# EQUITY-INTEGRATED POPULATION HEALTH STATUS REPORTING: ACTION FRAMEWORK

National Collaborating Centres for Public Health

Centres de collaboration nationale en santé publique

**Equity-Integrated Population Health Status Reporting: Action Framework**

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## LIST OF ABBREVIATIONS

| | |
|---|---|
| **BCCEWH** | BC Centre of Excellence for Women's Health |
| **CIHI** | Canadian Institute for Health Information |
| **EI-PHSR** | Equity-Integrated Population Health Status Reporting |
| **EU** | European Union |
| **FNIGC** | First Nations Information Governance Centre |
| **HOC** | Health Officers Council (BC) |
| **MCHP** | Manitoba Centre for Health Policy |
| **MHO** | Medical Health Officer |
| **NCCDH** | National Collaborating Centre for Determinants of Health |
| **PHSR** | Population Health Status Reporting |
| **RHA** | Regional Health Authority |
| **RHS** | Regional Health Survey |
| **SPRP** | Saskatoon Poverty Reduction Partnership |

SECTION 1

# INTRODUCTION

## PURPOSE OF THIS RESOURCE

Population health status reporting (PHSR) is a vital tool for addressing the social determinants of health and improving health equity. This resource provides an accessible action framework for people who are either directly engaged in creating community health status reports or are interested in learning about how they can use PHSR to drive action on improving health equity. It is our hope that the use of this action framework will strengthen the integration of health equity into the PHSR process, resulting in increased capacity to take action on the social determinants of health.

## TARGET AUDIENCE FOR THIS RESOURCE

The audience for this resource is the public health sector and its partners in data collection and reporting. This could include health/public health staff, community organizations that provide local data, or academic researchers. For this first version of the Equity-Integrated PHSR Action Framework (hereafter referred to as Action Framework) we have prioritized the public health audience and the context within which public health programs and services are provided. This is a starting point only; we anticipate that the Action Framework will be built upon and expanded over time to meet the needs of additional target audiences such as community partners and researchers.

Actors in the health system at all levels, including but not limited to senior leaders, medical health officers (MHOs), epidemiologists, managers and front-line staff, are well-positioned to use PHSR processes as a call to action for interventions that address the social determinants of health and improve health equity. They can engage community members in collaborative conversations to help everyone involved better understand the data. They can use existing tools to mobilize or support their community in taking action so all residents can reach their optimal health. They can also advocate for and drive change within the broader health system.

## EVERYONE HAS A ROLE TO PLAY – WHAT ACTIONCAN HEALTH PROFESSIONALS TAKE?

Embracing the challenge of integrating equity into existing or new PHSR processes can feel overwhelming – there are many steps that need to be taken. This Action Framework outlines an ideal equity-integrated PHSR process. At the same time we need to recognize that we work in complex organizations situated within even more complex environments. This resource is intended to help you identify and implement manageable steps specific to your context.

Health professionals generally, and public health professionals in particular, are in a good position to lead efforts to improve their communities' health because of their infrastructure and resources, and experience and expertise in convening communities and working with and interpreting data. Everyone has a role to play, and there are actions you can take within your sphere of influence that will help strengthen your organization's approach to improving health equity.

The actions to strengthen PHSR processes will look very different depending on what role each staff person plays within an organization. For example, for any given action, executive directors or MHOs would provide strategic leadership and direction, managers would plan, direct, coordinate and evaluate the activities, epidemiologists would lead the collection, analysis, monitoring and reporting of population level data. Other staff would be implementing and evaluating programs and services (i.e., the "doing"), as well as staying vigilant and raising equity-related issues for consideration.

We encourage you to read this document through the lens of your own role in the system and think about what you can do within your circle of influence. There may be some small changes you can make immediately in your day-to-day work, as well as some big changes you would like to try to encourage in the long-term. You could bring this Action Framework to a regular meeting with your supervisor, team or unit, or you could take it to your next strategic planning session. If you felt it was possible, you could pull together people from other teams or units who are doing PHSR work in your organization. As part of those conversations you could explore whether there are opportunities to apply components of this Action Framework to influence an existing PHSR process (e.g., could you change or supplement your current approaches to PHSR so equity is better integrated?). You could also talk about whether it might make sense to propose a new PHSR process and, if so, where there might be opportunities to do so.

# SETTING THE STAGE



Health equity values are the central driver for integrating health equity into PHSR.

**Health Equity Values:** Differences in health status must be assessed using the values of fairness and justice, recognizing that many differences are socially produced and unfair. The social, economic and political structures and systems that create these health inequities can and should be modified through collective action so that resources for health (including power and money) are more fairly distributed.

Traditionally, PHSR has focused on describing differences in health status between groups. However, integrating issues of equity means taking this a step further to consider these differences through an equity lens. This allows us to examine the social determinants and related upstream interventions associated with the differences identified in the data.

At the heart of this framework is the desire to use data to drive change. The rationale is that collecting and analyzing data through an equity-integrated PHSR process will support stakeholders' efforts in improving, monitoring and measuring efforts to address inequities. Specifically, it will help end-users of the data to:

1. identify where the greatest inequities are;
2. uncover the causes of inequities through greater exploration and contextualization of results;
3. decide where to target resources based on where there is potential for greatest impact;
4. identify the most effective actions or interventions to decrease inequity and increase equity; and
5. engage in target setting to push the system towards decreasing inequity and increasing equity.

## FRAMEWORK DEVELOPMENT

Public health practitioners and organizations from across Canada have identified the need for resources, tools, and collaborative learning on the topic of PHSR.[1] The idea of "purposeful" reporting has been identified as one of ten promising practices to advance health equity.[2] This became the starting point for exploring how the common public health practice of preparing health status reports could be better used to drive action on the social determinants of health. Between 2011 and 2013, the National Collaborating Centre for Determinants of Health (NCCDH) facilitated a collaborative learning project focused on how best to integrate health equity into PHSR. Project participants included managers, directors, researchers, epidemiologists, and medical officers of health.

The initiative found that there is no "one size fits all" approach to population health status reports and reporting processes because they assess a wide range of populations and issues and the intended purpose of any particular report is context-specific.[3] There was agreement, however, that the objectives of a population health status report and reporting processes that integrate health equity are to:

- advance shared health equity objectives;
- provide evidence-based analyses;
- result in action; and,
- support program and organizational accountability.

