HEALTH EQUITY FRAMEWORKS AS A TOOL TO SUPPORT PUBLIC HEALTH ACTION: A RAPID REVIEW OF THE LITERATURE

SUPPLEMENT – FRAMEWORK VISUALS

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INTRODUCTION

This supplement presents all the visual depictions of health equity frameworks that were identified and included in *Health equity frameworks as a tool to support public health action: A rapid review of the literature*.[1]

Forty-one of the 47 frameworks included in the original review presented their framework as a visual, in addition to providing narrative descriptions. Framework visuals were common across both the grey and published literature. Twenty-two of the 25 frameworks retrieved from the grey literature included visual depictions, and 19 of the 22 frameworks retrieved from the published literature search incorporated visual depictions.

Presenting a framework visually helps to convey complex concepts, actions and values — and the relationships between them — in a way that can be more accessible for visual learners and users of frameworks while serving as a complement to the narrative.

Framework authors used a broad range of visual approaches to portray each distinct framework. Visual techniques ranged widely and included the use of linear tables with arrows conveying relationships across interconnected concepts; logic models; Venn diagrams; flowcharts; jigsaw puzzles; cultural symbols like beadwork sewn into a hide (see quote below), clan names, Indigenous languages and elements from nature; geometric shapes like triangles and pentagrams; interconnected networks; steps in a process set against intersecting axes; and concentric or interconnected circles depicting different levels of action required to advance health justice for all.

Some framework visuals have been intentionally designed to convey the distinct knowledge system and world view that underpins a framework. For example, the authors of the Indigenous Health Commitments: Roadmap to Wellness framework[2] commented:

> 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.[p6]

Another example of how frameworks can convey distinct world views is illustrated by contrasting the depiction of the Improving Indigenous Cancer Journeys in BC: A Road Map framework authored by the First Nations Health Authority[3] — as stones in a flowing river situated against the sands of living well with trees in the background (see page 4) — with that of the framework developed by Horrill et al.[4] for nurses to redress inequities in health care access among Indigenous Peoples. Horrill et al.'s framework is portrayed as three interconnected circles showing actions required to advance equity at the intrapersonal, interpersonal and structural levels, followed by a table with sample actions for each level (see page 8).

This supplement can be used by public health practitioners and others to reflect on and better understand the many actions that organizations and systems can take to advance health equity, while recognizing that each framework was co-created or created in specific contexts, oftentimes for specific populations denied equity.

The framework visuals presented in this supplement are organized by the population that each health equity framework is focused on (see Table 1).

Table 1: Categories of framework visuals based on population of focus

Section	Population of focus	Number of frameworks with visuals
1	Indigenous or Aboriginal populations	16
2	People of colour or racialized communities	9
3	People experiencing inequities	11
4	Broad population focus with reference to multiple different equity-denied groups	3
5	Gender identity and/or sexual orientation	2

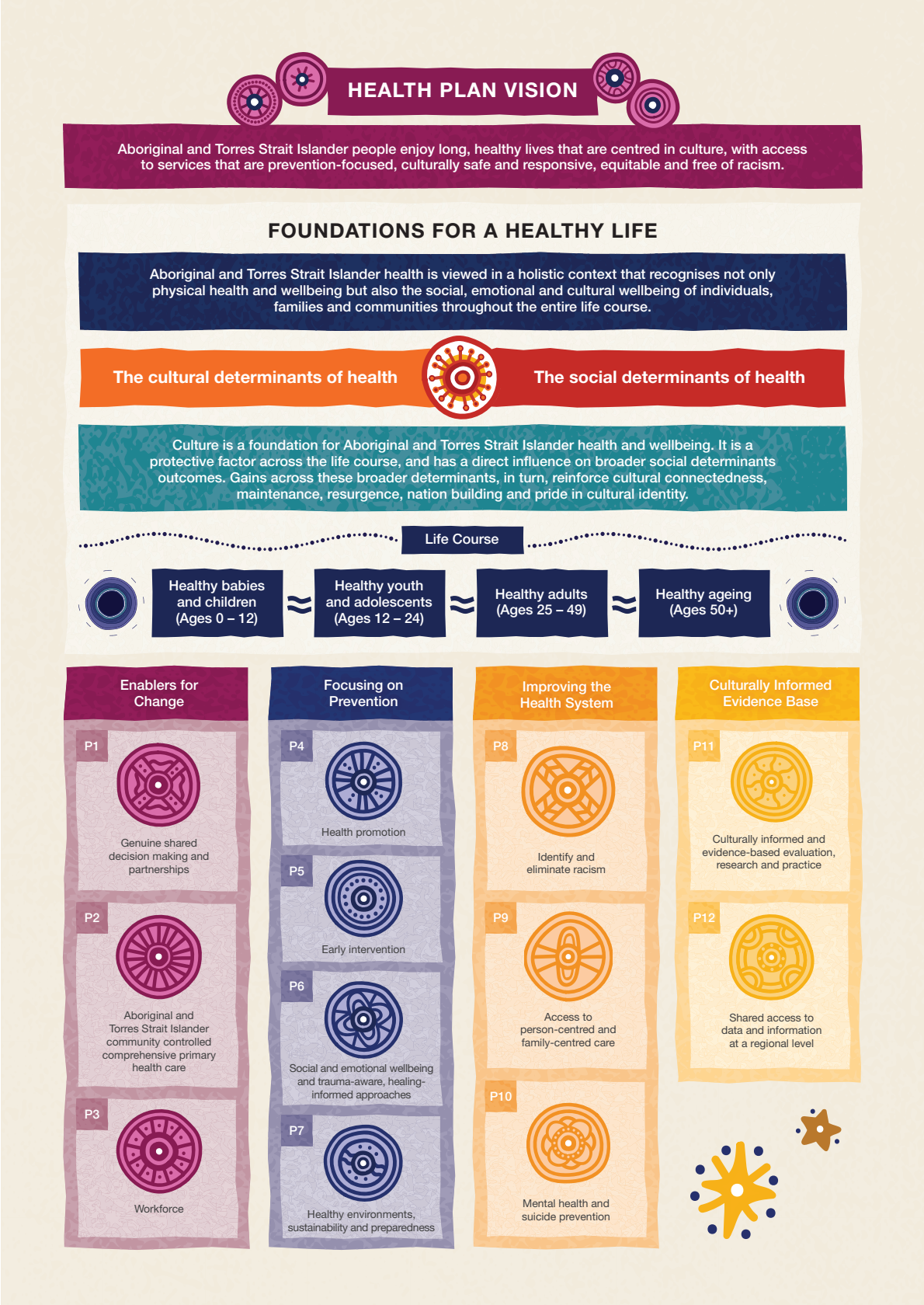
SECTION 1: INDIGENOUS OR ABORIGINAL POPULATIONS

1. ALBERTA HEALTH SERVICES. INDIGENOUS HEALTH COMMITMENTS: ROADMAP TO WELLNESS

a) Indigenous Health Commitments: Roadmap to Wellness framework[2(p6)]

2. AUSTRALIA DEPARTMENT OF HEALTH. NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PLAN 2021–2031

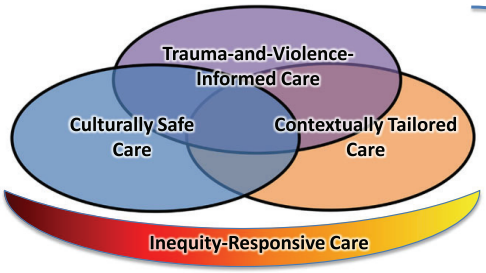
a) Health Plan framework visual[5(p6)]



3. BROWNE ET AL. ENHANCING HEALTH CARE EQUITY WITH INDIGENOUS POPULATIONS: EVIDENCE-BASED STRATEGIES FROM AN ETHNOGRAPHIC STUDY

a) Essential elements of equity-oriented primary health care with Indigenous Peoples[6(p5)]

