Health Equity Tools 2.0
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Equity
Lens in
Public
Health

Achknowledgements

We gratefully acknowledge the ELPH team's input and feedback on this work.
Please see our website, www.uvic.ca/elph for a full list of research team members.

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Introduction

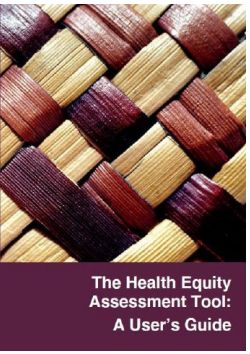
Equity Lens in Public Health (ELPH) is a 5-year program of research funded by the Canadian Institutes of Health Research (CIHR) and the Public Health Agency of Canada (PHAC). Our aim is to produce new knowledge for systemic promotion of health equity. The purpose of this inventory is to supply public health practitioners and policy-makers with a descriptive summary of health equity tools.

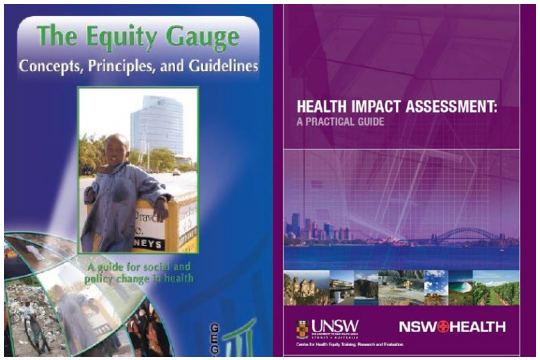
What is a health equity tool?

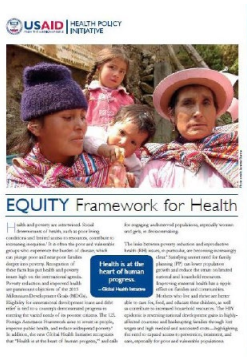
We have defined a health equity tool as a document or resource that clearly identifies improving health equity as a goal and provides a set of steps, questions, or a framework that people can follow to achieve this goal. By "tool" we mean a document or resource that either assesses the degree to which health equity is included in policies or programs, measures health equity, or promotes the inclusion of health equity in policies or programs.

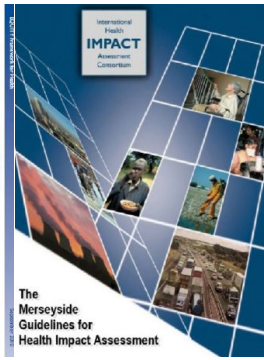
Why was the inventory created?

This inventory was created to help people working in public health make sense of the growing number of health equity tools available.









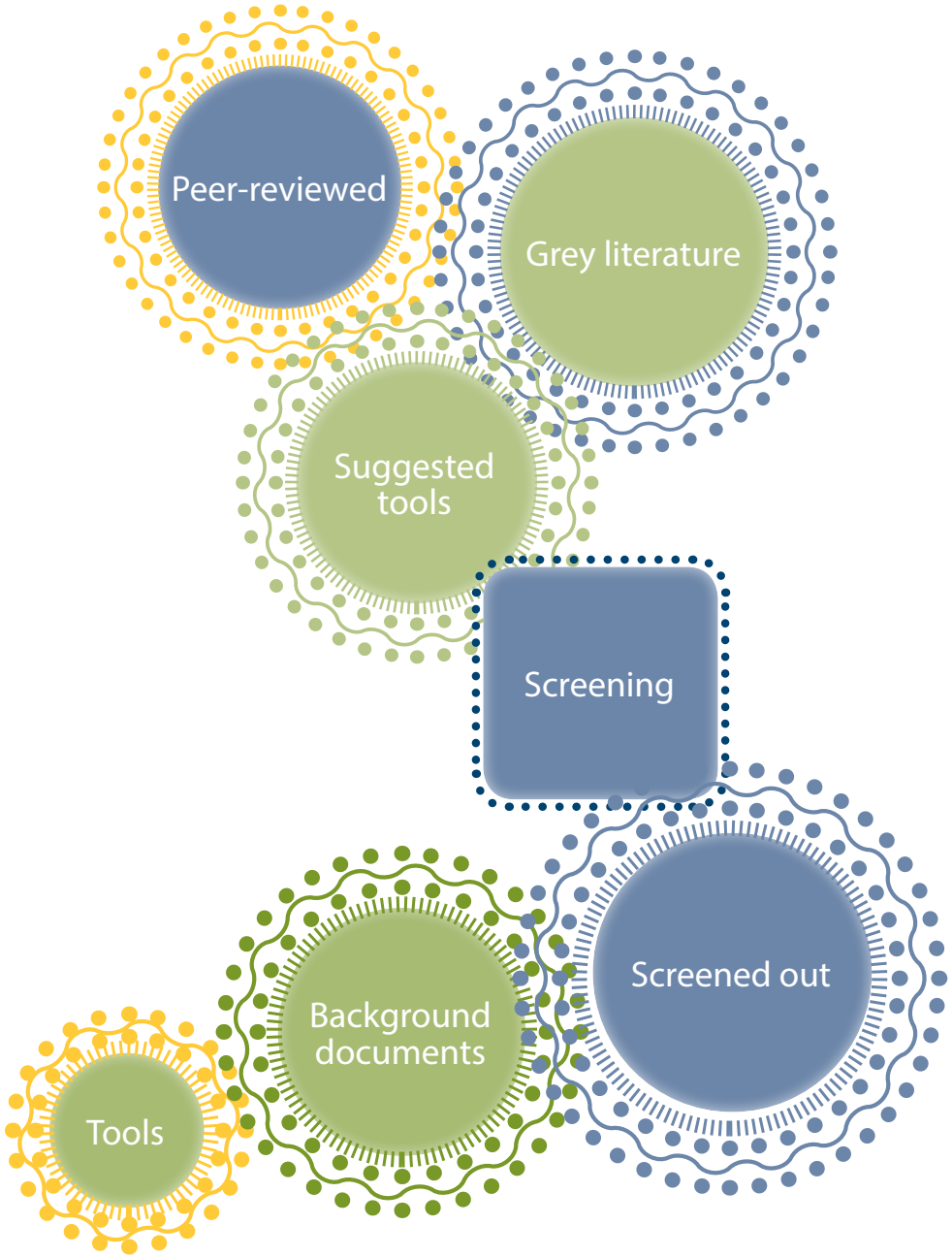
How was the inventory created?

- We published the first inventory in 2013 (Inventory 1.0) with 35 tools. For this first inventory, we searched peer-reviewed and grey literature published in English in or before the year 2011 and for the current inventory, we expanded the search to include the years 2012 and 2013. The literature search included reports, articles, and any document that self-identified as a tool, guide, resource, audit, or framework for health equity.

- For the original inventory, we searched nine databases using search terms such as health equity, inequities, and disparities combined with audit, impact assessment, framework, gauge, lens, tool, checklist, model, and guide. For the current inventory, we expanded our search terms to include: social justice, vulnerability, stigma, and marginalization. We searched the new terms in all years up to and including 2013, while the terms from Inventory 1.0 were searched for 2012 and 2013. Additionally, for both inventories, team members identified documents that they thought should be considered for inclusion.

- All documents were screened for relevance to public health and had to have a set of steps or a process to follow. Background documents that did not include the tool itself or a set of steps or process were screened out. We reviewed background documents, however, to identify any tools not retrieved in our initial searches.

- Each document was screened for inclusion by at least two members of the research team. We summarized all documents identified as tools.



How to use this inventory

Tool summaries

We've created detailed descriptions of each tool including the objective, intended users, how the tool can be used, and any information available about application and evaluation of the tool.

Purpose

Who would use it?

Description

This includes both a brief description of the tool document and an overview of the steps involved in using it.

Applications

We've noted any known applications of the tool. If there's no entry for application, it means we didn't find any indications it had been applied.

Evaluations

We've noted any evaluations conducted on the tool. If there's no entry for evaluation, it means we didn't find any evaluations for that tool.

Reference

The full citation for the tool.

Tool Categorization

To help users with their search for a tool, we have organized the tools into nine major categories reflecting broad areas of applications:

A. Equity Focused Health Impact Assessment Tools

This category of tools are all related to Equity Focused Health Impact Assessment Tools, also referred to as Health Equity Impact Assessment (HEIA) Tools.

B. Equity Focused Planning, Assessment, and Evaluation

This category includes tools for planning, evaluating and assessing the impact of policies, programs and/or services on health equity.

C. Indicators and Measurement

This category reflects tools that provide public health practitioners, decision makers and researchers with information about indicators for measurement and assessment of health equity.

D. Integrating Health Equity into Policies

This category of tools is relevant for decision makers and others to integrate health equity into policies.

E. Integrating Health Equity into Programs and Service Delivery

Tools for practitioners and organizational level decision makers to foster thinking about embedding health equity into program and service delivery.

F. Competencies, Training, Capacity Building, and Education

The emphasis here is on the development of practitioner competencies, training, capacity building and education. These tools promote the development of individual practitioners' knowledge and skills in promoting health equity.

G. Population Specific Approaches

This category of tools highlights perspectives and considerations of specific populations.

H. Community Engagement and Empowerment

This category of tools includes health equity resources for communities and tools related to community engagement and empowerment.

I. Health Equity Frameworks for Research

This category of tools highlights research approaches and strategies for focusing research on health equity.

About Appendix A

To help assess the tools, we have developed a list of practical and theoretical criteria. You can find this evaluation template in Appendix A. If you are unable to use the evaluation template, here are some questions to consider when determining if the tool is useful for you and your organization.

1. Is the purpose of the tool clearly identified throughout the text? (e.g., abstract, methods, results, discussion)
2. Who is the intended audience of this tool? (e.g., policy makers, researchers, front line staff)
3. Is the tool focused on a specific population that is experiencing inequities? (e.g., gender, children, minorities, low socioeconomic status, mental health)
4. Has the tool been applied to a policy, program, or every day professional practice? Or is the tool purely conceptual?
5. If the tool has been applied, has the tool been formally evaluated for effectiveness?
6. Does the tool have the potential to improve policies and/or programs related to health equity?
7. Does the tool clearly define health equity, health equality, or social justice?

STBBI Specific Health Equity Impact Assessment Tool

Purpose

This health equity assessment tool is specifically for the assessment of possible inequity created by a prevention-based policy, program, project, intervention or service meant for the people who are vulnerable to Sexually Transmitted and Blood-Borne infections (STBBIs).

Who would use it?

Health care practitioners, front line service providers (explicit).

Description

This specific tool for STBBI-health equity impact assessment includes the instructions to follow the steps of the assessment, an adaptable template, and a list of factors that impact vulnerability. The authors suggest that the tool is not an evaluation tool or framework; instead it is intended to inform the design and planning of new prevention-based initiatives. The tool is for the support of front line health workers and consists of traditional health impact assessment steps of identifying the gaps or needs, initial planning, initiative development, implementing the initiative, monitoring and adjustments, and finally evaluating and adapting of the project.

Applications

An example of filling out the STBBI HEIA template is included.

Reference

Canadian Public Health Association. (n.d.). Sexually transmitted infections and other blood-borne infections, including HIV, (STBBI) health equity impact assessment (HEIA) tool. Canadian Public Health Association. http://www.cpha.ca/uploads/pdf_files/heia_tool_en.pdf

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Appendix

Health Impact Assessment Evaluation Framework

Purpose

To put forward a conceptual framework that guides the evaluation of health impact assessment (HIA) effectiveness.

Who would use it?

Researchers and policy makers (implicit).

Description

The conceptual framework for evaluating HIA has three components: (1) context - encompasses the broader decision-making context, as well as the values, purpose and goals of the HIA; (2) process - includes the required actions necessary to undertake the HIA, and the structures and resources required to support these actions; and (3) impacts - includes both proximal and distal impacts. Proximal impacts may include informing decisions, as well as informing those potentially affected by such decisions regarding its potential benefits and alternatives. Distal impacts may include developing and strengthening of partnerships and engaging with the health, government, community, and private sectors.

Reference

Harris-Roxas, B., & Harris, E. (2013). The impact and effectiveness of health impact assessment: A conceptual framework. Environmental Impact Assessment Review, 42, 51-59.

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Appendix

Strategies For Incorporating Equity Into Health Impact Assessment (HIA)

Purpose

To provide strategies for practitioners that ensure the values of equity are meaningfully incorporated into health impact assessments.

Who would use it?

Stakeholders, decision-makers (implicit).

Description

The authors describe the following equity considerations that can be implemented in HIAs: (1) maximizing community engagement by involving and encouraging leadership from the impacted communities in the entire HIA process; (2) defining the impacted communities and identifying the appropriate methods to reach and work with those communities; (3) working with communities to select an HIA topic that is relevant to their needs; (4) developing the scope of HIA that sets equity-related goals; (5) involve impacted populations/communities in the data collection and analysis process; (6) involve communities in developing and prioritizing recommendations; (7) involve communities in reporting HIA findings to decision-makers; (8) discuss with the impacted communities the monitoring methods for HIAs; and (9) involve the impacted communities in designing and implementing the HIA evaluation.

Reference

Human Impact Partners. (2012). Strategies for incorporating equity into HIA.

http://www.ccbh.info/hipc/wp-content/uploads/2015/12/A.3equitystrategies_hip.pdf

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Appendix

Health Equity Impact Assessment

Purpose

The document is a planning tool to support the staff of Public Health Units (PHU) in Ontario to meet the specific requirements around health equity in the Ontario Public Health Standards (OPHS).

Who would use it?

Health practitioners, policy makers (explicit).

Description

The Health Equity Impact assessment (HEIA) tool is intended to support the integration of equity considerations into the development or evaluation of a policy, program, or initiative. The tool can help planners in discovering gaps in service delivery, program planning, and health needs for marginalized groups. The chart describes the steps involved for HEIA and linked requirements listed in OPHA standard and PHAS protocol. The steps are: (1) scoping about the population and determinants of health; (2) identifying potential impacts of the policy, program, or initiative; (3) mitigation to reduce the negative impacts and amplify the positive ones; (4) monitoring strategies to track impact over time; and (5) disseminating the knowledge.

Reference

Ministry of Health and Long Term Care. (2012). Health equity impact assessment workbook. Ontario Ministry of Health and Long Term Care.

http://www.health.gov.on.ca/en/pro/programs/heia/

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Appendix

Equity Focused Health Impact Assessment Framework

Purpose

To determine differential impacts of polices and practices on the health of the population as well as specific groups; to assess whether these differences are unfair and avoidable.

Who would use it?

People who are in a position to review or effect change in existing or potential policy and practice.

Description

Use of the framework involves six steps: screening, scoping, impact identification, impact assessment, recommendations and monitoring/evaluation. The framework can be applied prospectively or retrospectively. It provides a flexible and structured approach for introducing equity concerns and reduction of health inequities to policy agendas. It is a means for introducing evidence related to inequities and provides a focus on specific needs of differing population groups. Instructions for three levels of equity focused health impact assessment: rapid, intermediate, and comprehensive are included. The choice of level used depends on available resources and the degree to which impacts are already known.

Applications

This tool was used to assess a community funding program that sponsors arts, health, cultural and sporting agencies in their health promotion activities.

Evaluations

Harris-Roxas (2011) and colleagues evaluated a rapid equity-focused health impact assessment. See: Harris-Roxas, B., Harris, P. J., Harris, E., & Kemp, L. A. (2011). A rapid equity focused health impact assessment of a policy implementation plan: An Australian case study and impact evaluation. International Journal for Equity in Health, 10(6), 1-12.

Reference

Mahoney, M., Simpson, S., Harris, E., Aldrich, R., & Stewart Williams , J. (2004). *Equity focused health impact assessment framework*. The Australasian Collaboration for Health Equity Impact Assessment (ACHEIA).

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Appendix

Health Equity Impact Assessment (HEIA) Workbook: How to Conduct HEIA

Purpose

To identify a policy or program's unintended impacts on the health of marginalized groups. The ultimate goal is to reduce health inequities that result from barriers to access to health care.

Who would use it?

Ontario Ministry of Health and Long-Term Care (MOHLTC), Local Health Integration Networks (LHINs) and by health services providers.

Description

This workbook consists of instructions to assess and plan for the health equity implications of a policy on the health of marginalized groups. It contains a description of the purpose, when and who should conduct a HEIA, and how to do the audit following four steps: scoping, impact assessment, mitigation strategy and monitoring. This tool is based on Health Impact Assessment (HIA) methodology which has been applied widely. According to this document, HIAs often address health inequities but not in a targeted and systematic way.

Applications

The HEIA evolved and is currently in use in the UK, New Zealand, and Australia

Reference

Ontario Ministry of Health and Long-Term Care and Local Health Integration Networks. (2011). *Health Equity Impact Assessment (HEIA) Workbook: How to conduct HEIA*. Ontario: Author.

http://www.health.gov.on.ca/en/pro/programs/heia/docs/workbook.pdf

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Appendix

Health Impact Assessment-Based Tools

Purpose

Health impact assessment (HIA) is a process for predicting the health effects of policies, plans, projects or programs, and developing recommendations for mitigation of any negative effects.

Who would use it?

Policy makers, program planners, program managers.

Description

HIAs typically includes six steps (from Harris P. 2007):

1. Screening
2. Scoping
3. Identification
4. Assessment
5. Decision making and recommendations
6. Evaluation and follow-up

Application

HIAs are applied widely, but their inclusion of health equity considerations varies significantly. This has led to criticism that HIAs do not make very good health equity tools (Parry 2003, Morgan 2008). Given the wide range of HIAs with varying focus on health equtiy, we have included in this health equity tools inventory HIA tools that have a health equtiy focus or focus on a population of concern.

