RAPID REVIEW

National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

Health equity frameworks as a tool to support public health action: A rapid review of the literature

Prepared by the National Collaborating Centre for Determinants of Health
Prepared for the Population and Public Health Division, B.C. Ministry of Health

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National Collaborating Centre for Determinants of Health

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Review of the Literature on Health Equity Frameworks

Executive summary

Health equity frameworks are one tool that public health practitioners can use to continue reinforcing and amplifying public health's leadership role to action health equity work, whether as part of public health renewal or other organizational and system transformations. Readers can use the results of this review to deepen their understanding of how health equity frameworks can be used to start or continue disrupting systems of oppression and advancing equity in complex organizations and health systems, at multiple levels, including local, provincial or territorial levels.

Health equity frameworks provide practitioners and partners a way to not only build shared understanding of core equity concepts but also centre health equity work as critical in all organizational and system contexts. Together, this work helps to create shared momentum for health equity action. Frameworks can provide flexible, actionable guidance for practitioners and partners on ways to move forward together to achieve equitable processes and outcomes at point-of-care, organizational and system levels. Frameworks can also support accountability for health equity work as they can be used as a structure for assessing progress towards equity goals.

Given that much is known about the existence of health inequities across Canada, and the underlying drivers of these inequities (e.g., settler colonialism, White supremacy, racism), the National Collaborating Centre for Determinants of Health (NCCDH), in collaboration with the B.C. Ministry of Health, conducted a literature review focused on identifying health equity frameworks that can help to address these inequities. This review answers the question: Which health equity frameworks exist that can be used to inform public health planning, decision-making and service delivery?

Through a systematic search and screening process, the review team identified a total of 47 frameworks that can support health equity action in public health contexts. (Please see Appendix A for a complete list of all 47 included frameworks.) This report details the rigorous research process undertaken and reflects on assumptions and limitations that have influenced the results of the review. Descriptive thematic findings are presented by various framework elements, including framework goals, population of focus, structure, scope, foundational theories and concepts, development processes, and perspectives on implementation and evaluation.

Notably, most of the included frameworks come from the United States, followed by Canada; a high proportion of frameworks are from the grey literature; and many focus on advancing equity for Indigenous or Aboriginal populations in specified regions. Several frameworks identify the need to disrupt inequitable power relationships at clinical, organizational and system levels, which they present as foundational to health equity work. Additionally, disrupting racism is emphasized as central to all health equity work by several frameworks that aim to advance health equity in general. While it appears that most frameworks have not been implemented or evaluated, some implementation facilitators and evaluation approaches that public health practitioners can apply are described. These findings have implications for public health practitioners seeking to prioritize or embed equity at the core of programs and services.

The review concludes with a set of considerations for public health actors interested in creating or actioning health equity frameworks as part of an ongoing shared journey towards improved health outcomes for all. Readers are asked to consider how facilitators to *prioritize* health equity in large complex health systems – such as building workforce capacity and competency[1] – can be advanced through the creation and use of health equity frameworks.

Additionally, important considerations in developing and actioning health equity frameworks are outlined, including:

- reflecting on our own assumptions and biases,
- situating initiatives within broader commitments,
- working in true partnership through meaningful engagement and shared power with collaborators and codevelopers, and
- positioning Indigenous and Western knowledge systems as equal.

Background and context setting

Making the connection between public health renewal and health equity action

The B.C. Ministry of Health, in collaboration with the Office of the Provincial Health Officer, is renewing British Columbia's current Guiding Framework for Public Health. This framework "aims to improve the health and well-being of British Columbians" using several different mechanisms, including "supporting a population health approach and the public health role in health equity."[2(p4)] In accordance with an evidence-informed health equity approach, the B.C. Ministry of Health approached the NCCDH to conduct a review of the literature. This review, which identifies health equity frameworks that exist in the literature, can provide a foundation for public health renewal and further advance health equity action across British Columbia's public health system.

The COVID-19 pandemic has heightened public recognition of the urgent need to address broad and deeply rooted societal and health inequities driven by multiple intersecting systems of oppression (e.g., racism, settler colonialism, White[a] supremacy, sexism, ableism, classism, racialized capitalism). Repeated demonstrations of interpersonal, societal and institutional racism in community and health care settings, before and during the pandemic, have prompted public outcry, stimulated social justice movements, and captured national and international attention.

Dr. Theresa Tam reinforced this critical need to address health inequities in her 2020 report *From risk to resilience: An equity approach to COVID-19*, noting:

> *Ensuring that a health equity agenda is an integral component of pandemic planning and response efforts means that the actions we take to improve economic security and employment conditions, housing and healthy built environment, health, social service and education systems, and environmental sustainability can better protect people in Canada from health crises and create resilience and lasting equitable opportunities.*[3(p58)]

As literature describing the existence and root causes of health inequities in all provinces and territories in now-called Canada exists elsewhere,[b] this review is focused on describing health equity frameworks that are *actionable* in public health planning, decision-making and service delivery contexts. The results of this review can be used to continue reinforcing and amplifying public health's leadership role in advancing health equity, whether as a part of British Columbia's public health renewal process or other system transformation efforts in different jurisdictions across this land now known as Canada.

a The term *White* is capitalized throughout this report as this explicitly identifies people who are White, or whose ancestors are from Europe, as racialized. To do so helps to disrupt the White supremacist narrative that holds that Whiteness is a neutral standard or norm, and actively engages White people – as having a racial identify – in conversations about race. For further context, please see the following article: "Recognizing race in language: Why we capitalize 'Black' and 'White.'"

b For data on existing inequities, see, for example, the following reports: *Key health inequalities in Canada: A national portrait* (2018); *Social inequities in COVID-19 mortality by area- and individual-level characteristics in Canada* (2022); *First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada* (2015).

Prioritizing health equity in complex health systems

Despite heightened attention to advancing equity across health systems, questions about ways to action health equity remain. A recent study from British Columbia identified that prioritization of health equity is the first step in redirecting entire large, complex health systems towards health equity.[1]

However, the authors also reflected on challenges in health equity prioritization, commenting:

Effective prioritization of health equity within health systems must take into account competing and dominant values of efficiency, colonialism, individualism and biomedicine, and the lack of understanding of health equity concepts that act as barriers. Creating a core value for health equity throughout the health system is fundamental to counter this, but not sufficient to ensure prioritization." [1(pp11-12)]

These reflections highlight a key consideration for readers of this report: **valuing health equity is not enough to generate action.**

This sentiment is not unique to British Columbia; other jurisdictions have recognized the need for formalized, comprehensive commitments to advance equity beyond organizational value statements. Nova Scotia has passed first-of-its-kind legislation that commits to "developing a provincial strategy and health equity framework by July 2023" as part of its Dismantling Racism and Hate Act.[4]

Beyond Canada, jurisdictions such as Queensland, Australia are also exploring how to build enabling and authorizing environments to advance health equity. As we learned in a conversation with agency staff in the Queensland Government (August 2022), a policy process to advance health equity is being progressed, by, for example, building strategic alliances across government to support actioning a health equity framework and using a whole-of-government approach.

These examples illustrate that advancing equity is about more than raising awareness of inequities or structures of oppression – it requires changing people's mindsets, expanding spheres of influence both vertically and horizontally across and beyond large health systems, and using policy levers like legislation to advance health equity.

Health equity frameworks can be used as one tool to engage partners in discussions to both centre and formalize commitments to action health equity in organizational and systems contexts. Health equity frameworks can also be beneficial for:

- building shared understanding of core equity concepts,
- creating shared momentum for health equity action,
- providing flexible guidance on ways to move forward together to advance health equity, and
- providing a structure for measuring progress towards health equity goals and outcomes.

However, the breadth and depth of work required to advance health equity also illuminates the limitations of health equity frameworks: they are but a tool. Authors of one of the frameworks included in this review acknowledged:

A health equity tool on its own cannot be the cornerstone of an organizational strategy for action against [social inequalities in health]; rather, its integration should be viewed from a systemic, critical and reflexive perspective. To achieve the tool's full potential, it is necessary to work on assimilating equity into organizations and policies, by concurrently investing in strengthening organizational capacity and developing professional competencies.[5(pe82)]

Assumptions and limitations of this review

The review team recognizes that, as humans, we show up to this work with beliefs, assumptions and biases that impact how we do this work. For example, although we have employed a systematic process to produce a robust report with "neutral" descriptions of the literature, we are using a Western scientific approach to knowledge synthesis. As a result, our review is inherently limited by the world view within which it is grounded. The processes of identifying, collecting, analyzing, synthesizing and disseminating knowledge are not neutral. We have also made choices that introduce limitations in our findings (as one example, our search strategy impacts whose voices we hear).

In preparing this report, we did not engage First Nations, Inuit or Métis advisors for their perspectives on how we might centre Indigenous perspectives in this review. We acknowledge, with humility, that this is a limitation in our process. We recognize we have allowed colonial systems (e.g., Western knowledge systems, project management processes, timelines) to dictate our approach, thus perpetuating and reinforcing the very systems we aim to disrupt. While the team sought to decentre Western knowledge systems through the search strategy we used and how we applied the inclusion and exclusion criteria (See Appendix B), one of the questions that we continued to reflect on as we prepared this report is: Based on our methods, whose voices and which forms of knowledge are recognized as worthy?

In a conversation with Dr. Stephanie Nixon (Vice-Dean, Health Sciences and Director, School of Rehabilitation Therapy, Queen's University) in November 2022, Dr. Nixon challenged the assumed benevolence of health equity frameworks – that is, the perspective that these frameworks are only beneficial. She invited us to:

- use a critical theoretical lens to understand there are both positive and negative effects of social phenomena, including health equity frameworks; and
- intentionally seek to understand both types of effects in order to amplify the positive and mitigate the negative.

The point of such a critical theoretical approach is not to suggest that health equity frameworks are all bad. Rather, it is to reject the assumption that they are only good. This approach invites us to consider how what we take as given, normal or right in public health has been profoundly shaped by historic systems of inequality. Given Canada's founding as a settler colony and the Western Eurocentric orientation of medicine and public health, this means

critically reflecting on the ways that health equity frameworks have been created within larger contexts with norms designed to reproduce and extend these systems of inequality. A key tactic of these systems is for those in public health, health care and other connected sectors to remain oblivious to our roles in unwittingly reproducing the very inequities we are working to address.

As public health practitioners, it is necessary to reflect on how these systems might influence our work when identifying ways to address inequities and advance equity, using health equity frameworks or other approaches.

We invite readers reviewing this report and engaging in equity work to reflect on two different yet complementary questions:

- **How might health equity frameworks serve to maintain and extend the White settler colonial project and other systems of oppression that exist?**
- **How can we ensure that the health equity framework we create and/or use works to break down colonialism, White supremacy and other systems of oppression?**

While we raise these critical questions for creators and users of health equity frameworks, the scope of this review is focused on describing which health equity frameworks exist in the published and grey literature. Future work could entail a deeper critical analysis of these included frameworks. Additionally, this review does not provide the reader with recommendations on which frameworks to use or how to use them as this is highly dependent on the user's local context.

What is needed to move health equity efforts forward to realize a different future, instead of perpetuating present systems of oppression? As one starting point, in her 2019 article on critical allyship, Dr. Nixon urged us to consider how our fields have been shaped by intersecting systems of inequality that produce unfair and unearned advantages (privileges) for some and disadvantages (inequities) for others. Looking at these as two sides of a coin, where the coin represents a system of inequality, and our orientation to addressing inequities, Dr. Nixon wrote:

The goal is not to move people from the bottom of the coin to the top, because both positions are unfair. Rather, the goal is to dismantle the systems (i.e., coins) causing these inequities. Drawing attention to the top of the coin is important because inequity is relational: the bottom of the coin is disadvantaged compared to the top. Yet, issues of health equity are often framed exclusively as problems facing people on the bottom of the coin.... If the problem was viewed not only as the bottom of the coin, but also the coin itself (i.e., the unjust social structure that gives unearned disadvantage to people on the bottom), then a different set of solutions could follow, such as changes to policy and law to create safeguards against discrimination produced by the system of inequality.[6(p3)]

The aim of frameworks to advance health equity does not guarantee that their use will result in meaningful structural change instead of non-consequential or performative action. However, when employed by public health practitioners and other partners committed to and engaged in critical thinking, deep reflexivity, continuous learning and unlearning, and strategic action, frameworks offer a useful tool in the larger work of dismantling systems of oppression and advancing health equity.