A draft framework for equity-integrated PHSR was developed based on this work, informed by the content and concepts in similar frameworks.[a,b,c] The framework was reviewed and refined through a consultation process with public health stakeholders across Canada, and was adapted using the community collaborative approach similar to the Robert Wood Johnson Foundation Action Cycle.[4]

During the consultation process, all participants indicated they felt the framework was helpful for understanding how equity could be integrated systemically into PHSR, but felt it was not operational enough for them to be able to figure out how to apply it effectively in their day-to-day work. This resource is intended to meet that need.

a Community Tool Box. Chapter 3: Assessing community needs and resources. [Internet]. [date unknown] [cited 2015 Aug 17]. Available from: http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/develop-a-plan/main

b National Collaborating Centre for Methods and Tools. An introduction to evidence-informed public health and a compendium of critical appraisal tools for public health practice [Internet]. Hamilton (ON): National Collaborating Center for Methods and Tools, McMaster University; 2008; revised 2010 [cited 2015 Aug 12]. 27p. Available from: www.nccmt.ca/pubs/2008_07_IntroEIPH_compendiumENG.pdf

c Isfeld H, Haworth-Brockman M. Guidelines for Developing a Population-Based Gender and Health Profile Prairie Women's Health Centre of Excellence [Internet]. Washington (DC): Pan American Health Organization; 2009 [cited 2015 Aug 17]. 56 p. Available from: www2.paho.org/hq/dmdocuments/2009/Perfil-INGLES.pdf

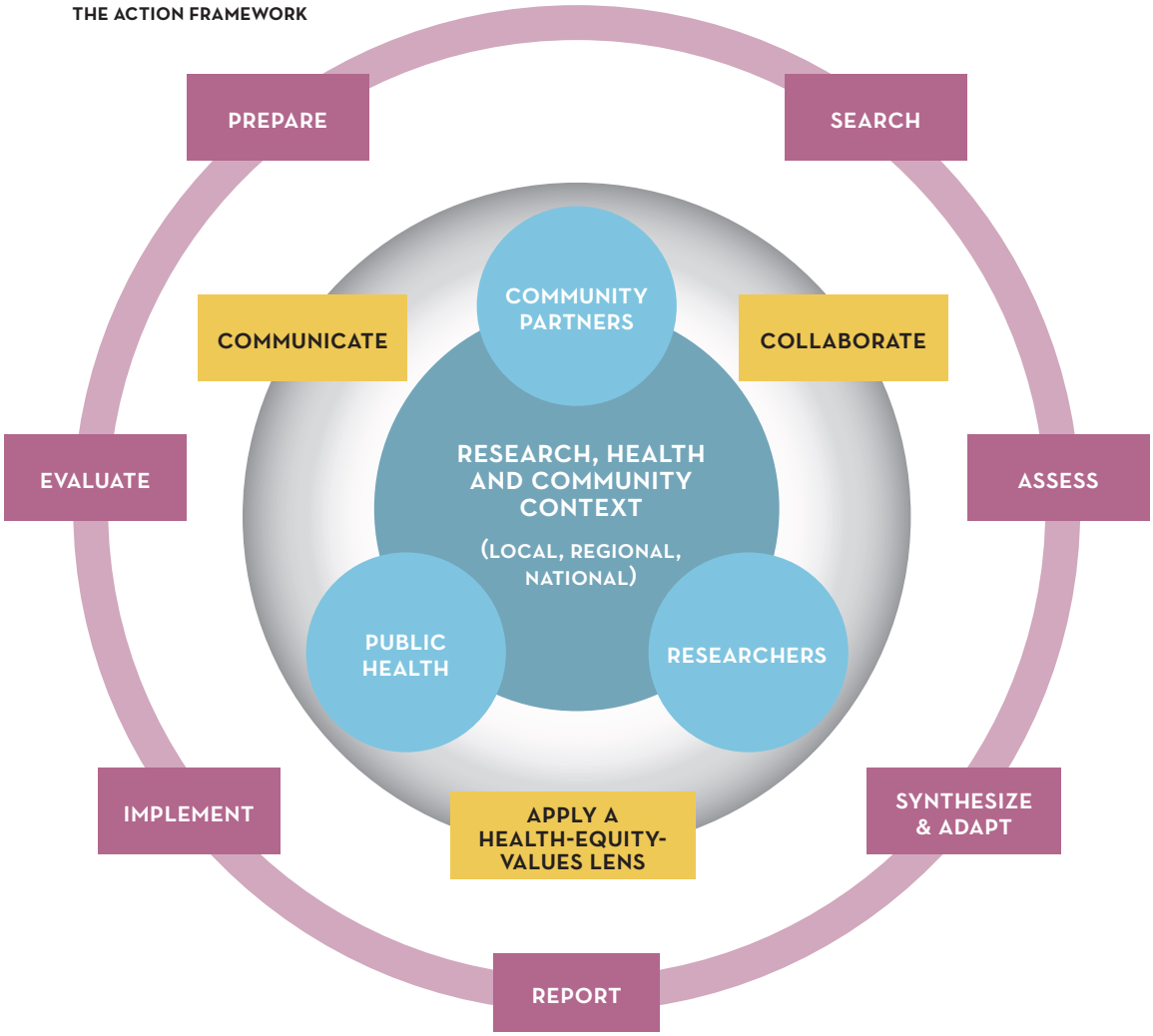
SECTION 3

# THE EQUITY-INTEGRATED PHSR ACTION FRAMEWORK

## INTRODUCING THE ACTION FRAMEWORK

This Equity-Integrated PHSR Action Framework identifies and describes the necessary elements in a PHSR process that integrates health equity in an effective manner. The elements are diverse and inter-related as part of a larger system. A change in any element affects the other elements in the system. For a one-page graphic of this Action Framework see Figure 1 below. Please refer to Appendices B-E for a graphic representation of all the Action Framework components described in this document.

**FIGURE 1:**
**THE ACTION FRAMEWORK**




| WHERE | WHO | HOW | WHAT |
|---|---|---|---|
| provides the context | describes the primary actors | describes the approach that needs to be included throughout the process | describes the steps of the PHSR process and the key questions to consider for integrating health equity |

This Action Framework is built on the core activities of a standard PHSR process described as the Stages of Population Health Status Reporting.[5] Each stage describes related activities as well as key considerations for integrating health equity at that particular stage. Although each element contributes to the overall system, Health Equity Values (see page 8) are the key drivers of the system, and are described as essential for the effective integration of health equity.

**Action Framework Components**

*Where – Local Community Context (local, regional, national)*[d]

The process of PHSR happens at many levels: local, regional and national. At each level there are different people, organizations, political cultures, and available data. But ultimately, the community context and local issues inform the reporting process, and are impacted by it as part of the larger system(s). Over time, the community is better equipped to take action to address health equity issues, and the outcome is improvement in health equity in the local community context.

Local leadership is essential at every step in the PHSR process in order to engage the appropriate stakeholders, identify the right indicators, contextualize the results and respond to the particular inequities identified in local communities.

*Who – Public Health, Community Partners, Researchers*[e]

The primary actors in a strong equity-integrated population health status reporting (EI-PHSR) process are the public health sector, community partners and researchers; a process led by any actor alone is less likely to result in action. The capacity for leadership and action of each is critical to being able to effectively integrate health equity into a PHSR process.

**PUBLIC HEALTH**

Public health actors and advocates are well-positioned to provide leadership to an effective PHSR process. The capacity of the public health sector for leadership and action is critical. This includes having the right mix of processes, resources (staff, funding), infrastructure and expertise.

Role: *Over time, public health professionals (and the health sector generally) provide the following*

- *Clear organizational goals for PHSR, including intended audiences and intended use*
- *Skills and resources to access and/or collect high quality data*
- *Skills and resources to analyze and present data and information*
- *Support and skills to communicate and engage the community and the health care system*

Outcomes: *Improved health sector/public health sector leadership and increased health sector/public health sector action*

d See Appendix B for graphic.

e See Appendix C for graphic.