Reference

This is a key reference that includes several HIAs:

Orenstein, M. & K. Rondeau (2009) *Scan of health equity impact assessment tools.* Calgary: Habitat Health Impact Consulting. Prepared for: The Strategic Initiatives and Innovations Directorate, Public Health Agency of Canada.

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Appendix

Whānau Ora Health Impact Assessment

Purpose

To determine the effect of policies on Māori health and well-being and how policies can support Māori health and well-being and reduce inequalities faced by Māori people.

Who would use it?

Policy makers and community groups.

Description

This 49-page document includes information on Health Impact Assessments (HIA) in general and the development of the Whānau Ora, as well as a guide, questions, and worksheets. As the tool is based on HIA, the key elements are screening, scoping, appraisal/reporting, and evaluation. Significant attention is paid to engaging affected groups in policy development. The authors recommend using the tool as early as possible in the policy making process.

Applications

The New Zealand Ministry of Health offers training and there is a list of reports from applications of this tool, available online at:
http://www.health.govt.nz/our-work/health-impact-assessment/whanau-ora-health-impact-assessment.

Evaluations

This builds on the Public Health Advisory Committee's, 'A Guide to HIA: A Policy Tool for New Zealand' (2005) and evaluated by Quigley and Watts (2006).
See: Quigley & Watts. (2006). An evaluation of the Whānau Ora HIA Guide: Informed via its use on the Ministry of Health's criteria for capital assistance for small drinking-water supplies. Wellington, NZ: Ministry of Health.

Reference

Ministry of Health. (2007). *Wha¯nau Ora health impact assessment*. Wellington, New Zealand: Ministry of Health.

http://www.health.govt.nz/our-work/health-impact-assessment/whanau-ora-health-impact-assessment

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Appendix

Worksheets for Health Inequalities Impact Assessment and Rapid Appraisal

Purpose

To promote access to services and amenities for identified priority populations, and to monitor implementation.

Who would use it?

Service developers and program planners considering new projects.

Description

This tool is used to assess the positive and negative health impacts proposed projects might have on health inequalities and to identify opportunities for health promotion for vulnerable groups. There is a series of worksheets and guidance notes offering guiding questions, based on the HIA Toolkit from Bro Taff Health Authority (1999). The impact assessment's framework includes the consideration of health determinants into the planning stage of a project in order to reduce health inequalities.

Applications

See Smith (2000) for a discussion of its application in Wales:
Smith, K. (2000). Implementing health inequalities impact assessment in Bro Taf. Cardiff: Directorate of Public Health, Bro Taf Health Authority.

Reference

National Public Health Service for Wales. (2004). *Worksheets for health inequalities impact assessment and rapid appraisal.* Wales: Author.

http://hiaconnect.edu.au/old/files/HIIA%20_Bro_Taf_all.pdf

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Appendix

Rapid Assessment Methods For Health-Equity Audit

Purpose

To track inequitable access to care across the care pathway for specific conditions in groups likely to be disadvantaged in some way.

Who would use it?

Decision makers, policymakers, healthcare organizations (implicit).

Description

The authors describe methods for identifying inequalities in diabetes care among elderly care-home residents in the United Kingdom. The approach involves four steps: (1) developing a framework for assessing current diabetes care using standardized methods of data collection and evaluation to facilitate audit of services: (2) using rapid-evaluation methods to describe the experiences of the patients and their care providers; (3) identifying care-home residents who are known to have diabetes; and (4) collecting data and synthesising information collected into a report. Rapid-evaluation methods used to assess quality of care-homes consisted of: (1) review of key publications; (2) interviews with key informants; (3) structured questions and check-lists; (4) care-home record review.

Reference

Aspray, T. J., Nesbit, K., Cassidy ,T. P., Hawthorne, G. (2006). Rapid assessment methods used for health-equity audit: diabetes mellitus among frail British care-home residents. Public Health, 120(11), 1042-51.

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Appendix

Equity Impact Review

Purpose

To identify, evaluate, and communicate the potential positive and negative impacts of a policy and program on equity.

Who would use it?

Policy makers, researchers (implicit).

Description

The focus of the tool is on promoting social equity of which health equity is as one dimension. The tool consists of three steps to provide a systematic approach to collecting information needed to inform planning and decision making for public policies and programs that impact equity in King County. The aims are to: (1) determine the potential impact of the proposal on equity; (2) assess who might be affected; and (3) review opportunities for action to mitigate negative impacts and enhance positive impacts. Checklists and worksheets for each stage are included followed by a final section with recommendations for the user regarding future implementation.

Reference

Albetta, G., Ciske, S. (2010). King County Equity Impact Review Tool.

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Appendix

Gradient Equity Lens

Purpose

To facilitate appropriate evaluation of policy actions at each stage of the policy cycle to promote health equality for children, youth, and families.

Who would use it?

Policymakers, decision-makers (explicit).

Description

The Gradient Equity Lens (GEL) comprises two dimensions that raise a series of questions and issues that decision-makers can pose and/or consider to better understand the unique nature of each policy action by linking those issues to certain circumstances. Dimension one is comprised of eight key areas that decision-makers can use as a checklist: (1) proportionate universalism; (2) intersectoral tools for all; (3) a whole systems approach; (4) scale and intensity; (5) lifecourse approach; (6) social and wider determinants; (7) non-geographic boundaries; and (8) gradient friendly indicators. Results are analyzed at the end of each key component and used to provide an overall rating of policy action. The rating can be useful in restructuring policy actions. Dimension two proposes six steps to help decision-makers design and evaluate proposed or existing policy actions: (1) describe the policy and its related action; (2) engage stakeholders; (3) focus evaluation design; (4) collect relevant data; (5) analyse, interpret and synthesise data; and (6) disseminate and seek feedback.
This document also provides a user guide for practitioners looking to implement the Gradient Equity Lens (GEL). This user guide contains checklists, rating systems, and worksheets to help apply the GEL.

Reference

Davies, J. K. and Sherriff, N. S. (2012). The gradient evaluation framework (GEF): A European framework for designing and evaluating policies and actions to level-up the gradient in health inequalities among children, young people and their families.

http://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/GEF%20-%20GefDocFinal_smallest.pdf

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Healthy Development Measurement Tool

Purpose

To evaluate city development plans and projects with respect to positive and negative effects on community health.

Who would use it?

Policy makers (explicit).

Description

The tool is being developed as a part of a two year collaborative project of the San Francisco Department of Public Health and the Eastern Neighborhoods of San Francisco to conduct a community health impact assessment. The intent is to evaluate the potential positive and negative health impacts of land use development on the local residents. The main aim of the project is to maintain the diversity of and achieve health equity for San Francisco residents. The tool described in this document is the Healthy Development Measurement Tool (HDMT). It is an evidence based tool for accountable and comprehensive health oriented planning. The tool is being designed with a vision of a healthy city including seven elements of: (1) environmental stewardship; (2) sustainable transportation; (3) public safety; (4) public infrastructure/ access to goods and services; (5) adequate and healthy housing; (6) healthy economy; and (7) community participation. The list of indicators for the seven elements of HDMT is presented with the step wise strategies to collect data for the indicators. The application of the tool is also discussed with the main objectives of assessing the health needs of the neighborhood, understanding the effects of a plan or project on the health needs, and recommending the planning policies for community health.

Applications

In the paper, the authors describe a pilot application of the HDMT on a proposed residential housing plan in a San Francisco neighbourhood.

Reference

Farhang, L., Bhatia, R., Scully, C. C., Corburn, J., Gaydos, M., & Malekafzali, S. (2008). Creating tools for healthy development: Case study of San Francisco's eastern neighborhoods community health impact assessment. Journal of Public Health Management and Practice, 14(3), 255-265.

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Appendix

Participative Evaluation Framework

Purpose

The purpose of the participative evaluation framework is to provide an evidence-based tool for evaluating projects or programs targeting health inequalities in local contexts.

Who would use it?

Health care practitioners (explicit).

Description

The participative evaluation framework drew on three systematic literature reviews that had been commissioned by the governments of the Netherlands, UK, and Northern Ireland. The framework consists of six common characteristics that were identified as a key to success in addressing health inequities in all reviews and consulted literature. These components are: (1) the importance of the healthcare setting; (2) use of pluralistic methods; (3) inter-agency and community partnerships; (4) a holistic view of health; (5) identification of minority needs; and (6) the use of health impact assessment. Evidence suggests that interventions that include these components are likely to be more successful in addressing health inequalities than projects that do not include the components. As an example, the authors provide the relevance of each of the framework's components to inform local service development by evaluating women's health needs in an area of Belfast.

Applications

The authors apply the framework to an intervention addressing women's psychosocial health needs.

Reference

Themessl-Huber, M.,Lazenbatt, A., & Taylor, J. (2008). Overcoming health inequalities: A participative evaluation framework fit for the task. The Journal of the Royal Society for the Promotion of Health, 128, 118-123.

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Appendix

Urban Health Equity Assessment And Response Tool (Urban HEART)

Purpose

To guide policymakers and leaders in using evidence to take action on health inequities. Urban HEART can be used as a tool to analyze inequities in health between people living in various parts of cities or belonging to different socioeconomic groups within and across cities. Finally, this tool can also be used to facilitate decisions on effective strategies and interventions to reduce health inequities.

Who would use it?

Policymakers, decision makers (explicit).

Description

Urban HEART assessment comprises 4 stages: (1) Assessment Phase; (2) Response Phase; (3) Policy Phase; and (4) Programme Phase. In the assessment phase, the processes, structures and mechanisms are used to identify indicators for local government, and to gather and validate data for indicators. The response phase describes how local governments identified and prioritized appropriate strategies and interventions that could address inequities in urban health based on the results of assessment. The policy phase describes how selected interventions identified during the response phase were budgeted and prioritized to ensure their inclusion in the policy-making process at the local government level. Finally, the programme phase describes processes, structures and mechanisms adopted and put in place to support the effective and efficient implementation of priority strategies and interventions on urban health equity. Also documented in the programme phase were issues and challenges encountered and project accomplishments.

Applications

The Urban HEART assessment tool has been used as a pilot-test in the following cities: Davao, Naga, Olongapo, Paranaque, Tacloban, Taguig, and Zamboanga. These cities are all located in the Philippines.

Evaluations

None of the pilot cities, except Paranaque, had reached the stage where measures were taken to ensure sustainability.

Reference

de los Santos, M. S. (2013). Report on documentation and evaluation of Urban HEART pilot in the Philippines.

http://www.who.int/kobe_centre/publications/Philippines.pdf

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Appendix

Human Impact Assessment (HuIA)

Purpose

The objective of Human Impact Assessment (HuIA) is to assess the health and social impacts of plans, programs and projects on human health and well-being with the overall goal of reducing health and social inequalities and inequities in the population.

Who would use it?

Policymakers, decision makers, public health institutions, government officials (implicit).

Description

HuIA is a philosophy or framework developed to bring together trends in assessing the effects on human health and well-being of a plan, program or project prior to its implementation. This type of analysis emphasizes the 'human' aspect of analysis, focusing on human beings as a whole instead of on the various health and social determinants.
There are two types of HuIA's, comprehensive HuIA and rapid HuIA. The stages of a comprehensive HuIA are: (1) screening and scoping; (2) acquiring information; (3) describing alternatives; (4) identifying impacts; (5) appraising alternatives; (6) reporting; and (7) monitoring. Comprehensive HuIA should be carried out at the development stage where a project, plan or program is currently being developed. Rapid HuIA is carried out rapidly, and is concentrated on a limited number of impacts and draws on existing information and experiences. Rapid appraisals include only a few stages of comprehensive impact assessment: (1) describing alternatives; (2) identifying impacts; and (3) appraising alternatives.

Applications

HuIA has been an established practice in Finland for more than ten years. HuIA is a statutory requirement in certain impact assessment processes in Finland.

Reference

Kauppinen, T. (2011). Human impact assessment as a framework for integration. In Vanclay, F., & Fonte, M. d. (Eds.), New directions in social impact assessment: Conceptual and methodological advances. Northampton, MA; Cheltenham, Glos, UK: E. Elgar.

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Appendix

Avoiding the Danger that Stop Smoking Services May Exacerbate Health Inequalities: Building Equity Into Performance Assessment

Purpose

To find out whether a public health initiative reduces or exacerbates health inequities. The authors use a framework to evaluate the impacts of a public health initiative (stop smoking services) on health equity.

Who would use it?

This framework may be of interest to anyone planning or implementing smoking cessation programs.

Description

The authors describe a method for analyzing data from a public health stop smoking initiative and the impacts on health equity. The authors assess whether the program is effective for all socioeconomic groups, or whether the program exacerbates health inequities by improving conditions for more affluent people. Application of this evaluative framework combines measures of the overall number of people who quit smoking with measures of socioeconomic disparity among smokers to provide estimates of the relative gap in smoking cessation rates between socio disadvantaged and affluent neighbourhoods.

Applications

As an example, the framework is applied to a smoking cessation program in Derwentside, a former Primary Care Trust in the north east of England. When applied to the Derwentside program, the authors show that while overall levels of smoking were reduced, the gap in the quit rate per adult between affluent and deprived neighbourhoods was lower than the gap in smoking prevalence. This meant that affluent areas benefited more and that the program was not contributing to reduction of health inequities.

Reference

Low, A., Unsworth, U., Low, A., & Miller, I. (2007). Avoiding the danger that stop smoking services may exacerbate health inequalities: Building equity into performance assessment. *BMC Public Health, 7*(198), 1-9.

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Appendix

An Equity Framework for Health Technology Assessments

Purpose

To include ethical considerations and equity in Health Technology Impact Assessment.

Who would use it?

People setting up HTAs, and specifically for informing the terms of reference of advisory bodies involved in HTA.

Description

The Equity Framework for Health Technology Assessments (HTA) is a way of systematically evaluating the effects of a health care intervention, usually to inform decision making about which health interventions to implement. The Framework's objectives are twofold: (1) to structure health technology assessment discussions though consideration of all potentially relevant factors and evidence, and (2) ensure sufficient detail in minutes and accounts of decisions to allow for retrospective analysis of decisions taken. The framework includes consideration of equity, domains of equity, and embedded inequity as specific elements.

Reference

Culyer, A. J., & Bombard, Y. (2012). An equity framework for health technology assessments. *Medical Decision Making, 32*(3), 428-441.

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Appendix

The Health Equity Assessment Tool (HEAT): A User's Guide

Purpose

To promote health equity in health policies, programs and services.

Who would use it?

Health sector workers, including policy makers, non-governmental organizations (NGOs), community groups, social services and local governments.

Description

The Health Equity Assessment Tool (HEAT) is used to assess equity dimensions of a health problem and help users to tackle health inequities when deciding on policies and programs. This 44-page guide book reveals ways of promoting health equity through mainstream health policies, programs and services. The tool consists of 10 questions for assessing health initiatives for their current or future impact on health equity. The guidebook includes worksheets and case studies.

Applications

The document includes a chapter with two case studies discussing the application of HEAT by the Ministry of Health in New Zealand and a regional health board. According to the introduction, the tool has been well-used in public health, but its use in clinical services has been limited to date.

The HEAT tool has been adapted for use in other locations, for example: Bernalillo County, New Mexico, USA: http://www.bcplacematters.com/resources/health-equity-assessment-tool/

Reference

Signal, L., Martin, J., Cram, F., & Robson, B. (2008). *The health equity assessment tool (HEAT): A user's guide*. Wellington, New Zealand: Ministry of Health.

https://www.health.govt.nz/system/files/documents/publications/health-equity-assessment-tool-guide.pdf

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Appendix

Health Equity Audit: A Guide for the NHS

Purpose

To use evidence on inequalities to inform decision making related to investment, service planning, and delivery and to evaluate impacts of action on inequities.

Who would use it?

Executive level decision makers, performance managers, acute care and other service providers. Designed for the UK's National Health Service.

Description

This 40-page guide contains a brief overview of health equity audits and the health equity audit cycle, followed by several examples of HEAs from the UK. The HEA cycle consists of six steps: (1) Agree on partners and issues; (2) Equity profile – Identify the gap; (3) Agree on high impact local action to narrow the gap; (4) Agree on priorities for action; (5) Secure changes in investment and service delivery; and (6) Review progress and assess impact. This tool can be used to focus assessment on projects that will have the most impact on health inequities as well as addressing dimensions of health including social class, geography, gender, ethnicity, age and vulnerable groups. Life expectancy and infant mortality are identified as primary issues.

Applications

Aspinall and Jacobson (2005) describe how the HEA has become embedded in the UK national strategy as a mandatory requirement for Primary Care Trusts. A self-assessment tool was developed to help address organizational development issues underpinning the Health Equity Audit (HEA) process and is designed as a precursor to the Health Equity Audit to assess an organization's readiness and capacity to use the HEA.
See: Aspinall, P. J., & Jacobson, B. (2005). Managing health inequalities locally: A baseline survey of primary care trusts' experience with health equity audit in the implementation year. Health Services Management Research: An Official Journal of the Association of University Programs In Health Administration / HSMC, AUPHA 18(4): 223-231

Reference

Department of Health. (2003). *Health equity audit: A guide for the NHS: National Health Service*. United Kingdom: Author.

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084138

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Appendix

Health Risks and Health Inequalities in Housing: An Assessment Tool

Purpose

To assess the health risks of housing and judge the level of health risk associated with unhealthy or unsafe housing in order to promote health equity through improved housing conditions.

Who would use it?

England's Housing Learning & Improvement Network (LIN) prepared this tool for housing and health professionals.