Methodology

Review question

This report provides a descriptive summary of health equity frameworks for development, use or adaptation in public health contexts. The question used to guide all stages of the review was: Which health equity frameworks exist that can be used to inform public health planning, decision-making and service delivery?

The question was organized using the PCC (population–concept–context) framework to identify the main concepts in the research question and to guide the search strategy used by the librarian. The question is detailed in Table 1.

TABLE 1: Research question

P (population)	People who experience inequities
C (concept)	Health equity frameworks, models, guidelines for measuring health and well-being indicators, in the context of the B.C. Ministry of Health and its public health partners
C (context)	British Columbia provincial/regional focus

Search method

The literature search was designed and conducted by an information specialist following PRISMA-S guidance.[7] The review team consulted colleagues at the NCCDH, staff at the National Collaborating Centre for Methods and Tools and external research associates to explore strategies for making space for different voices while also containing the scope of the review. See the section Background and context setting – Assumptions and limitations (p.6) for more background on this approach. The team intentionally decided to include three languages and a broad range of jurisdictions, including all 38 Organisation for Economic Co-operation and Development (OECD) countries, to help decentre Western knowledge systems and expand the types of frameworks identified for this review. Further, the team incorporated "reconciliation" concepts into the search strategy. The team did not engage Indigenous advisors; however, we did reflect on lessons learned from engagements conducted for a previous review with a similar research question.

PUBLISHED LITERATURE

The electronic database search for published literature was conducted on June 26, 2022. Published literature was identified by searching the National Library of Medicine's PubMed database. The search strategy consisted of both controlled vocabulary, such as the National Library of Medicine's MeSH (Medical Subject Headings), and keywords. The main search concepts were health equity and frameworks, and the following jurisdictions of interest were included: Circumpolar Region, Canada, Australia, Austria, Belgium, Chile, Colombia, Costa Rica, Czech Republic, Denmark , Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom and United States (with a specific focus on Alaska and Washington). No filters were applied to limit the retrieval by study type; however, retrieval was limited to English-, French- and Spanish-language items published from 2015 to the current date. The search returned 3,860 citations.

GREY LITERATURE

The grey literature was searched July 9–12, 2022 and July 23–27, 2022. For the grey literature search strategy, a broad internet search (using Google), a more focused search of published literature (using Google Scholar), and a targeted search of organizations and think tanks identified as relevant by the review team were performed. Given the published literature search strategy used broad search parameters and the project timelines were limited, the review team decided to limit the search parameters for the grey literature to include only the following jurisdictions of interest: Circumpolar Region, Canada, Australia, Denmark, Finland, New Zealand, Norway, Sweden, United Kingdom and United States (especially Alaska and Washington); and limited to the English language, from 2015 to the present. The grey literature search required a total of 16 hours of searching and returned 160 citations.

Selection process

The NCCDH review team (four NCCDH staff and two research consultants) completed an initial round of screening (at the title and abstract level) and a second round of screening (at the full-text article level) of all published and grey literature citations against the inclusion/exclusion criteria detailed in Appendix B. The review team conducted interrater reliability tests for both published and grey literature screening to ensure a consistent approach in the application of the inclusion/exclusion criteria.

Appendix C presents the PRISMA chart that details the steps the review team took, with the support of an information specialist, to identify the included results.

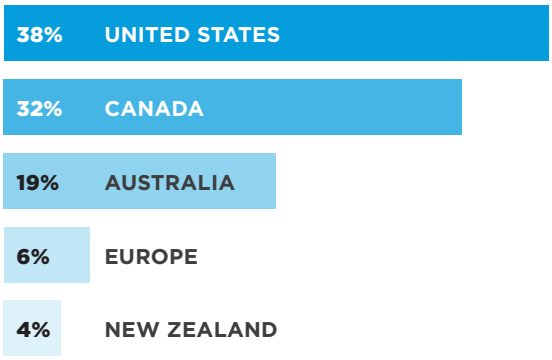
Synthesis of findings

A total of 47 frameworks were selected for inclusion in this review. (Please see Appendix A for a list of all the included frameworks.) Of these, 25 records were found through the grey literature search and the remaining 22 were found through the published literature search. It is worth noting that grey literature is a rich source of health equity literature. Less than 1% of the published literature records reviewed were selected for inclusion, whereas 16% of the grey literature records reviewed were included. For example, for the frameworks included from Australia, the majority (7/9, 78%) were identified in the grey literature. This may have implications for future research identifying equity-focused frameworks, documents or plans.

Jurisdiction and language

For both the grey and the published literature, the majority of frameworks are from the United States (combined total of 18/47, 38%) and Canada (15/47, 32%). The remaining frameworks come from Australia, Europe and New Zealand (see Figure 1).

FIGURE 1: Distribution of frameworks by jurisdiction



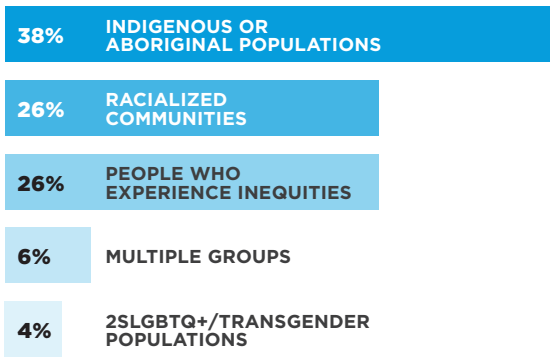
With respect to language of publication, 100% of included records were published in English. While the review team included French and Spanish language filters in the search strategy, no French or Spanish frameworks were selected for inclusion using the identified inclusion/exclusion criteria.

Population of focus

Most commonly, frameworks focus on Indigenous or Aboriginal populations in a specified geographical location (18/47, 38%), including First Nations (living at home and away from home), Inuit, Métis, Māori, and Aboriginal and Torres Strait Islander Peoples.

Figure 2 provides a further breakdown of population groups represented in the frameworks. Many frameworks focus on people of colour or racialized communities (12/47, 26%) or "people experiencing inequities" broadly (12/47, 26%). Three frameworks have a broad population focus but specify multiple different equity-denied groups (e.g., people who are incarcerated, people living with mental illness).

FIGURE 2: Distribution of frameworks by population



Two frameworks reflect gender identity and/or sexual orientation: one focuses on people who identify as Two-Spirit, lesbian, gay, bisexual, transgender, queer, non-binary and intersex (2SLGBTQ+) and the other on people who identify as transgender.

The high proportion of frameworks specific to various Indigenous populations is consistent with recent attention to reconciliation and addressing inequities resulting from settler colonialism, as discussed earlier under context setting (see section on Background and context setting – Making the connection between public health renewal and health equity action, p.4). The common focus on people of colour or racialized communities is also noteworthy and will be discussed further in relation to policy approaches for disrupting racism (see the section Framework foundation – Policy approaches centred on disrupting racism, p.16).

Framework foundation

The frameworks are grounded in an extremely wide array of foundational elements, including:

- theories, models and concepts;
- knowledge systems; and
- legislation, rights-based and policy approaches (including disrupting racism).

In some cases, these foundations are explicit, while in other instances, they are either implicit or remain unclear. These broad underpinnings indicate that health equity work can emerge from and be supported by many different foundational elements. Understanding the foundations of a framework can assist users in determining whether the framework is compatible with their context, values and intended purpose.

THEORIES, MODELS AND CONCEPTS

A wide range of theories, concepts and models[c] are identified in the frameworks, reinforcing the point made above that health equity action can be broadly grounded. The following list is a sample of some of the many different theories, models and concepts that the framework authors referenced:

- Quality improvement
- Knowledge translation and exchange
- Collective impact, systems theory
- Complexity theory
- Coalition action theory
- Intersectionality
- Theories of change
- Cultural safety
- Cultural humility
- Critical race theory
- Ethical space
- Two-eyed seeing
- Power
- Socioecological model
- Public health framework for reducing health inequities
- Potential health effects of climate variability and change
- Community change model
- Unity model built on Papequash and Musqua life circle teachings

As an example, one framework brings the theoretical concepts of critical race theory and intersectionality

c The review team did not attempt to classify or organize the different theories, models and concepts as this was beyond the scope of this review.

together, with dimensions of time across past, present and future, into an action framework to eliminate health inequities experienced by African Americans.[8] The authors noted that their use of dimensionality as a concept "is an approach to understanding the origins of health inequities among African American populations"[8(p148)] and provides a starting point to be able to address and reverse unjust, avoidable inequities. The Human Impact Partners' Strategic Practices framework notes that the strategic practices are positioned as part of a larger theory of change.[9]

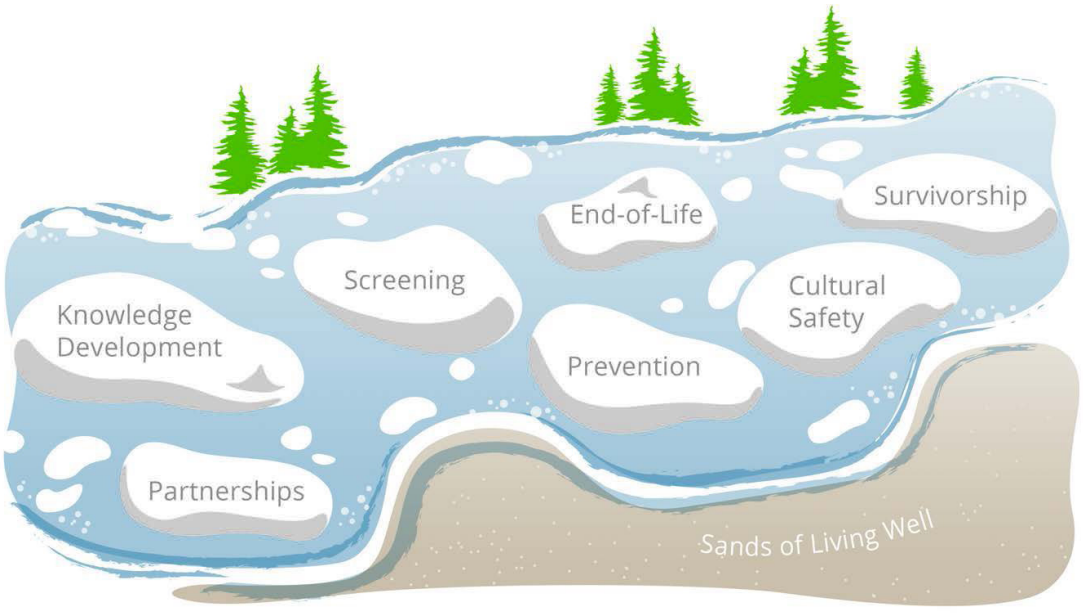
Another framework identifies the importance of shared decision-making and, as part of that, shifting power to communities who have been made to experience inequities.[10] Horrill et al.[11] also linked the responsibility of nurses to provide culturally safe and trauma- and violence-informed care for and with Indigenous Peoples with the concept of power and the role that power plays. They further noted that nurses need to address inequitable power relationships, present in all health care interactions, and build trusting, collaborative relationships. In addition, cultural safety requires nurses to examine structural power imbalances embedded in larger political, economic and social systems. Connected to the concept of power, these authors acknowledged their own privilege and positionality as White settlers who, while they have worked extensively with Indigenous Peoples in nursing and academic contexts, are not Indigenous themselves. They also identified that a critical next step for them is to engage with Indigenous Peoples about the framework.[11]

KNOWLEDGE SYSTEMS

Many of the frameworks appear to be grounded primarily in either Indigenous or Western knowledge systems, whereas others appear to span across both broadly defined systems. In some instances, the authors explicitly identified the knowledge system that the framework is situated within.