**COMMUNITY PARTNERS**

The community (including government, community organizations and other grass-roots leaders) are essential for both providing evidence within a PHSR process, but also helping to understand the meaning and implications of this information for health equity in the community. Population health status reporting that results in action on health equity requires that community partners be engaged throughout the entire PHSR process in order to consider local and political preferences and appropriate actions.

Role: *Over time, community partners help build capacity for leadership and action*
Outcomes: *Improved community leadership and increased community action*

**RESEARCHERS**

Researchers work in a variety of settings and disciplines, including academia, public health, social and economic programs and services, and government survey departments (e.g., Statistics Canada, Canadian Institute for Health Information). Collectively, researchers play an important role in building understanding of the causes of health inequities and effective interventions.

Role: Over *time, researchers help integrate a health equity lens into research and data*
Outcomes: *More ef*fective integration of a health equity lens into research and data

## Applying the Action Framework

*How – Communicate, Collaborate, Apply a Health-Equity Values Lens*[f]

For each of the three components in the How section of this Action Framework, the information has been organized into two parts: 1) questions to ask; and 2) examples of potential actions and promising practices that could be taken in support of that component.

To inform this resource, we conducted a scan for Canadian population health status reports that offer diverse approaches to integrating equity into PHSR. We did not find a single case study example (report or process) that demonstrated success in addressing all the components of the EI-PHSR Action Framework. We did find many, however, that contained practices that looked promising in terms of effectively addressing certain elements of the Action Framework, and those are the promising practices described in this resource. They are not intended to be a comprehensive or exhaustive list. We are always looking for additional examples of promising practices – please send them to us using the contact information provided at the end of this resource.

f See Appendix D for graphic.

#### APPLY A HEALTH-EQUITY-VALUES LENS

We want to ensure that differences in health status are assessed for fairness and justice (see Health Equity Values in Section 2), recognizing that many differences are socially produced and unfair.

**Questions to Ask:**

1. *How do we ensure that we are thinking about the social, economic and political structures and systems that create these health inequities?*
2. *How do we consider the types of collective action that can more fairly distribute resources for health (including power and money)?*

**Examples of Potential Actions**

***Ground the process in a principled commitment to health equity values as the driver of PHSR. Start with clear definitions of health inequity and identification of all the social determinants that contribute to those health inequities.***

- Promising practice: BC's Health Officers Council (HOC) report *Health Inequities in BC*,[6] offers definitions of health inequalities and inequities, which sets the stage for a solid analysis of differences in health status and outcomes in BC's population. Unlike many other PHSR reports, this report is very clear that there is a moral imperative for understanding and mitigating health inequities.[6, p9]
- Promising practice: The European Union (EU) report *Health Inequalities in the EU*,[7] explicitly aims to describe "the magnitude of both health differences in the EU and the social determinants that give rise to potentially avoidable inequalities — health inequities".[7, p7]
  It is consequently an excellent example of using health equity values to frame PHSR.

***Apply a sex- and gender-based analysis to understand the sex, gender, and diversity dimensions of health and health inequities.***

- Promising practice: A report from the Prairie Women's Health Centre of Excellence (PWHCE)[8] adds greater depth to the definition and analysis of health inequity by looking beyond the traditional focus on socioeconomic status and geography to a consideration of sex, gender, and diversity. They argue that many unjust and avoidable differences in health between women and men stem from the social construction of sex and gender.

**COLLABORATE**

We want to include people from all sectors in order to strengthen the evidence and improve our understanding of what it means.

**Questions to Ask**

1. *How do we invite people to be part of our team when we don't know them?*
2. *How do we build trust?*
3. *How do we move to action?*

**Examples of Potential Actions**

***Create a community of practice as an alternative to a community defined in terms of geography.***

- Promising practice: PHSR reports produced by the Manitoba Centre for Health Policy (MCHP)[9] are grounded in consultations with researchers, policy makers and health planners from all five Regional Health Authorities (RHAs) as well as Manitoba Health. They have created a community of practice, dubbed The *Need to Know Team*,[10] that helps to guide the research undertaken by MCHP and attempts to bring it closer to policy. With a focus on new knowledge creation and development, individual and organizational capacity building, and research dissemination and application, the Team[g] has made important contributions to rural and regional health planning in the province, and has won national recognition as a best practice model for knowledge translation.
- The Team comes together for two-day, highly interactive meetings, held three times a year.[11] These meetings provide the forum for selection, development and interpretation of Team research projects; participation in capacity-building activities (for example, "101" sessions on research concepts and methods); planning for dissemination of the research; and opportunities for both structured and informal networking. Between meetings, Team members undertake "homework" activities such as consulting with RHA management on future research topics and developing research dissemination plans. The regions identify their representatives on the Team, which has resulted in an interesting and effective mix of participants including, but not limited to, nurses, public health managers and social workers. Essential elements in the Team's success include development of trust, the quality of relationships, adequate time commitment of partners, committed leadership, and genuine partnership.[12]

g The Team is made up of 30+ individuals, including approximately 20 health authority representatives (up to four from each of the five regions), as well as 10-15 MCHP and Manitoba Health representatives.

- Promising practice: The *Advancing Practice Committee*[13] in Quebec is a unique community of practice network facilitated by staff at the Eastern Township's Observatory for Community Development (L'Observatoire estrien du développement des communautés). The network meets monthly to discuss topics of interest about community development, including the reduction of social inequities. The committee provides researchers and health sector practitioners with an opportunity to share data, knowledge and resources. It is made up of 18 people from sectors such as health, environment, social economy, community development, and employment, and from academic and practice disciplines. Monthly presentations are rotated between practitioners and researchers (keeping this balance throughout the program). At the end of each session, presenters are tasked with summarizing the factors that may facilitate the implementation of the desired change, and the challenges and obstacles to making the desired change.[12]

***Involve communities in all stages of the PHSR process.***

- Promising practice: The First Nations Information Governance Centre (FNIGC) is a great example of communities being at the heart of the PHSR process, called the Regional Health Survey (RHS).[14] They have given communities control over the PHSR process, including decisions about participation, choice of indicators, ownership of data and the information reported. The purpose of an early independent review of the 2002/2003 RHS15 was to assess the quality of the research design and the consistency of the research process with the principles of First Nations' ownership, control, access and possession of research (commonly known as the "OCAP principles").[16] The review concluded that "Compared to … surveys of Indigenous people from around the world… RHS was unique in First Nations ownership of the research process, its explicit incorporation of First Nations values into the research design and in the intensive collaborative engagement of First Nations people… at each stage of the research process."[15, piv]
- Promising practice: The Capital District Health Authority in Nova Scotia[17] created the Understanding Communities Unit[18] to serve as the population health assessment and surveillance unit for the health authority. It acts as a resource to Capital Health staff and partners in developing the capacity to conduct population health research and evaluation, and to support advocacy, planning and action aimed at improved population health. What makes it a promising practice is its commitment to citizen engagement and involvement of community health boards in these activities.

**COMMUNICATE**

We want to make sure everyone who is helping to create the population health status report is up-to-date, and those who will use the report are also in the loop.