Key Dimensions of Equity-Oriented Services



4 General Approaches:

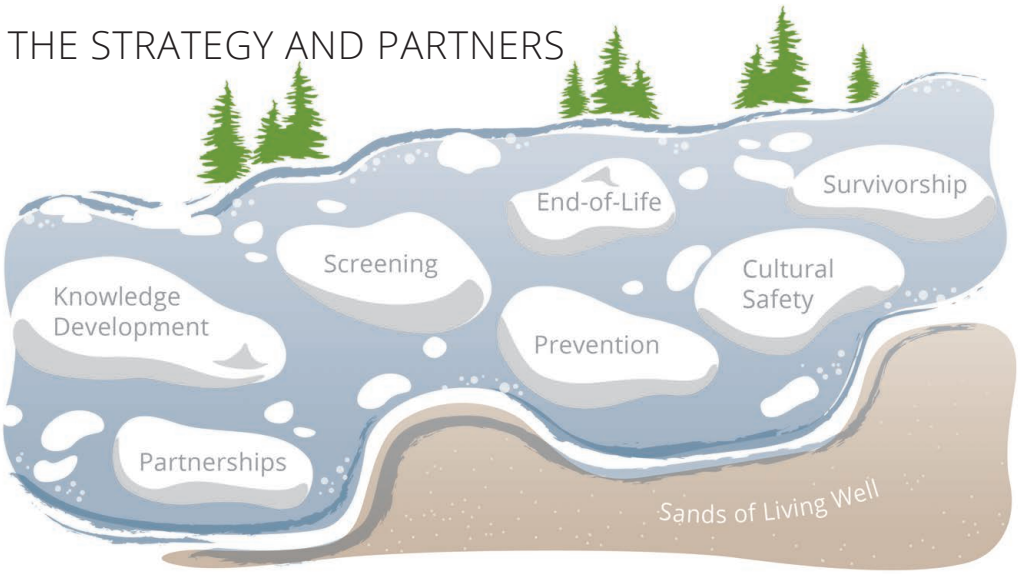
- Partnerships with Indigenous peoples
- Action at all levels (patient-provider; organizations; systems)
- Attention to local and global histories
- Attention to unintended and potentially harmful impacts of each strategy

10 Strategies to Guide Equity-Oriented Services with Indigenous Peoples:

- Explicitly commit to fostering health equity
- Develop supportive organizational structures, policies, and processes
- Optimize use of place and space
- Re-vision the use of time
- Attend to power differentials
- Tailor care, programs and services to local Indigenous contexts
- Actively counter racism and discrimination
- Ensure meaningful engagement of patients and community leaders
- Tailor care to address inter-related forms of violence
- Tailor care to address the social determinants of health

4. FIRST NATIONS HEALTH AUTHORITY, ET AL. IMPROVING INDIGENOUS CANCER JOURNEYS IN BC: A ROAD MAP

a) Improving Indigenous Cancer Journeys in BC: A Road Map framework[3(p4)]



This strategy provides a road map to improve the Indigenous cancer journey, and is 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. It reflects the voices of Indigenous people with cancer, survivors and their families, and presents a united and clear path forward to improve Indigenous cancer journeys and experiences in the province.

5. FIRST NATIONS HEALTH AUTHORITY. URBAN AND AWAY-FROM-HOME HEALTH AND WELLNESS FRAMEWORK

a) Urban and Away-from-Home Health and Wellness Framework[7(p25)]

FRAMEWORK AT A GLANCE

MEANINGFUL REPRESENTATION

Develop sustainable and meaningful engagement pathways with the urban and away-from-home population across BC.

RESEARCH AND KNOWLEDGE DEVELOPMENT

Develop ethical and solution-oriented strategies for urban and away-from-home research and knowledge development.

PARTNERSHIPS

Develop and continue to nurture meaningful partnerships with First Nations, provincial ministries, provincial and regional health authorities, Indigenous service organizations and health and wellness organizations through engagement and implementation of this Framework

COORDINATING PROGRAMS AND SERVICES

Coordinate new and ongoing urban and away-from-home programs and services to increase efficiency and avoid duplication

ENHANCING PROGRAMS AND SERVICES

Through partnerships, operationalize a continuum of care that brings together the best of traditional and cultural approaches with western approaches, and encompasses a range of fully integrated programs and services

INTEGRATING THE SOCIAL DETERMINANTS OF HEALTH

Partners acknowledge the social determinants of health and recognize the efficiency and equity in investing in upstream and preventative supports for the urban and away-from-home population

URBAN PARTICIPATION: "WITH US, NOT FOR US"

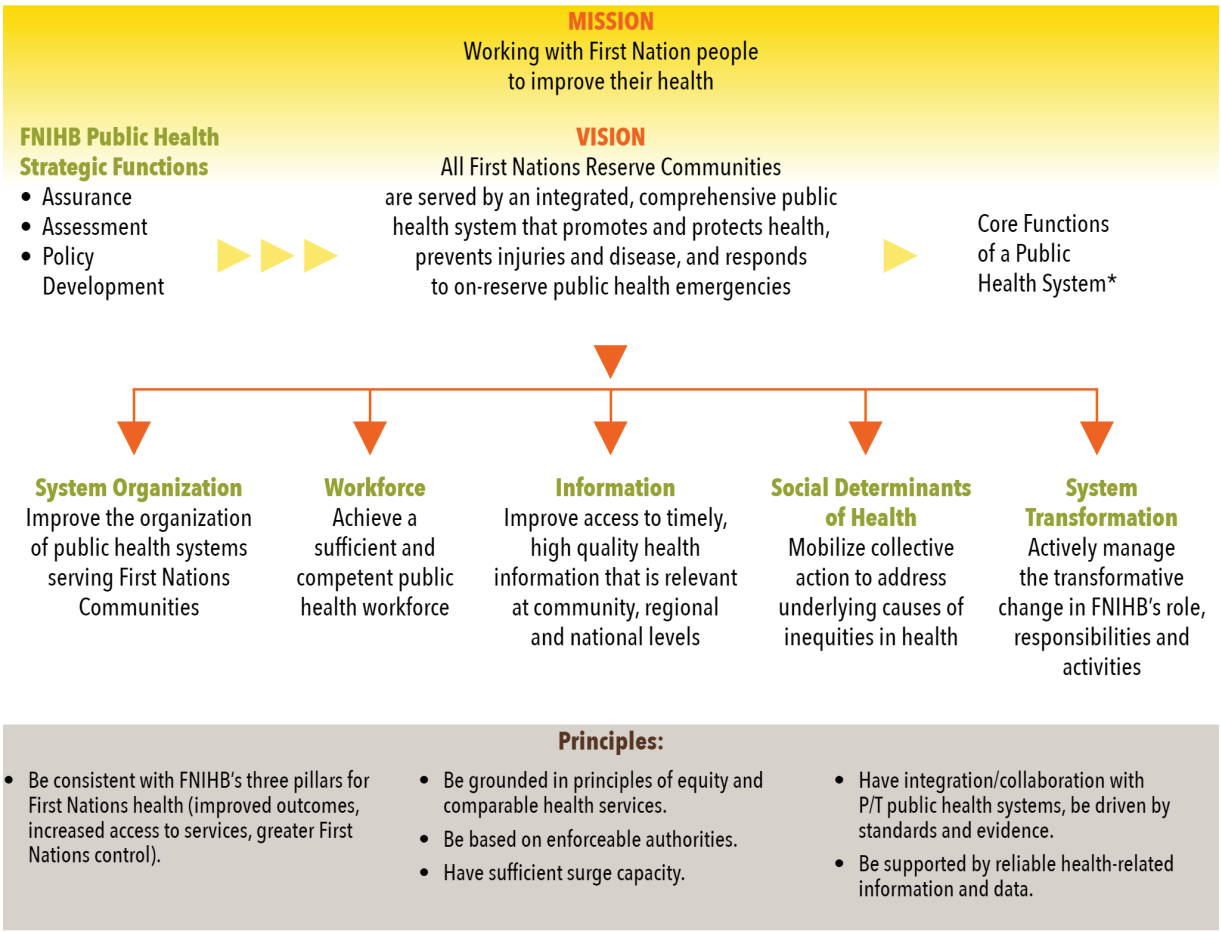
Develop a strategy or strategies and set of guiding principles for First Nations participation and inclusion in urban and away-from-home health and wellness services.