Description

Poor housing has significant detrimental effects on health, and people with fewer financial resources, who are already disadvantaged when it comes to health, are more likely to live in sub-standard housing. As part of this tool key health risks associated with housing are summarized. The tool enables the user to record a judgment about the level of health risk attributable to unhealthy or unsafe housing conditions, and to compare this with the adequacy of local practice in mitigating the risk. Specifically, the tool includes two checklists. The first checklist uses a five-point scale to assess each health risk and the extent of housing and neighbourhood conditions known to be associated with the risk while the second assesses local policy and practice with regard to minimizing the risk to health from these conditions. Ratings can be entered into an MS Excel spreadsheet and graphed to show the 'performance gap' between the extent of risk and the extent of good practice.

Applications

Examples of data input from a completed risk assessment and the associated radar graph produced from part of the data are provided. Further case studies are available online.

Reference

Blackman, T. (2005). *Health risks and health inequalities in housing: An assessment tool*. London: Department of Health.

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Appendix

Mental Well-Being Impact Assessment: A Toolkit for Well-Being

Purpose

To help users to understand what puts mental well-being at risk, and what can be done to improve and sustain mental well-being.

Who would use it?

A broad range of decision-makers in a variety of settings. The authors suggest that anyone interested in the mental well-being impact of polices, services, or programs could use the tool.

Description

This 141-page toolkit consists of an overview of the tool, policy context in Europe and the UK, an account of the current evidence, lists of questions and worksheets, detailed instruction on how to complete a MWIA, guidelines on developing indicators, and a list of resources to support the process. Equity and social justice are identified as core values in this process. This was developed in the UK, and is based on health impact assessment steps (e. screening, scoping, appraisal etc.).

Reference

Cooke, A., Friedli, L., Coggins, T., Edmonds, N., Michaelson, J., O'Hara, K., . . . Scott-Samuel, A. (2011). *Mental well-being impact assessment: A Toolkit for well-being* (3 ed.). London: National MWIA Collaborative.

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Appendix

Urban Health Equity Assessment and Response Tool: User Manual

Purpose

To identify health inequities in urban areas and develop actions to reduce health inequities based on the evidence generated.

Who would use it?

The authors suggest that local communities, program managers, and municipal and national authorities might use the tool.

Description

The Urban Health Equity Assessment and Response Tool (Urban HEART) is a 59-page decision making support manual. The manual guides users through the process of identifying health inequities and planning actions to reduce them. The authors of the tool organize health inequities into four domains: physical environment, social and human development, economics, and governance and politics.

Steps:

1. Build an inclusive team
2. Define your local indicator set and benchmarks
3. Assemble relevant and valid data
4. Generate evidence
5. Assess and prioritize health equity gaps, and gradients
6. Identify the best response

Applications

Since the launch of the pilot program in 2008, Urban HEART has been pilot-tested in cities in Brazil, Indonesia, Islamic Republic of Iran, Kenya, Malaysia, Mexico, Mongolia, Philippines, Sri Lanka and Viet Nam. Up to 2011, officials in nearly 50 countries have been trained on using Urban HEART.

Reference

World Health Organization. (2010). *Urban Health Equity Assessment and Response Tool: user manual.* Kobe: The WHO Centre for Health Development.

http://www.who.int/kobe_centre/measuring/urbanheart/en/

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Appendix

Local Indicators

Purpose

To improve the health and well-being of Maori living in the Auckland District Health Board (ADHB).

Who would use it?

Decision makers (implicit)

Description

The Auckland DHB Maori Health Plan is designed to improve health outcomes and reduce health inequalities for Maori. The plan contains Maori health priorities and indicators at the national, regional, and local levels. The issues behind each priority are identified with a focus on health disparities. The appendix section of the document contains the process for developing indicators to support the Maori Health Plan.

Reference

Auckland District Health Board. (2015). Maori health plan.

http://www.adhb.govt.nz/documents/Maori_Health_Plan_2015_16.pdf

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Appendix

The Public Health Handbook of Health Inequalities Measurement

Purpose

To provide a comprehensive collection of material for those concerned with documenting, measuring and understanding health inequalities in order to reduce them.

Who would use it?

People working at all levels in the health care sector (explicit)

Description

This 216-page handbook focuses on the measurement of inequalities in health and death. The authors' intention was to provide a menu of possible dimensions of inequality and methods of measuring and monitoring inequalities to which a local researcher can refer. The handbook has 10 sections (1) measuring inequality by social categories; (2) measuring inequality by health and disease categories (using data from administrative sources); (3) measuring inequality by health and disease categories (using data from surveys); (4) use of indexes to measure deprivation; (5) a selection of indexes of multiple deprivation; (6) indexes: properties and problems; (7) data sources: availability and problems; (8) designing surveys to measure inequality; (9) inequalities and methods of measurement; and (10) context, history and theory.

Reference

Carr-Hill, R. A., & Chalmers-Dixon, P. (2005). The public health observatory handbook of health inequalities measurement. J. Lin (Ed.). South East Public Health Observatory.

http://snspms.ro/UserFiles/File/doc/the_public_health_observatory_handbook.pdf

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Appendix

Steps To Create Local Health Profile From Online Resources

Purpose

This "A How-to Guide" can help in creating a neighborhood health profile to plan for the best ways of dealing the critical health issues.

Who would use it?

Health practitioners (implicit)

Description

This guide is a resource for those interested in creating a local health profile. The creation of a health profile can inform health promotion actions. The authors proposed the use of this tool for obtaining data and to use the data for promoting a "high quality of life for all". Online resources are provided for accessing indicators and local data which consist of county health rankings and road maps, Center for Disease Control and Prevention (CDC) national public health track network Community design indicators, CDC chronic disease indicators, behavioural risk factor surveillance system, Youth risk behaviour surveillance system, Food environment atlas, Food desert locator, Community health status indicators, CDC WONDER database. The steps are provided to use these websites for creating the health profiles within the United States.

Reference

Center for Disease Control. (n.d.). Creating a health profile of your neighborhood: A how-to guide.

http://www.cdc.gov/healthyplaces/toolkit/sources_of_health_data.pdf

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Appendix

Urban Health Equity Indicators

Purpose

To outline an approach for promoting greater urban health equity through the drafting and monitoring of indicators.

Who would use it?

Municipalities, county health departments, school districts, and community-based organizations

Description

The authors offer a few brief examples of what urban health equity indicators could entail. In Richmond, California, the indicator process was developed from ongoing community organizing and land use planning, and included community-based organizations, the city, and county health department. The community process began through a process called "Measuring What Matters" in which over ten different community-based organizations identified priority issues, chose indicators, collected and analyzed data, and published reports containing qualitative and quantitative data. The city organized a participatory process to draft and implement the Health and Wellness Element, which included a set of goals and metrics aimed at promoting and monitoring progress on population health. To track and monitor indicators, the Richmond Health Equity Partnership was developed.

In Mathare, Nairobi, nongovernmental organization Muungano Support Trust organized residents to survey themselves and document community assets and vulnerabilities in three waves 2007 through 2012. Data were combined with spatial maps of community assets and hazards that will be used for planning process.

In both examples, the authors organized community health priorities into three health equity categories: (1) living conditions; (2) economics and services; and (3) political power and outcomes. For each category, indicators were selected that constituted elements of the category. Table 2 in the document provides examples of equity categories and indicators that could be used for monitoring processes.

Applications

Richmond, California, United States and Mathare Valley, Nairobi, Africa.

Reference

Corburn, J., & Cohen, A. K. (2012). Why we need urban health equity indicators: Integrating science, policy, and community. PLOS Medicine, 9(8), e1001285.

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Appendix

Symmetry Index

Purpose

To incorporate attitudes towards inequality into a measurement of socioeconomic health inequalities.

Who would use it?

Statisticians, policymakers, researchers, public health officials, organizations, government (implicit)

Description

This document proposes an alternative index to the extended concentration index. The extended concentration aims to measure socioeconomic inequalities by applying the index to various health variables. To address the issue of symmetry, the authors incorporate a symmetry property based on median income rank that assigns a high negative weight to the poor and a high positive weight to the rich (symmetry index). However, neither the symmetric index nor the extended concentration index meet the mirror requirement where socioecomonic inequalities in health gains mirror socioeconomic inequalities in health deficits. As such, the authors transform both to create a generalized version of both the symmetric index and the extended concentration index.

Reference

Erreygers, G., Clarke, P., & Van Ourti, T. (2012). "Mirror, mirror, on the wall, who in this land is fairest of all?"—Distributional sensitivity in the measurement of socioeconomic inequality of health. Journal of Health Economics, 31(1), 257-270.

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Appendix

Steps of Actions for Eliminating Health Inequities

Purpose

To create conditions for promoting health equity, combating diseases, and improving the quality of life and life expectancy in communities by building leadership capacity to eliminate health inequities.

Who would use it?

Individuals, community leaders, employers, policy-makers, health professionals (explicit)

Description

This document identifies action steps for building the leadership among individuals, community leaders, employers, policy-makers and health professionals to eliminate health inequities. The actions are: exercising leadership; communicating; building local strategic alliances; building expertise and trust; using health impact assessment; engaging with people having poor health status; diversifying the workforce; and collecting, monitoring, using and reporting new indicators. Further, potential indicators of social and economic dimensions of health and health equity are summarised. The major indicator domains included are: income and wealth, social conditions, political influence, corporate decisions, labor process and labor markets.

Reference

Hofrichter, R. (2010). Health equity: Exploring the social and economic dimensions. National Association of County and City Officials, United States.

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Appendix

Inequality Indexes & Their Decomposition

Purpose

To put forward a method that appropriately measures health inequality using decomposition indices for ordinal data.

Who would use it?

Researchers (implicit)

Description

Conventional measures of inequality (i.e., Gini coefficient, Theil index) are not well-suited to handle ordinal level variables (such as self-reports and health surveys) as they rely on the mean and are sensitive to rescaling. In this paper, the authors develop a new method to examine data by population subgroups that preserves the order of the ordinal categories after transformation.

Applications

The authors apply the inequality decomposition method to a 2002 wave of a Swiss health survey to calculate the impact of health inequality in Switzerland.

Reference

Kobus, M., & Miłoś, P. (2012). Inequality decomposition by population subgroups for ordinal data. Journal of Health Economics, 31(1), 15-21.

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Appendix

Performance Measurement System

Purpose

To develop a performance measurement system for health equity across 18 different hospitals in the Toronto, Ontario area.

Who would use it?

Policy makers, healthcare practitioners, researchers (explicit)

Description

An analysis of all 18 hospital health equity plans was conducted in a three-step process: (1) Hospital-specific analysis: assessing each hospital's understanding of health inequities and its current framework of action for responding to health inequities; (2) cross-hospital synthesis: assessing hospitals' progress in responding to health inequities, and gathering feedback from the hospitals to develop a performance measurement and management system; and (3) stakeholder dialogue: engaging with hospital and community members to address barriers and challenges identified in planning that were addressed in steps 1 and 2, and develop a collaborative action plan.

Evaluations

Feedback was given by hospitals on developing a performance measurement system. Key issues identified were: leverage of existing performance measurement systems, the development of a coordinated data strategy, examples of data elements and the types of data that need to be collected, integrate monitoring with evaluation, health inequities at multiple stages, the need to get information on inequities at the primary care level, the need for an electronic tracking system, defining short and long-term measures of success, and system measurements of health inequities.

Reference

Nakaima, A., Sridharan, S., & Gardner, B. (2012). Towards a performance measurement system for health equity in a local health integration network. Evaluation and Program Planning, 36(1), 204-212.

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Appendix

Community Health Assessment

Purpose

To assist in incorporating social determinants of health indicators in community health assessment.

Who would use it?

Practitioners, researchers (implicit)

Description

The document provides the nine main domains of determinants of health with examples of indicators and data sources. The nine domains are: (1) economic security and financial resources; (2) livelihood security and employment opportunity; (3) school readiness and educational attainment; (4) environment quality; (5) availability and utilisation of quality medical care; (6) adequate, affordable and safe housing; (7) community safety and security; (8) civic involvement; and (9) transportation. The authors suggest that these nine domains can be used to inform health priorities in an area.

Reference

National Association of County and City Health Officials. (n.d.) Community health assessments and community health improvement plans for accreditation preparation demonstration project: Resources for social determinants of health indicators.

http://www.naccho.org/programs/public-health-infrastructure/community-health-assessment

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Appendix

Gini Impact Analysis

Purpose

To assess three Gini measures before and after an intervention: (1) the standard Gini, (2) the Extended Gini; and (3) the Extended Proportional Gini in assessing healthy life expectancy.

Who would use it?

Policy makers, researchers (implicit)

Description

The authors summarise different implications of different Gini measures. The standard Gini formula is applied to assess the pure inequity introduced as an impact of interventions in three dissimilar groups defined in terms of the healthy life expectancy (HALE). The Extended Gini is used by assigning relative weights to the groups differing by HALE to determine the priority group or the worst off group for receiving the intervention. Finally, the impact of intervention is assessed by using the Extended Proportional Gini for the shortfall inequality or the proportionalism.

Applications

The authors apply the Gini measures to sample life expectancy data.

Evaluations

Yes, theoretically in the paper using sample life expectancy data.

Reference

Norheim, O. F. (2010). Gini impact analysis: Measuring pure health inequity before and after interventions. Public Health Ethics, 3(3), 282-292.

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Appendix

A Set of Disparity Metrics

Purpose

To evaluate the racial/ethnic and socio-economic status (SES) disparities in obesity among youth over-time using several disparity measures.

Who would use it?

Researchers (explicit)

Description

The authors provide an overview of different disparity metrics used to: (1) measure disparities among groups with poorest health outcomes; (2) examine disparities using relative and absolute scales; (3) assess ordered (based on SES) and unordered (based on racial/ethnic) groups; and (4) compare "best" and "worst" groups. Using childhood obesity as an example, they found that the choice of metric may lead to different conclusions when examining health disparity (race, ethnicity, SES) trends over time.

Reference

Rossen, L. M., & Schoendorf, K. C. (2012). Measuring health disparities: Trends in racial– ethnic and socioeconomic disparities in obesity among 2-to 18-year old youth in the United States, 2001–2010. Annals of Epidemiology, 22(10), 698-704.

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Appendix

Fair Financing for Health and Health Care

Purpose

To question the general health and health care situation in a country and to question health sector reforms in the context of wider societal issues in order to assess fair financing of the health care system.

Who would use it?

Policy makers and data analysts.

Description

The author outlines essential issues and questions in a matrix on pages 27 to 33 that could be used as a check-list to measure the drive towards fairness, equity and social justice in health and health care. The author suggests that this can be applied to the general health and health care situation in a country, or to health sector reforms in the context of wider societal issues. The Fair Financing Scale consists of ratings on a series of issues including health inequities, health care inequities, health determinants inequities, taxes, health financing inequities, health reform issues, general reform issues and value debates.

Applications

Gericke and colleagues (2005) applied this to a national health insurance system in Yemen. See: Gericke, C., Drupp, M., Velter, M. B., Doetinchem, M. O., Krech, R., Scheil-Adlung, X., ... & Al-Agbary, A. (2005). Towards a national health insurance system in Yemen Part 3: Materials and documents. World Health Organization.

Reference

Schwefel, D. (2004). *Fair financing for health and health care.* Berlin: European Commission's Working Group on Fair Financing. Commissioned by German Agency for Technical Cooperation (GTZ).

http://detlef-schwefel.de/219-Schwefel-fair-financing-2004.pdf

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Appendix

How to Analyse Ethnic Differences in Health, Health Care, and the Workforce: A Toolkit for the NHS

Purpose

To assist the UK's National Health Service (NHS) trusts and other organizations to meet their legal requirement to assess whether their policies negatively impact certain ethic groups.

Who would use it?

The target audiences are public health and information analysts in NHS organizations. The authors suggest that the tool may be of interest to a wider constituency.

Description

The UK's NHS collects ethnicity data on both employees and patients. The authors of this tool suggest that this data could be used to improve health equity for patients and cultural diversity in the workforce. This 117-page toolkit contains directions for what data to collect, how to collect it, report it, and analyze it. The toolkit has detailed instructions, many specific to the UK context, for the best ways to assess equity using ethnicity data collected from patients and health workforce.

Reference

Aspinall, P. J., & Jacobson, B. (2006). *How to analyse ethnic differences in health, health care, and the workforce: A toolkit for the NHS*. London: London Health Observatory.

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Appendix

Incorporating Concepts of Inequality and Inequity into Health Benefits Analysis

Purpose

To improve estimates of the health benefits of policies, particularly pollution control policies by including health equity in the calculations.

Who would use it?

Policy makers. This tool would require some specialized knowledge in quantitative data analysis.

Description

In this academic article, the authors assess health equity indicators for conformance to general principles, or axioms, of health equity measurement. The authors compare frameworks for health benefits analysis and environmental justice analysis to develop appropriate inequality indicators. The authors assess various indices for fit and equity, and conclude that the Atkinson index is the best fit although results may be improved if other indices are used as well.

Applications

The authors present an example of their proposed inequality index, but it does not appear that this has been applied in any actual health benefits analysis.

Reference

Levy, J. I., Chemerynski, S. M., & Tuchmann, J. L. (2006). Incorporating concepts of inequality and inequity into health benefits analysis. *International Journal for Equity in Health, 5*(1), 2.

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Appendix

Local Basket of Inequalities Indicators

Purpose

To support local action toward UK national inequalities targets for life expectancy and infant mortality.

Who would use it?

The tool is for use in the UK by local authorities or primary care trusts in the National Health Service. It is designed for users with a wide range of technical ability.

Description

To compare geographic areas, users of this tool would combine population health indicators with information related to the social determinants of health. Thus, users would indentify areas of health disadvantage. Similar techniques can be used to assess health inequity within a geographic area. Seventy indicators including measures of health status/outcomes, social determinants of health and access to services are included. Users can choose indicators of local interest from among the 70 options.