**Questions to Ask**

1. *How do we make sure everyone knows what stage the process is at?*
2. *How do we share our story so that others are inspired to join us?*

**Examples of Potential Actions**

***Develop and implement a communications plan as early as possible in the process. It should identify key messages aimed at specific target audiences and articulate the most appropriate and effective mechanisms for reaching those audiences.***

- Promising practice: The *Better Health for All* series created by Saskatoon Health Region is available through the *Public Health Observatory - Reports & Publications* section of its website.[19] For many of the reports listed, copies of the full versions are provided, as well as a "Call to Action" and, where available, a link to supporting infographics. These different documents were created for very different audiences. Similarly, in the *Health Equity Resources* section of the Sudbury & District Health Unit's website,[20] there exists a range of resources targeted at different audiences. Both organizations take their reports out to the community using consultation processes that also have communications plans. A key document in Sudbury's series is *Opportunity for All: The Path to Health Equity*.[21] It provides local data to help inform the community dialogue required to mobilize strengths and recognize and respond to inequities.
- Promising practice: Public Health Ontario shares data summaries, including many reports stratified by population characteristics, at the annual provincial public health conference. They also provide a series of ten infographics on their website,[22] using current data and innovative visuals to present an overview of the complex factors that influence and shape Ontario's population health status. Additional planned products include supplementary data tables at the provincial and public health unit level and online interactive data visualizations with explanatory text.

*What: The Seven Steps of the PHSR Process and Potential Actions*[h]

The National Collaborating Centre for Methods and Tools has identified seven steps of Evidence-Informed Public Health,[23] which formed the basis of the What section of this Action Framework. For each of the seven steps in this Action Framework, the information has been organized into two parts: 1) questions to ask; and 2) examples of potential actions and promising practices that could be taken in support of that step.

h See Appendix E for graphic.

**PREPARE**

**Questions to Ask**

1. *Who needs to be part of the process?*
2. *What are the key questions and issues/problems?*
3. *In what ways are equity values integrated into our investigation questions?*

**Examples of Potential Actions**

***Ensure all the key players that are needed have been invited to be part of this process. Set up a Steering Team and Working Groups as required.***

- Promising practice: Communities are at the heart of the FNIGC's RHS[14] process: they make decisions about whether or not to participate in the survey; they provide input about which issues should be explored through the survey; they control data collection, analysis, and reporting and; they take responsibility for action to improve community health and well-being.[16] This community engagement process of the RHS represents an unparalleled model of preparation.

***Initiate conversations with senior leadership across the organization regarding health equity values in order to strengthen the health equity values base for PHSR.[24]***

- Promising Practice: The NCCDH has developed a fact sheet *Let's Talk Health Equity*,[24] designed to be used by public health practitioners and decision making groups in the local context. It guides users on how to discuss health equity issues and makes the integration of health equity into public heath practice more explicit and intentional.

**SEARCH**

**Questions to Ask**

1. *What is the best way to find the relevant research evidence?*
2. *What indicators will help us answer the research question?*
3. *What other data are available?*
4. *Do we need to develop a plan to collect additional data?*

**Examples of Potential Actions**

***Ensure population health status reports disaggregate population level data by socio-demographic, geographic, and economic equity dimensions. These equity dimensions (i.e., factors that may explain health inequities) could include (but not necessarily be limited to) factors such as income, age, sex, sexual orientation, ethnicity, Aboriginal/Indigenous status, immigrant status, education, employment, homelessness, rural vs. urban residence and neighbourhood deprivation. There might also be unique factors (beyond those listed here) that impact health equity in different populations. For example, the ways in which various Aboriginal groups are provided access to health services can greatly impact health service utilization and therefore health outcomes. Unique factors like these should be considered in all data collection exercises.***

- Promising practice: BC's Provincial Health Service Authority led a provincial process to develop a prioritized list of 52 health equity indicators, to inform analyses and decision-making related to health equity in BC.[25] A set of cross-cutting demographic, geographic and socio-economic equity dimensions[i] for stratifying the indicator data was developed to support the analysis.[25, p11]

i These equity dimensions included the following: income, age, sex, sexual orientation, ethnicity, First Nations status, immigrant status, education, employment, homelessness, rural vs. urban residence and neighbourhood deprivation.

***Use a health indicators framework like the Canadian Institute for Health Information (CIHI) framework, or adapt it as required in collecting, analyzing and reporting data.***

- Promising practice: A recent Provincial Health Service Authority document provides an example of how an adapted CIHI framework was used to organize a prioritized suite of health equity indicators for use in BC.[25, p8] A BC Centre of Excellence for Women's Health document provides a similar example.[8, p60]
- Promising practice: A report by the Association of Local Public Health Agencies and Ontario Public Health Association[26] provides possible indicators that could be used at the local public health level in Ontario to document and measure broad health activity and action on health equity. It is hoped that these indicators will provide a basis for a health unit to measure progress towards maximizing the engagement to reduce health inequities.
- Promising practice: *The Trends in Health Inequalities in Canada* report was recently released by the Canadian Population Health Initiative at CIHI. The analysis examines national and provincial/territorial trend data over time to show whether gaps between the highest and lowest income groups are increasing, persisting or decreasing. Several measures summarizing income-related inequality have been analyzed, along with income-specific rates for a range of health indicators, and policies and interventions designed to reduce inequality are showcased.[27] There is a second pan-Canadian health inequalities indicators report expected in 2016 which is being developed collaboratively by the Public Health Agency of Canada, Statistics Canada, CIHI, and the Pan-Canadian Public Health Network.

***Identify indicators to help answer the research question.***

- Promising practice: During the data selection stage for the report *Rethinking Women and Healthy Living in Canada*, the editors "made decisions on which variables, among alternative measures of certain characteristics, were most appropriate to the analysis, given [their] understanding of issues affecting women".[8, p7]

***Make use of complementary and comparable or linked data sets to augment the health data available.***

- Promising practice: The Manitoba Centre for Health Policy oversees the *Population Health Research Data Repository*,[28] a comprehensive collection of de-identified administrative, registry, survey, and other data relating to Manitoba residents from 80+ databases. It was developed to describe and explain patterns of health care and profiles of health and illness, facilitating inter-sectoral research in areas such as health care, education and social services. It was built up gradually, based on a solid foundation of trust and reciprocity between researchers and a supportive provincial government.

***Consider whether non-traditional indicators need to be included in the process.***

- Promising practice: The *Community Health Indicators Toolkit*[29] developed by the Saskatchewan Population Health and Evaluation Research Unit was designed to assist with identification and collection of data that would help measure progress on improving community health. It is comprised of six key domains (economic viability, environment, identity & culture, food security, services & infrastructure and healthy lifestyles) and associated indicator categories. Using a participatory research design, communities provided input that informed the development of the framework, logic model and community-proposed indicators, many of which are non-traditional in nature. For example, in the Identity & Culture domain, two proposed indicators are: 1) level of volunteering at cultural events; and, 2) number and types of spiritual activities and participation levels. The framework suggests indicators to use but also can act as a guide to help users develop other indicators that reflect the uniqueness of their community.