For example, the First Nations Health Authority's framework Improving Indigenous Cancer Journeys in BC: A Road Map is grounded in First Nations and Métis perspectives on health and wellness.[12] This is evident in multiple areas, including the framework visual (see Figure 3); the background section that

FIGURE 3: Framework visual for Improving Indigenous Cancer Journeys in BC: A Road Map[11(p4)]



emphasizes the importance of cultural safety and defines cultural safety, cultural humility, shared decision-making and Indigenous forms of wellness; and engagement processes used in framework development (e.g., listening to Elders, sharing stories, gathering wisdom).

In comparison, another framework was created using a Delphi method that engaged experts in a multistep iterative consensus approach to identify and refine a series of recommendations to improve the health of "ethnic minorities" in Denmark, suggesting it was developed using a Western scientific approach.[13]

Other frameworks clearly draw on and use both Indigenous and Western knowledge systems. One framework was codeveloped in a multilingual setting, using both Yolŋu (Indigenous people located in what is now known as Northern Australia) and Western knowledge to create the core knowledge domains and supporting cultural practices.[14] Another framework, focused on Indigenous primary health care and policy research, states that it applies concepts from both Indigenous and Western knowledge systems.[15]

A framework aimed at improving care for First Nations communities in Quebec identifies its mission as "to accompany Quebec First Nations in achieving their health, wellness, culture and self-determination goals,"[16(p6)] and it references self-determination and a strengths-based approach as foundational. Although this framework is specific to First Nations communities, besides identifying self-determination, any other grounding in Indigenous concepts appears to be absent.

Two frameworks reference specific approaches to navigate the complexities involved in spanning both Indigenous and Western knowledge systems: "two-eyed seeing" and "ethical space." Two-eyed seeing "stresses the importance of viewing the world through both Western (what is considered to be mainstream) and Indigenous worldviews and ways of knowing."[17(p3)] Ethical space, a conceptual framework for generating meaningful and reciprocal relationships between different cultural groups, acknowledges that both Western and Indigenous ways of being and operating are systems that include values and rules. People can create ethical space by navigating these cultural differences with humility, honesty and commitment, and trusting one another's expertise.[18]

LEGISLATION, RIGHTS-BASED AND POLICY DIRECTIVES

Several frameworks take a rights-based or policy approach to their work, referencing, for example:

- United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP),
- Truth and Reconciliation (TRC) Calls to Action,
- treaty rights, and
- legislation or government policy directions.

Embedding frameworks in larger rights-based or legislative and policy contexts may offer added impetus for the implementation of frameworks and support the creation of enabling and authorizing environments. Pertinent examples are shared below.

UNDRIP, TRC Calls to Action and treaty rights:
The Indigenous Health Commitments framework from Alberta Health Services explicitly aligns goals and actions with articles in UNDRIP and TRC Calls to Action, which, given the international and national significance of these documents, may provide additional impetus for framework actions.[18]

Other frameworks, while not tying specific goals or actions to UNDRIP, leverage it as an essential starting point. One such framework, focused on advancing access to care and improving population health outcomes for Aboriginal and Torres Strait Islander peoples, references UNDRIP and grounds the work in national priority documents for Australia (i.e., National Agreement on Closing the Gap).[19]

The Guide to He Korowai Oranga Māori Health Strategy framework connects the principles of partnership, participation and protection back to the relationship delineated by the Treaty of Waitangi between the Māori and New Zealand Government. One of the strategy's key threads includes enabling "Māori to exercise control over their own health and wellbeing, as well as the direction and shape of their own institutions, communities and development as a people."[20(p8)]

Placing people at the centre of their care regarding their experiences, choices, dignity and rights is echoed by the National Aboriginal Community Controlled Health Organisation's framework,[21] also part of the same larger policy context in Australia to "close the gap" in health outcomes between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.

Legislation

An example of how legislation has been used to advance health equity is referenced in Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework.[22] The Queensland Government has legislated the prioritization of

We invite readers to reflect on the language of "closing the gap" between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians. Language that conveys that those who are disadvantaged need to become like those who are advantaged, presenting non-Indigenous Australians as the norm to which all others should aspire, is problematic. Drawing on the coin model of privilege and critical allyship[6] (see section on Background and context setting – Assumptions and limitations, p.6), this language suggests that the goal of health equity work is to move people from the bottom of the coin to the top instead of dismantling the underlying systems of oppression metaphorically represented by the coin.

Aboriginal and Torres Strait Islander peoples' health equity in all health services, and requires providers to engage them in the design, delivery and evaluation of health services. The purpose of this engagement is "to create the strongest foundation we could to drive health equity, achieve life expectancy parity by 2031 and eliminate institutional racism through a combination of laws, policies and practices."[22(pii)]

As part of this work, the authors noted the centrality of Aboriginal and Torres Strait Islander peoples' advice: "Listen to us. Work with us. Journey with us. Partner with us to create the future we want for our children. Learn from the past. Trust us to lead."[22(pii)]

A framework by the Northwestern Melbourne Public Health Network[23] takes a human rights-based approach to its health equity work. Ontario Health's framework[24] is linked to provincial legislation including the Connecting Care Act (which articulates the importance of equity and working towards equitable health outcomes as core to a public health care system) and legislated requirements in the French Language Services Act.

Policy approaches centred on disrupting racism:
A foundational policy focus for many of the included frameworks is on disrupting racism. For 30 of the 47 included frameworks (64%), the focus on racism is not surprising given they are designed to advance equity for either Indigenous Peoples (18/47, 38%) or people of colour and racialized communities (12/47, 26%). What is striking, however, is that a small number of other frameworks – even without this specific population focus – centre the disruption of racism as fundamental to their work. For example, the approach taken for the Strategic Practices framework[9] was described as:

We lead explicitly – though not exclusively – with race because racial inequities persist in every system [Health, Education, Criminal Justice, etc.] across the country, without exception.... Racism operates at individual, institutional, and structural levels and is therefore present in every system we examine.[25]

Another framework, which provides conceptual guidance for health policy-makers to broadly address the social determinants of health and achieve planetary health and health equity, highlights the following:

Our claim that equity cannot be achieved unless and until structural and systemic racism are eliminated means that elimination of racism is perhaps the most crucial aspect of the entire conceptual framework and, therefore, is reflected in all examples of health policies given in this consensus paper.[26(p12)]

Overall, the wide-ranging foundational approaches found among the 47 included frameworks underscore the complexity, depth and breadth of work that is required at multiple levels to address health inequities.

Visual depiction

Almost 90% of the selected frameworks (41/47) include a graphic that summarizes or presents the framework. The visuals vary greatly and include charts or tables; cyclical, stepwise or hierarchical pathways; and abstract artworks or natural landscapes with metaphors linking the environment to equity work. The presentation of the framework may reflect or draw from the knowledge system the framework is grounded in (see section on Framework foundation – Knowledge systems, p.12).

On a related note, three frameworks from the grey literature highlight artwork from Indigenous and Aboriginal artists.[18,21,27] These frameworks feature art by Indigenous artists, refer to additional Indigenous paintings or depict the framework with beadwork, explaining the symbolism (see Figure 4). The authors' decisions to intentionally profile these artists and artworks contrast with other frameworks that present concepts in more technical ways.

FIGURE 4: Beadwork representing the Indigenous Health Commitments: Roadmap to Wellness framework[17(p6)]

The authors of this framework describe it as follows:

In our model, beadwork symbolizes how we seek to work (by listening, understanding, acting and being) and the directions of our work (people, processes, wise practices and quality outcomes). Each small bead is sewn into the hide and a vital part of a much larger picture. All the beads are connected to each other and rely on one another for strength. Each bead represents a person that plays a role in building healthy communities. We need many beads coming together to realize the commitments made in this roadmap.

The hide itself represents the significant connection back to the land.

The one white bead in our model is a spirit bead, an intentional flaw to remind us to be humble, as only Creator is perfect. It also reminds us to continuously learn and that our work is life-long.

Beadwork traditions are passed down through generations of Indigenous families and communities. Similarly, we hope the messages in the *Indigenous Health Commitments: Roadmap to Wellness* are transmitted across AHS and transform and sustain our way of working over time.

Framework goal

Each of the frameworks includes a goal related to advancing health equity. For some frameworks, the goal is succinct and straightforward, stating that the framework aims to promote health equity or address root causes of health inequities. Other framework goals are more detailed; for example, they include a mechanism for how to advance equity. Still other goals are more complex as they tie in additional concepts such as racism or climate change.
In some cases, the framework goal provides insight into who the framework's target audience is. Framework goals may reference local health/public health departments, national governments, ministries of health, local organizations from health and social services sectors, or individual service providers such as health or public health practitioners.

Table 2 highlights common categories of framework goals with corresponding examples.

TABLE 2: Common types of framework goals with examples

TYPE OF FRAMEWORK GOAL	EXAMPLES OF GOALS
Straightforward and lacks detail (e.g., general statement about promoting health equity or addressing inequities)	» Understand inequities and advance actions that promote health equity.[28]
Includes more detail by referencing collaboration or partnership to advance equity	» Build community support across intersectoral partners and work with communities to facilitate a coordinated approach.[29] » Incorporate elements of the social, political, corporate and commercial determinants, and centre the role of health equity actors and corporate actors engaged in policy-making work to advance equity in rural and remote areas.[30]
Includes more detail by acknowledging partnerships with community	» Enhance the ability of state health departments and collaborators to work in close partnership with communities to implement interventions focused on addressing obesity in equity-denied populations.[31] » "Empower" the Indigenous community.[14] [*Note: We encourage critical reflection on use of this language, which suggests that community does not already have power and that others need to "bestow" power on them.*]
Connects to related concepts such as racism	» Disrupt and dismantle health inequities and focus on tackling the adultification of Black children in emergency room settings.[32] » "Guide individual nurses in integrating cultural safety and [trauma and violence-informed care] into nursing practice with the goal of disrupting the status quo and redressing inequitable access to care among Indigenous Peoples in Canada."[11(p2)]
Connects to related concepts such as climate change	» Illustrate the complexity of the relationships between health inequities and climate change and highlight the significance of collective action to address them.[33] » Outline "actions [local health departments] can take to advance health equity and climate resilience within their current programs."[34(p10)]

Framework level

Frameworks were categorized by the level at which actions were outlined, for example, individual, organizational, regional, system or across multiple levels.

Over half of the frameworks were described as multilevel frameworks (28/47, 60%). Other frameworks stipulated action either at the individual level (e.g., addressing bias, learning, unlearning); at organizational levels (e.g., internal policies, practices); or through partnerships and action at various levels (e.g., community, regional or system-wide).

One example of a multilevel framework is the Systems Health Equity Lens (Figure 5) that uses a socioecological model to "shift the health system towards health equity as a value, priority and set of actions across all levels."[28(p1)] Note the concentric rings in the model that illustrate different levels at which action is required to achieve equity. As another example of a multilevel framework, the VicHealth Framework for Health Equity (Figure 6) provides sample actions at the societal level (e.g., legislation); community level (e.g., organizational policy); and individual level (individual interventions for knowledge, behaviours and attitudes).[35] Note the centre column in the figure that highlights the influence of societal context, social position and daily living conditions. This particular framework served as a starting point for recent efforts to prioritize equity in Queensland, Australia (see section on Background and context setting – Prioritizing health equity in complex health systems, p.5).