Applications

Examples are provided of the use and interpretation of an indicator. The indicators list has now been incorporated into the indicators portal: https://indicators.ic.nhs.uk/webview/

Reference

Fitzpatrick, J., & Jacobson, B. (2003). *Local basket of inequalities indicators*. London, UK: Association of Public Health Observatories and Health Development Agency.

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Appendix

Measuring Health Inequalities between Genders and Age Groups with Realization of Potential Life Years (RePLY)

Purpose

To measure avoidable health inequalities between age-sex groups that could be reduced through policy intervention.

Who would use it?

Policy makers, or anyone with responsibility for resource allocation decisions.

Description

Realized Potential Life Years (RePLY) is the ratio of age at death to the potential length of life. The authors of this tool define health equity as a condition where everyone in a given population can fully realize his or her potential life span. RePLY is more informative than life expectancy which may mask inequalities due to natural mortality risk differences between groups. Those who have an unavoidable death have fully realized their potential lifespan, while those with avoidable death realize only a fraction of their potential lifespan. This measure can reveal health inequalities as well as social disadvantage because it identifies deaths that could be prevented through the allocation of resources.

Applications

The authors applied this tool to data from 191 countries (Tang, Petrie & Prasada Rao, 2009).
See: Tang, K. K., Petrie, D., & Prasada Rao, D. S. (2009). Measuring health inequality with realization of potential life years (RePLY). Health Economics, 18, S55-S75.

Reference

Tang, K. K., Petrie, D., & Rao, D. (2007). Measuring health inequalities between genders and age groups with realization of potential life years (RePLY). *Bulletin of the World Health Organization, 85*(9), 681-688.

http://www.who.int/bulletin/volumes/85/9/06-037382.pdf

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Appendix

Systems Thinking

Purpose

To highlight how systems thinking, in relation to the built environment, can be used to shape individual and population health and facilitate the alignment between urban planning and public health.

Who would use it?

Public health experts, policy-makers, planners (implicit)

Description

In this paper, the authors describe systems approaches that can embed population health into municipal planning and priority settings. Because built environments are complex systems, the authors propose that a systems thinking approach would be useful and appropriate for addressing complex systems. Systems thinking enables planners and public health professionals to better understand how the built environment influences health. By using a systems approach, planners and public health professionals can help deconstruct complex problems and allow for a better understanding of their impact on people, places, and health. Systems maps and qualitative models are tools that can be used to visually represent complex systems.

Reference

Williams, L. M., Wellesley Institute, & Canadian Electronic Library (Firm). (2013). Getting to know the built environment as a complex system. Toronto, Ontario: Wellesley Institute.

http://www.wellesleyinstitute.com/wp-content/uploads/2013/12/Getting-To-Know-The-Built-Environment-As-A-Complex-System.pdf

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Appendix

Typology Of Policies To Tackle Health Inequalities

Purpose

To present a typology of policies that can reduce health inequalities in populations.

Who would use it?

Policymakers, policy evaluation researchers (explicit)

Description

The authors propose a typology of four categories of policies to reduce health inequalities: (1) targeting interventions to address health gaps between socioeconomically disadvantaged and wealthier groups, including interventions that specifically target the socioeconomically worst-off; (2) developing universal policies that benefit the whole population with a focus on the worst-off socioeconomic groups with the better-off socioeconomic groups; (3) redistributive policies to address unintended consequences of universal policies that that increase inequities for those with social disadvantages and leave privileged groups unaffected; and (4) using proportionate universalism to focus on health problems or determinants that increase with social disadvantage.

Applications

Targeted interventions have been applied in the UK, USA, and Venezuela. Focusing on universal policy has been applied in the UK. Redistributive policy can be found in policies such as social housing or rental vouchers, security income, and cash transfer programs in the UK. Proportionate universalism can be found in the 2006 Catalan Health Survey.

Reference

Benach, J., Malmusi, D., Yasui, Y., & Martínez, J. M. (2013). A new typology of policies to tackle health inequalities and scenarios of impact based on Rose's population approach. Journal of Epidemiology and Community Health, 67(3), 286-291.

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Appendix

Equality Triangle Lens

Purpose

To guide health promotion programs and design interventions for reducing health inequalities.

Who would use it?

Public health planners, health promotion workforce and social policy makers (explicit)

Description

The document is divided into two parts. In part one, the equity triangle tool is introduced for the integration of equity issues into program/service planning and evaluation. The equity triangle consists of three parts: equality of access, equality of opportunity and equality of impacts and outcomes. Each part has an accompanying questionnaire. For example, equality of access includes questions to assess barriers related to cost, culturally appropriate service delivery, and physical accessibility. The equality of opportunity is assessed by understanding barriers to social, geographic and economic resources and includes questions about place (built/natural), education, employment and social influences. For the equality of impacts and outcomes, the measurement of success is assessed with questions pertaining to evaluation and dissemination. The second part of the document includes approaches to reduce health inequalities using case studies.

Reference

Boyd, M. (2008). People Places Processes: Reducing inequalities through balanced health promotion approaches.

htpp://www.whealth.com.au/documents/health/kwhd_people_places_processes.pdf

Social Capital Intervention

Purpose

The purpose of the network approach is to promote health equity considerations in developing social capital intervention models using appropriate theories.

Who would use it?

Please note if this is explicitly stated or implied?
Policymakers, decision makers, government officials (implicit)

Description

The authors propose three elements of network social capital theory that underpin the network approach. They highlight how the three elements can inform the development of social capital intervention research that will help to identify the most effective interventions to advance health equity. The three elements are: (1) the definition of network social capital; (2) the theoretical implications of taking a network social capital approach; (3) the social and psychosocial mechanisms linking social capital to health. The authors identify and describe four social capital models: (1) social capital as channel for health objectives; (2) social capital as ultimate objective; (3) social capital as intervention target; and (4) social capital as segmenting device. Finally, the authors provide a set of guiding principles for social capital interventions.

Reference

Moore, S., Salsberg, J., & Leroux, J. (2013). Advancing Social Capital Interventions from a Network and Population Health Perspective. In Global Perspectives on Social Capital and Health (pp. 189-203). New York, NY: Springer.

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Appendix

Health Equity Framework / Key Success Conditions

Purpose

To provide a set of five strategies that have been proven successful in various European initiatives to address health disparities.

Who would use it?

Health policy makers and target/ outcome evaluators (implicit)

Description

Five areas need to be considered when developing and implementing strategies to address health disparities: (1) focusing on the social determinants of health - focus on social determinants (education, access and affordability to nutritious food, and employment opportunities) through changes in public policies, financial resources, comprehensive programs, and policy/ action incentive alignment; (2) thoughtful selection of targets and design for evaluation - incorporate evaluation and target/ outcome monitoring from the early stages. Set attainable targets to motivate policy and track progress; (3) mechanisms to steer policy - set quantifiable targets, mandate health equity as a priority in a national strategy or legislation, use impact assessments to consider health inequality in all policies, and engage senior government; (4) strong linkages from the national to local level - support local institutions with resources, time, funding, monitoring, training and by employing participatory policy development process to create relevant and feasible interventions and targets; and (5) coordination among policy actors - ensure coordination among different governmental levels, departments, and organizations to strengthen the links between health and non-health sectors to effectively address issues in the social determinants of health.

Reference

Haber, R., & Wong, E. (2013). Learning from others.

http://www.wellesleyinstitute.com/wp-content/uploads/2013/04/Learning-From-Others-Comprehensive-Health-Equity-Strategies-in-Europe.pdf

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Appendix

Health Unit Framework

Purpose

To promote health equity among residents in the Leeds, Grenville, & Lanark District Health Unit.

Who would use it?

Policymakers, decision-makers, government officials (implicit)

Description

Health equity within the population is identified by the authors as one of four goals that guides programs and policies within the health unit. To achieve this strategy they outline four health equity related outcomes and various strategies that can be used to achieve each: (1) residents have food security; (2) residents have strong social connectedness; (3) residents have access to healthy living opportunities; and (4) residents have access to public health services.

Applications

This strategic plan is currently providing direction for the health unit for the years of 2013-2018.

Reference

Leeds, Grenville, & Lanark District Health Unit. (2013). Moving upstream strategic plan 2013 – 2018.

http://www.healthunit.org/reportpub/strategic/strategic_plan_2013-2018.pdf

Health Systems Reform Framework For Resolving Health Inequities

Purpose

To assess the contribution of sub-national governments to addressing health inequities and how they are doing this.

Who would use it?

Policymakers, researchers (implicit)

Description

The authors used the following methodologies to assess how sub-national governments contribute to health inequities. First, at the level of health outcomes, the authors focused on maternal and child health, and nutrition indicators of health status. Second, to assess equity in public resource allocation, the authors derived expenditures on health, education, and GDP per capita and household income per capita. Third, at the household level, they used a national survey to examine changes in household out of pocket expense (OOP) expenditure on health and risk of catastrophic health expenditure.

Reference

Brixi, H., Mu, Y., Targa, B., & Hipgrave, D. (2013). Engaging sub-national governments in addressing health equities: challenges and opportunities in China's health system reform. Health Policy and Planning, 28(8), 809-824.

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Appendix

Effective Governance for Health Equity

Purpose

To identify general governance functions that can be used by countries to reduce health inequities. These governance structures are used to improve systems-level action on the social determinants of health by fostering concerted action across sectors and involving multiple stakeholders.

Who would use it?

Policy makers at all levels of government in the WHO European Region. (implicit)

Description

This resource recommends functions to embed in governance systems in order to promote health equity. A systems checklist is provided to describe the key characteristics of systems that are effective governance mechanisms for reducing health inequities. The tool emphasizes the importance of a political commitment to addressing the social determinants of health through joint action and policy integration at all levels of government, intersectoral collaboration, and the creation of frameworks explicitly designed to reduce health inequities. It describes how accountability for improved outcomes can be built into systems through legal structures and entities that create partnerships such as "governance boards" in order to monitor and report on progress made. The authors stress the importance of coherent policy goals and the use of intelligence gathering, data sharing, and research to promote evidence-based decision making. Capacity building, increased investment in public health, and greater inclusion of local people and communities in addressing solutions are also important aspects of this tool. Finally, the features of an effective health equity delivery system are described.

Reference

Brown, C., & Harrison, D. (2013). Governance for health equity in the WHO European region. Copenhagen: WHO Regional Office for Europe.

http://www.euro.who.int/en/publications/abstracts/governance-for-health-equity

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Appendix

Typology for Interventions Targeting Healh Inequality

Purpose

The main purpose of this tool, a typology of equity-focused interventions, is to provide a range of strategies to tackle social-inequalities in health.

Who would use it?

Policy makers and practitioners (explicit)

Description

The author outlines a typology of health equity-focused interventions to guide actions for reducing health inequalities. The typology consists of programme based theory interventions that aim to: (1) strengthen individuals – increase individual level knowledge, beliefs, self- esteem, life skills, and powerlessness; (2) strengthen communities – increase community-level social cohesion and mutual support; (3) improve living and working conditions – improve access to housing, sanitation, uncontaminated food, safer work places, health care, and social care; and (4) promote healthy macro policies – ensure legal and human rights, healthier macroeconomic labour market policies, encouragement of cultural values, and environmental hazard control. The authors present three case studies as examples of how the typology can be applied to: (1) work environment interventions; (2) smoking interventions for inequalities; and (3) life course interventions.

Reference

Whitehead, M. (2007). A typology of actions to tackle social inequalities in health. Journal of Epidemiology and Community Health, 61(6), 473-478.

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Appendix

Conceptual Framework of Organizational Capacity for Public Health Equity Action (OC-PHEA)

Purpose

To guide research, dialogue, reflection and action on organizational capacity in public health that will promote, implement and sustain equity focused actions.

Who would use it?

Researchers, public health organizations (implicit)

Description

The authors present a Conceptual Framework of Organizational Capacity for Public Health Equity Action (OC-PHEA) that can be used to achieve health equity goals. There are three steps in the framework for action by organizations: (1) develop actions that will mitigate health inequities using data on inequities to develop policies, programs, and services; (2) address social and structural conditions that lead to health inequities through community development, advocacy, collaboration with other sectors, education for awareness about health equity, and by conducting health equity impact assessments on public policies; and (3) monitor health inequities, set targets to reduce health inequities, and evaluate outcomes of health equity actions.

Reference

Cohen, B. E., Schultz, A., McGibbon, E., VanderPlaat, M., Bassett, R., GermAnn, K.,…Fuga, L. A. (2013). A conceptual framework of organizational capacity for public health equity action (OC-PHEA). Canadian Journal of Public Health, 104(3), e262-e266.

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Appendix

Twin-Aim Theory of Social Justice

Purpose

The goal of the social justice framework is to help illuminate the role that participants' consent should play in health and science policy.

Who would use it?

Policymakers, decision-makers, public health institutions (implicit)

Description

The authors also present the twin-aim theory, which has both a positive and a negative aim. The positive aim is concerned with the sufficiency of each core element of well-being. The negative aim is concerned with reducing systemic injustice. The overall aim of this theory is to improve human well-being, as well as to improve public health institutions.

Reference

Faden, R., & Powers, M. (2011). A social justice framework for health and science policy. Cambridge Quarterly of Healthcare Ethics, 20(4), 596-604.

10 Promising Practices

Purpose

To reduce social inequities in health at the Local Public Health Level.

Who would use it?

Practitioners, policy makers (implicit)

Description

The document is a set of fact-sheets presenting 10 promising practices to reduce health inequities and improve the health of the population. The practices are proposed as a framework for taking action on health equity and are based on a literature review and analysis conducted by the Sudbury and District Health Unit. The listed practices are: (1) targeting with universalism – everyone should have the opportunity to be healthy and practice healthy behaviors; (2) purposeful reporting – reporting on the relationship between health and social inequities in all health status reports; (3) social marketing – defining and understanding target populations in order to tailor interventions and communications; (4) health equity target setting – making health equity explicit in targets; (5) equity-focused health impact assessment – assessing the potential health impacts on programs and policies; (6) competencies/organisational standards – identifying core competencies for public health; (7) contribution to evidence base – need for interventions designed to reduce health inequities and intentional dissemination of these findings; (8) early childhood development - importance of early childhood promotion and prevention; (9) community engagement – building relationships with target populations, service users, professionals in the community; and (10) intersectoral actions – building relationships between public health and other agencies. Each fact sheet for each listed practice includes resource links for further information and other related projects. Also, the document includes sections that discuss the challenges of implementing practices to reduce health inequities.

Applications

Each of the 10 practices listed in the document is supported by evidence-based information and an example of how it has been applied.

Reference

Sudbury & District Health Unit (2012). 10 Promising practices to reduce social inequalities in health: What does the evidence tell us? Sudbury, Ontario.

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Appendix

Health In All Policies (HIAP)

Purpose

To improve population health, health equity and the context in which health systems function by amending public policy-making across sectors to achieve the most beneficial impacts.

Who would use it?

Policymakers (explicit)

Description

The authors provide instructions on how to include HiAP in policy and programs. This 358-page book describes the application of HiAP involves the following steps: (1) identifying policy developments across sectors with potential implications for health and health equity; (2) assessing impacts; (3) advocating and negotiating for changes. The authors also state that long-term vision and sustained efforts are needed for HiAP to be successful. The book addresses the ways that health perspectives could be incorporated into public policies in practices at the national level within all government sectors that influence health.

Reference

Ministry of Social Affairs and Health, Finland. (2013). Health in All Policies: Seizing opportunities, implementing policies.

http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf?ua=1

Whole Systems Analysis

Purpose

To use a whole systems analysis approach to examine healthcare financing mechanisms of three African countries.

Who would use it?

Policy makers (explicit)

Description

A whole systems analysis is used to examine health financing mechanisms, healthcare expenditure, and the distribution of health-care benefits of Ghana, South Africa, and Tanzania. This whole systems analysis considers the benefits from both public and private sectors to assess the equity of health-system financing and service use in each African country being examined. The overall distribution of financing in each country was progressive but benefits in each of Ghana, South Africa, and Tanzania favoured higher income groups while the burden of illness was greater for lower-income groups. The whole systems analysis approach allows for policy makers to take into account which health financing mechanisms should be expanded and which are most appropriate for individuals whose employers do not provide health insurance.

Applications

Whole systems analysis was used to assess the health financing mechanisms in three African countries: Ghana, South Africa, and Tanzania. These countries were chosen because they were all considering universal health coverage, but each country was at a different stage of development.

Reference

Mills, A., Ataguba, J. E., Akazili, J., Borghi, J., Garshong, B., Makawia, S., ... & McIntyre, D. (2012). Equity in financing and use of health care in Ghana, South Africa, and Tanzania: Implications for paths to universal coverage. The Lancet, 380(9837), 126-133.

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Appendix

Achieving Health Equity on a Global Scale through Community-Based, Public Health Framework for Action

Purpose

To create a fundamental shift in global health policy away from the medical model towards a public health framework for action that recognizes and addresses the social determinants of health.

Who would use it?

Policy makers (explicit)

Description

The authors propose that global health policy needs to shift the focus from treating disease to preventing disease. They argue that this can only be done through a public health framework for action that seriously considers how social determinants challenge prevention efforts. This shift is needed to provide a multi-sectoral, comprehensive platform for identifying critical components that impact health, and for developing effective long-term strategies for change.

Reference

Anderko, L. (2010). Achieving health equity on a global scale through a community-based, public health framework for action. The Journal of Law, Medicine & Ethics, 38(3), 486-489

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Appendix

Healthy Homes Policy Toolkit

Purpose

The purpose of this toolkit is to provide definitions on key terms in policy advocacy and change, present a health equity framework for policy advocacy and change, and how to achieve successful policy change through two case studies.

Who would use it?