NATION-BASED AND NATION-SHARED SERVICES

Comprehensive funding approach that enables long term Nation-based planning, and collaboration between communities and Nations, to efficiently deliver services within economies of scale

6. FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION. PUBLIC HEALTH FOR FIRST NATIONS IN QUEBEC: SHARED RESPONSIBILITY, CONCERTED ACTION

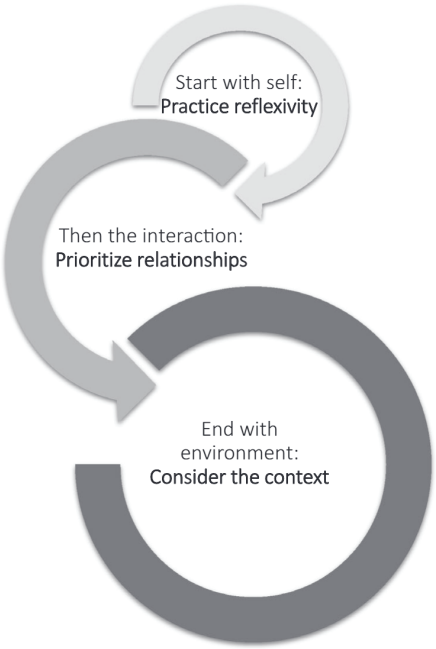
a) First Nations and Inuit Health Branch's public health strategic framework for First Nations[8(p31)]



* Core Functions of a Public Health System: Population health assessment, health surveillance, disease & injury prevention, health promotion, health protection, and public health emergency preparedness and response

7. HORRILL ET AL. NURSES AS AGENTS OF DISRUPTION: OPERATIONALIZING A FRAMEWORK TO REDRESS INEQUITIES IN HEALTHCARE ACCESS AMONG INDIGENOUS PEOPLES

a) A cultural safety and trauma- and violence-informed care framework for redressing inequities in health care access[4(p8)]



INTRAPERSONAL DOMAIN: PRACTICE REFLEXIVITY

First, start with yourself. Take a critically reflexive approach, shifting the focus inward, and reflect on:

- What attitudes, values and beliefs do you hold towards those who are different than you, both personally and professionally? For example, how do you feel and think about someone who is of a different ethnicity, culture, ability or gender? What may have shaped those attitudes, values and beliefs?
- How are you positioned personally and professionally as a nurse (socially, historically and economically) in relation to the patient(s) and their families that you provide care for?
- How do you think your attitudes, values, beliefs and positionality impact your nursing practice? How might these impact access to healthcare for patients? Consider engaging with a mentor or an online tool to help you identify and challenge the hidden biases that you may have.

INTERPERSONAL DOMAIN: PRIORITIZE RELATIONSHIPS

Next, shift your perspective to those around you, and critically evaluate how you relate to/with patients and how they relate to/with you:

- How do you relate to patients or families that are different from you? Similar to you? How would a patient rate your interactions? Ask for feedback from a trusted colleague.
- How can you establish trusting, collaborative relationships with patients and families that convey respect and acceptance? Use communication and body language, including basic manners and active listening; use language that is non-judgmental and avoid technical language.
- How can you share in power and vulnerability to establish a partnership with a patient or family rather than a hierarchy? Think about ways you could involve the patient and family in their care.
- What strengths does this patient and/or family have? Consider how you could acknowledge and support them in using these strengths.
- Do you speak out against behaviors among nurses and other healthcare providers that convey negative attitudes or judgment (i.e., eye rolling, labeling patients, etc.)? Seek out colleagues or groups of like-minded healthcare professionals who can support you in your efforts to call out racism and other forms of stereotyping and discrimination.

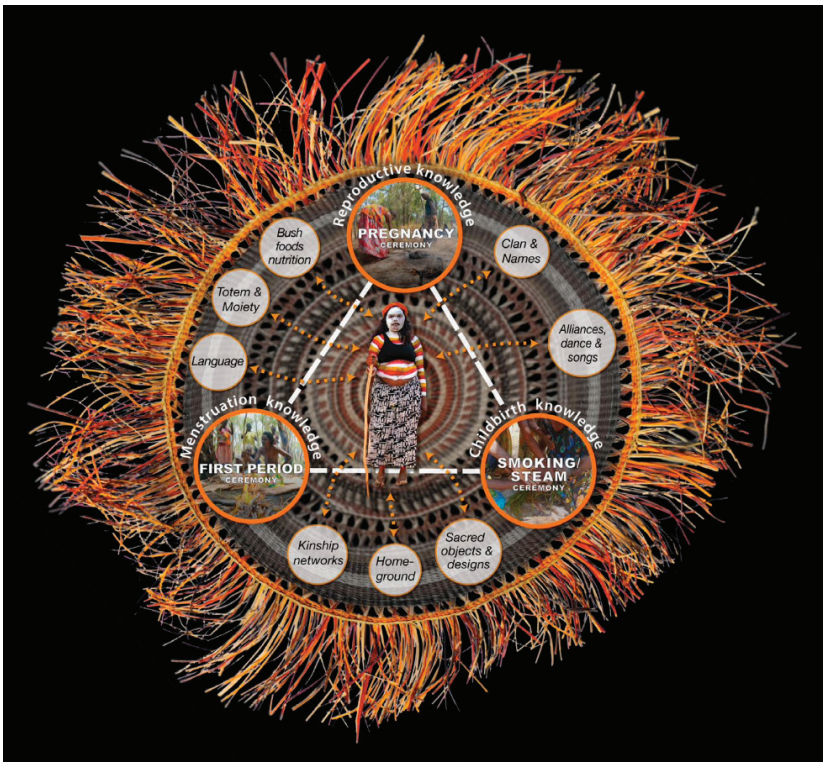
STRUCTURAL DOMAIN: CONSIDER THE CONTEXT

Finally, consider where the patient is situated, how context is shaping what is happening in the situation, and how you can draw attention to the structural determinants of health in your practice:

- How is this patient situated historically/socially/economically? Are you aware of the structural determinants of health faced by this patient or group that may be impacting his/her access to healthcare or health? Engage with organizations working with or advocating for structurally disadvantaged groups.
- Can you acknowledge the context of the patient's life or address any of the social or structural inequities experienced by this patient to improve their access to care? Partner with other members of the healthcare team or organizations outside of your workplace.
- Do you understand the historical context of colonialism and its ongoing effects on health and access to healthcare? Participate in circles of reconciliation and ceremony.
- How can you make the clinical or physical space feel safe and welcoming? Solicit feedback from patient advocacy groups.
- What steps can you implement as a nurse and a global citizen to disrupt or dismantle structural inequities? Advocate to elected officials and professional nursing organizations; participate in protests; join or form a committee within your workplace; propose or revise policies within your organization; write an op-ed.

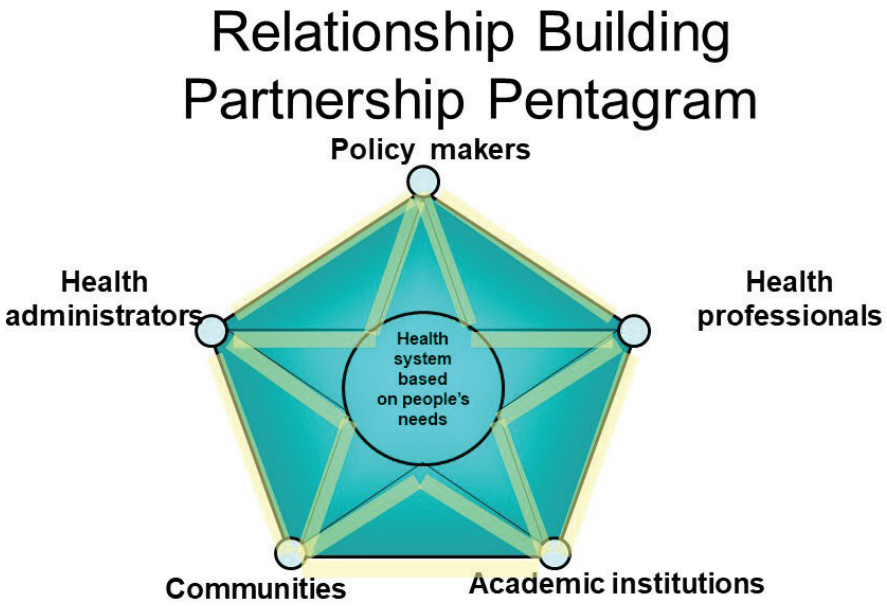
8. IRELAND ET AL. "WE ARE SACRED": AN INTERCULTURAL AND MULTILINGUAL APPROACH TO UNDERSTANDING REPRODUCTIVE HEALTH LITERACY FOR YOLŊU GIRLS AND WOMEN IN REMOTE NORTHERN AUSTRALIA

a) A reproductive health literacy framework for Yolŋu girls and women[9(p197)]