FIGURE 5: Systems Health Equity Lens multilevel framework[27(p1)]

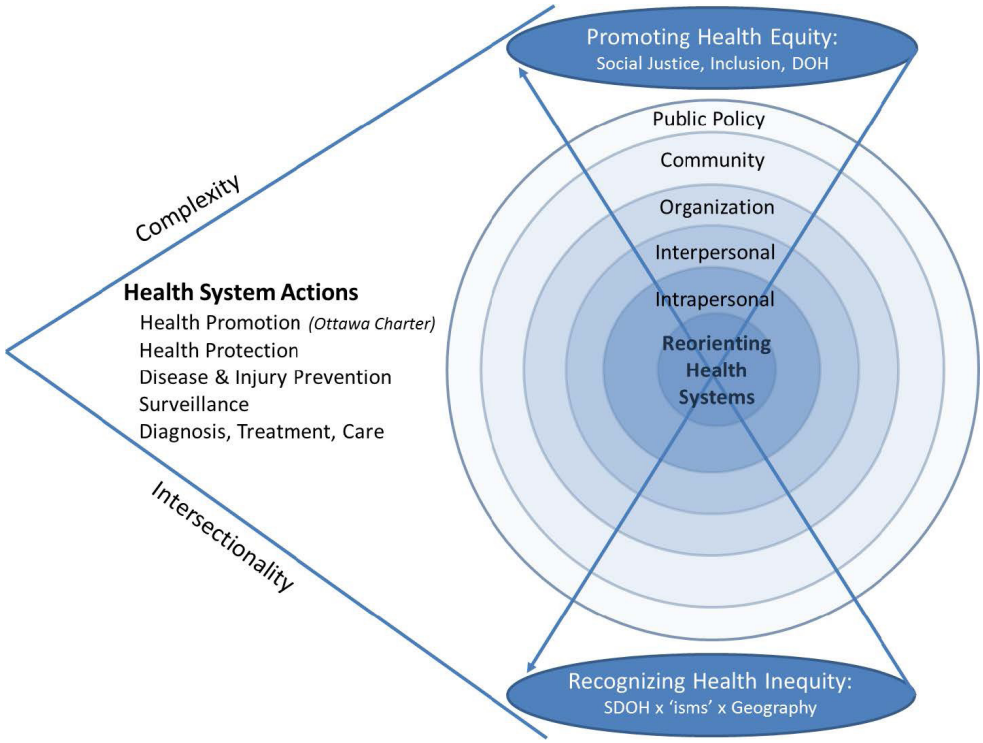
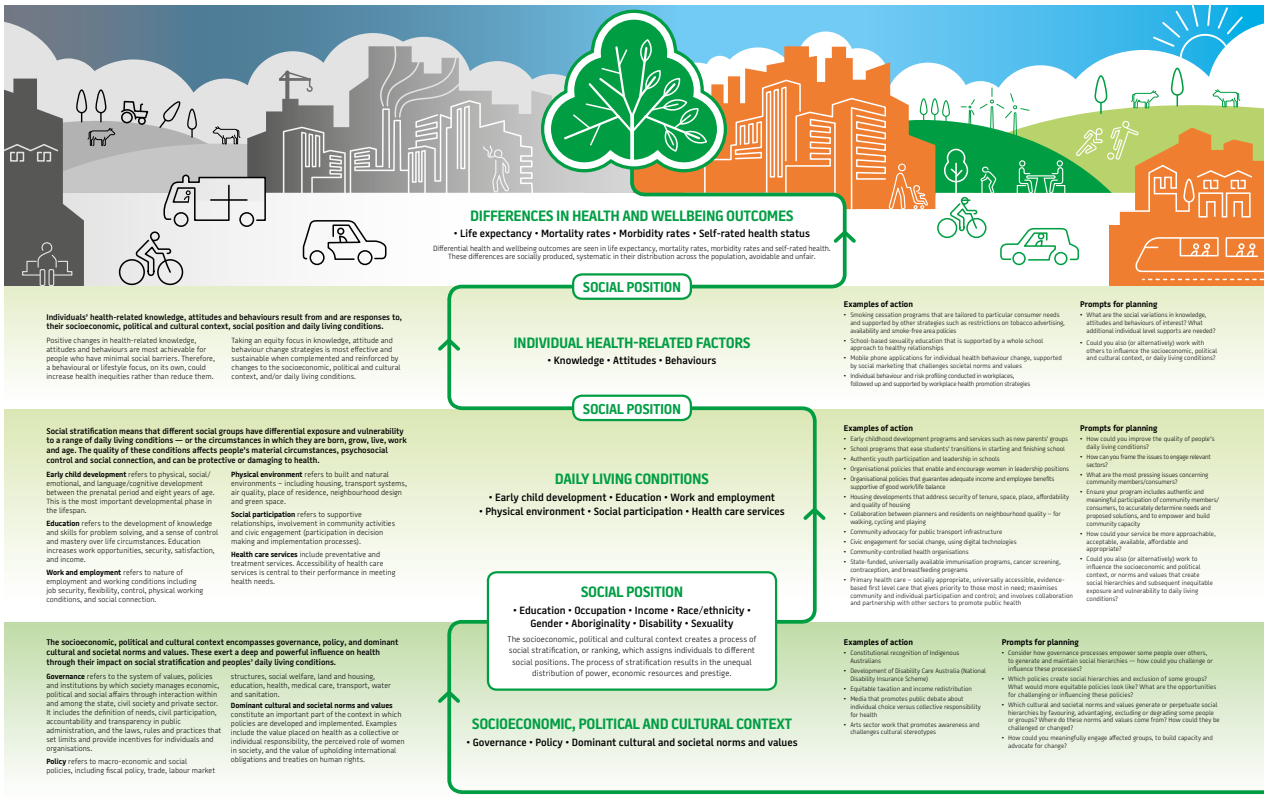


FIGURE 6: Multilevel VicHealth Framework for Health Equity[34(p3)]



Fair Foundations: The VicHealth framework for health equity

The social determinants of health inequities: the layers of influence and entry points for action

VicHealth

It is not surprising that many frameworks acknowledge the importance of comprehensive action at multiple levels to advance equity. Given that numerous structures and systems interact to produce inequities, it follows that solutions will require attention to these various intersecting drivers. Coordinated, system-wide action will be discussed later as a key facilitator for implementing equity interventions (see section on Framework implementation – Implementation levers, p.27).

Some frameworks emphasize a dual internal/external focus, noting that action is required first within one's own agency and then translated beyond into the broader health system. For example:

Ontario Health (OH) recognizes a high-quality health care system, that is grounded in an organizational culture focused on equity, inclusion, diversity, anti-racism and Indigenous cultural safety, is fundamental to building and nurturing a healthy workplace within OH and contributing to better outcomes for patients and families within the broader health system.[24(p2)]

Similarly, the Human Impact Partners' framework discusses an inside/outside approach that "requires health departments to build internal capacity and a will to act on the social determinants of health and health equity. It also requires developing relationships with and mobilizing communities and government to advocate for action on health equity."[36]

There are, however, potential limitations with an approach that is initially inward-facing. Lengthy, ongoing internally focused discussions can limit the extent to which progress is made on actions to advance equity with and for communities made to experience marginalization.

Framework structure

There is considerable variety in how the included frameworks are structured. The organization of each framework frequently appears to be influenced by the purpose of the framework and the level of intervention that the framework targets. In addition, cross-cutting themes or principles such as trauma-informed care, Indigenous ways of being and knowing, and accountability are often integrated across these diverse structures.

Common approaches to organizing the frameworks include:

- use of a stepwise approach, in some instances guided by a program management cycle or quality improvement approach;
- identification of priority domains for action, with domains focused on, for example, core elements required for equitable care, ways of being and working, relationships and partnerships, and public health functions; and
- provision of societal and/or system-level strategic recommendations.

STEPWISE FRAMEWORKS

A common way of organizing frameworks is to structure them by a series of progressive, sequential steps that users can take to guide their health equity work.

Some frameworks make explicit use of program management stages (e.g., planning, implementation, evaluation and sustainability)[5] or integrate program management stages with an individual's or organization's health equity journey (e.g., waking up, getting ready, reaching out, implementing, coalescing, creating change and maintaining[37] – see Figure 7). Other frameworks are structured in stages in line with, for example, phases of a person's cancer care journey: partnership, screening, prevention, cultural safety, survivorship, end-of-life and knowledge development.[12]

Additionally, some frameworks are organized by first defining the scope of existing inequities (drawing on different data sources including centring the voice of people living those inequities) or identifying systemic drivers of inequity, followed by identification of strategic actions required to redress those inequities and systemic drivers.[8,11,15,31] One of these frameworks names these steps of problem definition and resolution as remove, repair, restructure, remediate and provide.[8]

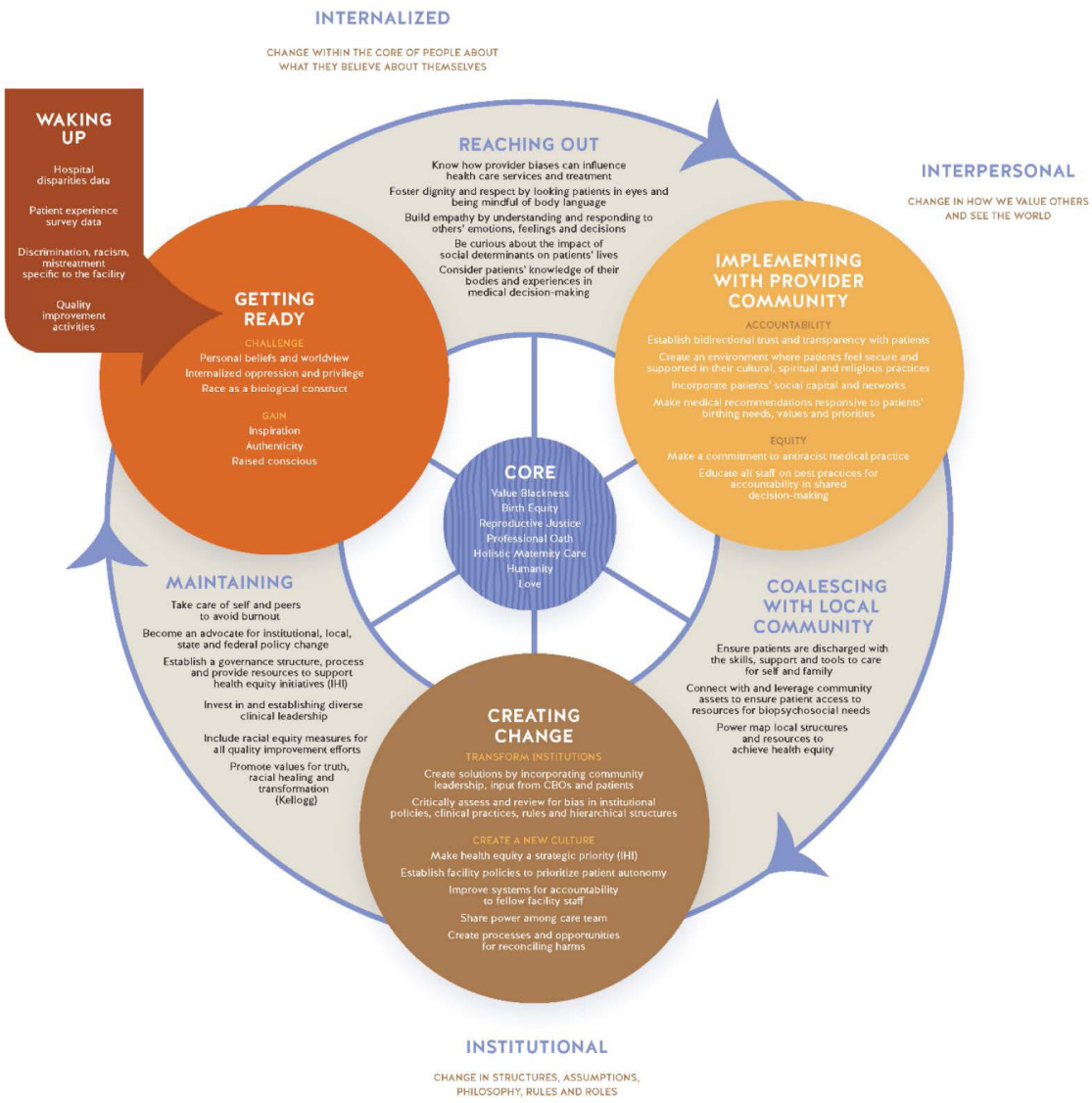
While the guided structure of stepwise frameworks may be useful, a caution for users of this type of framework is to ensure that the framework allows for the flexibility required to take actions that are grounded in and tailored to local contexts.

