, because we have 'response ability'—the ability to respond, to health inequities and social injustices."[10(p155)]

"I hope this is a sign of more to come — opportunities to connect and collaborate across colonial borders."

Participant

Taking an equity, social justice and anti-oppression approach to dietetics, both within and outside of public health nutrition-focused roles, creates opportunities to encourage change across all public health roles and levels.[8] Building competence around health equity concepts through knowledge- and skill-based learning is critical to dietetics education, training and ongoing professional development.[11] Equally important is practising critical reflexivity and "intentional and vulnerable self-examination of our individual and collective positions within, as well as our direct and indirect roles in perpetuating, the systems that undergird privilege and oppression."[11(p163)]

It is through advancing health equity that dietitians can strengthen their place in the public health workforce and make meaningful contributions to population health.

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