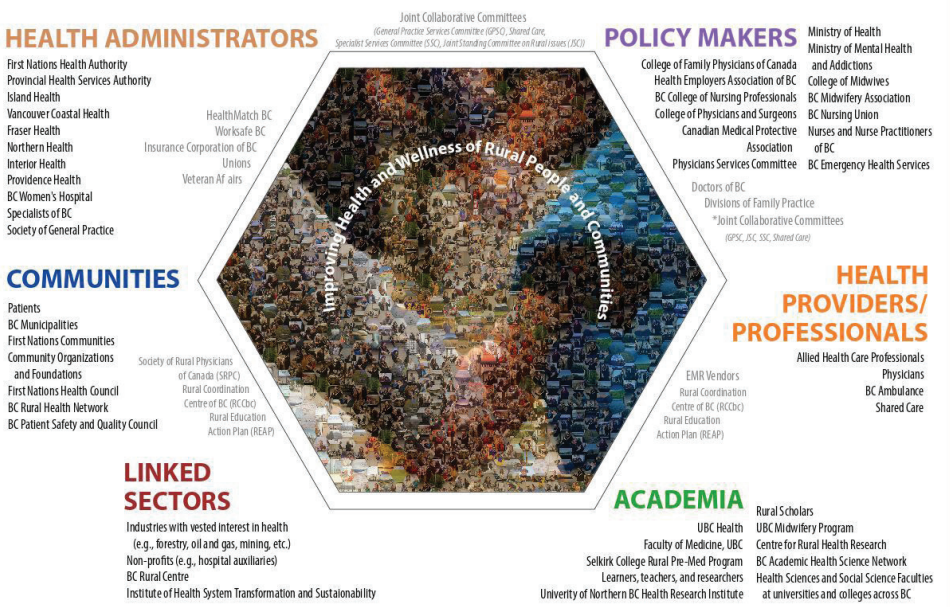


9. MARKHAM ET AL. ADDRESSING RURAL AND INDIGENOUS HEALTH INEQUITIES IN CANADA THROUGH SOCIALLY ACCOUNTABLE HEALTH PARTNERSHIPS

a) Partnership Pentagram[10(p2)]



b) Partnership Pentagram Plus[10(p2)]



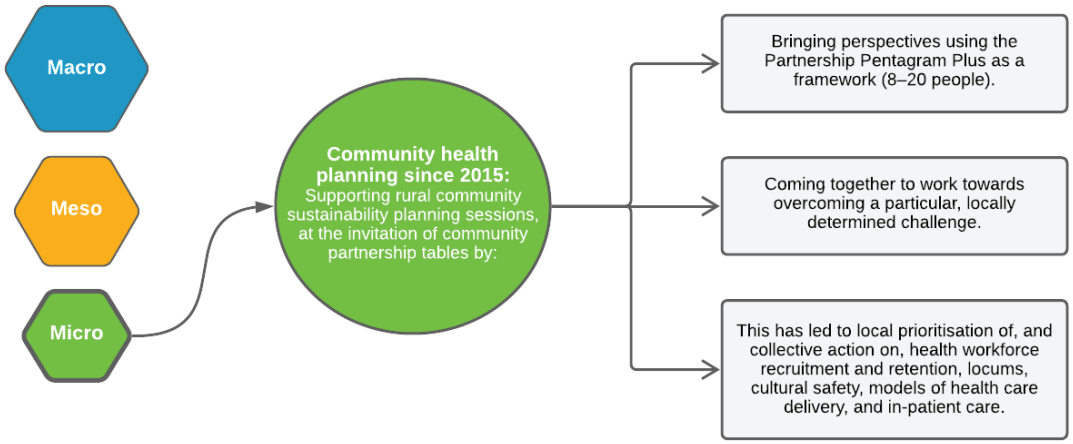
c) Scapegoats for collective failure[10(p3)]

In complex system undertakings, like health, whoever is **not** there provides a useful excuse for collective failure.

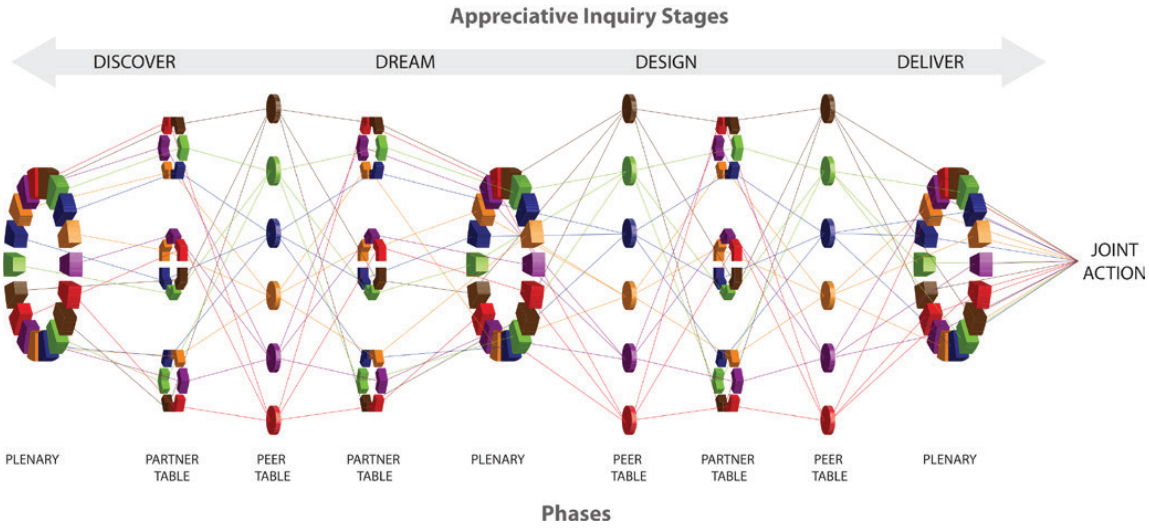
For example:

no policy-makers = lack of will
no managers = too much bureaucracy and red tape
no health professionals = greedy doctors and unions
no academics = ivory tower rather than real world
no patients/communities = unrealistic expectations
no linked sectors = don't care about community

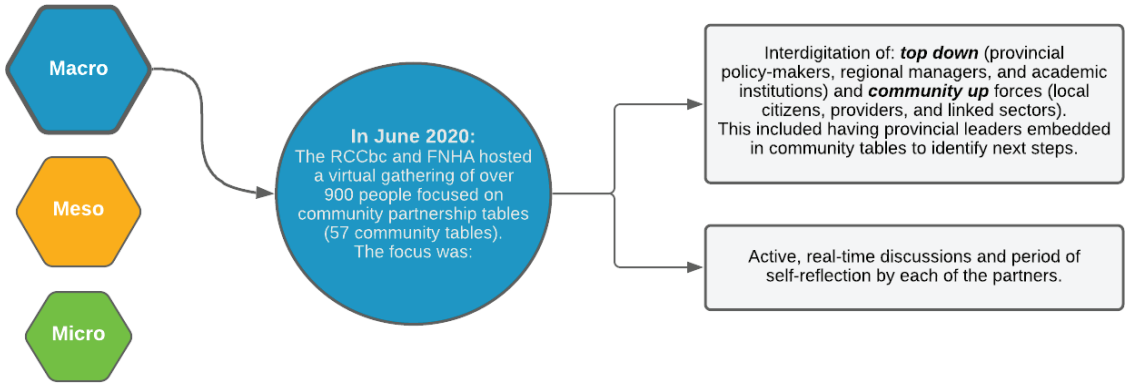
d) Application at a micro (community) level[10(p4)]



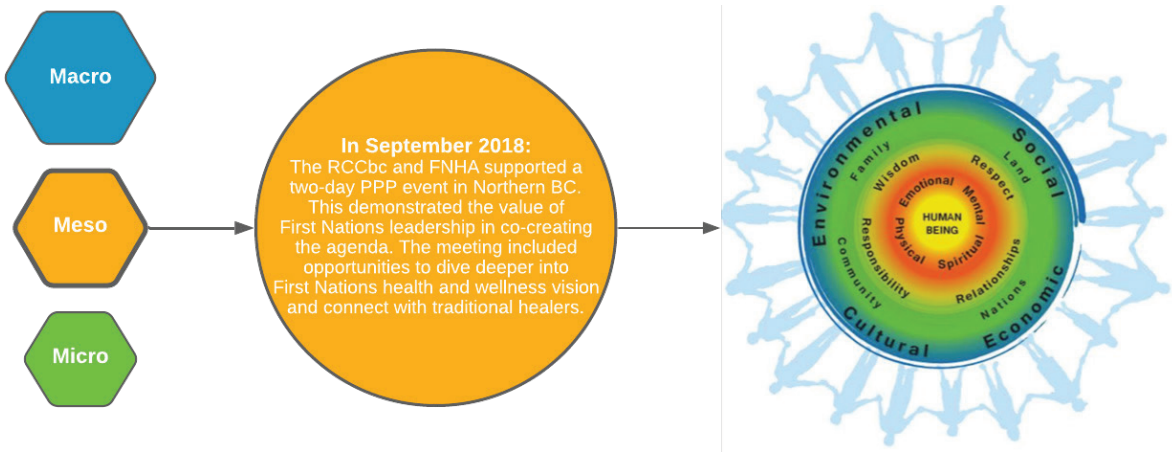
e) Breathing and weaving[10(p4)]



f) Application at a macro (provincial) level[10(p4)]



g) Application at a meso (regional) level[10(p4)]



10. 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

a) National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People[11(p7)]

National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People, 2018-2023

The Framework recognises the rights of Aboriginal and Torres Strait Islander people to access health care that is high quality, safe, effective, responsive and culturally respectful.