Health department directors, environmental health program staff, health educators, housing inspectors, state environmental health officials, asthma or chronic disease program staff, housing advocacy groups, legislators, policy decision-makers (explicit)

Description

The healthy homes policy framework includes upstream approaches that measure the impact of decisions that affect communities most impacted by health inequities. Upstream approaches create strategies to decrease negative impact by looking at the root causes of social determinants of health. An equity lens can be applied to policy through: 1) direct advocacy (education and influencing decision makers on public policy; 2) public engagement (building awareness and support); 3) media engagement (getting your message out to decision maker and the public). The authors describe a community needs assessment on environmental health concerns. Stakeholders included both community members and the Health Assessment and Evaluation Department. The authors identify five steps in the assessment: 1) conducting an internal capacity analysis; 2) ensuring key stakeholders are involved in creating policy agenda; 3) setting clear policy advocacy goals; 4) gaining further community input through outreach and media engagement; and 5) analyzing and framing the policy issue that is being addressed.

Reference

Lyons-Eubanks, K. (2010). Healthy homes policy toolkit. Multnomah County Environmental Health Division, Portland.

http://www.ci.richmond.ca.us/DocumentCenter/Home/View/9050

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Appendix

Re-Visioning Public Health Ethics

Purpose

The purpose of this paper is: a) to critique and identify inadequacies in the dominant individualistic ethics frameworks based on the autonomy-centred principles of contemporary bioethics when considered in relation to a public health agenda; and b) to present the principles of relational autonomy, relational social justice and relational solidarity as alternative principles to guide a transparent, fair and inclusive public policy making process.

Who would use it?

Policymakers, decision-makers, government officials (implicit)

Description

Relational public health ethics comprises a minimum set of principles that offer an alternative perspective to traditional bioethics frameworks. The authors argue that an approach to public health ethics requires a social rather than an individual starting place, one that recognizes community as foundational and at the same time makes clear how individuals are inseparable from communities and populations. The principles of relational public health ethics are: (1) relational autonomy, in which actions are aimed at the common good and health of populations but also recognize the rights and interests of individuals by attending to the ways in which competing policy options may affect opportunities for members of different social groups. It embraces the understanding that persons are inherently socially, politically, and economically-situated beings; (2) relational social justice, which differs from the traditional bioethics principle of justice that is concerned with non-discrimination and the fair distribution of benefits and burdens. Rather, relational social justice is concerned also with fair access to social goods (e.g., rights, opportunities, power, self-respect) and with correcting patterns of systemic injustice in social groups; and (3) relational solidarity, is distinguished from conventional solidarity that focusses on common interests among discrete individuals but relies on oppositional categories of "us" and "them" that result in exclusion of some. Instead, relational solidarity, which builds on relational understandings of personhood and autonomy, expands the category of "us" to "us all," eliminates the binary opposition of us and them, and values interconnections while emphasizing our shared interests in survival, safety and security.

Reference

Kenny, N. P., Sherwin, S. B., & Baylis, F. E. (2010). Re-visioning public health ethics: A relational perspective. Canadian Journal of Public Health / Revue Canadienne De Sante'e Publique, 101(1), 9-11.

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Appendix

Canadian Nurses Association's Social Justice Framework

Purpose

To ensure recognition of key attributes and guiding principles of social justice when reviewing and evaluating projects, policies or specific issues.

Who would use it?

Health care policy makers and health care decision makers specifically in the field of nursing (implicit)

Description

The framework is based on 10 attributes that can be examined in relation to positional statements, policy documents, etc. The 10 attributes that should be considered are: (1) equity (including health equity) - just/fair treatment of all individuals, equitable access to health care; (2) human rights - as defined in the United Nations Universal Declaration of Human Rights and the Canadian Charter of Rights and Freedoms; (3) democracy and civil rights - all individuals have equal rights and sovereign power without differences in rank or privilege; (4) capacity building - availability of and access to services that help strengthen individual and institutional core skills, capacities, insight, knowledge and experience; (5) just institutions - fair institutional practices; (6) enabling environments - support positive, sector-wide change, policy development and community empowerment; (7) poverty reduction - increase standard of living and/or involvement of the poor in social and political life; (8) ethical practice - defined by ethics review boards and the CNA Code of Ethics for Registered Nurses; (9) advocacy - active pursuit of support for the rights of a person or a cause; and (10) partnerships - equitable sharing of rights, roles and responsibilities among private, public, government, community or the non-governmental organizations sectors

Applications

As an example, the authors apply the Social Justice Gauge to the International Council of Nurses position statement on the Universal Access to Clean Water.

Reference

Canadian Nurses Association. (2006) A means to an end, an end in itself. Canadian Nurse, 102(6), 18-20.

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Appendix

Applying Clinical Epidemiological Methods to Health Equity: The Equity Effectiveness Loop

Purpose

To inform the development and evaluation of population health interventions and policies across socioeconomic gradients.

Who would use it?

National and international organizations, such as the World Health Organization.

Description

Use of the "equity effectiveness loop" framework can highlight equity issues and factors that influence health equity gaps through assessment of health needs, effectiveness, cost effectiveness and monitoring of population health interventions and policies. The loop consists of five steps arranged in a circle:

1. Burden of illness and aetiology
2. Equity effectiveness
3. Economic evaluation
4. Knowledge translation and implementation
5. Monitoring of programme

Applications

The author applies the framework in two examples: nets treated with insecticide for malaria prevention and total joint arthroplasty for osteoarthritis.

Reference

Tugwell, P., de Savigny, D., Hawker, G., & Robinson, V. (2006). Applying clinical epidemiological methods to health equity: The equity effectiveness loop. [Review]. *British Medical Journal, 332*(7537), 358-361.

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Appendix

EQUITY Framework for Health

Purpose

To improve responses to the health needs of the world's poorest people by integrating equity into health policies, plans, and development agendas.

Who would use it?

Policy makers and program planners.

Description

The EQUITY Framework for Health is an approach to integrating equity into health policies to address the needs of the poor. EQUITY stands for: Engage and empower the poor; Quantify the level of inequalities; Understand barriers to equitable access; Integrate equity goals, approaches, and indicators into policies, plans and development agendas; Target resources and efforts to reach the poor; Yield public-private partnerships for equity.

Applications

The overview describes the application of the framework to women's reproductive health in Peru. The additional briefs in this series provide further guidance and examples of the use of each component of the framework with other groups.

Reference

USAID Health Policy Initiative. (2010). *EQUITY Framework for Health*. Washington, D.C.: Author.

http://pdf.usaid.gov/pdf_docs/Pnadx908.pdf

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Appendix

The Equity Gauge: Concepts, Principles, and Guidelines

Purpose

To monitor health equity and actions to reduce health inequities.

Who would use it?

Policy makers, practitioners, and program planners.

Description

This 35-page document contains a description of health equity gauges and instructions for completing one. The health equity gauge approach requires involvement of a range of actors concerned with development and social justice including researchers, health workers, policy makers, the media, the general public and non-governmental organizations. The authors describe three interrelated pillars of the equity gauge: (1) social/political/economic assessment and monitoring, (2) advocacy, (3) community empowerment. Specific, detailed guiding questions, suggestions, and summary tables are provided for each pillar, highlighting multi-level and systemic determinants of inequity for numerous disadvantaged social groups. This tool was developed through an international collaboration funded by the Rockefeller Foundation.

Applications

There are 13 countries listed on the Global Equity Gauge Alliance (GEGA) website as having developed an equity gauge as part of the GEGA. For example, Chile (Vega, 2002) and South Africa (Scott, 2008) have developed equity gauges. McCoy et al. (2003) give some reflections on early experiences.

Reference

Global Equity Gauge Alliance. (2003). *The equity gauge: Concepts, principles, and guidelines. A guide for social and policy change in health*. Durban: Global Equity Gauge Alliance and Health Systems Trust.

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Appendix

First Steps to Equity: Ideas and Strategies for Health Equity in Ontario

Purpose

To provide an equity lens on health assessment, analysis and planning activities and to assess population health programming, social and environmental conditions to promote health equity.

Who would use it?

People and organizations working to promote health equity especially in relation to the Ontario Public Health Standards.

Description

In this report, the authors lay out steps, ideas and resources for organizations and individuals wishing to promote health equity in Ontario. Included are examples and steps for promoting health equity already in place or that could be expanded as part of the new Ontario Public Health Standards (OPHS) particularly the Population Health Assessment and Surveillance Protocol. A general set of questions are outlined for applying a health equity lens to the Population Health Assessment and Surveillance Protocol. The goal is to help users understand social and environmental conditions that need to be addressed to minimize barriers to health in public health programs. Additional health equity tools, including a rapid equity focused health impact assessment, and health equity audits are provided in an appendix.

Applications

A number of case studies are included.

Reference

Patychuk, D., & Seskar-Hencic, D. (2008). *First steps to equity: Ideas and strategies for health equity in Ontario*. Toronto: First Steps to Equity.

http://dev.healthnexus.net/sites/default/files/resources/first_steps_to_equity.pdf

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Appendix

Monitoring Equity in Health and Healthcare: A Conceptual Framework

Purpose

To generate and apply knowledge for monitoring equity in health and healthcare.

Who would use it?

Policy-oriented researchers.

Description

The author provides a conceptual framework outlining the essential components of a system for monitoring equity in health and health care. The elements of the conceptual framework are identification of key questions, identification and definition of social groups to be compared, selecting health indicators and determinants and measures of disparities between social groups. The author outlines 8 steps in the process of monitoring equity in health and health care. The 8 steps are:

1. Identify social groups;
2. Identify general concerns and needs for equity in health and determinants of health;
3. Identify both qualitative and quantitative sources of information;
4. Identify indicators of health status, determinants of health and health care;
5. Describe current avoidable patterns of inequalities;
6. Describe trends in patterns over time;
7. Develop a public process for considering policy implications of information;
8. Develop a strategic plan for implementating, monitoring and research that involves stakeholders.

Reference

Braveman, P. A. (2003). Monitoring equity in health and healthcare: A conceptual framework. *Journal of Health, Population and Nutrition (JHPN), 21*(3), 181-192.

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Appendix

Social Inequities in Health and Ontario Public Health

Purpose

To provide the basis for development of tangible provincial government and non-governmental organization (NGO) action on social inequities.

Who would use it?

Provincial governments, NGOs, and community organizations considering development of a comprehensive strategy to improve health equity.

Description

This 31-page document provides provincial government and local public health strategies to tackle social inequities around individual lifestyles, social and community networks, living and working conditions, and socio-economic, cultural, and environmental conditions. The tool is a list of recommendations for government action and starts on p. 15. The recommendations were adapted from Dahlgren & Whitehead (2006) discussion paper "Levelling Up", Ross (2003) and Lefebvre, Warren, Lacle, & Sutcliff (2006).

Reference

Sutcliffe, P., Laclé, S., Michel, I., Warren, C., & Etches, V. (2007). *Social Inequities in Health and Ontario Public Health*. Sudbury, ON: Ministries of Health Promotion, Health and Long-Term Care and Children and Youth Services and the Sudbury & District Health Unit, Northwestern Health Unit and Simcoe Muskoka District Health Unit.

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Appendix

Disparity in Cancer Care: A Canadian Perspective

Purpose

To provide a Canadian perspective on disparities in cancer care, to propose a new conceptual framework, and to make recommendations for eliminating disparities within the health care system and beyond.

Who would use it?

Researchers, general public, health care practitioners (explicit)
Policy makers (implicit)

Description

The authors describe societal conditions that can create health inequities and cancer risks. They propose recommendations for action to eliminate cancer care disparities through: exploring the extent of disparities, developing evidence-based policies that address root causes and major determinants of disparities, and a commitment to ongoing assessments of interventions.

Reference

Ahmed, S., & Shahid, R. K. (2012). Disparity in cancer care: A Canadian perspective. Current Oncology, 19(6), e376.

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Appendix

Health Promtion for People with Intellectual Disability and Obesity

Purpose

To highlight issues in healthcare faced by people with intellectual disability and obesity, and aspects that health professionals must consider when engaging in health promotion.

Who would use it?

Healthcare practitioners, policy makers, public health practitioners (implicit)

Description

The authors propose five health promotion strategies can be implemented to help obese individuals with intellectual disability: (1) support strategies - this is a team-based approach where participation and partnership between client, family, and health professionals is important to work towards a set of shared goals; (2) educational change approach - creation of opportunities for learning to improve one's personal health; (3) behavioural change approach - focuses on the importance of healthy sleeping patterns, exercise programs, and activities; (4) social change approach - tackles underlying causes of ill health, focusing on efforts of achieving change in physical, social and economic environments. Group support and coping strategies are very important for this approach; and (5) evaluation methods - should consist of both pre and post-test, along with process/formative evaluation, outcome/summative evaluation, and an impact evaluation.

Reference

Doody, C. M., & Doody, O. (2012). Health promotion for people with intellectual disability and obesity. British Journal of Nursing, 21(8), 460.

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Appendix

Maryland Oral Health Literacy Model

Purpose

To improve the quality of oral health care and delivery, increase primary prevention, and decrease oral health disparities by improving the oral health literacy of the public, of health care providers, and of policy makers.

Who would use it?

General public, health care practitioners, policy makers (explicit)

Description

There are three stages to the Maryland oral health literacy model: (1) extensive needs assessment; (2) development and implementation of interventions; and (3) measurement of outcomes.

Evaluations

The paper presents preliminary findings on the implementation of the Maryland oral health literacy model. Results suggest that the understanding of the purpose of fluoride is low (58%) among parents and caregivers; that individuals with private dental insurance were significantly more likely than those with Medicaid to report favourable listening practices among providers; and that African American patients were more than twice as likely to report being treated unfairly due to race, ethnicity, or levels of education.

Reference

Horowitz, A. M., & Kleinman, D. V. (2012). Oral health literacy: A pathway to reducing oral health disparities in Maryland. Journal of Public Health Dentistry, 72(s1), S26-S30.

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Appendix

Vision Surveillance System

Purpose

To assess vision health disparities by linking ophthalmic/vision measures (both through self-reports and performance-based measures) with current public health interventions in order to prevent vision loss and to improve the use of eye care services.

Who would use it?

Researchers, policy makers (implicit)

Description

A vision surveillance system aims to provide data on the identification and monitoring of disparities associated with vision loss, through employing 6 specific strategies. A vision surveillance system must: (1) link data collection and analyses with ongoing public health interventions; (2) effectively assess vision loss through the use of both self-reports and performance-based measures; (3) effectively assess the utilization of eye care; (4) include defined populations; (5) include and sustain ophthalmic/vision measurement and question components within current national surveys; (6) be forged among federal agencies and other stakeholders to monitor trends in disparities and the nation's eye health status.

Reference

Lee, P. P., West, S. K., Block, S. S., Clayton, J., Cotch, M. F., Flynn, C., ... & Saaddine, J. B. (2012). Surveillance of disparities in vision and eye health in the United States: An expert panel's opinions. American Journal of Ophthalmology, 154(6), S3-S7.

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Appendix

Rights-Based Approach

Purpose

The purpose of a rights-based approach is to integrate health equity considerations into food and poverty human rights agenda to reduce health disparities.

Who would use it?

Policymakers, decision-makers, government officials (implicit)

Description

The authors describe rights-based campaigning approaches that identify the State's failures to fulfil its obligations to ensure food security in the population. These approaches can be used to attract new constituencies to anti-poverty work, and to build alliances between disparate groups to coordinate activities and advocacy.

Rights-based approaches encourage States to entrust a specific institution with responsibility for overseeing and coordinating implementation, and to develop a national strategy to ensure food and nutrition security for all, with indicators and benchmarks to assess progress. The authors also recommend that a food poverty focus be built into national poverty reduction strategies.

Reference

Dowler, E., & O'Connor, D. (2012). Rights-based approaches to addressing food poverty and food insecurity in Ireland and UK. Social Science & Medicine, 74(1), 44-51.

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Appendix

Guidelines for Achieving Health Equity in Public Health Practice

Purpose

The purpose of the guidelines for achieving health equity in public health practice is to increase awareness of and draw attention to health inequity, provide method for evaluating accountability, and enable local health departments to gain understanding of their capacity to address health equity.

Who would use it?

Local health departments (LHDs) (explicit)

Description

There are seven guidelines for achieving health equity in public health practice: (1) monitor health status and track the conditions that influence health issues facing the community; (2) protect people from health problems and health hazards; (3) give people information they need to act collectively in improving their health; (4) engage with the community to identify and eliminate health inequities; (5) develop public health policies and plans; (6) maintain a competent public health workforce; and 7) contribute to and apply the evidence base of public health and relevant fields. Examples of how health equity considerations are taken into account are discussed for each guideline.

Reference

National Association of County and City Health Officials. (2009). Guidelines for achieving health equity in public health practice.

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Appendix

Social Justice Youth Development (SJYD)

Purpose

To foster critical consciousness among young people and encourage them to take actions to achieve equitable change in their communities.

Who would use it?

Policymakers, youth workers (explicit)

Description

The authors present a Social Justice Youth Development (SJYD) model that assumes social transformations begin with self-transformation and provides a way to connect individuals with social change. The SJYD model incorporates three key contributions to the field of youth development. First, it is important to use an ecological framework or contextual lens rather than an individual or psychological framework because this will allow for a better understanding of everyday needs and problems that confront youth. Second, youth must have an opportunity to heal from the impacts of hostile environment forces. Third, using the theoretical concept of praxis, SJYD encourages youth to explore the causes of community and social issues and act toward addressing those problems.

The authors describe how progressive hip-hop can encourage young people to move through three levels of awareness that can change their thinking about the world, and work as a catalyst for equitable change: (1) self-awareness level - how young people using hip-hop culture can express pain, anger and frustration through music, poetry, and spoken words; (2) social awareness level - individuals use hip-hop culture to organize, inform, and politicize at the community level; and (3) global awareness level - hip-hop culture carries some possibility to unite youth through common experiences of suffering and common struggles of resistance.