FRAMEWORKS ORGANIZED BY PRIORITY DOMAINS FOR ACTION

Another common approach to organizing frameworks is through articulation of priority domains for action, which are not presented in a sequential order. Depending on the goals of the framework, these domains focus on, for example:

- ways of being and working together (e.g., through listening, understanding, being and acting, accompanied by actions focused on people, process, wise practices and quality outcomes);[18]
- centring relationships and partnerships (e.g., finding common interests and direction across partners, jointly identifying how to move forward, identifying what is working and using deliberative dialogues);[17] or
- public health functions (e.g., promotion, protection, disease and injury prevention, surveillance).[28]

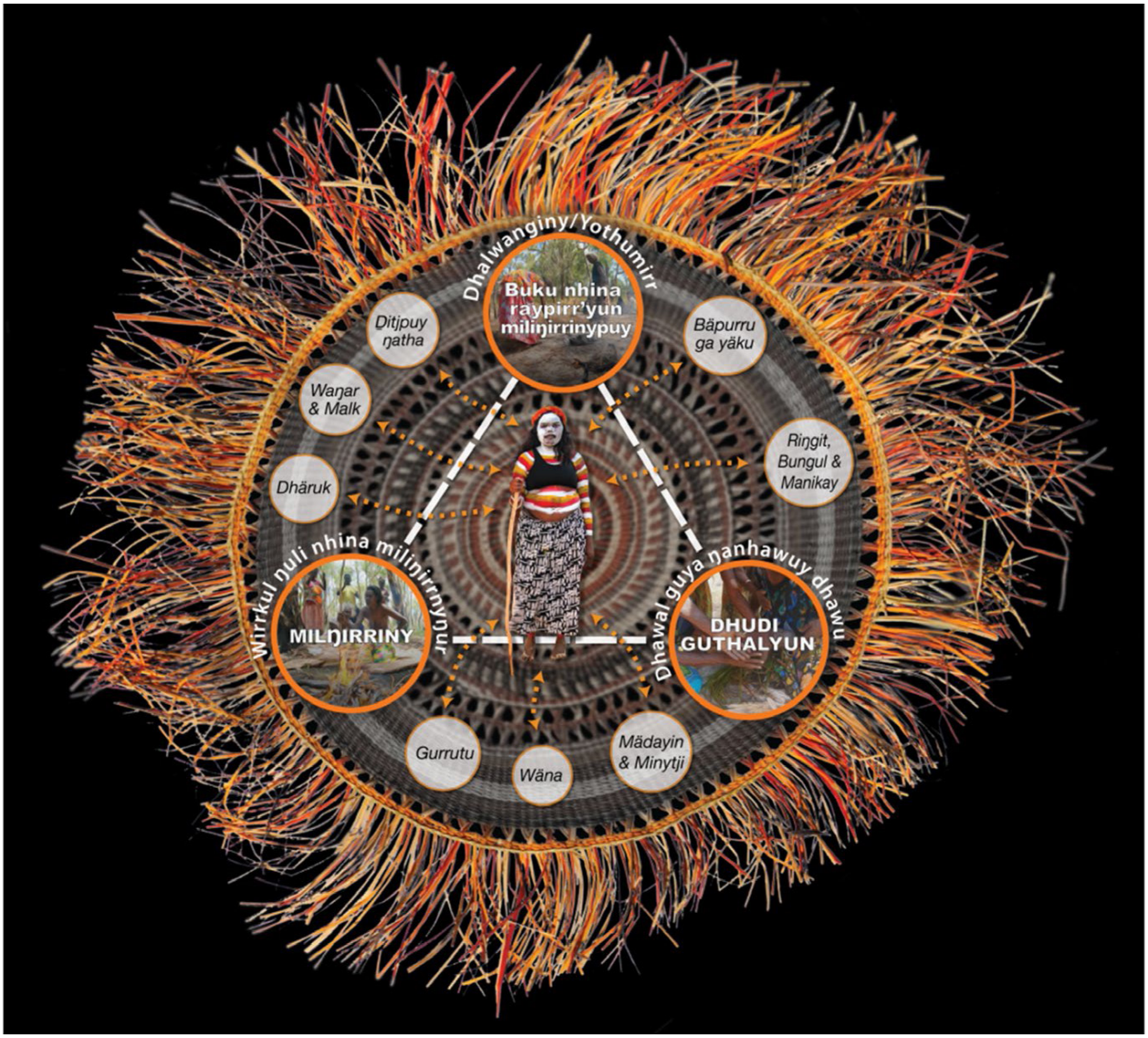
FIGURE 7: Cycle to Respectful Care framework stages for health care professionals[36(p7)]



Another area of focus for priority domains are core elements required to achieve equitable care. A framework designed to strengthen reproductive health literacy among Yolnu girls and women (see Figure 8) focuses on three knowledge domains (menstruation, reproduction, childbirth) integrated with cultural practices (such as clan names, sacred objects, dance and song).[14] Another framework with the goal of "effective and culturally-appropriate implementation of prevention and treatment interventions for Māori communities"[38(p2)] structures its domains in the following way: culture-centred approach; community engagement and community-engaged research; applying systems thinking to position individual behaviours within larger political, social and economic contexts; and creating equal partnerships between knowledge users and researchers.

In addition, some frameworks use intersecting axes or continua. For example, one framework includes four health equity intervention areas (focus on children and youth, healthy lifestyles and environments, infectious disease prevention, health risk management and emergency preparedness) with an axis on continued surveillance of population health and determinants of health that intersects across all four focus areas.[39] Another framework is structured along two continua, one ranging from intentionally disinviting to intentionally inviting care services for 2SLGBTQ+ people that intersects with a second continuum with access to care indicators in different areas (e.g., community engagement, leadership, policies and procedures).[40]

FIGURE 8: Yolnu women's reproductive health literacy framework integrating cultural practices[13(p196)]



SOCIETAL AND/OR SYSTEM-LEVEL STRATEGIC RECOMMENDATIONS

A small number of the included frameworks are structured around high-level strategic recommendations at system or societal levels.

One framework, focused on advancing the health of "ethnic minorities" in Denmark, identifies system-level strategic recommendations. These include recommendations to strengthen and adapt health system policies and strategies, strengthen health-promoting local communities and improve access to health services.[13] Another framework identifies areas for action to guide the "development of health policies that address planetary conditions within the contexts of structural and systematic racism, and promotion of equity in matters of individual, population, and planetary health."[26(p18)] These areas for action include economic stability, planetary conditions, and neighborhoods and the built environment, intersecting with a range of core concepts (e.g., individual and population factors, planetary health-related quality of life).

Other less common approaches to framework structure include organizing the framework around:

- core concepts – for example, centring equity as core to population health outcomes; interacting spheres of influence on health outcomes (systems of power, relationships and networks, individual factors and physiological pathways); and a historical, life-course perspective;[41] or
- intended outcomes – for example, for community members, community cohesion and safety, participation and representation, education and lifelong learning.[42]

As demonstrated above, there are many ways to structure a health equity framework, often guided by the intended purpose and outcome of the framework, underlying values or principles, or whose voices were centred in the development process.

Framework development process

Approaches to framework development also vary considerably among the included frameworks. This section describes themes that emerged from these approaches, including:

- building on existing literature,
- engaging diverse partners in collaborative framework development, and
- using a range of engagement processes.

When applied with flexibility and humility, these approaches may reflect promising development practices. This section also discusses the rationale for and value of iterative codevelopment approaches.

BUILDING ON EXISTING LITERATURE

Many frameworks reference pre-existing strategies, research or frameworks that were used to inform the creation of the current framework. For example, Leimbigler et al.'s framework for rural health equity "includes and combines the political, commercial, and corporate determinants with the World Health Organization's list of [social determinants of health]),"[30(p751)] and Restar et al.'s framework for transgender populations builds on the World Health Organization's Gender Responsive Assessment Scale.[43] Other frameworks likewise expand on existing equity-focused frameworks or tools with relevance for the public health field.[5,10,17,33]

Several frameworks describe iterative research processes used to generate frameworks from existing literature. For example, Peterson et al.[41] described how they began by reviewing conceptual and theoretical frameworks that investigated how different levels have an impact on health (e.g., development and biology, neighbourhood and community, sociopolitical). Next, a group of health professionals and applied researchers jointly reviewed the findings and selected several elements of existing frameworks to adapt for a new framework as no existing framework met the group's criteria. A new framework was iteratively developed building on 12 interviews with health equity, public health and social science partners.

Processes that build on existing efforts, leveraging resources already invested and lessons learned, may be more efficient than "starting from scratch."

ENGAGING DIVERSE PARTNERS IN COLLABORATIVE FRAMEWORK DEVELOPMENT

Most frameworks, from both the grey literature and the published literature, describe how they were codeveloped with various partners using different engagement methods.

Partners that were instrumental in collaborative and iterative development processes include pre-existing committees, community groups, professional networks, researchers, health councils, boards of health and others. Partners ranged from regional to national levels, with some national actors including the Public Health Agency of Canada, First Nations and Inuit Health Branch and Assembly of First Nations,[16] and the National Aboriginal Community Controlled Health Organisation.[21]

The Improving Indigenous Cancer Journeys in BC framework identifies a range of partner organizations involved in its development as part of an ongoing commitment by BC Cancer, First Nations Health Authority, Métis Nation British Columbia, and BC Association of Aboriginal Friendship Centres to work in collaboration.[12(p4)]

USING A RANGE OF ENGAGEMENT PROCESSES

Frameworks also discuss various processes used to collect feedback from additional partners, beyond the codevelopers, to inform framework development. Sample activities include public engagements such as meetings and surveys with community members and grant-makers,[44] in-person forums, roundtable community discussions, and online and in-person questionnaires.[12]

The First Nations Health Authority's Urban and Away-From-Home Framework outlines how its development process included:

research and site visits to First Nations and Indigenous health and wellness services across BC, Ontario and Alaska as well as community dialogues across all five BC health regions … [and] two consecutive rounds of conversations with First Nations community representatives through the engagement and approvals pathways process at regional caucus, sub-caucus and wellness gatherings.[45(p6)]

The Indigenous Health Commitments: Roadmap to Wellness framework by Alberta Health Services refers to the "journey thus far," explaining that:

Ethical space was the process used during the Listening Days – a series of discussions between the Indigenous Health Program and human resources leadership about Our People Strategy and diversity and inclusion. The discussion became a broader focus on reconciliation and its influence on Indigenous health.[18(p11)]

Many frameworks describe a comprehensive, multistep development approach that integrates efforts to build on existing literature and engage communities for their input. For example, one framework was developed "using input from three sources: (a) an expert panel, (b) a review of existing planning and change models, (c) states and communities who provided information used in case studies."[31(p85)] Insights from the expert panel were integrated with key steps from a variety of planning and change models into a simple six-step planning process. Another framework notes the development process involved a literature review, a town hall discussion with over 250 community psychiatrists on ways to address structural racism, the expert opinion of clinicians and administrators, and alignment with other health inequity frameworks.[46]

Several frameworks also acknowledge the input of community members, people with lived expertise of inequities, and their families or caregivers,[23] including "those whose voices are not heard as often."[42(p14)] For one framework, Green et al. explained how their approach emphasized including people of different identities or perspectives, and development of an actionable framework "was achieved by eliciting feedback from Black birthing individuals across the United States and incorporating the findings to inform a framework to achieve respectful care."[37(p2)] Similarly, Daley et al. described how their framework, focused on equitable home care for 2SLGBTQ+ communities, was codeveloped by researchers and community advisory committees that included 2SLGBTQ+ members with "diverse experiences of disability, race, Two-Spirit identity, and age" and a specific committee that provided an older adult lens.[40(p5)]