VISION

Aboriginal and Torres Strait Islander people have access to and receive the highest attainable standard of primary health care wherever and whenever they seek care.

AIM

To foster a collective commitment by all governments and organisations to build a sustainable, coordinated and responsive primary health care system, which uses best practice, evidence-based and CQI approaches to provide culturally-safe, high-quality, comprehensive primary health care services.

PRINCIPLES

Aboriginal and Torres Strait Islander people are at the centre of care with respect for their experiences, choices, dignity and rights.

The ACCHO sector provides expertise in CQI and its leadership and guidance in implementing the Framework is recognised.

There is a need for flexibility in approaches and tools to meet the needs of local communities and health care services.

There is recognition of the need for partnerships and collaboration within and between primary health care sectors.

DOMAIN 1:

BEING CULTURALLY RESPECTFUL IN CQI

Culturally respectful CQI ensures that Aboriginal and Torres Strait Islander people, communities and health care services are actively engaged in identifying priorities and developing policies and programs that lead to improved access, high-quality care, positive experiences and better health outcomes.

DOMAIN 2:

DOING CQI

CQI to improve health care services for Aboriginal and Torres Strait Islander people is embedded as part of organisational and clinical governance, in the roles and responsibilities of staff and teams, and in the use of indicators, data and patient information management systems.

DOMAIN 3:

SUPPORTING CQI

Partnerships between government, the ACCHO sector and PHNs provide leadership, resources and a collaborative environment for CQI.

CQI capability is supported through investment in data analysis and interpretation, CQI tools and resources, and workforce.

DOMAIN 4:

INFORMING CQI

Quality indicators and benchmarks that align with evidence for good practice in primary health care are used to inform CQI planning, implementation and reporting.

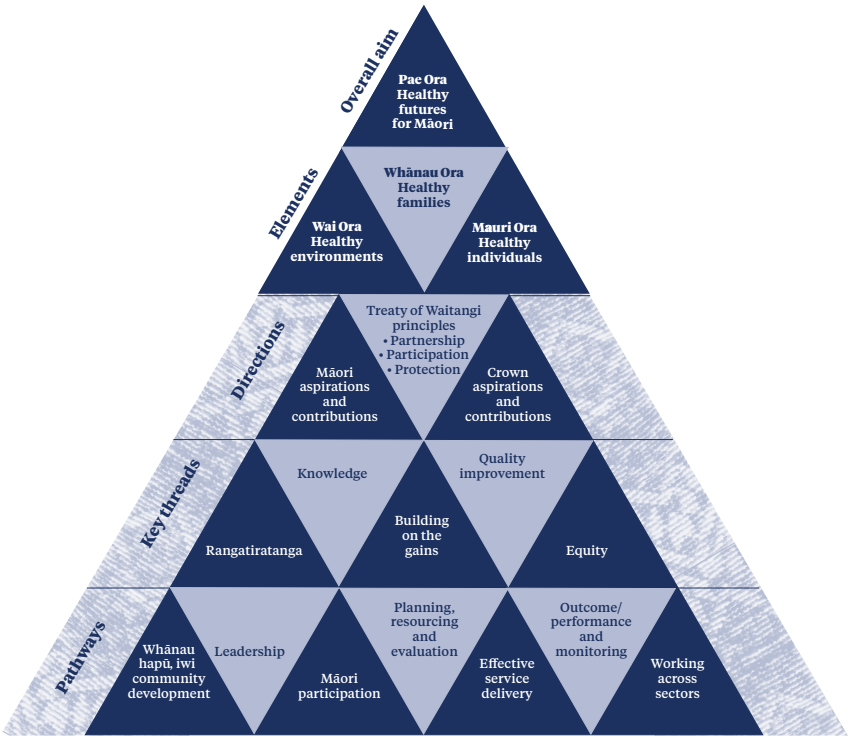
CQI research and knowledge translation supports improved primary health care services and health outcomes.

b) Domain 1 – Being culturally respectful in CQI (extract)[11(p8)]

Domain 1: Being culturally respectful in CQI					
Focus Area	**What does it look like?**	**Quality Outcome**	**P**	**S**	**G**
Providing culturally respectful primary health care	The Cultural Respect Framework outlines the organisational, communication, workforce, consumer, stakeholder, and evidence that underpins culturally respectful health service delivery.	Primary health care is culturally safe, and changes made to health centre systems and processes work well for Aboriginal and Torres Strait Islander communities.			
Cultural respect in the design and implementation of CQI	Aboriginal and Torres Strait Islander people, communities and health services are actively engaged in identifying priorities and in developing policies and programs that lead to improved access, high-quality and culturally-safe care, positive experiences and better health outcomes. Partnerships are established and maintained with Aboriginal and Torres Strait Islander communities and organisations to ensure CQI implementation is responsive to their needs and aspirations.	Cultural respect is understood, valued and embedded by all organisations including PHNs and general practices in the planning, resourcing and implementation of CQI in Aboriginal and Torres Strait Islander primary health care.			

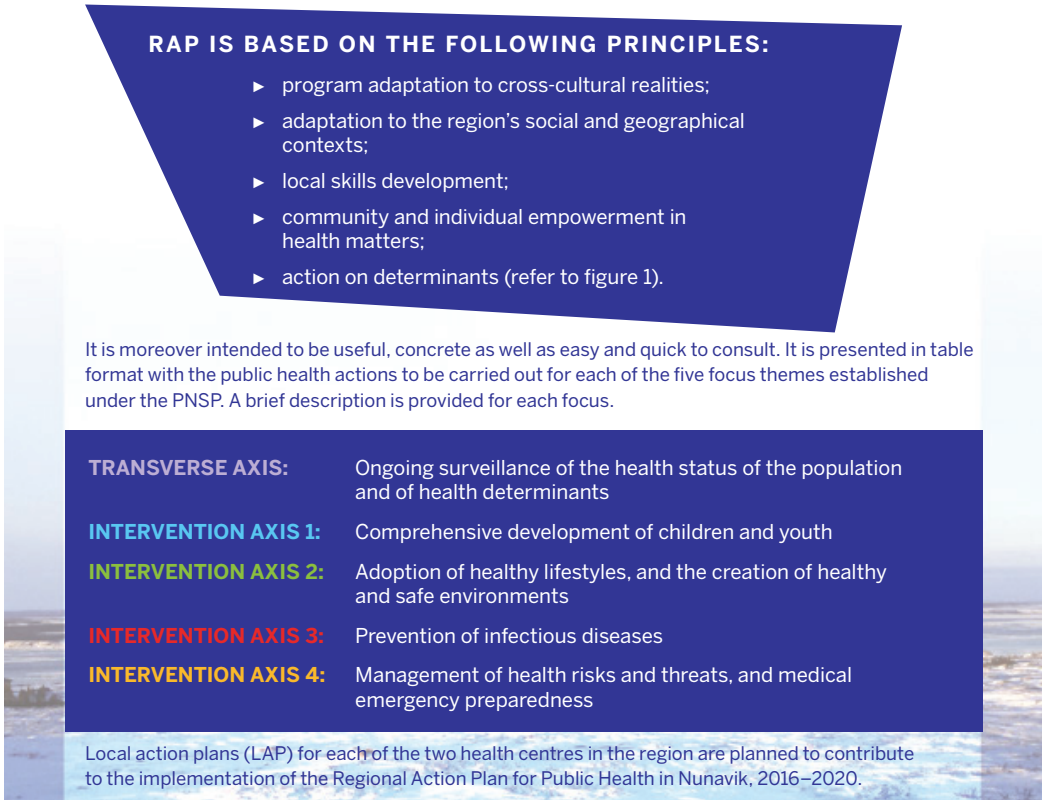
11. NEW ZEALAND MINISTRY OF HEALTH. THE GUIDE TO HE KOROWAI ORANGA: MĀORI HEALTH STRATEGY 2014

a) Māori Health Strategy overarching aim[12(p4)]