**ASSESS**

**Questions to Ask**

1. *What are the data sources and the quality of the data?*
2. *What limitations are inherent in the sources and data?*
3. *Is there evidence available from other quantitative, qualitative or participatory research that can be used to complement the data?*
4. *How do research approaches, data collection and analysis integrate health equity values?*
5. *Do the various indicators adequately measure both assets and deficits?*
6. *How well are population demographics disaggregated by geography, economic and social characteristics?*

**Examples of Potential Actions**

***Identify proxy indicators that can be used to provide additional and necessary information in situations where the required data do not exist, access to existing data is a challenge and/or quality of data is less than ideal due to methodological limitations.***[8]

- Promising practice: The report *Rethinking Women and Healthy Living in Canada* analyzes the sex, gender, diversity and equity dimensions of healthy living among women in Canada.[27] Throughout the report, proxy indicators are sometimes selected to represent a phenomenon in the absence of a direct measure. For example, "age was interpreted not only as a biological condition that is often highly predictive of increased risks to health, but also as a proxy variable representing life stages, and the roles and status assumed by or ascribed to women of different ages."[8, p69] Another choice involves selecting the Canadian Community Health Survey's "standard index" of household food security, over the "modified index." Although the two are similar, they measure somewhat different aspects including how gradations of severity are gauged. The standard index was ultimately chosen because the "literature identified child hunger as a significant concern among women and [it] offers a better gauge of food insecurity of female-headed households with children, as well as sensitivity in detecting low-level food insecurity" (i.e., food insecurity without hunger).[30, p7-8] The authors made their decision of which data to use based on their overall objectives for the project.

***Identify other quantitative, qualitative or participatory research that can be used to complement the data.***

- Promising practice: The *Falls Injuries to Older Women* section of the report *Rethinking Women and Healthy Living in Canada*,[8] starts with several pages of quantitative survey data that describe the incidence, characteristics, circumstances, risks and outcomes of falls injuries to older women. The report then notes that although "little attention has been given to the influence of gender dynamics on falls injury risks and preventive strategies" there are a few studies to suggest that "gender dynamics can be seen to influence the negotiation of falls prevention strategies in the relationship between an informal caregiver and a parent with a history of falls."[31, p267] The report gives an example with the results of a study conducted through in-depth interviews with 35 seniors and their caregivers (23 female, 12 male adult children). The qualitative study found and described the ways in which the female and male caregivers differed in the way they approached their parents to prevent subsequent falls, important information that survey data could not provide.

***Consider how existing assets can be leveraged to promote community involvement and empowerment.***

- Promising practice: Unlike many population health status reports, the FNIGC's RHS[14] also deals explicitly with assets and deficits – factors that protect against ill health as well as those that contribute to poor health. For example, the RHS looks at perceptions of community strengths such as family values, elders, and traditional ceremonial activities,[14, p194] and community challenges such as alcohol and drug abuse, housing, and employment or number of jobs.[14, p191]

**SYNTHESIZE & ADAPT**

**Questions to Ask**

1. *How can we synthesize, adapt and integrate different types of evidence to paint a more complete picture of inequities?*
2. *What recommendations can we make for practice based on the available evidence?*
3. *How are health equity values integrated into our recommendations?*
4. *How do the recommendations relate to the local context?*

**Examples of Potential Actions**

***Include recommendations for action along with the analysis of the issues and opportunities in any population health status report that are prepared. In those recommendations, propose partnerships with other sectors.***

- Promising practice: The *Canadian Population Health Initiative* report[32] demonstrates the importance of collaborating with partners outside of the health sector (in this case, the environmental sector). Few studies incorporate indicators such as air quality or heat extremes into PHSR. Although the report does not explicitly address health equity, the alignment of environmental factors with socioeconomic factors and hospital utilization helps open the door for a discussion about health inequities.

***Propose that asset mapping (i.e. taking an inventory of community assets) be used to determine policy options and help to identify what types of assets to measure in order to address particular disparities.***

- Promising practice: Most indicator reports aimed at addressing inequities are focused on deficit or disparity indicators (e.g., income inequalities). Morgan and Ziglio[33] challenge health professionals to consider adding an asset-based approach to PHSR. A health asset is a factor or resource that enhances the ability of individuals, groups, communities, populations, social systems and institutions to maintain and sustain health (e.g., measures of community cohesiveness).

***Consider recommendations that will increase equity rather than potentially increase inequity (e.g., targeting low income neighbourhoods with high levels of vulnerability in school readiness).***

- Promising practice: The Human Early Learning Partnership at UBC developed a policy brief[34] calling for a system that incorporates the principle of proportionate universality for children in their early years. It argues that this would create and maintain a platform of universal services organized in a way that would eliminate the barriers to access that affect populations in the highest need.

***Develop policy recommendations based on the findings.***

- Promising practice: The HOC report from BC includes specific recommendations for action to address health inequities and provides examples of successful practices elsewhere in Canada and in some other parts of the world.[6, p67-73] The second BCCEWH report, *Worth a Second Look*, addresses the policy and practice implications of EI-PHSR. It provides concrete examples of the importance and benefits of applying sex- and gender-based analysis to policy analysis.[35, p11-22]
- Promising practice: The final section of the EU health inequalities report is devoted to an analysis of many EU and country-level policies that can or do have an impact on health and social inequalities[7, p133-146] and to recommendations for EU member states and regions.[7, p147-151] Here again, the authors have looked beyond differences in health to consider how policies and interventions can address health and social inequities.

REPORT

**Questions to Ask**

1. *Who is our audience and what is the best way to communicate what we have learned?*

**Examples of Potential Actions**

***Adapt reporting strategies to particular target audiences (e.g., scientists, policy analysts, community/ advocacy groups, public, peers, government, and senior leadership in the health sector).***

- Promising practice: The Chief Public Health Officer's reports[36] are good examples of the level and type of information that is more accessible to lay audiences than some of the technical reports in existence. Similarly, because the HOC[6] and BCCEWH reports[35, 37] are narrative rather than technical, they are more accessible to a broader range of audiences.
- Promising practice: The FNIGC utilizes "a culturally informed interpretation process that can be presented back to communities in a way that is usable and that reinforces their ways of seeing, relating, knowing and being."[14, p3]

***Explore the possibility of making data available online in order to reach a broader and larger audience.***

- Promising practice: The FNIGC has an online application[38] that provides unprecedented access to its published data in the form of charts, tables and graphs that can be exported for use in presentations, reports and academic papers. It is still in the process of being populated with the most up-to-date data.
- Promising practice: The Population Health Research Data Repository housed at the Manitoba Centre for Health Policy[28] is a comprehensive collection of administrative, registry, survey, and other data primarily relating to residents of Manitoba. It was developed to describe and explain patterns of health care and profiles of health and illness, facilitating inter-sectoral research in areas such as health care, education, and social services. A four-step process[39] must be followed to access to the databases housed in the Repository.

***Use infographics for visually communicating health equity information.***

- Promising practice: Public Health Ontario produced a visual distribution of vulnerabilities in school readiness by sex and by material deprivation.[40] This is an example of an infographic that attracts attention, and has the potential to improve immediate and long-term memorability and support learning by organizing information, engaging prior knowledge and improving comprehension.