Crowshoe et al.'s framework, related to enhancing quality care for Indigenous Peoples, notes:

> *Key participants in [engagement sessions] included (i) Elders and knowledge holders as a means of being guided by Indigenous epistemologies and knowledge; (ii) Indigenous leadership; (iii) health service providers and health systems decision-makers; and (iv) community members with professional commitments to population health equity and [primary health care] transformation in Alberta.*[15(p726)]

For some frameworks, the development process is not described at all. Of these, many frameworks only list authors or funding sources.[8,9,29,32,35] Others note that the framework was developed as part of a "larger project" (e.g., research study) but still do not provide any detail about the specific development process.[27,34]

COMPREHENSIVE DEVELOPMENT APPROACH

The Ontario Health framework outlines a comprehensive development approach and provides specific details on who was engaged. In addition to engagement consultations both internal and external to the organization, framework development was informed by "an appreciation of the current state of resources and supports, a scan completed by the Wellesley Institute ... and engagement with Black team members and leaders at Ontario Health."[24(p8)]

The framework describes surveying, consulting and having discussions with various groups or individuals within Ontario Health, including but not limited to Equity, Inclusion, Diversity and Anti-Racism Working Groups, the Integrated Executive Leadership Team, the Ontario Health Patient and Family Advisory Council, and Black team members.
External consultations were conducted with home and community care providers, mental health and addictions partners (including acute and community mental health and addictions sectors), primary care providers and leaders (including the Indigenous Primary Health Care Council), and many others.[24]

These lists, while specific to the context within which Ontario Health operates, may be useful for other jurisdictions as they reflect on key partners and informants to engage in efforts to advance equity.

RATIONALE FOR CODEVELOPMENT

Frameworks that describe codesign or codevelopment processes often provide a rationale for why this approach is important. For example, one framework notes that broad consultations were held to "ensure the Plan reflects the needs of Tasmanian Aboriginal people state-wide."[47(p6)] Another notes that "the Framework has been developed for Aboriginal people by Aboriginal people … [and] recognises that Aboriginal engagement and involvement is essential to improve Aboriginal health and wellbeing."[27(p3)]

Other frameworks acknowledge that collaborative development allows for collecting input on priorities for plans, policies and programs from the people who will be impacted by these efforts.[12,42,44] One notes the importance of collecting stories from people with lived and living experience: "We heard many stories of our brothers and sisters who have been through the cancer journey, and we wanted to make sure the wisdom of Indigenous cancer patients, survivors and their caretakers are reflected in this strategy."[12(p10)]

These statements highlight the value of codevelopment, suggesting it is necessary for generating appropriate, quality strategies that will contribute to improved health and well-being outcomes – importantly, outcomes that are identified as a priority by communities themselves.

Framework implementation

Overall, while the included frameworks are actionable in that they identify what needs to be done, there is limited detail about how to do this work or how it was done. There are, however, useful exceptions to this trend (detailed below) that can assist organizations and systems moving towards implementation of health equity.

IMPLEMENTATION LEVERS

This section discusses implementation levers that can be used to advance action on health equity frameworks. Where possible, implementation mechanisms articulated in the frameworks have been aligned with seven implementation levers, identified in the British Columbian context, for prioritizing health equity in large health systems.[1]

These implementation levers are:

- Ensure a coordinated, comprehensive approach to prioritizing health equity in health systems
- Allocate resources to health equity work
- Build capacity to engage in health equity work
- Recruit, engage and support health equity champions
- Build health equity as a systems value
- Clearly identify health equity as a strategic priority
- Integrate health equity into decision-making

The Ontario Health framework provides a high-level overview of concrete actions for implementation. Along with recommendations and initial proposed activities for application of the framework within the

agency and across the health system, it specifies who is accountable and notes broadly that Ontario Health's "Equity Accountable Office will support all activities related to the Framework."[24(p19)]

Embedding accountability for health equity action across how the organization and its partners work, and resourcing this accountability function, supports a coordinated, comprehensive health equity approach across systems and can help to protect resources needed for health equity implementation.

Several frameworks provide real-world actions and/or case studies that align with the implementation lever of building competency. For example, one of the Human Impact Partners' Strategic Practices is building organizational capacity. Under this practice, some actions that health department leadership and staff can take include:

Have an ongoing process of education, structured dialogue, and organizational development that engages all department staff to:

1. Explain the evidence around health inequities and its sources
2. Explore the root causes of health inequities – oppression and power – and how to address them
3. Discuss the values and needs of the community
4. Build core competencies and capacities of staff to successfully achieve health equity.[9]

When working to build competency in identifying and disrupting racism, one framework asks: "How do you know if racism is the root cause of health disparities you are seeking to address?"[48(p3)] To help answer that question, the authors provided a checklist that the population you are engaging with might be experiencing, including barriers to wealth accumulation, educational inequities or disproportionate housing insecurity.

Building competency can include developing "knowledge of health equity concepts including recognition of sources of inequities and oppression (colonialism/racism, gender and sex discrimination, ageism, ableism, neoliberalism/capitalism), power and privilege"[1(pp10-1)] through effective, structured trainings.

Practical case studies related to building organizational capacity are also provided for the Human Impact Partners' framework.[9] For example, one case study details how the New York City Department of Health and Mental Hygiene launched an initiative that "builds staff skills to address racism, implement policies to lessen the impact of structural oppression, and strengthen collaborations with communities across the city."[49] Notably, this work was sparked by a newly appointed health commissioner who "clearly stated that advancing health equity needs to be a shared priority for all divisions and agency staff" and established a Center for Health Equity. The commissioner also "spoke out publicly about why public health and health care professionals should address racism and other forms of oppression … [and] authored "#BlackLivesMatter – A Challenge to the Medical and Public Health Communities" in the *New England Journal of Medicine*."[49]

This case study demonstrates how health equity champions can "create value and increase relative priority for health equity, as well as support development of health equity competencies within their organizations."[1(p10)]

Daley et al. provided seven steps in their framework that can each help to facilitate its implementation. Some of the actions identified in these steps include:

- secure financial resources;
- strike an equity, diversity and inclusion committee;
- ensure ongoing leadership and staff training in equity, diversity and inclusion;
- ensure members of equity-denied groups are hired into leadership positions;
- create implementation and evaluation plans; and
- assess organizational change.[40]

Multiple frameworks acknowledge the importance of partnerships and collaborations during implementation processes. Co-implementation of frameworks by multiple partners is connected to a coordinated, comprehensive approach to advancing equity. As the Scottish Government's framework notes:

Moving into the implementation and monitoring phase we therefore plan to build on the same participatory, partnership approach used in developing the Framework. We will broaden our engagement with a wide range of organisations and individuals, from grassroots community organisations to practitioners working in the public sector, academia and policy makers to develop this approach over the first six months of the Framework's life.[42(p16)]

Queensland's Aboriginal and Torres Strait Islander Health Equity Framework emphasizes that "the voices, lived experiences and cultural authority of Aboriginal and Torres Strait Islander peoples are integral to the co-design, co-ownership and co-implementation of the Health Equity Strategies."[22(p12)] This framework further identifies that codesign means shared decision-making, beginning as early as possible on the journey.

A framework from British Columbia makes the connection between ensuring that each phase of work is informed by community engagement and facilitating greater First Nations representation and authority throughout the health system.[45]

Additionally, one framework identifies that cross-sectoral collaborations are required to address the connections between health and social determinants and encourages different sectors to "demonstrate their commitment to this Framework by aligning their strategic planning."[27(p24)] This speaks to the importance of formalizing equity commitments by explicitly identifying health equity as a strategic priority and using a coordinated, comprehensive approach to advancing equity.

Reinforcing the use of a coordinated, comprehensive approach to advancing equity is the learning from application of one framework that "establishing a shared language was a critical first step toward implementing a health equity agenda."[41(p744)] This framework is a "tool for leaders and professionals in public health research and practice to reflect on and support a shift toward addressing health inequities resulting from the interplay of structural, relational, individual, and physiological factors."[41(p741)]

Of note is that frameworks created and actioned through partnerships can help to foster a systems value for health equity, "underpinned by social justice and grounded in recognition of structural causes of inequities," where equity is prioritized by partners across public health and health care.[1(p10)]

IMPLEMENTATION CHALLENGES, OPPORTUNITIES AND LESSONS LEARNED

Explicitly naming equity as a strategic priority is not always sufficient to ensure comprehensive action.[50] Health equity language may be presented solely for rhetorical purposes, and short project lifespans do not always allow for plans to be fully implemented.[50] This suggests that reliance on one implementation lever alone is insufficient and that comprehensive approaches are required to generate and sustain health equity action.

As noted previously, there are inherent limitations to frameworks. For example, "a health equity tool cannot be the cornerstone of an organizational strategy to fight against [social inequalities in health]; rather, it must be incorporated as part of a systemic strategy of professional and organizational development."[5(pe71)]

Guichard et al. described the results of a study assessing conditions that facilitated use of an actual health equity tool, including:

- user-friendliness,
- literacy,
- resources to adapt and apply the tool,
- competency development, and
- organizations and policies that promote use of the tool in daily activities and in actioning equity more broadly.[5]

Agencies planning to develop or apply equity tools or frameworks may benefit from assessing these factors within their local context.

Lessons learned from the application of Markham et al.'s Partnership Pentagram Plus framework suggest that implementation requires:

- time, as this method is time-intensive;
- measuring different indicators of success (e.g., through iterative processes), given that attribution is challenging in a complex system;
- facilitation expertise in appreciative inquiry approaches;
- building relationships across silos;
- ongoing investment in relationship building to sustain momentum; and
- First Nations leadership (political and health).[17]

On a related note, the National Aboriginal Community Controlled Health Organisation's framework outlines facilitators for successful quality improvement initiatives, reflecting close alignment with implementation facilitators identified by van Roode et al.[1] These facilitators include:

- whole of organization commitment,
- coordinated and comprehensive approaches,
- workforce training, and
- collecting and using data.[21]

As some of the included frameworks were developed in the last 3 years, it is possible that implementation of these frameworks is now underway and details of these efforts are not yet publicly available. There is an opportunity for organizations and systems that do implement frameworks to publish both the successes and the failures of their implementation to contribute to the evidence base for equity action.

As we discuss in the considerations for advancing health equity (see section on Considerations for advancing equity – Considerations for all stages of health equity work, p.35), the process of working together is just as important, if not more important, than the details of what needs to be done or the outcomes. For example, commitments to working in partnership and solidarity may be more impactful than highly prescriptive plans that lack space for nuance or flexibility. One framework advises, "This is about how change is to be made rather than solely about what change is required; if change is not made in the right way, it will not last."[47(p3)]

Additionally, as none of the included frameworks provide robust, in-depth implementation guidance, this may reflect that there is no "right" path to advancing equity. Some strategies may require trial and error and pilot testing, accompanied by developmental evaluation, to determine what will work in a certain context.[21] **The lack of implementation detail in the frameworks suggests it is not necessary to have all the answers before embarking on this work.**

Framework evaluation

While many of the frameworks share only limited information about plans to evaluate the specific framework, authors acknowledged the critical importance of evaluation and how results can be used, for example, to:

- advance what is known about what works (and what doesn't work) to progress health equity,
- support greater accountability for health equity work, and
- continue to refine frameworks as more is learned about their use.

Several frameworks reference evaluation throughout, while others include a discrete evaluation domain within the framework's structure. Additionally, several frameworks share practical evaluation approaches and tools. Of note, only one of the frameworks mentions an evaluation is currently underway, and another framework shares evaluation results in only limited detail.

Results presented in this section suggest there is an evaluation gap in the literature and potentially in practice as well.