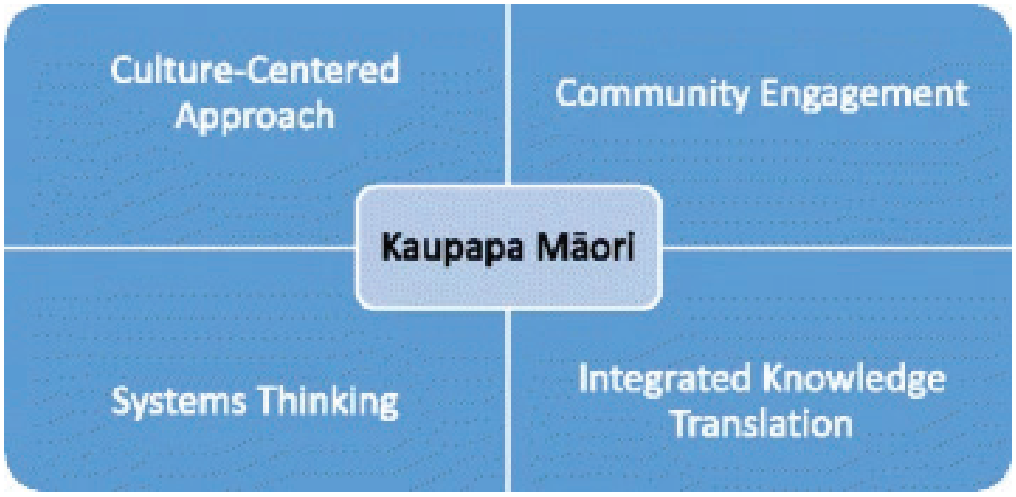
12. NUNAVIK REGIONAL BOARD OF HEALTH AND SOCIAL SERVICES. REGIONAL ACTION PLAN FOR PUBLIC HEALTH 2016–2020

a) Nunavik Regional Action Plan (RAP) for Public Health framework[13(p11)]



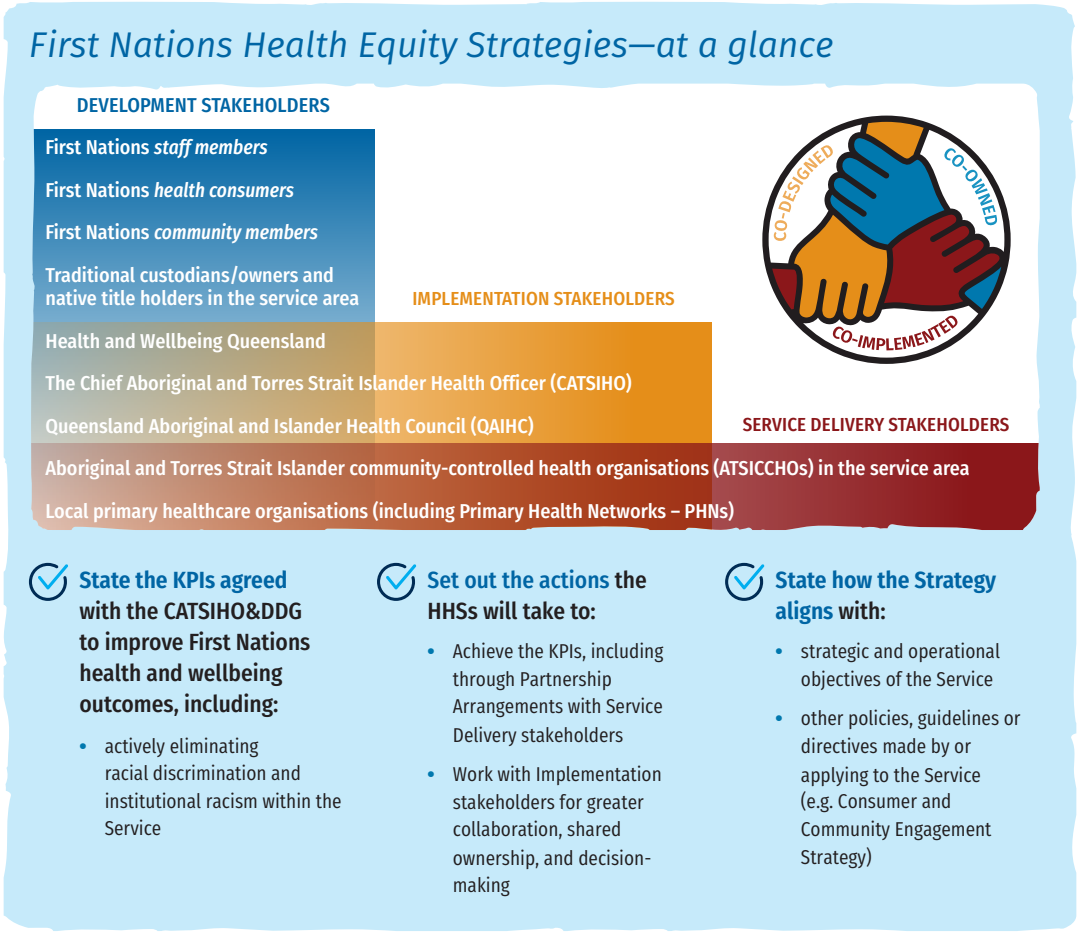
13. OETZEL ET AL. IMPLEMENTATION FRAMEWORK FOR CHRONIC DISEASE INTERVENTION EFFECTIVENESS IN MĀORI AND OTHER INDIGENOUS COMMUNITIES

a) Key elements of implementation framework for Māori communities[14(p3)]



14. QUEENSLAND HEALTH ET AL. MAKING TRACKS TOGETHER: QUEENSLAND'S ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH EQUITY FRAMEWORK

a) Queensland's Aboriginal and Torres Strait Islander Health Equity Framework strategies (extract)[15(p13)]



15. TASMANIAN ABORIGINAL CENTRE ET AL. CLOSING THE GAP: TASMANIAN IMPLEMENTATION PLAN 2021 – 2023

a) Tasmanian Implementation Plan framework priority reforms (extract)[16(p8)]

Priority Reform One: Partnership and shared decision-making

PRIORITY REFORM ONE – FORMAL PARTNERSHIPS AND SHARED DECISION-MAKING				
Priority Reform One Outcome: Aboriginal and Torres Strait Islander people are empowered to share decision-making authority with governments to accelerate policy and place-based progress on Closing the Gap through formal partnership arrangements.				
Priority Reform One Target: There will be formal partnership arrangements to support Closing the Gap in place between Aboriginal and Torres Strait Islander people and governments in place in each state and territory enshrining agreed joint decision-making roles and responsibilities and where Aboriginal and Torres Strait Islander people have chosen their own representatives.				
Action	**Status**	**Funding**	**Timeframe**	**Minister**
Aboriginal Engagement Strategy The Partners, in consultation with Tasmanian Aboriginal people and Aboriginal community-controlled organisations, will develop a responsive Aboriginal Engagement Strategy that provides funding, details and actions for ongoing, culturally respectful, and genuine high level engagement with Aboriginal people, Aboriginal community-controlled organisations, and service providers and ensures Aboriginal engagement equity.	New	TBC	January 2022	Minister Aboriginal Affairs
Review Current Partnership Structures The Tasmanian Government, in consultation with the Peak and Tasmanian Aboriginal people, will review existing Tasmanian Government partnership structures for effectiveness and to avoid of duplication.	New	TBC	By June 2022	Minister for Aboriginal Affairs
Five Policy Priority Partnerships The Tasmanian Government will partner with Tasmanian Aboriginal people to establish five initial Policy Partnerships, Justice (adult and youth incarceration); Social and emotional wellbeing (mental health); Housing; Early childhood care and development, and Aboriginal and Torres Strait Islander languages (National Agreement, clause 38)	New	TBC	Beginning November 2021	Minister for Aboriginal Affairs and relevant Ministers

16. WESTERN AUSTRALIA DEPARTMENT OF HEALTH. WA ABORIGINAL HEALTH AND WELLBEING FRAMEWORK 2015–2030

a) WA Aboriginal Health and Wellbeing Framework[17(p1)]

Vision

Aboriginal people living long, well and healthy lives.