***Include tables or text as appropriate; consider what will resonate most with the target audience.***

- Promising practice: In addition to traditional communication formats such as charts and graphs, the Capital District Health Authority[17] and the HOC[6] reports also make good use of maps to illustrate the distribution of inequities across the population, with the intention of making the information more accessible and relevant to local communities. Similarly, Public Health Ontario provides "Snapshots",[41] a collection of interactive map-based dashboards showing both geographic and temporal trends for key public health indicators by public health unit and for Ontario overall. It provides dynamically linked tables, graphs, and maps with pre-calculated statistics.

***Generate a series of reports rather than one single annual population health status report. Each report would focus on a different topic, issue, population and/or region.***

- Promising practice: Saskatchewan's *Health Status Report*[42] is intended to be a living document and chapters are updated on a regular basis.[j] The report consists of three distinct components: 1) an executive summary targeted at the general public; 2) content chapters (e.g., injuries, chronic disease and cancer) targeted at health planners and decision makers; and, 3) charts targeted at medical health officers, epidemiologists and other data analysts. Each chapter is written as a stand-alone report, with the intention of making the data more focused and usable.

**IMPLEMENT**

**Questions to Ask**

1. *How can we frame the findings so that they engage everyone?*
2. *What is the best way to explore potential actions, spanning from community mobilization to policy development?*
3. *How can we collaborate to implement these potential actions?*

**Examples of Potential Actions**

***Use Health Impact Assessment and Health Equity Impact Assessment tools to support this stage.***

- Promising practice: See The Ontario Ministry of Health and Long-Term Care's *Health Equity Impact Assessment Tool*.[43] This tool helps decision-makers identify unintended health equity impacts (positive and negative), and initiate equity-based improvements in program or service design.

***Start a community conversation around addressing population health and equity issues by inviting public health staff, MHOs, health region partners and key external health organizations in the community. The conversation should involve:***

- reviewing the data;
- generating ideas from stakeholders about what they are seeing and why;
- discussing questions specifically targeted to equity issues;
- exploring possible barriers to equity within the health care system; and,
- identifying what might be done to address those barriers.
  - Promising practice: In the FNIGC's RHS process[14] the communities involved control data collection, analysis, and reporting, and they take responsibility for action to improve community health and well-being. This community engagement process serves as an exceptional example of how to collaboratively review, analyze and act upon the data.
  - Promising practice: Saskatoon Health Region's Public Health Observatory continues to advance and refine its *Better Health for All initiative*[19] for engaging the community around population health and equity issues. Beginning in 2013, Public Health Observatory staff together with the MHOs pulled together meetings with internal health region partners and key external health organizations in the community. They presented the data and generated ideas from stakeholders about what they were seeing and why. During this process they included questions specifically targeted to equity issues, which helped everyone explore possible health system barriers to equity and identify what might be done to address those barriers.[44]

j This usually happens when a sufficient period of time has elapsed in order to allow the appropriate databases to be updated to make it efficient and effective to update the specific chapter.

**EVALUATE**

**Questions to Ask**

1. *How well did the PHSR process contribute to achieving our organizational goals for the report, where improved equity is included and integrated among those goals?*
2. *In what ways did increased community capacity to take action on the social determinants of health and health equity result from the process?*

**Examples of Potential Actions**

***Assess (via online surveys, focus groups or interviews conducted with key stakeholders) whether or not:***

- the PHSR process achieved the organizational goals for the report;
- the PHSR process increased community capacity to take action on the social determinants of health and health equity; and
- collecting and analyzing data on health equity indicators over time has supported stakeholders' efforts in improving, monitoring and measuring equity work.

Note: *Within the context of this initiative to-date, not a great deal of information has been found regarding evaluations of equity-integrated PHSR processes. Through the consultation process, some informants talked about the fact that they were evaluating their PHSR activities, but we were not able to identify a concrete example. As a next step in this initiative, it will be important to seek out more information about PHSR processes in place nationally, provincially, regionally and locally across Canada that are applying an equity lens and to collect any exiting evaluative process and outcome information. Doing so will serve to inform and improve those initiatives as well as endeavours in other jurisdictions.*

# INTEGRATED EXAMPLES





This resource is intended to provide an accessible action framework for people who are either directly engaged in creating community health status reports or are interested in learning about how they can use PHSR to drive action on improving health equity. We are confident that integrating equity into PHSR processes can help communities become better equipped to take action to address health equity issues, and we are starting to see examples of policy and practice changes where this has occurred.

We have used three examples below to illustrate how an integrated approach to health equity within a PHSR process can result in change. They are not definitive, but they do a nice job of capturing what an integrated approach might accomplish.

- Promising practice: *A Profile of Women's Health in Manitoba*[45] brings together current information about many facets of women's health, including a review of available data on health, health care use and several determinants of health, and presents a gender-based analysis of the inter-relation of the factors and complicated influences they have on women. The *Profile* describes and explains these factors, and points to policies and programs which can lead to improvements and change. The *Profile* together with the learning from a series of ten regional consultations across Manitoba informed the development of the renewed *Manitoba Women's Health Strategy* in 2011.[46] Additionally, workshops in Manitoba to build capacity for gender-based analysis, such as that provided in the *Profile*, have had a lasting impact. Gender based analysis influences the interpretation of disaggregated health data for regional community health assessments. Certain activities that address priorities identified in the *Manitoba Women's Health Strategy* can be traced back indirectly to the inequities identified in the *Profile*. For example, in 2011, enhanced breast screening resources such as vans and other transportation to fly-in communities helped address barriers related to culture, access and transportation noted in the Profile.

- Promising practice: Saskatoon Health Region's 2008 landmark report *Health Disparity in Saskatoon: Analysis to Intervention*,[47] focused community attention on the issue of health inequities. A wide array of community partners came together with the Saskatoon Regional Intersectoral Committee in the years that followed to establish the Saskatoon Poverty Reduction Partnership.[48] This partnership is currently inviting organizations and individuals in their community to fill in the gaps between current conditions and the community they want to build, and to help identify and prioritize next steps. A recent preview document is a key tool to help inform those conversations and decisions. This preview document also introduces the framework for developing a *Community Action Plan* to reduce poverty.

- Promising practice: Based on strong population health data (largely provided by MCHP), the Winnipeg Regional Health Authority has adopted a health equity approach in the delivery of all aspects of health services.[49] Regional health plan proposals are evaluated using health equity criteria, and population and public health strategic plans are guided by the principle of "targeted universalism."[2] Recently, the Winnipeg Regional Health Authority collated 1,000 health equity recommendations from the literature, and will use these to develop its health equity strategy.

# MOVING THE ACTION FRAMEWORK FORWARD





As you work your way through this resource, and as you read these examples of how an equity lens has been successfully applied to several PHSR processes, we hope you feel inspired and supported to apply it in your day-to-day work. This Action Framework can be used as a guide in the planning and development of a new PHSR process. We are not asking you to start from scratch in every case; indeed that is not practical or necessary. But by using an equity lens you will probably find many more opportunities to influence existing processes, and, of course, your own individual work. Listed below are some things you can do to engage with this Action Framework.