FRAMEWORKS WITH DISCRETE EVALUATION DOMAINS

Several frameworks include a focused evaluation domain. In the framework by Payne et al.,[31] one of the six toolkit domains, "monitoring and evaluating progress," provides information on creating a logic model to enable planning and evaluation of interventions. In addition, the framework provides an overview of formative, process and outcome evaluation methods to assess the success of change strategies, and connects the reader to other evaluation measures and resources. This framework also details how codevelopment contributed to full evaluation plans that include developing measures that work well in multiple languages, data collection activities and data use methods.

The First Nations Health Authority's road map framework includes a "knowledge development" domain, which is a component of evaluation as its objective is to "increase research and surveillance opportunities to better understand Indigenous cancer journeys."[12(p23)]

Ontario Health's framework includes two evaluation domains, one focused on collecting equity data and the other on reporting and evaluating to drive improvement.[24,51] Supporting these two domains is a series of output indicators that can be used to capture baseline data and measure change over time. Starting metrics, identified collaboratively as part of the broader engagement process used to develop the framework, are provided for each of the framework's 11 components (e.g., disrupt racism, reduce inequities). Many of these starting metrics reference ways to embed accountability for this work into routine practice (e.g., project senior leadership team has agenda time to review progress against framework goals).[24]

FRAMEWORKS WITH PRACTICAL APPROACHES AND TOOLS TO EVALUATE EQUITY INTERVENTIONS

Several frameworks describe practical tools that can be used to evaluate equity interventions. For example, Hogan et al. presented a scale – not yet validated – called the Hogan/Rowley Institutional Measure of Equity (H.R.I.M.E.) to evaluate an organization's impact on addressing inequities.[8] The numerical scale ranges from -6 to +6, with these points on the scale reflecting the following:

- -6: the organization influences other actors to implement actions that are regressive and further entrench health inequities
- 0: there is no mention of or information on actions to address inequities
- +6: organizational equity initiatives are integrated throughout and influence the work of others towards equity, building synergy across communities and sectors

In a case study of this framework, the sample organization was assigned a score of 3 (i.e., institution provides active support), supported by data that "staff goes through anti racism training and other trainings to understand the role race plays."[8(p152)]

Another practical evaluation tool is a set of organizational indicators where "each of the six indicators has evaluation prompts that take into account dynamics of power and privilege that can assist organizations to undertake systematic self-assessments of their policies, programs, and services."[40(p8)] Results of the self-assessments can be used to identify organizational change needed and support implementation of strategies to provide "consistently inclusive, affirming care for 2SLGBTQ+ people."[40(p8)]

Several frameworks provide case studies of real-world actions with practical tools and approaches. For example, the National Aboriginal Community Controlled Health Organisation's framework focusing on equity in quality improvement projects shares information about the development and use of data dashboards to identify and measure change.[21] These dashboards help to foster friendly competition among teams and are created every 6 months to encourage long-term change. The framework authors noted that quality improvement project reporting is used to advocate for better policy and funding for health equity work.

FRAMEWORK WITH A DETAILED EVALUATION PLAN

Ward et al.'s framework[10] provides in-depth evaluation plans given its dual intent is to (1) guide the implementation of health equity interventions underpinned by equitable partnerships and (2) evaluate the effectiveness of these partnerships focused on addressing health inequities.

The authors linked the extent to which partnerships are equitable with the effectiveness of a partnership's ability to work towards shared goals of reducing health inequities. Equitable partnerships are characterized by shared leadership and power and meaningful participation.[10]

Processes that can contribute to more equitable partnerships include "changes in power relations within partnerships and improvements in individual and community capacity (e.g., knowledge, influence in decision-making processes), which contribute to the achievement of long-term partnership goals and objectives."[10(p27)] Long-term framework outcomes include policy and practice changes, new programs and interventions embedded as part of an organization's ways of working, and reduced inequitable health outcomes.

The framework includes equity metrics, specific indicators and data collection methods for each of the five framework domains that identify a stepwise partnership approach to working towards greater health equity. See Table 3 for an example taken from this framework under the domain "a focus on equity in partnership processes."

The authors recommended the use of formative evaluation given the cyclical, iterative nature of partnerships. Further, they recommended that "metrics to evaluate equity in partnership processes and outcomes be generated and agreed upon within the partnership and driven by community priorities."[10(p30)]

TABLE 3: Example of equity evaluation metric, indicator and data collection method[10(p31)]

METRIC	INDICATOR	DATA COLLECTION METHOD
Issues analyzed are community-identified and relevant	Partnership activities are informed by community facing inequity	Document review, e.g., meeting minutes

FRAMEWORKS WITH LIMITED REFERENCE TO EVALUATION PLANS

For many frameworks, evaluation efforts and plans are either only briefly referenced or not well described. While only one of the included frameworks notes that an evaluation is currently underway (and shares very limited detail about it), the authors recognized the importance of sharing evaluation results with others to broadly advance what is known about health equity framework implementation:

As we continue to evaluate the [Health Equity Framework], we look forward to opportunities to work collaboratively with those who have developed frameworks on health equity, to share lessons learned and reflect on refinements of these tools for the field.[41(p745)]

Given the limited information shared about any evaluation efforts or plans, it is not surprising that there is very little information describing the *results* of any framework evaluations. It is possible that most frameworks have not yet been evaluated or that, even if evaluation is occurring or complete, results have not yet been made public.

Several frameworks identify that, once efforts to implement and evaluate the framework have occurred, further research and refinements to the framework will be required. A connected point is the need to "consider how the Framework can remain responsive and flexible to accommodate new evidence and change in the demographic and policy environments over the later phases of the Framework's life span and to reflect the progress made to date."[42(p16)] Presumably, evaluation data will help implementors to make these framework adjustments as contexts and evidence continue to evolve.

Overall, while frameworks share only limited evaluation plans and almost no evaluation results, many framework authors noted the importance of evaluation given so little is known about what works to advance health equity.

Results in this section suggest there is an evaluation gap in the literature and potentially in practice as well, indicating the need to resource evaluations and share evaluation results widely to support organizational and system learning.

Considerations for advancing equity

Drawing on the findings of this review, the following section presents a series of considerations for readers in their work to advance health equity, whether they plan to develop, adapt or use a health equity framework or not. More specifically, these considerations can support the B.C. Ministry of Health, regional partners, and other provincial and territorial jurisdictions to action health equity in the context of public health renewal or broader organizational and system transformation efforts.

Considerations for all stages of health equity work

- How we work and how we journey together matters just as much as the outcome. As one framework states, "This is about how change is to be made rather than solely about what change is required; if change is not made in the right way, it will not last."[47(p3)] This emphasis on quality of process is especially important given that health equity work is messy, iterative, cyclical and highly dependent on specific context.
- Reflect on one's own world view, social location, assumptions and biases, and commit to continuous learning – and unlearning when needed – to deepen and strengthen approaches to working through the complexities inherent in health equity work.
- Situate health equity work within larger formal commitments, including legislation (e.g., provincial and federal UNDRIP legislation, Nova Scotia's Dismantling Racism and Hate Act); policy directives; or other system-wide strategic, operational or implementation plans. Doing so may help to strengthen accountability for ensuring this work happens.
- Centre the disruption of inequitable power relationships and rebalancing power between different actors, and the disruption of racism and White supremacy, as foundational in all health equity work.
- Leverage and embed the seven core facilitators (implementation levers) to prioritize health equity in large complex health systems[d] in all system transformation and public health renewal work, and identify ways in which a health equity framework can support this work.
- There is no "right" path to advancing health equity. It is not necessary, or always possible, to have all the answers before embarking on this work. Implementation strategies will require testing, refinement and the use of developmental evaluation to determine what will work in different contexts.[21]

d The seven core facilitators are: ensure a coordinated, comprehensive approach to prioritizing health equity in health systems; allocate resources to health equity work; build capacity to engage in health equity work; provide supports for health equity champions; build health equity as a systems value; clearly identify health equity as a strategic priority; and integrate health equity into decision-making.[1]

Considerations for creating, adapting or applying equity frameworks

Question to what extent a particular health equity framework will either advance or hinder the extensive structural changes required to achieve true health equity. As a starting point, ask yourself these critical questions:

- What is the intended goal of your health equity work, and does the selected framework's underlying values and principles align?
- Does the health equity framework call for the deep critical analysis required to achieve the structural changes and system transformation that is needed?
- Why do you believe that use of this specific framework is an appropriate next step?

To select a framework most appropriate for the context you're working in, ask yourself:

- Where is the focus of the organization's health equity work? Examples include:
    - public health functions such as surveillance, health promotion and public health system management;
    - downstream functions such as service delivery at the point of care; and
    - upstream functions such as influencing system-level policy and power building with communities made to experience marginalization.
- What stage is the organization at in their health equity journey?
- What voices, perspectives and forms of knowledge inform the framework?
- How is the health system organized in the jurisdiction that the organization is working in? Is there alignment between the framework level(s) of intervention and context where change is desired?

Integrate deep, meaningful and comprehensive community engagement and creation of equitable partnerships – including shared decision-making and power – at all stages when codeveloping, co-implementing and co-evaluating a health equity framework.

Considerations specific to First Nations, Inuit and Métis Peoples

Recognizing that decolonization, reconciliation and self-determination with First Nations, Inuit and Métis Peoples are vast, complex areas of work, the following points are presented as only preliminary considerations:

- Position Indigenous knowledge systems and Western knowledge systems as equal in all health equity work. Two-eyed seeing and ethical space are two approaches discussed in this review that support the use of distinct world views. In the National Collaborating Centre for Indigenous Health's *Visioning the future report*, Dr. Margo Greenwood wrote:

Establishing population and public health care systems that are free of racism and discrimination and in which Indigenous peoples have the choice to access health services that are rooted in both Indigenous knowledge(s) and Euro-Western paradigms is a dream that must be realized.[52(p26)]

- Disrupting racism and White supremacy is central to advancing equity given that racism operates across systems and structures at multiple levels, which intersect to drive inequities.

- Integrate critical analyses of systems of power (e.g., settler colonialism) and use of decolonization approaches to advance health equity and self-determination with and for First Nations, Inuit and Métis Peoples. Power analyses may be a useful tool to promote cultural safety and thereby advance health equity.
- Deepen and strengthen engagement with different First Nations, Inuit and Métis advisors at all stages of a public health renewal or system transformation process that centres health equity. As quoted by Horrill et al., Walker and Behn-Smith advised there is "remarkable opportunity for individuals working within the medical system to acknowledge and honor relationships as one of the key medicines for Indigenous peoples."[11(p10)]

Gaps in the literature and implications for future work

- The limited number of action-oriented frameworks that exist in the literature contain little detail regarding specific implementation steps, evaluation plans or results. A potential reason for this lack of detail is that there is no one right way to move forward given health equity work needs to be shaped by and is highly specific to context.
- Approach evaluation of health equity interventions and frameworks as required work that needs appropriate resourcing.
- Share evaluation findings, whether negative or positive, publicly to contribute to the evidence base for advancing health equity as part of a larger approach to advance organizational and system learning.

Conclusion

Through a systematic search and synthesis of the literature, the review team identified 47 action-focused frameworks to answer the question: Which health equity frameworks exist that can be used to inform public health planning, decision-making and service delivery?

In addition to providing a descriptive synthesis of core framework elements – including goals, population of focus, structure, foundational theories and concepts, development processes, and perspectives on implementation and evaluation – this review invites users of frameworks to question their own assumptions and world views as foundational work when cocreating, selecting or applying a framework. This paper challenges the assumed benevolence of all health equity frameworks and encourages users to retain a critical lens when working to advance equity. Given that frameworks are created in deeply inequitable contexts, framework users are asked: How can we ensure that the health equity framework we create and/or use works to break down colonialism, White supremacy, racism, transphobia, sexism and other systems of oppression? A follow-up question to this is: How can we ensure that the way we work together helps to disrupt inequitable power relations and larger systems of oppression?

Connected to the above, the included frameworks highlight two foundational elements of health equity work: (1) centring the disruption of inequitable power relationships and rebalancing power between different actors, and (2) disrupting racism and White supremacy.