There are two implications of the SJYD model for policymakers and youth workers. First, the model highlights the idea that youth exist in communities, and not only in schools and programs. By having this knowledge, policymakers/youth workers can go deeper to understand daily challenges faced by youth. Second, it is important that stakeholders put greater emphasis on quality of youth programs rather than the quantity of youth being served. Authors argue that emphasis on serving a greater number of youth is counterproductive to youth development at the individual level.

Reference

Ginwright, S., & Cammarota, J. (2002). New terrain in youth development: The promise of a social justice approach. Social Justice, 29(90), 82-95.

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Appendix

Review Cycle of Equity and Health Strategies, Programmes and Activities (SPAs) for Equity

Purpose

To raise awareness about health equity and social determinants of health among professionals in health and associated sectors. To provide a tool for assisting with the practical integration of equity into health strategies, programs and activities.

Who would use it?

Professionals working in health (explicit)

Description

This document provides a checklist for an equity analysis of equity-focussed strategies, programs, and activities (SPAs). Once a working team has been formed and the SPAs selected, the team begins to reflect on, analyze, and plan the different elements of the checklist, which are: (1) specifying aims of the SPAs; (2) identifying the SPAs' target population; (3) evaluation of people's needs; (4) analysis of the SPAs' interventions; (5) implementation of interventions; (6) intersectoral action; (7) participation; (8) expected SPA's results; (9) equity challenges.

Applications

The authors use various examples through the document to highlight each of the SPAs activities.

Reference

Ministry of Health, Social Services, and Equality. (2012). Methodological guide to integrate equity into health strategies, programmes, and activities. Madrid, Spain.

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Appendix

World Café Methodology

Purpose

The World Café methodology is a tool used in a structured meeting or conference to answer specific questions or identify strategies to address an issue. This allows for multi-layered discussions to build upon one another. The purpose of this World Café event was to answer a set of equity-focused questions related to addressing mental health inequities.

Who would use it?

World Café participants who can include any stakeholder interested in the topic of discussion at the event (e.g., practitioners, policy makers, people affected by the issue, community leaders).

Description

In a World Café, participants move from table to table, not as a group, but in different formations thus allowing everyone who attended the meeting to come into contact with each other during the discussions. The notes from the discussions are organized thematically and analyzed to identify key elements of the discussion.

The authors structured their World Café discussion around five questions relating to aspects of the team's interest in mental health and social inequities: (1) what are some of the social and structural barriers that impact people's mental health recovery?; (2) what are the strengths and weaknesses of current mental health recovery models with respect to addressing social and structural inequities?; (3) what would components of a recovery model look like that integrated social and structural inequities and how would we get there?; (4) how can people's experiences with mental health issues inform the development and practice of recovery?; and (5)what would it take to support and implement this model? Notes from the each of the round table discussions were analyzed to identify aspects of a mental health system that were causing social and structural inequities and to identify key components of an effective mental health system. In the last stage of the World Café, participants engaged in a creative knowledge exchange by developing skits illustrating the results of the discussions.

Applications

In addition to the example provided above, the World Café methodology has been used in the context of many public health and other health related conferences.

Evaluations

In any conference, there is usually a participant evaluation that focusses on experiences of the event and what they learned from it. These evaluations are often reported in conference proceedings or reports.

Reference

Morrow, M., & Weisser, J. (2012). Towards a social justice framework of mental health recovery. Studies in Social Justice, 6(1), 27-43.

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Appendix

Position Statement for Eliminating Disparity

Purpose

A position statement by the Association of Nurses in AIDS Care (ANAC) for the advocacy of equitable HIV specialty care and eliminating the disparities in care.

Who would use it?

Health care practitioners, nurses (explicit)

Description

The ANAC proposed six suggestions for the nurses to eliminate the disparities by: (1) acknowledging the relationship between culture and health; (2) identifying system barriers; (3) assisting community mobilisation; (4) culturally sensitive risk reduction strategies; (5) screening for racial and ethnic minorities; and (6) acting as patient navigators.

Reference

Association of Nurses in AIDS Care. (2012). Health Disparities. Journal of the Association of Nurses in Aids Care, 23(5), 467-468.

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Appendix

Assessing Equity in Clinical Practice Guidelines

Purpose

To assess how well Clinical Practice Guidelines (CPGs) address health equity.

Who would use it?

Anyone assessing or developing clinical practice guidelines.

Description

The authors provide a list of five questions, or an "equity lens," for assessing clinical practice guidelines (CPGs). The Knowledge Plus Project of the International Clinical Epidemiology Network developed this equity lens for CPGs. The Network's goal is to improve CPG development by encouraging consideration of sociopolitical dimensions like equity and local appropriateness. The five questions that comprise the "equity lens" are:

1. Do the public health recommendations in the guidelines address a priority problem for disadvantaged populations?
2. Is there a reason to anticipate different effects of intervention in disadvantaged and privileged populations?
3. Are the effects of the intervention valued differently by disadvantaged compared with privileged populations?
4. Is specific attention given to minimizing barriers to implementation in disadvantaged populations?
5. Do plans for assessing the impact of the recommendations include disadvantaged populations?

Applications

As an example, the authors apply the equity lens to the Philippine Heart Association's planned guidelines for the diagnosis and management of dyslipidemia.

Reference

Dans, A. M., Dans, L., Oxman, A. D., Robinson, V., Acuin, J., Tugwell, P., . . . Kang, D. (2007). Assessing equity in clinical practice guidelines. *Journal of Clinical Epidemiology, 60*(6), 540-546.

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Appendix

Promoting Action on Equity Issues: A Knowledge to Action Handbook

Purpose

To provide a framework to incorporate evidence-informed action into health service planning and decision-making through the development of a knowledge translation strategy.

Who would use it?

Health administrators, managers of diversity programs, and leaders within ethno-cultural communities.

Description

This 74-page handbook guides the reader through development of comprehensive strategy for health equity. This tool guides the user in framing the issue, identifying knowledge users and stakeholders, and evidence gathering. Barriers to evidence-based action and effective communication strategies are identified. By structuring the planning process according to a "knowledge to action" strategy, formulation of a coherent organizational intervention is fostered. It is based on the experiences learned in implementing initiatives within the Winnipeg Regional Health Authority, particularly their promotion of a Language Access interpreter service.

Applications

The document uses specific case examples from the development of the Winnipeg Regional Health Authority Language Access service.

Reference

Bowen, S., Botting, I., & Roy, J. (2011). *Promoting action on equity issues: A knowledge to action handbook*. Edmonton: School of Public Health, University of Alberta.

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Appendix

Toolkit to Address Inequalities in Access to Care

Purpose

To help users to locate evidence they can use to enhance equitable access to healthcare.

Who would use it?

Health services managers and health care providers.

Description

This 18 page toolkit provides a step by step approach to finding peer-reviewed research and grey literature evidence on which to base decisions and actions that promote access to health care. It could be used as a next step after the conduct of a local health impact or health needs assessment or health equity audit. Steps:

A. Identify and define the issue
B. What does the evidence tell you?
C. Decide and agree on intervention and action
D. Implement and monitor
E. Evaluate

Applications

This has been applied in the UK and the document provides a list of case studies and contact details.

Reference

Peters, J., Goyder, L., Blank, L., & Ellis, L. (2004). *Toolkit to address inequalities in access to care*. Sheffield, UK: University of Sheffield.

http://www.shef.ac.uk/scharr/sections/ph/research/h_i/toolkit

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Appendix

Core Competencies

Purpose

To identify STBBI (sexually transmitted and blood-borne infections) specific front line service provider core competencies aimed at strengthening health services and improving health outcomes for those with STBBIs, including HIV.

Who would use it?

Health care practitioners (explicit)

Description

The core competencies for STBBI prevention are: (1) knowledge of STBBI epidemiology and treatment; (2) respect for a diverse range of beliefs, values, and practices that influence sexual practices and decision making; (3) effective use of interventions; (4) advocacy for individuals with STBBIs and HIV; and (5) planning, implementation, adaptation, and evaluation of STBBI program and policies. These competencies are further refined into detailed aspects. Though the competencies are developed for health care practitioners but can also be used by other organisations and professionals.

Reference

Canadian Public Health Association. (n.d.). Core competencies for STBBI prevention. Canadian Public Health Association.

http://www.cpha.ca/uploads/pdf_files/cpha_en.pdf

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Appendix

Health Equity Framework for Change

Purpose

To align public and private partnerships and resources that meet the needs of students and to create equitable conditions to promote community health.

Who would use it?

Policymakers, school district officials (implicit)

Description

The author describes a health equity framework that focuses on building internal capacity to help school districts develop partnerships, and engage with stakeholders including parents in school district policy change. The framework is meant to ensure that health programs and services meet the needs of students and families, by recommending on-going data collection and analysis. Figures 4, 5, and 6 provide meaningful examples of pathways for improving student outcomes; health equity frameworks for change; and an outcomes framework for a school district.

Reference

Do, R. (2013). Toward a full-service community school district in West Contra Costa County: Laying the groundwork and lesson learned to strengthen cross-sector collaboration for student success & health equity (Doctoral dissertation).

http://www.ci.richmond.ca.us/DocumentCenter/View/26997

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Appendix

Life Course Model

Purpose

To inform the life course model's incorporation into maternal and child health nutrition leadership education and training. This tool provides strategies for incorporating the model into the strategic planning.

Who would use it?

Those responsible for strategic planning, leadership education, and training programs (explicit)

Description

Three strategies were proposed and challenges of incorporating the model in training were discussed: (1) incorporation of training grants: development of coursework, leadership training, skill development, continuing education, experience, and material; (2) incorporation through collaboration: collaborations with state- and community-based maternal and child health programs, interdisciplinary care, collaborations with other training programs, and advocacy; and (3) incorporation by others: model incorporation into its grant guidance and incorporation through advocacy for change and prevention.

Challenges related to incorporating the model include: impact of funding allocations on training, the need for research on the models to inform policies, and uncertainties about the feasibility and effectiveness of incorporating the model in training.

Reference

Haughton, B., Eppig, K., Looney, S. M., Cunningham-Sabo, L., Spear, B. A., Spence, M., & Stang, J. S. (2013). Incorporating the life course model into MCH Nutrition leadership education and training programs. Maternal and Child Health Journal, 17(1), 136-146

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Appendix

Toolkit for Obesity Disparity

Purpose

To increase the capacity of state health departments and their partners to address obesity in populations that are affected by health disparities.

Who would use it?

Health practitioners, policy makers (explicit)

Description

The toolkit provides a suggested process for planning, implementing, and evaluating programs to address obesity disparities at the state level. Using a health equity lens, there are six steps in the process: (1) assessing programs and building capacity; (2) gathering and using data to identify and monitor obesity disparities through a health equity lens; (3) developing multi-sector and non-traditional partnerships; (4) applying a health equity lens to design and selection of strategies; (5) monitoring and evaluating progress; and (6) ensuring sustainability. Throughout the toolkit, several resources with web-links are provided to be used in each of the steps.

Applications

Supplementary information is provided in appendices, including case study examples and information on related projects.

Reference

National Center for Chronic Disease Prevention and Health Promotion. (2012). Health equity resource toolkit for state practitioners addressing obesity.

https://www.cdc.gov/nccdphp/dnpao/state-local-programs/health-equity/pdf/toolkit.pdf

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Appendix

Core Competency Based Trainings for Community

Purpose

To evaluate whether training community health workers (CHWs) using a core-competency framework would enhance their roles in community-academic initiatives (CAIs).

Who would use it?

Educators (explicit)

Description

The core-competency based training includes nine core competencies: (1) CHW role and history; (2) communication skills; (3) interpersonal skills; (4) informal counseling; (5) service coordination; (6) capacity-building skills; (7) advocacy skills; (8) technical skills; and (9) organizational skills. Specialized sessions were added to ensure that CAI-CHWs gain skills and knowledge integral to build research capacity. Topics covered in these specialized sessions include: (1) community-based participatory research; (2) basic research design and instrument development; (3) informed consent; (4) computer skills; (5) research ethics and institutional review board compliance; and (7) general background information on diabetes, asthma, nutrition, and mental health to increase CHW awareness and recognition of these conditions and appropriate linkages for services. Upon completion of the core-competency training program, participants exhibited an awareness of social justice context of their role and work.

Evaluations

The tool has been evaluated for the implementation in a piloted CAI-CHW training program of the New-York University Prevention Research Center.

Reference

Ruiz, Y., Matos, S., Kapadia, S., Islam, N., Cusack, A., Kwong, S., & Trinh-Shevrin, C. (2012). Lessons learned from a community–academic initiative: The development of a core competency–based training for community–academic initiative community health workers. American Journal of Public Health, 102(12), 2372-2379.

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Appendix

Capacity Building Tool

Purpose

To provide suggestions for actions to address the social determinants of health and improve health equity.

Who would use it?

Health practitioners (implicit)

Description

The document was developed as part of a European Union wide collaborative initiative, DETERMINE. The suggestions for actions to deal with social determinants of health and for tackling health inequities include building capacities at the organisational and governance level. The authors also provide supporting resources for the capacity building actions. For the improvement of health equity, six priority areas are identified including: (1) awareness raising and advocacy: (2) developing the information and evidence base: (3) organisational development: (4) skills development: (5) partnership development and leadership: and (6) policy development. Each individual priority area is discussed and action statements, suggested activities, and available resources are provided.

Applications

The DETERMINE project was a 3-year initiative involving 50 stakeholder groups from 26 European countries. The authors acknowledge that the goal of the initiative was not to build capacity, but rather to identify capacity building needs, and exchange experiences and resources.

Reference

Stegeman, I., Costongs, C., Chiotan, C., Jones C., Bensaude de Castro Friere, S. (2009). A menu for capacity building & awareness raising actions to address the social determinants of health. Determine, EU.

http://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/Menu-for-CB-Actions_1.pdf

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Appendix

Charter of Peel

Purpose

The aim of the Charter, developed through a meaningful engagement process, is to foster inclusiveness and equity in the Regional Municipality of Peel, Ontario.

Who would use it?

Policymakers, decision-makers, government officials (implicit)

Description

The Charter of Peel states that individuals using this document should engage in self-reflection practices. Examples of self-reflection include: (1) be open-minded and respectful of all types of diversity; (2) understand biases, privileges, and power differences; and (3) improve clarity of communication with diverse people. Organizations could also benefit from the Charter by creating realistic action plans with sufficient resources to implement change initiatives. This can be achieved by setting up monitoring and evaluation mechanisms that measure equity outcomes and changes. Organizations could use the Charter as a benchmark to ensure that policies, practices and behaviours are equitable and inclusive. Finally, the document provides a list of resources that can aide developers in the implementation of the charter.

Applications

Yes, the charter has been applied in the Regional Municipality of Peel.

Evaluations

Yes, the Charter has been evaluated by the Regional Municipality of Peel.

Reference

Charter of Peel. (2013). Diversity and inclusion charter of Peel: Backgrounder & guidelines.

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Appendix

Disparity Reduction Roadmap

Purpose

To address racial and ethnic disparities through a focus on the development of an organizational road map for reducing health disparities.

Who would use it?

Organizations, policymakers, and researchers (explicit)

Description

The authors propose a disparity reduction roadmap to reduce health disparities. This roadmap consists of 6 steps that are vital for effective implementation of health inequity reduction and its long-term sustainability. The six steps are: (1) to recognize disparities and commit to reducing disparities. This can occur when by examining data by race, ethnicity and language, and providing diversity training to healthcare providers; (2) to implement basic quality improvement structures and processes, such as developing a culture where quality and staff improvement are valued, and top administrative staff are supportive; (3) recognize that equity is a fundamental component of quality care and make equity an integral component of quality improvement efforts; (4) to be successful, individualize interventions to reduce health care disparities to specific contexts, patient populations, and organizational settings; (5) evaluate the intervention and adjust the program be based on data that are stratified by race, ethnicity, and language; and (6) healthcare providers should seek to sustain the interventions that have been implemented.

Reference

Chin, M. H., Clarke, A. R., Nocon, R. S., Casey, A. A., Goddu, A. P., Keesecker, N. M., & Cook, S. C. (2012). A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. Journal of General Internal Medicine, 27(8), 992-1000.

Standards of Practice for Culturally Competent Nursing Care

Purpose

To advocate for culturally competent care by nurses for the individuals, families, communities, and populations that nurses serve.

Who would use it?

Nurses, healthcare organizations, policymakers, decision-makers (implicit)

Description

The authors provide a list of 12 standards of practice for culturally competent nursing care. Each standard focuses on one of the following: (1)social justice; (2) critical reflection; (3) transcultural nursing knowledge; (4) cross cultural practice; (5) healthcare systems and organizations; (6) patient advocacy and empowerment; (7) multicultural workforce; (8) education and training; (9) cross cultural communication; (10) cross cultural leadership; (11) policy development; and (12) evidence-based practice and research. The authors also provided many suggestions for implementing these standards into nursing practices.

Reference

Douglas, M. K., Pierce, J. U., Rosenkoetter, M., Callister, L. C., Hattar-Pollara, M., Lauderdale, J., . . . Pacquiao, D. (2009). Standards of practice for culturally competent nursing care: A request for comments. Journal of Transcultural Nursing, 20(3), 257-269.

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Appendix

Organizing Framework & Multilevel Interventions

Purpose

To synthesize the findings of interventions designed to reduce health disparities in cancer care among racial and ethnic minorities.

Who would use it?