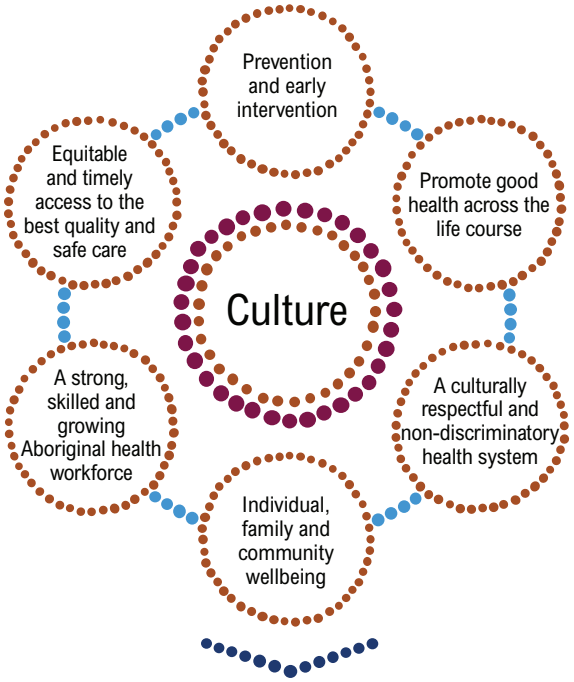
Aim

The *WA Aboriginal Health and Wellbeing Framework 2015–2030* identifies a set of guiding principles, strategic directions and priority areas to improve the health and wellbeing of Aboriginal people in Western Australia for the next 15 years.

Guiding principles

- Cultural security
- The health and wellbeing of Aboriginal people is everyone's business
- Partnerships
- Aboriginal community control and engagement
- Access and equality
- Accountability

Strategic directions



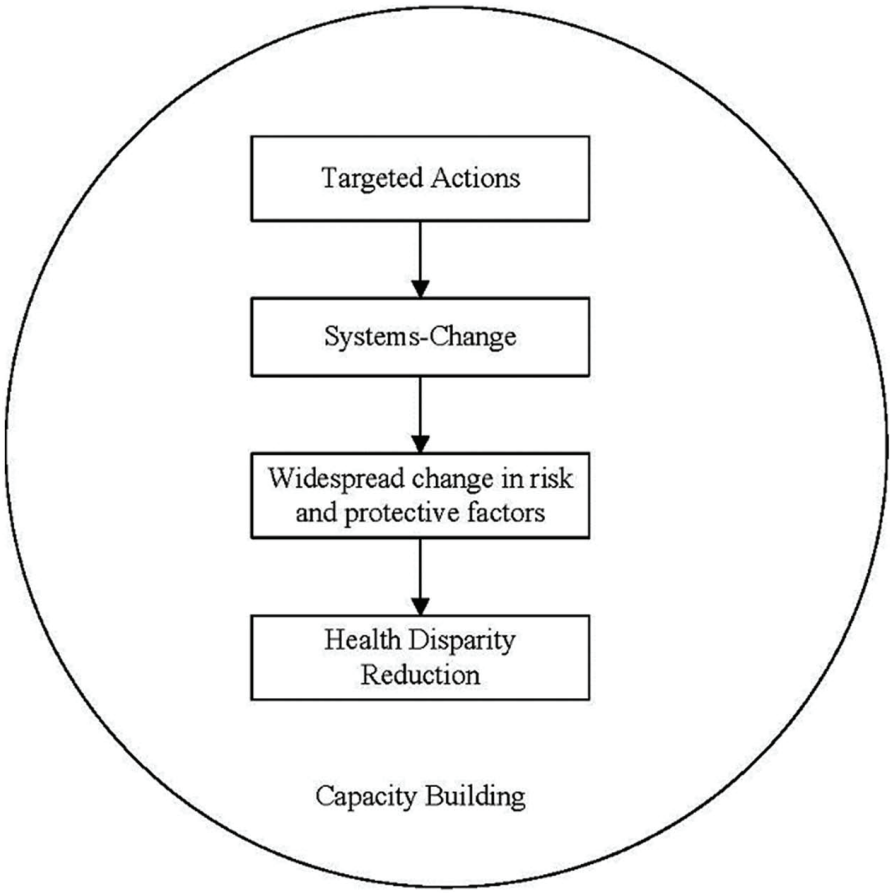
Priority areas

- Addressing risk factors
- Managing illness better
- Building community capacity
- Better health systems
- Aboriginal workforce development
- Data, evidence and research
- Addressing the social determinants of health

SECTION 2: PEOPLE OF COLOUR OR RACIALIZED COMMUNITIES

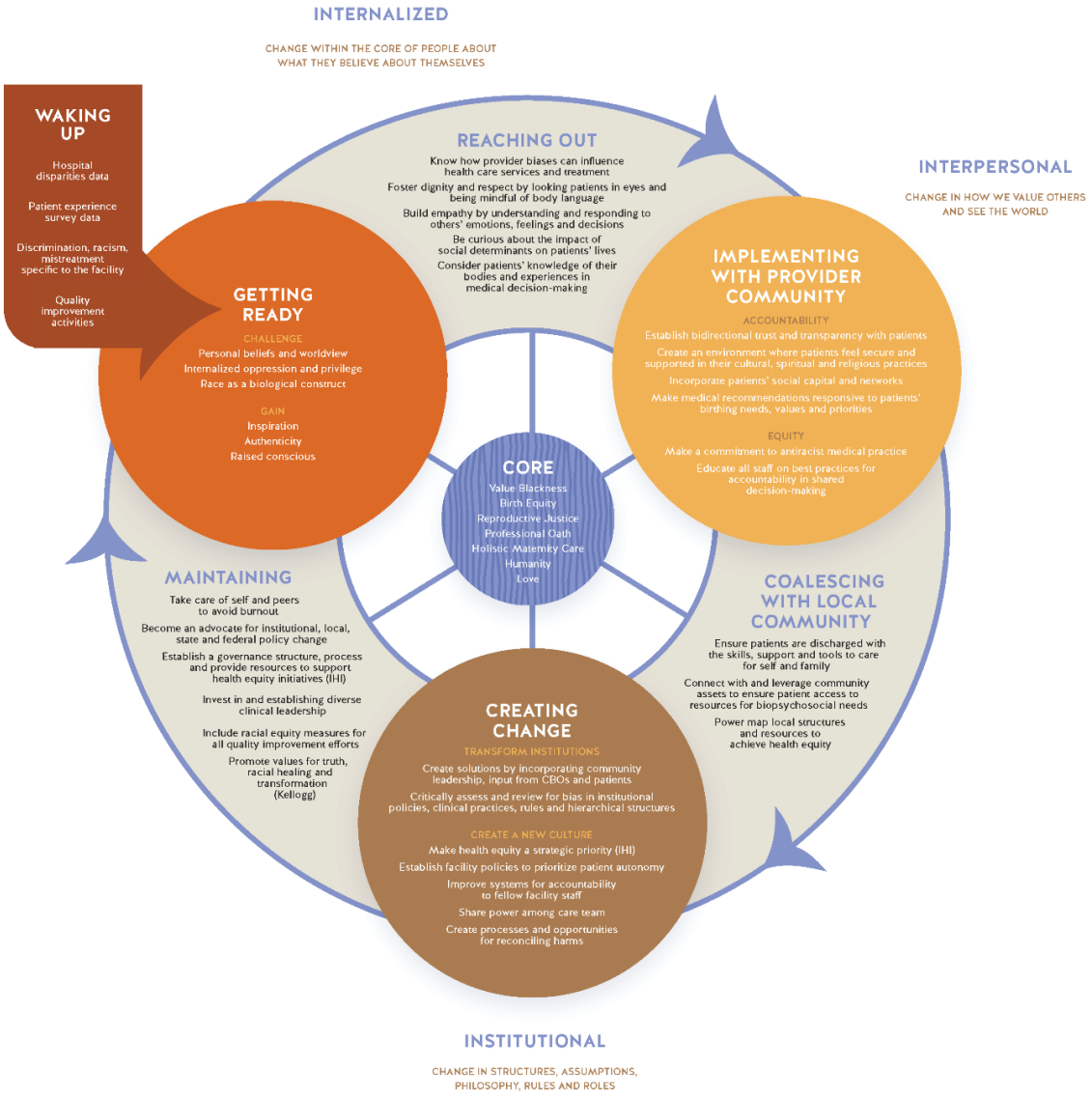
1. COTTON ET AL. A CASE STUDY ON A UNIVERSITY-COMMUNITY PARTNERSHIP TO ELIMINATE RACIAL DISPARITIES IN INFANT MORTALITY: EFFECTIVE STRATEGIES AND LESSONS LEARNED

a) REACH policy systems and environmental framework for health disparity reduction[18(p676)]



2. GREEN ET AL. THE CYCLE TO RESPECTFUL CARE: A QUALITATIVE APPROACH TO THE CREATION OF AN ACTIONABLE FRAMEWORK TO ADDRESS MATERNAL OUTCOME DISPARITIES

a) Cycle to Respectful Care framework[19(p7)]