Health equity frameworks, when used by practitioners actively engaged in critical thinking, deep reflexivity, continuous learning and unlearning, can offer one potentially useful tool in the larger work of dismantling systems of oppression and advancing health equity for all.

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APPENDIX A

Included health equity frameworks

As a reference for the reader, Table A1 briefly identifies all 47 included frameworks. Although each framework is not directly cited in the narrative of the report, and thus each one does not have a reference number in this table, they have all been included in the data analysis and synthesis process, and form part of the report findings.

TABLE A1: All frameworks included in the review (in reference number order)

AUTHOR (first named)	TITLE	REF #
Guichard et al.	Adapting a health equity tool to meet professional needs (Québec, Canada)	5
Hogan et al.	Dimensionality and R4P: a health equity framework for research planning and evaluation in African American populations	8
Human Impact Partners	Strategic practices	9
Ward et al.	A conceptual framework for evaluating health equity promotion within community-based participatory research partnerships	10
Horrill et al.	Nurses as agents of disruption: operationalizing a framework to redress inequities in healthcare access among Indigenous Peoples	11
First Nations Health Authority et al.	Improving Indigenous cancer journeys in BC: a road map	12
Smith et al.	Recommendations for ethnic equity in health: a Delphi study from Denmark	13
Ireland et al.	"We are sacred": an intercultural and multilingual approach to understanding reproductive health literacy for Yolŋu girls and women in remote Northern Australia	14
Crowshoe et al.	The Indigenous primary health care and policy research network: guiding innovation within primary health care with Indigenous peoples in Alberta	15
First Nations of Quebec and Labrador Health and Social Services Commission	Public health for First Nations in Quebec: shared responsibility, concerted action	16
Markham et al.	Addressing rural and Indigenous health inequities in Canada through socially accountable health partnerships	17
Alberta Health Services	Indigenous health commitments: roadmap to wellness	18
Australia Department of Health	National Aboriginal and Torres Strait Islander health plan 2021–2031	19
New Zealand Ministry of Health	The guide to He Korowai Oranga: Māori health strategy 2014	20

APPENDIX A

Included health equity frameworks

AUTHOR (first named)	TITLE	REF #
National Aboriginal Community Controlled Health Organisation	National framework for continuous quality improvement in primary health care for Aboriginal and Torres Strait Islander people 2018-2023	21
Queensland Health et al.	Making tracks together: Queensland's Aboriginal and Torres Strait Islander health equity framework	22
North Western Melbourne Primary Health Network	Access and equity framework: a framework for improving health equity in the North Western Melbourne PHN region, July 2021 to June 2024	23
Corpus Sanchez International	Building a framework & plan to address equity, inclusion, diversity & anti-racism in Ontario: final report submitted to Ontario Health	24
Kuehnert et al.	Defining the social determinants of health for nursing action to achieve health equity: a consensus paper from the American Academy of Nursing	26
Western Australia Department of Health	WA Aboriginal health and wellbeing framework 2015–2030	27
Pauly et al.	Reorienting health systems towards health equity: the systems health equity lens	28
Cotton et al.	A case study on a university-community partnership to eliminate racial disparities in infant mortality: effective strategies and lessons learned	29
Leimbigler et al.	Social, political, commercial, and corporate determinants of rural health equity in Canada: an integrated framework	30
Payne et al.	CDC's health equity resource toolkit: disseminating guidance for state practitioners to address obesity disparities	31
Kock et al.	Addressing adultification of Black pediatric patients in the emergency department: a framework to decrease disparities	32
Rudolph et al.	Climate change and health inequities: a framework for action	33
Rudolph et al.	Climate change, health, and equity: a guide for local health departments	34
Victorian Health Promotion Foundation	Fair foundations: the VicHealth framework for health equity	35
Green et al.	The cycle to respectful care: a qualitative approach to the creation of an actionable framework to address maternal outcome disparities	37
Oetzel et al.	Implementation framework for chronic disease intervention effectiveness in Māori and other indigenous communities	38

APPENDIX A

Included health equity frameworks

AUTHOR (first named)	TITLE	REF #
Nunavik Regional Board of Health and Social Services	Regional action plan for public health 2016–2020	39
Daley et al.	A framework for enhancing access to equitable home care for 2SLGBTQ+ communities	40
Peterson et al.	The health equity framework: a science- and justice-based model for public health researchers and practitioners	41
Scottish Government	Race equality framework for Scotland 2016-2030	42
Restar et al.	Expanding gender-based health equity framework for transgender populations	43
Alaska Department of Health and Social Services	Healthy and equitable communities strategic plan 2022-2025	44
First Nations Health Authority	Urban and away-from-home health and wellness framework	45
Talley et al.	The Self-assessment for Modification of Anti-Racism Tool (SMART): addressing structural racism in community behavioral health	46
Tasmanian Aboriginal Centre et al.	Closing the gap: Tasmanian implementation plan 2021 – 2023	47
Malawa et al.	Racism as a root cause approach: a new framework	48
Freeman et al.	A framework for regional primary health care to organise actions to address health inequities	50
Ontario Health	Ontario Health's equity, inclusion, diversity and anti-racism framework	51
Browne et al.	Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study	
Wooten	Integration of health equity in a local health department: California Conference of Local Health Officials (CCLHO) framework for local public health departments (LHDs)	
Howell et al.	Reduction of peripartum racial and ethnic disparities: a conceptual framework and maternal safety consensus bundle	
Clarke et al.	A roadmap to reduce racial and ethnic disparities in health care	
Rouvinen-Wilenius et al.	Finnish NGOs promoting health equity in the context of welfare economy	
Saskatchewan Health Authority	Unity framework	

APPENDIX B

Inclusion and exclusion criteria

Table B1 identifies the inclusion and exclusion criteria used by the review team to identify relevant health equity frameworks for the review. Based on conversations with NCCDH Indigenous Advisors for a previous review on a similar topic, the review team applied these criteria flexibly to allow for some nuance in how they are applied, especially if the framework was specific to First Nations, Inuit and Métis Peoples.

Our definition of frameworks is guidance (may or may not be structured) to move forward and act on achieving equitable processes and health equity outcomes. Framework components include, for example, goals and objectives; steps; short-term, medium-term and long-term actions; values and principles; and grounding in legislation or larger strategic directions.

Overall, the review team focused on identifying frameworks that included and were based on different forms of knowledge and ways of knowing (e.g., Western, Indigenous, qualitative/storytelling). This is one methodological approach that was used to help decentre Eurocentric knowledge systems. We aimed to include frameworks that acknowledge complexity, interconnectedness and intersectionality within health equity work, and that reflect the value of various forms of knowledge.

At the first level of screening (title and abstract), if the team was unsure whether the framework was actionable, the team moved the framework to the second full-text stage of screening for assessment.

APPENDIX B

Inclusion and exclusion criteria

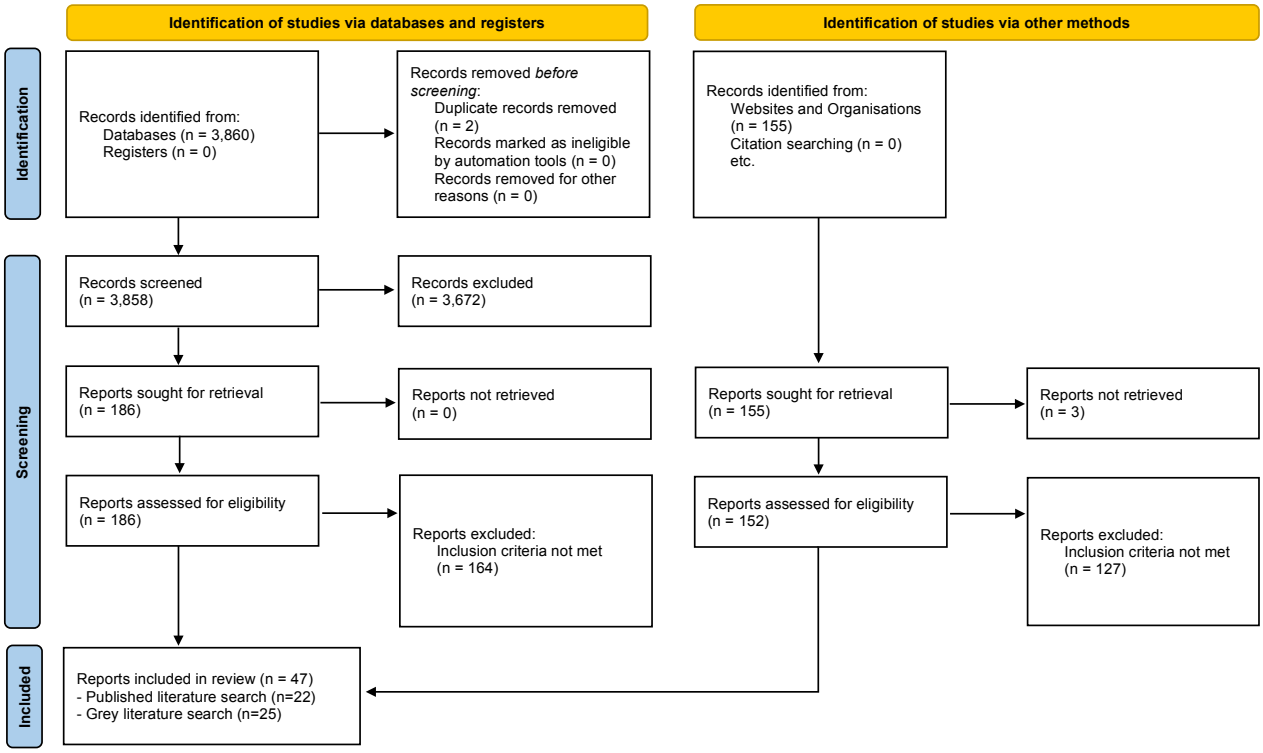
TABLE B1: Inclusion and exclusion criteria

INCLUSION CRITERIA	EXCLUSION CRITERIA
» Describes or analyzes a framework with a health equity focus (i.e., objectives related to advancing health equity) that has not necessarily been implemented or evaluated » Includes a focus on concrete action (i.e., steps to advance health equity, not the importance of health equity) » Focus on regional, provincial/territorial and/or national levels in health care/public health system » Focus on equitable population-level health outcomes » Framework is relevant to/applicable in the public health context » Framework is developed collaboratively (e.g., with community members, health system partners) » Framework addresses reconciliation or decolonization	» Frameworks without a health equity focus » No goals, objectives or outcomes identified » Goals or objectives are not equity-informed » Frameworks without any identified domains/areas of action (i.e., included frameworks need to offer guidance for action) » Frameworks that explicitly devalue different forms of knowledge and ways of knowing (e.g., Indigenous, Black) – i.e., racist frameworks » Frameworks that adopt a strict biomedical approach » Clinical interventions (e.g., clinical guidelines, best practice guidelines, clinical standards, individual-level interventions) » Theoretical articles without a framework » Opinions or commentaries without a framework » Research guidelines with an equity focus » Research on inequities (i.e., defining or describing the problem) » Conceptual description of barriers and facilitators to advancing equity (i.e., lacking rationale, examples of actions, etc.) » Explanatory/causal frameworks that explain how inequities arise » Equity-focused recommendations from professional associations or studies that are not concrete and actionable » Articles narrowly focused on a single aspect of advancing health equity that lack comprehensive approaches (e.g., only describe the importance of partnership) » Research agendas with equity focus » General commitments to health equity without concrete actions identified » Not available publicly or through NCCDH/St. Francis Xavier University library services » Frameworks do not align with a public health context » Research identifying barriers and facilitators to advancing equity at organizational and system levels » Overarching policy recommendations (e.g., eliminate poverty, eliminate health inequities) that are not actionable at provincial or regional levels

APPENDIX C

Final PRISMA 2020 flow diagram for review

PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources



Adapted from: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/

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