Researchers, policy makers (explicit)

Description

The authors use a modified version of the organizing framework developed by Taplin et al. (2012) to examine multilevel influences on health outcomes. The framework is comprised of seven levels: (1) individual patient; (2) family and social supports; (3) provider/team; (4) organization and/or practice setting; (5) local community environment; (6) state health policy environment; and (7) national health policy environment. The framework is applied to the 26 studies identified from the systematic review. Of the 26, 12 had enough data for the meta-analysis using the Physiotherapy Evidence Database (PEDro) coding scheme. The findings suggest that multilevel interventions on cancer care have positive outcomes across a multitude of health behaviour outcomes, including cancer prevention and screening, and improving the quality of health care system processes.

Reference

Gorin, S. S., Badr, H., Krebs, P., & Das, I. P. (2012). Multilevel interventions and racial/ethnic health disparities. JNCI Monographs, 2012(44), 100-111.

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Appendix

Roadmap for Future Research

Purpose

To develop a roadmap that will guide future research and identify how decision makers at various levels can use existing knowledge to reduce climate-related health risks of indigenous people.

Who would use it?

Decision makers (explicit)

Description

The author describes five key components of a roadmap for future research: (1) indigenous conceptualizations of approaches to health - need to be articulated and central to research if we are to focus on relevant health risks and capture the complex, culturally-mediated interaction among social, biophysical, and biomedical determinants of vulnerability; (2) collection of baseline data on socioeconomic and biomedical determinants of health - there is need to develop an understanding of the sensitivity of health outcomes to climate, including the identification of indicators to measure and monitor, drawing upon both traditional and scientific knowledge; (3) develop and improve surveillance and environmental monitoring systems - new research initiatives should work with indigenous populations to collect information on climate-related health outcomes using information for future modeling; (4) evaluation of opportunities for policy intervention - comprehensive evaluation of adaptation by indigenous people to examine the effectiveness, desirability, and feasibility of adaptations related to climate change; assess urgency; evaluate durability of adaptations under different climate and socioeconomic scenarios; and assess equity considerations; and (5) interdisciplinary approaches - involves collaboration across the health, natural, and social sciences, and the active engagement of indigenous communities and organizations, health professionals, and policymakers.

Reference

Ford, J. D. (2012). Indigenous health and climate change. American Journal of Public Health, 102(7), 1260-1266.

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Appendix

Broader Structural Factors for Cancer Care

Purpose

To provide a framework for understanding inequalities faced by Indigenous populations in cancer care.

Who would use it?

Health care practitioners (implicit)

Description

The authors seek to understand factors contributing to the inequalities Indigenous cancer patients face during cancer care and treatment. The framework identifies three distinct levels of factors that influence inequalities in care: (1) Patient Factors - Indigenous patients are more likely to have co-morbidities, are more likely to receive a later-stage cancer diagnosis, and to have a lower socioeconomic status; (2) Treatment processes - including communication issues, conscious and unconscious stereotyping by healthcare practitioners, and the complex, multi-stepped processes involved in receiving cancer care; and (3) Structural and Health system-level Factors - including the location and resourcing of health services, waiting times and service quality, and the mainstream focus of health-care that inadvertently neglects the needs of Indigenous and minority populations.

Reference

Hill, S., Sarfati, D., Robson, B., & Blakely, T. (2013). Indigenous inequalities in cancer: What role for health care? ANZ Journal of Surgery, 83(1-2), 36-41.

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Appendix

Te Tiriti O Waitangi

Purpose

To apply the "Te Tiriti O Waitangi", an agreement signed between the British government and Maori Chief in 1840 for improved Maori health outcomes. To address racism and promote cultural safety in nursing practice.

Who would use it?

Health care practitioners (explicit)

Description

The Maori concepts from Te Tiriti O Waitangi are presented as a means of promoting cultural safety in practice and thereby improving health outcomes. The common principles of governance and self-determination of the Te Tiriti are used to address racial discrimination and to inform development of Maori health services. The issues of cultural safety, overcoming the barriers of racism, and integration of cultural safety practice from the individual level to the institutional level for health promotion are key components of the framework. Further, the concept of cultural safety is used to reduce racism among nurses and reduce interactional barriers between clients and nurses. The integration of cultural safety from individual to institutional level is suggested in order to build partnerships with communities and to progress towards social justice and equity in health care services for a marginalised population.

Reference

Oda, K., & Rameka, M. (2012). Students' corner: Using Te Tiriti O Waitangi to identify and address racism, and achieve cultural safety in nursing. Contemporary Nurse, 43(1), 107-112.

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Appendix

The Purnell Model for Cultural Competence

Purpose

The purpose of the Purnell Model for Cultural Competence is: (1) to provide a framework for all healthcare providers to learn concepts and characteristics of culture; (2) define circumstances that affect a person's cultural worldview in the context of historical perspectives; (3) provide a model that links together the most central relationships of culture; (4) interrelate characteristics of culture to promote congruence and to facilitate the delivery of consciously sensitive and competent healthcare; (5) provide structure for analyzing cultural data; and (6) view the individual, family, or group within their unique ethno-cultural environment.

Who would use it?

Health-care providers, educators, researchers, managers, and administrators in all health disciplines (explicit)

Description

The Purnell Model is circular in nature and includes the following: (1) an outer area representing global society; (2) the first ring representing community; (3) the second ring representing family; and (4) the inner ring representing the person. The inner ring of the model is divided into 12 pie-shaped wedges depicting cultural domains and their concepts: (1) overview, inhabited localities, and topography; (2) communication; (3) family roles and organization; (4) workforce issues; (5) biocultural ecology; (6) high-risk behaviors; (7) nutrition; (8) pregnancy and childbearing practices; (9) death rituals; (10) spirituality; (11) health-care practices; and (12) health-care providers. The center of the model represents unknown phenomena. Under the circles is a jagged line representing cultural consciousness. The domains can be used for assessing patients in different settings, as well as be used by health care providers to better understand their own cultural beliefs, attitudes, values, practices, and behaviors.

Reference

Purnell, L. D. (2012). The Purnell model for cultural competence. In L. D. Purnell (Ed.), Transcultural Health Care: A Culturally Competent Approach (pp. 15-19). Philadelphia: FA Davis Company.

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Appendix

The Power Study Framework

Purpose

The purpose of the conceptual POWER Framework is to help choose indicators, analyze data, interpret findings, and report results.

Who would use it?

Policy-makers, health care providers, decision-makers, and consumers

Description

There are five components of the conceptual framework. The framework is guided by: (1) holistic definition of women's health; (2) emphasizing importance of social determinants of women's health; (3) make distinction between "sex" and gender"; (4) centered around the concept of equity; and (5) developed by stakeholder input.

Applications

Yes (http://powerstudy.ca/wp-content/uploads/downloads/2012/10/Chapter12-SDOHandPopsatRisk.pdf)

Reference

Clark JP, Bierman AS. The POWER Study Framework. In: Bierman AS, editor. Project for an Ontario Women's Health Evidence-Based Report: Volume 1: Toronto; 2009.

powerstudy.ca/wp-content/uploads/downloads/2012/10/Chapter2-ThePOWERStudyFramework.pdf

Mental Health Promotion Lens

Purpose

To help policy makers to consider in a systematic way the social and environmental determinants of mental health when developing or reviewing policy or programs.

Who would use it?

Policy makers (explicit)

Description

The document contains the background information on mental health promotion in Victorian government policy with the action areas and goals. Further, the document describes the alignment of risk and protective factors for mental health listed in Figure 1 of the document. Based on the background information, six steps for policy setting and planning are given for ensuring that mental health promotion is integrated in the policies: (1) rationale/vision setting; (2) priority setting; (3) partnership development; (4) planning; (5) implementation; and (6) evaluation and dissemination. A mental health promotion lens for policy planning is illustrated in a descriptive chart with information on population, the setting and actions required.

Reference

Department of Health. (2010). Using policy to promote mental health and well-being: an introduction for policy makers. Prevention and Population Health Branch, Victorian Government Department of Health, Melbourne, Victoria.

Five-Step Approach to Address Children's Health in All Policies

Purpose

To implement children's health in all policies for six pressing children's health issues.

Who would use it?

Policymakers, decision-makers (implicit)

Description

The 94-page document describes a five-step approach for implementing children's health in all policies in regards to: obesity, oral health, special health care needs, adolescent risk behaviors, access to quality child care services, and poverty. The 5-step approach comprises: (1) identify why the children's health issue is important and describe the causes; (2) describe the magnitude of the children's health issues; (3) identify policy efforts and opportunities to improve children's health and well-being relative to the particular health issues; (4) identify evidence-informed policy solutions to address the children's health issue at local and state levels to improve the home, school and community environments; and 5) describe the potential impact of the policy solutions.

Reference

Lin, T., & Homan, S. (2010). Children's health in all policies: A workbook. Kansas Health Institute, Topeka.

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Appendix

Social Justice Framework

Purpose

To articulate a model for urban health nursing (including public health nursing) organized around the concept of social justice, and re-conceptualized understandings of the existing nursing meta-paradigm concepts of nursing, environment, person, and health. Social justice, in this model, lies at the centre of nursing practice but is intimately interconnected with the other meta-paradigm concepts. The premise is that by centering practice around social justice, we will ensure the distribution of life resources (material and social) in a way that benefits the marginalized and constrains the self-interest of the privileged.

Who would use it?

Nurses, nursing leaders and educators, nursing policy makers (implicit)

Description

This revised nursing meta-paradigm framework comprises the following concepts: (1) Social justice, from a communitarian perspective, is both a guiding philosophical orientation (theory) and a dynamic implementation process (practice). It contrasts with an individually-based nursing reliance on a material view of justice that recognizes individual characteristics in resource distribution and advantages individuals on the basis of their presence in the location of care. Social justice is viewed from a population perspective thus avoiding allocation of a disproportionate share of resources on the basis of individual characteristics; (2) Person has usually been characterized in nursing as an ahistorical, acontextual, generic individual. In this model, the concept of person transcends the individual to encompass aggregates, communities, populations and nations. The concept of person is multicentred and incorporates an evolving population-level agency; (3) Environment includes the physical and psychosocial environment and goes beyond the immediate confines of the clinic, hospital, or geographic community. Here, environment includes political and economic structures, and their effects on health and illness. A reconceptualized view of environment leads to upstream solutions at community, population, societal and global levels; (4) Health in nursing has traditionally been viewed as an individual or personal process leading to a primary focus on individuals and thus an emphasis on personal responsibility for health with little attention to institutional and societal influences; and finally (5) Nursing has primarily been defined as individual or group care within a caring relationship. This overarching focus on the individual does not attend to the complexity of community and environmental level health challenges, which require a population consciousness in nursing with an understanding of community and global aspects of health care.

Applications

Yes, this framework has been applied by the Community Health Nurses of Canada as the theoretical basis for community health nursing standards of practice. Available at https://www.chnc.ca/nursing-standards-of-practice.cfm.

Reference

Schim, S. M., Benkert, R., Bell, S. E., Walker, D. S., & Danford, C. A. (2007). Social justice: Added metaparadigm concept for urban health nursing. Public Health Nursing, 24(1), 73-80.

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Appendix

A Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities

Purpose

To guide the development of a protocol for the evaluation of activities being funded in the United States and elsewhere. The framework was created by the Office of Minority Health (OMH).

Who would use it?

Geared toward people working in health services.

Description

In this framework, a systems approach to addressing racial/ethnic minority health problems is used and includes evaluating individual and system level changes.. Five steps are outlined that must be taken to ensure that strategies and practices aimed at improving racial/ethnic minority health and reducing racial/ethnic health disparities are effective: (1) identify the long-term problems, (2) identify the key factors that contribute to those long-term problems, (3) identify or develop strategies and practices that effectively address the contributing factors and the long-term problems, (4) identify expected outcomes and impacts and determine appropriate measures or indicators of such results, and (5) document progress in achieving agreed-upon objectives and goals.

Applications

This tool has been applied as a framework by Nanney and Davey (2008) for school wellness policies and practices, and by Hilton and Lester (2010) on oral health disparities:

Nanney, M. S., & Davey, C. (2008). Evaluating the distribution of school wellness policies and practices: A framework to capture equity among schools serving the most weight-vulnerable children. Journal of the American Dietetic Association, 108(9), 1436.

Hilton, I.V., & Lester, A.M. (2010). Oral health disparities and the workforce: A framework to guide innovation. Journal of Public Health Dentistry, 70 (Suppl 1), S15-S23.

Reference

Graham, G. N. (2008).*A strategic framework for improving racial/ethnic minority health and eliminating racial/ethnic health disparities*. US Department of Health and Human Services, Office of Minority Health.

https://minorityhealth.hhs.gov/Assets/PDF/Checked/OMH%20Framework%20Final_508Compliant.pdf

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Appendix

Understanding Health Disparities

Purpose

To better understand the complex causes of health disparities among racial and ethnic groups.

Who would use it?

State-level health policy makers in the United States.

Description

This document is a background paper from the Commonwealth Fund report (McDonough 2004) and includes a list of recommendations for developing policies to eliminate racial and ethnic health disparities. This is a framework for examining the intricate web of factors that can contribute to health disparities and background information to create a common understanding of the issue of health disparities. The author provides guidelines developed at the 1999 Agency for Healthcare Research and Quality conference for designing interventions.

Reference

Health Policy Institute of Ohio. (2004). *Understanding health disparities*. Columbus, OH: Author.

http://www.healthpolicyohio.org/wp-content/uploads/2014/02/healthdisparities2005.pdf

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Appendix

Culturally Relevant Gender Application Protocol Workbook

Purpose

To promote equality for aboriginal women in health, social and economic outcomes through a process of empowerment.

Who would use it?

Policy makers, practitioners and evaluators.

Description

The Culturally Relevant Gender Application Protocol (CR-GAP) is a strategy for considering the interests and perspectives of aboriginal women in policy development and evaluation. Background information and a set of questions to support community engagement of Aboriginal women in policy development processes are included in the workbook. Engagement with aboriginal women is key to promoting health equity. The workbook is organized around the three intended outcomes: equity in participation, balanced communication, and equality in results. This strategy can be applied at any point in policy development or continuously throughout the process of developing, applying and evaluating policy.

Reference

Native Women's Association of Canada. (2010). C*ulturally relevant gender application protocol workbook.* Ottawa: Author.

https://www.nwac.ca/wp-content/uploads/2015/05/2010-NWAC-Culturally-Relevant-Gender-Application-Protocol-A-Workbook.pdf

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Appendix

Framework for Girls' and Women-Centred Health: An Implementation Guide for Vancouver Coastal Health

Purpose

To contribute to improvements in health for women and girls by assessing programs and services for inclusiveness and empowerment of women and girls.

Who would use it?

Staff in Vancouver Coastal Health (VCH), a regional health authority in British Columbia, Canada. It may be useful for anyone providing health services to women and girls.

Description

This 12-page booklet contains a gender-based analysis of women's health, tips for using the framework, a checklist for assessing programs and services, examples of best practices and a glossary. The framework is represented as a flower. The outer petals represent determinants of health, the inner petals represent elements of best practices. The inner circle is an Aboriginal four quadrant or medicine wheel framework, and the centre reads "Girls, women and their communities". The checklist goes through the best practices elements found on the framework's inner petals, which include categories such as respect and safety, empowerment, involvement and participation, and social justice.

Applications

The document provides some examples from health services in VCH.

Reference

Vancouver Coastal Health. (2009) *Framework for girls' and women-centred health: An implementation guide for Vancouver Coastal Health*. Vancouver, BC: Author.

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Appendix

The Health Analysis and Action Cycle: An Empowering Approach to Women's Health

Purpose

To provide an analysis of the Health Analysis and Action Cycle (HAAC) as an empowering community development process to promote women's health.

Who would use it?

The focus is on women and people working in community development.

Description

The Health Analysis and Action Cycle (HAAC) tool is conceived as an empowering approach that promotes health for women by enabling them to review and act on their health and environmental situation. Participants examine their own beliefs surrounding health and illness in order to plan and take action for themselves. The Cycle uses a participatory, empowerment process with the women engaged in every step. Health mapping is used to link the factors that impact health in order to focus health preventive measures and the actions that can be taken to achieve holistic health. Gibbon uses social network analysis as an approach to consider health within a socio-environmental context.

Applications

This paper uses a case study approach to describe the application of the HAAC with women in rural Nepal.

Reference

Gibbon, M. (2000). The health analysis and action cycle: An empowering approach to women's health. *Sociological Research Online, 4*(4).

http://www.socresonline.org.uk/4/4/gibbon.html

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Appendix

Building a Democratic Voice Through Community Engagement in Water Policy Decision Making

Purpose

To develop an approach that will enhance community engagement in water policy decision making and empower communities to hold decision makers accountable.

Who would use it?

Policymakers, decision-makers, government (implicit)

Description

The Community Water Center (CWC) identified four components (Physical Infrastructure, Source Water Protection, Institutional Capacity, and Community Power) to achieve universal access to safe, affordable drinking water: (1) the community water system must have adequate physical infrastructure, for example, wells, pipes, storage tanks, treatment facilities, and water service delivery technologies - this component will be the most expensive to implement; (2) there should be a reliable source of clean healthy water available, such as a river or an aquifer; (3) a community and its water service provider must have the institutional capacity to operate and maintain the system affordably - institutional capacity is the water provider's ability to keep the water system running safely and efficiently; and (4) the community itself must have the political power to hold decision makers accountable, and not just the water service provider, including local, regional, and state government officials.

Reference

Francis, R., & Firestone, L. (2011). Implementing the human right to water in California's central valley: Building a democratic voice through community engagement in water policy decision making. Willamette Law Review, 47(3), 495-537.

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Appendix

Health Equity Initiatives

Purpose

To encourage and support the further development of existing initiatives and partnerships to address the social determinants of health inequities.

Who would use it?

Health care practitioners (implicit).