## APPLY THE ACTION FRAMEWORK TO YOUR OWN WORK

Identify small, manageable steps you can take within your own role. As you are reflecting on this Action Framework and how to apply it, think about the small changes you can make immediately, as well as the big changes you would like to try to influence in the long-term.

As mentioned previously, the action you take to strengthen a PHSR process will look very different depending on what role you play within an organization. In the Prepare step of this Action Framework, a potential action you could take would be to "initiate conversations with senior leadership across the organization regarding health equity values in order to strengthen the health equity values base for population health status reporting" (see page 15). The following are examples of how this action might be applied at different levels.

- **Senior leaders** could request time on a meeting agenda and lead a conversation with their colleagues.
- **Managers** could suggest to their senior leader(s) that they initiate a meeting with their colleagues and if a meeting is set, they could write speaking notes or prepare slides to support that conversation, making reference to the *Let's Talk Health Equity* fact sheet.
- **Front-line staff** could provide local examples for speaking notes or slides to demonstrate need or tell a success story (to get people's attention and make it relevant for them).
- **Epidemiologists** could support the conversation with data from a level that is as granular as possible – stratifying different indicators by equity dimensions.[k]

k These equity dimensions could include (but not necessarily be limited to) factors such as: income, age, sex, sexual orientation, ethnicity, Aboriginal/Indigenous status, immigrant status, education, employment, homelessness, rural vs. urban residence and neighbourhood deprivation.

## USE THE ACTION FRAMEWORK AS A CONVERSATION STARTER WITH OTHERS

- Bring it to a regular meeting with your supervisor, your team or your unit. Starting to talk about it could be an effective way to introduce the topic of how to integrate equity into PHSR processes and set you on the path towards applying an equity lens.
- Take it to your next strategic planning session. Include a discussion about how equity can be better integrated into the goals, objectives, activities and outcomes, drawing on content or examples from this Action Framework.
- Pull together people from teams/units who are doing PHSR in your organization in addition to those on your own team/unit (e.g., surveillance, program planning, evaluation). It is important to build equity into all stages of the health services planning cycle, not just when data are being collected.

The following questions may help you initiate and guide the discussion, and help you decide what to do next.

1. Do we all share a common understanding of equity/inequity and equality/inequality?
2. Do we all share a common understanding of equity-integrated PHSR?
3. Where do our daily activities fit within this Action Framework?
4. What opportunities for action do we have that fit within this Action Framework? Where are there opportunities to influence an existing PHSR process by applying components of this Action Framework to our work? Can we change-up or supplement our current approaches to PHSR so equity is better integrated? Should we be proposing a new PHSR process, and, if so, where are there opportunities to do so?
5. As we think about opportunities for action, who are the other partners we could/should be working with?

## CONTACT US

We are always keen to hear from you. Please contact us directly at the NCCDH (nccdh@stfx.ca) if you:

- Have questions about this Action Framework or how it might be applied;
- Would like to contribute additional sample actions and/or promising practices;
- Have ideas for revisions or additions to this Action Framework that would increase its utility; or,
- Have suggestions about additional resources that would be helpful to you as you strive to strengthen action towards addressing health inequity.

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APPENDIX A

# GLOSSARY OF TERMS[1]

**Health Status**

*Health*

- Health is the physical, spiritual, mental, emotional, environmental, social, cultural and economic wellness of the individual, family and community.

*Health inequality*

- Health inequality refers to measurable differences in health between individuals, groups or communities. It is sometimes used interchangeably with the term "health disparities".

*Health inequity/ health equity*

- Health inequity is a sub-set of health inequality and refers to differences in health associated with social disadvantages that are modifiable, and considered unfair.
- Health equity means all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions.

**Interventions**

*Targeting with universalism*

- Targeting with universalism is an approach to providing programs and services that makes them available to all (universal) and reaches out to vulnerable and marginalized populations so that they get supports and services that meet their needs (targeted).

*Upstream/ downstream*

- Upstream interventions and strategies focus on improving fundamental social and economic structures in order to decrease barriers and improve supports that allow people to achieve their full health potential.
- Downstream interventions and strategies focus on providing equitable access to care and services to mitigate the negative impacts of disadvantage on health.

*Asset-based approach/ strength-based approach*

- An asset-based approach promotes capacity and connectedness by making visible and valuing the skills, knowledge, connections and potential in an individual, group or community.

1 National Collaborating Centre for the Determinants of Health. (2015) Glossary of Essential Health Terms. Available from: http://nccdh.ca/resources/glossary/

**Root Causes**

*Risk factors/ risk conditions*

- Risk factors are individual characteristics and behaviours that increase the chance a person will get sick or injured, or die prematurely.
- Risk conditions are environmental and social factors that increase the chance an individual, group or community will have lower levels of health compared to the overall society.

*Advantage/ disadvantage*

- Advantage and disadvantage refer to the social, political, economic and power resources available to an individual, group or community in relation to another.
- Those with advantage over others can be described as "privileged", and those in positions of disadvantage are often identified as "underprivileged".

*Social inclusion/social exclusion*

- Social inclusion/social exclusion refer to the dynamic and multi-dimensional social process at all levels (individual, group and community) that is driven by unequal power relationships across economic, political, social and cultural dimensions. Unequal access to resources, capacities and rights leads to health inequities.

*Social determinants of health*

- The social determinants of health are the interrelated social, political and economic factors that create the conditions in which people live, learn, work and play.
- The intersection of the social determinants of health causes these conditions to shift and change over time and across the life span, impacting the health of individuals, groups and communities in different ways.

*Assets/ deficits*

- Assets are individual, group and community characteristics and resources that contribute to health and well-being, and support resilience.
- Deficits are risk factors and risk conditions that increase the chance that an individual, group or community will have lower levels of health and well-being compared to the overall society.

APPENDIX B

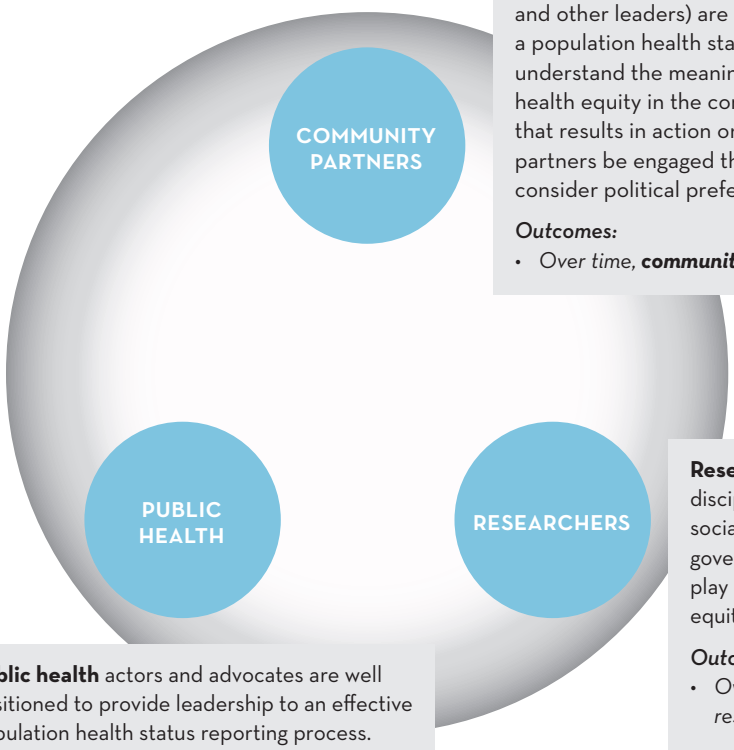
# EI-PHSR ACTION FRAMEWORK - WHERE

The process of population health status reporting happens at many levels ... local, regional and national. At each level there are different people, organizations, political cultures, and available data. But ultimately, the community context and local issues inform the reporting process, and are impacted by it, as part of the larger system. Over time, improvements in health equity occur in the local community context.