Description

This workbook is based on the existing resources and lessons from previous projects aimed at developing initiatives to increase health equity in communities. This workbook has several case studies and health equity tools. The guidelines are presented in a sequential order of 7 detailed sections about forming a cumulative knowledge base or presenting a process for achieving health equity. The guidelines include how to: (1) enlist the participants; (2) assess social determinants of health; (3) build community capacity; (4) focus initiatives on social determinants of health inequities; (5) develop and implement an action plan; and (6) assess and improve the initiative's progress. Further recommendations are provided.

Reference

Brennan Ramirez, L. K., Baker, E. A., Metzler, M. (2008). Promoting health equity: A resource to help communities address social determinants of health. Centers for Disease Control and Prevention, Atlanta: U.S. Department of Health and Human Services.

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Appendix

Community Action Framework

Purpose

To implement community action to reduce health inequalities through the participation of stakeholders.

Who would use it?

Policymakers, decision makers, government, stakeholders, community planners (implicit)

Description

The authors describe a three-stage model that was implemented in two neighbourhoods. The three stages are: (1) making alliances with partners and stakeholders - working groups were set up between stakeholders and active participants, with periodic meetings during the evaluation period; (2) developing a participatory needs and assets assessment - this involves developing reports using quantitative and qualitative methods, and comparing health indicators between each neighbourhood; and (3) planning, implementing, and evaluating interventions on the community prioritized needs. Details about each of these stages are provided by the authors.

Applications

This tool has been applied in two disadvantaged neighbourhoods, Poble Sec and Roquetes in Barcelona.

Evaluations

In this paper, the feasibility of the model at each stage was assessed through the percentage of achievement of 18 indicators. These evaluations took place from 2007 and 2011. Achievement of indicators exceeded an average of 75% in both neighbourhoods.

Reference

Fuertes, C., Pasarín, M. I., Borrell, C., Artazcoz, L., & Díez, È. (2012). Feasibility of a community action model oriented to reduce inequalities in health. Health Policy, 107(2), 289-295.

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Appendix

A Framework Linking Community Empowerment and Health Equity: It is a Matter of CHOICE

Purpose

To assess the influence of equity and empowerment on health outcomes.

Who would use it?

Program planners and policy makers.

Description

The acronym (CHOICE) represents the important elements of the relationship between health equity and community empowerment. CHOICE stands for Capacity-building, Human rights, Organizational sustainability, Institutional accountability, Contribution, and Enabling environment. The author provides a description of each element, a review of supporting evidence, significance and examples to illustrate the contribution of each element to the framework. The elements form the basis of a tool to assess the link between equity and community empowerment and impact on health. The author recommends that further work is needed to create a practical, valid, and reliable tool.

Applications

This framework has been applied to two case studies (Ratna and Rifkin 2007) and one evaluation (Motamed, Rifkin and Rougemont 2011):

Ratna, J., & Rifkin, S. (2007). Equity, empowerment and choice: From theory to practice in public health. Journal of Health Psychology, 12(3), 517-530.

Rotamed, S., Rifkin, S. B., Rougemont, A. C., & the community from Meinier. (2011). An evaluation of the Lime Tree Project: The creation of a new village centre and an intergenerational living space near Geneva, Switzerland. Available online: http://www.ghf12.org/?p=2123

Reference

Rifkin, S. B. (2003). A framework linking community empowerment and health equity: It is a matter of CHOICE. *Journal of Health, Population and Nutrition (JHPN), 21*(3), 168-180.

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Appendix

PATHways II: The Next Steps. A Guide to Community Health Impact Assessment

Purpose

To facilitate the development of a Community Health Impact Assessment Tool (CHIAT) using a health promotion and community development process.

Who would use it?

Groups or organizations interested in fostering healthy communities.

Description

People Assessing their Health (PATH) is a process that uses community-driven health impact assessment to build the capacity of people to be active participants in the decisions that affect the well-being of their community. This process is meant to result in a customized tool for evaluating policies, programs or services likely to affect health in the community. The 42-page guide includes background and context for PATH and community health impact assessment, a case study, and practical instructions. The process involves a reflective, story-telling approach that is grounded in the principles of adult education and is distinctive in that it engages a community in developing the assessment tool (CHIAT) as a means for that community to initiate its own impact assessment. This is in contrast to traditional HIA in which communities are consulted rather than engaged.

Applications

This has been applied in Canada and India. The authors give one example in the document and further examples are provided by Cameron et al. (2011).
See: Cameron, C., Ghosh, S., & Eaton, S.L. (2011). Facilitating communities in designing and using their own community health impact assessment tool. Environmental Impact Assessment Review, 31, 433-437.

Reference

Antigonish Women's Resource Centre. (2002). *PATHways II: The next steps. A guide to community health impact assessment*. Antigonish: Author.

http://awrcsasa.ca/archive/pdfs/PATHways%20II%20manual.pdf

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Appendix

A Planning Guide: Health Inequalities and the Voluntary and Community Sector

Purpose

To promote consideration of health equity in project planning by non-governmental organizations working with disadvantaged groups.

Who would use it?

Voluntary and community sector organizations (NGOs) interested in addressing health inequalities. Some of the information is specific to the UK.

Description

This 35-page guide includes a four phase process from planning a project, conducting a needs assessment, creating an issues checklist, to evaluating outcomes. This document was developed in consultation with key stakeholders from non-governmental organization (NGO) membership and key partners working in the area of health inequalities. The guide provides extensive suggestions for funding sources and NGO supports relevant to UK audiences and could be used at project start up, evaluation, or to assess an expansion or change of direction. The authors adapted parts of this tool from the Merseyside model of health impact assessment (See: Scott-Samuel, A., Birley, M., & Ardern, K. (2001). The Merseyside guidelines for health impact assessment (2nd ed.). Liverpool: IMPACT).

Reference

Chiwera, B. (2011). *A planning guide: Health inequalities and the voluntary and community sector.* London: National NGO Forum, Royal Society for Public Health.

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Appendix

Translational Environmental Research in Rural Areas (TERRA) Framework

Purpose

To analyze environmental health risks experienced by families living in rural areas and to provide successful intervention for those families living in inequitable conditions.

Who would use it?

Nurses, health administration, policymakers, decision-makers (implicit)

Description

The authors provide a conceptual framework that is intended to strengthen nursing's rapidly evolving body of science by addressing environmental health and social justice. iConcepts in the TERRA framework include: (1) macro-determinants of environmental health, which are physical-spatial, economic resources, and cultural ideologies; (2) environmental health inequities, which refers to differential distribution of resources available to reduce exposure to environmental risk; (3) environmental health risks refer to potential biological, chemical, physical, and social agents that have health consequences; (4) environmental health mental models, refer to the beliefs about risks; (5) environmental risk reduction interventions, refer to services provided by health services that mitigate against environmental health risks; (6) proximal outcomes, refer to knowledge, risk interpretation, and/or self-efficacy; and (7) distal outcomes, refer to reductions in exposure and decrease in disease incidence or severity. The TERRA framework is very flexible, and because of this, it could also be used to inform policy decisions to produce more effective public healthcare systems.

Reference

Butterfield, P., Postma, J., & ERRNIE Research Team. (2009). The TERRA framework: Conceptualizing rural environmental health inequities through an environmental justice lens. Advances in Nursing

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Appendix

Framework For Effect Of Neighborhood Built Environment On Health Outcomes

Purpose

To present a framework for nurses to study the impact of built environment on health, particularly in vulnerable populations.

Who would use it?

Nursing researchers, public health clinicians (explicit)

Description

The authors propose a nursing framework as an adaption of an existing model (Schulz & Northridge, 2004) that links the built environment to health outcomes, social determinants of health and environmental health promotion. The framework has three sections: regional-level influences, neighborhood-level influences, and individual-level influences. Regional-level influences include: (1) distribution of wealth; (2) employment/educational opportunities; and (3) political influences. Neighbourhood-level influences are those that surround residents' homes where daily activities occur. Walkability is a central concept to this model. Individual-level influences are health behaviors, specifically walking that are affected by the walkability of the built environment.

Applications

This framework has been applied to research investigating the effects of built environment on health and health disparities. Specifically, Scott and Wilson (2011) used this framework to identify social determinants of health among African Americans in the rural Deep South. Franzini et al., 2009 examined the influences of physical and social neighborhood environments on children's physical activity and obesity also employed the framework. Maley, Warren and Divine (2010) used the Schulz and Northridge model to study how members of rural community perceived the effects of built, natural, and social environments on health promotion behaviors.

Reference

DeGuzman, P. B., & Kulbok, P. A. (2012). Changing health outcomes of vulnerable populations through nursing's influence on neighborhood built environment: A framework for nursing research. Journal of Nursing Scholarship, 44(4), 341-348.

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Appendix

Mediation Model of RCT Context and Participant's Life Context

Purpose

To implement research strategies for enhancing the recruitment, retention, and intervention relevance for individuals living with disadvantaged and unstable life circumstances.

Who would use it?

Project staff (interveners, data collectors, project coordinators) (explicit)

Description

The authors present a tool to guide the process of including ethnically and socio-economically diverse populations in clinical research. Specifically, the tool provides strategies for implementing community-based Randomised Control Trials (RCT) implementation in diverse populations. The conceptualisation of the strategies is based on a mediation model of RCT context and participant's life context, including: (1) unstable housing; (2) unstable contact information; (3) limited access to health care and social services; (4) limited financial resources; (5) unsafe or inaccessible physical environment; (6) conflict between health or other personal or family goals; (7) criminal activity or incarceration; (and (8) substance use or dependence. The model compares the implementation of a highly controlled and stable RCT with the unpredictable/unstable life circumstances of many research participants. The challenges identified are: (1) tracking and scheduling participants; (2) retaining staff; (3) collecting accurate data; (4) negotiating health and socio-economic trade-offs; (5) understanding life and medical histories; and (6) defining the scope of the intervention. Further, the practical application of the strategies to overcome these challenges and to implement an RCT effectively is discussed.

Applications

In the paper the authors apply the tool to an RCT.

Evaluations

The authors evaluate the process and implementation of the tool in an RCT. The RCT is aimed at preventing medically serious pressure ulcers and improving quality of life among adults with spinal cord injury.

Reference

Pyatak, E. A., Blanche, E. I., Garber, S. L., Diaz, J., Blanchard, J., Florindez, L., & Clark, F. A. (2013). Conducting intervention research among underserved populations: Lessons learned and recommendations for researchers. Archives of Physical Medicine and Rehabilitation, 94(6), 1190-1198.

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Appendix

Various Analytic Appraoches (Fixed-Effect and Random-Effect) for Accounting the Context in Health Inequalities Study

Purpose

To compare analytical approaches used to account for the total (observed and unobserved factors) contribution of contextual influences on the development of health disparities in the general population.

Who would use it?

Researchers, epidemiologists (explicit)

Description

The authors examine the use of various statistical models that attempt to account for the neighborhood level environmental or contextual impacts on health disparity. The use of fixed-effects and fixed-effects hybrid models, to account for the cluster level confounding, is discussed over the more commonly used ordinary and random-effects models. The authors argue that results from the ordinary and random-effects models result in biased findings and that the fixed-effects and hybrid models offer better estimations of within-neighbourhood individual-level disparities.

Applications

The authors apply the different measures to the 1999-2001 birth certificate data of Durham and Wake counties of North Carolina.

Evaluations

In the paper the authors examine the various approaches to measure health disparities and to evaluate the potential improvements in the statistical models. The dataset used for the statistical analysis is 1999-2001 birth certificate data of Durham and Wake counties of North Carolina.

Reference

Schempf, A. H., & Kaufman, J. S. (2012). Accounting for context in studies of health inequalities: A review and comparison of analytic approaches. Annals of Epidemiology, 22(10), 683-690.

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Appendix

Recommendations for Conducting Equity-Focused Systematic Reviews and Considerations for Knowledge Translation

Purpose

To provide recommendations for conducting equity-focused systematic reviews consistent with the recommendations of PRISMA-E 2012 (checklist of items for reporting equity focused reviews) and to provide guidelines related to knowledge translation for these types of reviews.

Who would use it?

Those working in health systems research and aiming to implement evidence-informed policies and make decisions related to health equity. (explicit)

Description

Consideration of health equity in the systematic review process should include the following 10 steps: (1) define conceptual approach to health equity; (2) develop a theory-based approach (may include an analytic framework where health equity is identified as an outcome); (3) frame the health equity questions; (4) include relevant study designs to assess health equity questions; (5) identify information sources for health equity questions; (6) define search terms for health equity questions; (7) develop data extraction tools for health equity; (8) assess the influence of context and process on health equity outcomes; (9) use synthesis approaches to assess effects on health equity; and (10) collect data related to applicability and equity.

Five questions should be considered when designing, implementing, and evaluating KT interventions related to health equity: (1) What should be transferred? - systematic reviews offer decision makers not only reviews of tools that work for achieving health equity, but also help determine the audience of these interventions, as well as their cost and possible pitfalls; (2) To whom should research knowledge be transferred?; (3) By whom should research knowledge be transferred?; (4) How should research knowledge be transferred? - barriers and facilitators of a strategy should be assessed prior to choosing and applying it; and (5) With what effect should research knowledge be transferred?

Reference

Welch, V. A., Petticrew, M., O'Neill, J., Waters, E., Armstrong, R., Bhutta, Z. A., ... & Tugwell, P. (2013). Health equity: Evidence synthesis and knowledge translation methods. Systematic Reviews, 2(1), 1-10.

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Appendix

PRISMA-E

Purpose

To provide structured guidance on transparent reporting of the methods and results of equity-focused systematic reviews using PRISMA-Equity (PRISMA-E).

Who would use it?

Researchers (explicit)

Description

A standard set of guidelines for Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) have been developed, yet none focus explicitly on equity. The authors convened a two-day workshop to discuss additional guidelines for equity-focused systematic reviews. The standard PRISMA includes 20 items and, based on the results of the workshop, the authors suggest an additional 14 items be added for improved reporting of equity-focused studies. The suggested extensions include the: (1) title; (2) summary/abstract; (3) rationale; (4) objectives; (5) eligibility criteria; (6) information sources; (7) search; (8) data items; (9) synthesis of results; (10) additional analysis on equity; (11) study characteristics; (12) synthesis of results; (13) additional analysis' results; and(14) conclusions of the study. The article includes the checklist of items for both the standard PRISMA and expanded PRISMA-E.

Reference

Welch, V., Petticrew, M., Tugwell, P., Moher, D., O'Neill, J., Waters, E., & White, H. (2012). PRISMA-Equity 2012 extension: Reporting guidelines for systematic reviews with a focus on health equity. Revista Panamericana de Salud Pública, 34(1), 60-67.

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Appendix

Conceptual Framework

Purpose

To provide a framework to guide health researchers, practitioners, and policy makers in detecting, understanding, and reducing or eliminating health and health care disparities among vulnerable populations.

Who would use it?

Researchers, health-care practitioners, policy makers (explicit)

Description

The authors provide a conceptual framework that organizes health and health care disparities research into three sequential phases: detection, understanding, and reduction/elimination. When detecting disparities, it is important for researchers to precisely define health disparities and vulnerable populations, and consider potential selection biases and confounding factors. To better understand the root causes of disparities, researchers should identify the multilevel determinants of health disparities at the individual, provider, and organizational level. To reduce or eliminate health and health care disparities, researchers are encouraged to evaluate current interventions, translate and disseminate strategies into routine care, and change policy through researcher-community collaborations.

Reference

Kilbourne, A. M., Switzer, G., Hyman, K., Crowley-Matoka, M., & Fine, M. J. (2006). Advancing health disparities research within the health care system: A conceptual framework. American Journal of Public Health, 96(12), 2113.

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Appendix

Appendix A: Health Equity Tools Criteria Template

Reference:

A. Classification

1. Is the purpose of the tool clearly described?

- ◯ Yes. Identify and provide page number:
- ◯ No

2. Does the purpose of the tool as stated match the content of the tool?

- ◯ Yes
- ◯ No

3. Are the users of the tool identified? (check all that apply)

- ☐ None specified
- ☐ Policy makers
- ☐ Educators
- ☐ Researchers
- ☐ Administrators
- ☐ Community members
- ☐ Practitioners
- ☐ Other

4. Are you planning to use this tool for its intended purpose?

- ◯ Yes
- ◯ No

5. Are there additional resources or background information provided to support the use of the tool?

- ◯ Yes
- ◯ No

B. Practical Criteria

1. The tool has the potential to contribute to improvements in programs and/or policies.

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
◯	◯	◯	◯	◯

2. The tool will contribute to the identification of specific or potential actions to improve health equity.

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
◯	◯	◯	◯	◯

3. There is a step in the tool that engages or calls for participation of the community or people affected by health inequities.

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
○	○	○	○	○

4. The tool is easy to use and understand.

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
○	○	○	○	○

Comments:

5. The tool is quick to use and short.

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
○	○	○	○	○

Comments:

6. There is a clear set of steps that guide the use of the tool.

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
○	○	○	○	○

C. Theoretical Criteria

1. Is there a definition of health equity or social justice?

   ◯ Yes - What is the definition?
   ◯ No

2. Although *promoting health equity* and *reducing health inequity* may seem to be the same thing, they often require different strategies. Is there an explanation of how health equity can be *promoted*?

   ◯ Yes
   ◯ No

3. Is there an explanation of how health inequity can be *reduced*?

   ◯ Yes
   ◯ No

4. Are references provided with the tool to support the theoretical orientation or the empirical basis for the tool?

   ◯ Yes
   ◯ No

5. Is there a theory explicitly identified that the tool is based on? If so, what is it? This may be a difficult question to answer as not all tools have a specific theoretical orientation and sometimes there is a mix of theories but it is important to note that a strong theoretical underpinning is important for a strong tool.

   ◯ Yes
   ◯ No
   ◯ Unsure