***Outcome:*** *The community is better equipped to take action to address health equity issues.*

APPENDIX C

# EI-PHSR ACTION FRAMEWORK - WHO




The **community** (including government, community organizations and other leaders) are essential for both providing evidence within a population health status reporting process, but also helping to understand the meaning and implications of this information for health equity in the community. Population health status reporting that results in action on health equity requires that community partners be engaged throughout the entire process in order to consider political preferences and appropriate actions.

*Outcomes:*

- *Over time, **community capacity** for leadership and action is built*

**Researchers** work in a variety of settings and disciplines, including academia, public health, social and economic programs and services, and government survey services. Collectively, researchers play an important role in better understanding health equity issues and effective interventions.

*Outcomes:*

- *Over time, the **integration of health equity** in research and data improves*

**Public health** actors and advocates are well positioned to provide leadership to an effective population health status reporting process. The capacity of the public health sector for leadership and action is critical. This includes having the right mix of processes, resources (staff, funding), infrastructure and expertise.

*Outcomes:*

- *Clear **organizational goals** for population health status reporting, including intended audiences and intended use*
- *Access to **high quality data** and/or **data collection** skills and resources*
- *Skills and resources to **analyze data and information***
- *Organizational support and skills to **communicate** and **engage** the community*

APPENDIX D

# EI-PHSR ACTION FRAMEWORK - HOW

**COMMUNICATE**

We want to make sure everyone who is helping to create the population health status report is up-to-date, and those who will use the report are also in the loop.

How do we make sure **everyone knows** what is going on? How do we **share our story** so that others are **inspired** to join in?

**COLLABORATE**

We want to include people from all sectors in order to strengthen the evidence and improve our understanding of what it means.

How do we **invite** people to be part of our team when we don't know them? How do we **build** trust? How do we **move to action?**

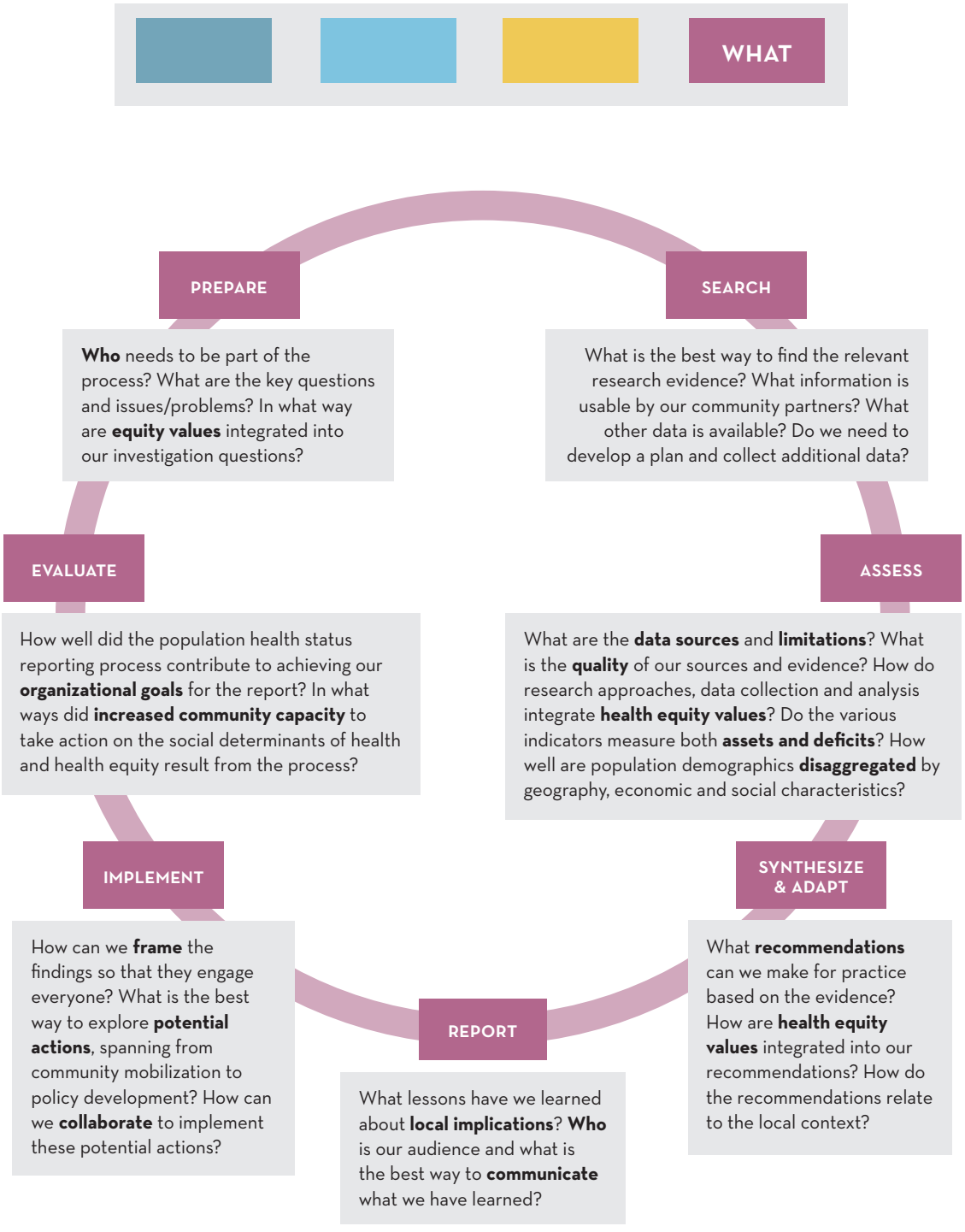
**APPLY A HEALTH-EQUITY-VALUES LENS**

We want to ensure that differences in health status are assessed for fairness and justice, recognizing that many differences are socially produced and unfair.

How do we ensure that we are thinking about the social, economic and political **structures and systems** that create these health inequities? How do we consider the types of **collective action** that can more fairly **distribute resources for health** (including power and money)?

APPENDIX E

# EI-PHSR ACTION FRAMEWORK - WHAT



**NOTES**

National Collaborating Centres for Public Health

Centres de collaboration nationale en santé publique

NCC for Aboriginal Health

NCC for Methods and Tools

NCC for Environmental Health

STRENGTHENING PUBLIC HEALTH ACROSS CANADA

NCCPH.CA

NCC for Infectious Diseases

NCC for Determinants of Health

NCC for Healthy Public Policy