3. HOGAN ET AL. DIMENSIONALITY AND R4P: A HEALTH EQUITY FRAMEWORK FOR RESEARCH PLANNING AND EVALUATION IN AFRICAN AMERICAN POPULATIONS

a) R4P health equity framework domains[20(p149)]

Table 1 Recommendations on how to assess each component of R4P

Domain	Lines of inquiry for assessment
Repair *Assess experiences, attitudes, behaviors, and **beliefs of disparity populations about the institution** that have roots in the past, and may have bearing on willingness of or ability to engage with institution*	What are some examples of historical legacy, occurrences that negatively impact on knowledge, attitudes, beliefs, practices; historical trauma, legacy of privilege or discrimination? These interventions focus on reparation of damage, public relations, marketing, improved engagement
Restructure *Assess **structures in the organization** that maintain systematic exclusion of disparity populations; or provide advantage/ privilege to others at the exclusion of disparity populations (Sources of "insults"; structures that continue to create risk for some populations)*	What are some structural (policy, procedures, rules, regulations, traditions, physical environment, resources, etc.) that continue to systematically exclude, hold back or privilege some over others? This could relate to admissions, retention, course selection, course content, etc. These interventions focus on change in the institution itself
Remediate *Assess needs for **protection of individuals in disparity populations** against existing insults, protections that need to be in place until the insult can be structurally removed*	What conditions in the organization do disparity populations need to be buffered from/protected from, until restructuring occurs and the insult is no longer there? "Risk reduction". These actions usually focus on changing something in the individual
Remove *Identify Structures, attitudes, beliefs, practices or experiences **specific to "Race/ethnicity", low SES or gender** that confer disadvantage to these populations*	May overlap with Repair, Restructure, Remediate—**but** relate SPECIFICALLY to racism, gender and income disadvantage? Looking specifically at these prevents evaluator from "cherrypicking" and/or from succumbing to personal discomfort of dealing with racism, class and gender issues. These interventions focus on change in the institution itself and may also focus on personal assessment of where the individual confers implicit privilege or bias based on ethnicity/race, SES or gender
Provide *Focus on **HOW services of the organization are IMPLEMENTED from a qualitative standpoint**. Culturally, and economically feasible delivery of services, that accommodates all gender roles and responsibilities, along with providing the required resources and environmental supports, so that it is the easiest option for people to choose and take advantage of to achieve equity*	How can ethnicity/racism, class, gender be better considered in services delivered by the institution? (e.g. how classes are taught, who teaches, course offerings, advising, student support, other…)

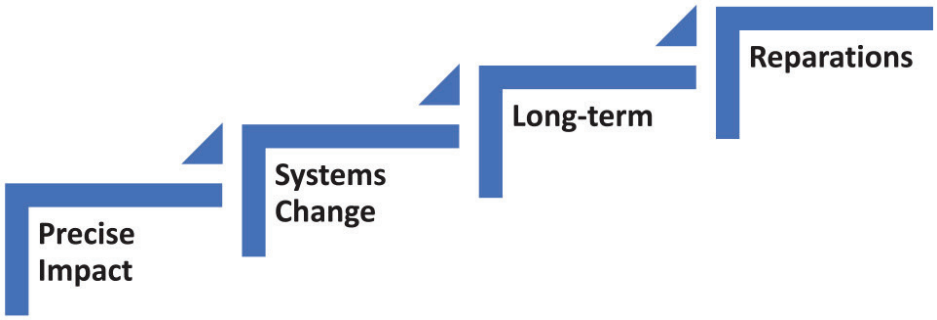
4. HOWELL ET AL. REDUCTION OF PERIPARTUM RACIAL AND ETHNIC DISPARITIES: A CONCEPTUAL FRAMEWORK AND MATERNAL SAFETY CONSENSUS BUNDLE

a) Reduction of peripartum racial and ethnic disparities bundle (extract)[21(pp277)]

Theme in Commentary	Domain in Bundle
Inability to assess disparities because they are not reliably measured	1. Readiness • Establish systems to accurately document self-identified race, ethnicity, and primary language 2. Reporting and Systems Learning • Build a culture of equity, including systems for reporting, response, and learning similar to ongoing efforts in safety culture
Lack of recognition of disparities at both the personal and systems level	1. Readiness • Provide staff-wide education on peripartum racial and ethnic disparities and their root causes 2. Recognition • Provide staff-wide education on implicit bias • Establish a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect 3. Response • Ensure a timely and tailored response to each report of inequity or disrespect
Specific knowledge of the magnitude of racial and ethnic disparities that exist within a health care system	1. Readiness • Engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams 2. Reporting and Systems Learning • Develop a disparities dashboard that monitors process and outcome metrics stratified by race and ethnicity with regular dissemination of the stratified performance data to staff and leadership • Implement quality improvement projects that target disparities in health care access, treatment, and outcomes • Consider the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system level when conducting multidisciplinary reviews of severe maternal morbidity, mortality, and other clinically important metrics
Communication barriers	1. Readiness • Evaluate non-English language proficiency (e.g., Spanish proficiency) for providers who communicate with patients in languages other than English • Educate all staff (e.g., inpatient, outpatient, community-based) on interpreter services available within the health care system 2. Response • Engage in best practices for shared decision-making

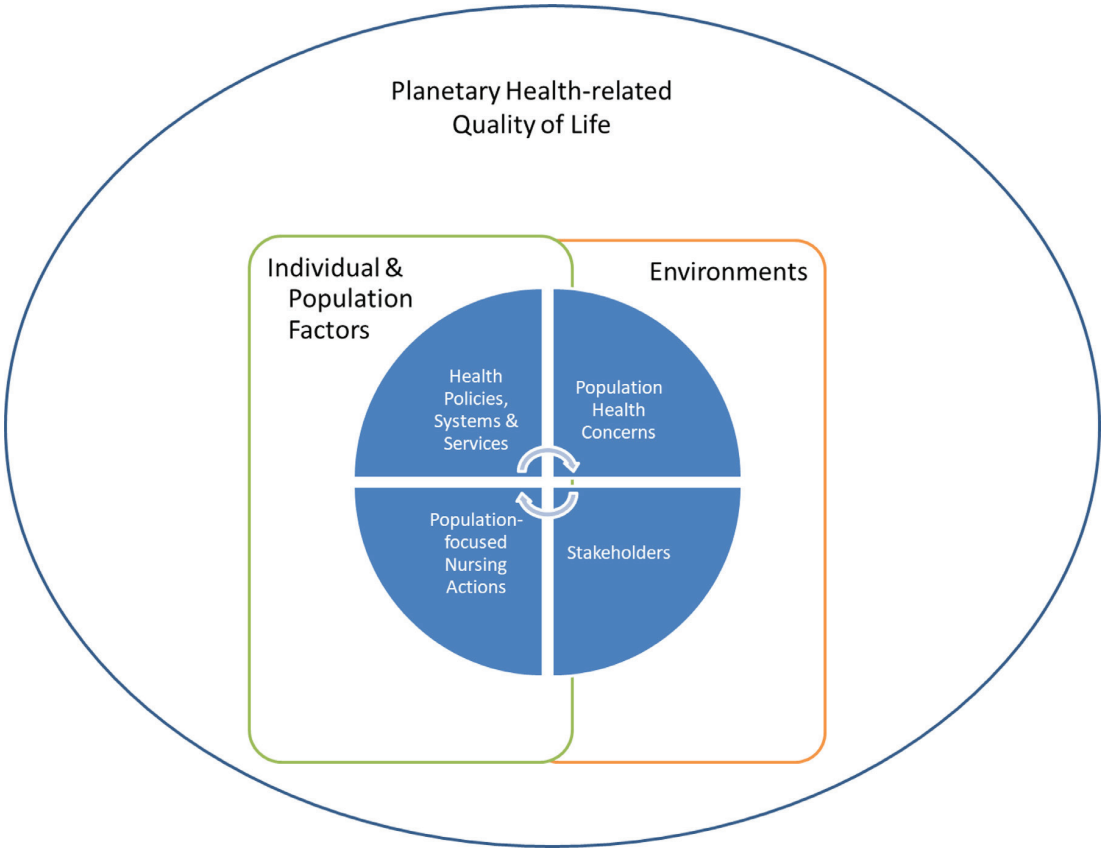
5. KOCH ET AL. ADDRESSING ADULTIFICATION OF BLACK PEDIATRIC PATIENTS IN THE EMERGENCY DEPARTMENT: A FRAMEWORK TO DECREASE DISPARITIES (RACIALIZED COMMUNITIES)

a) Racism as a Root Cause (RRC) Framework[22(p556)]

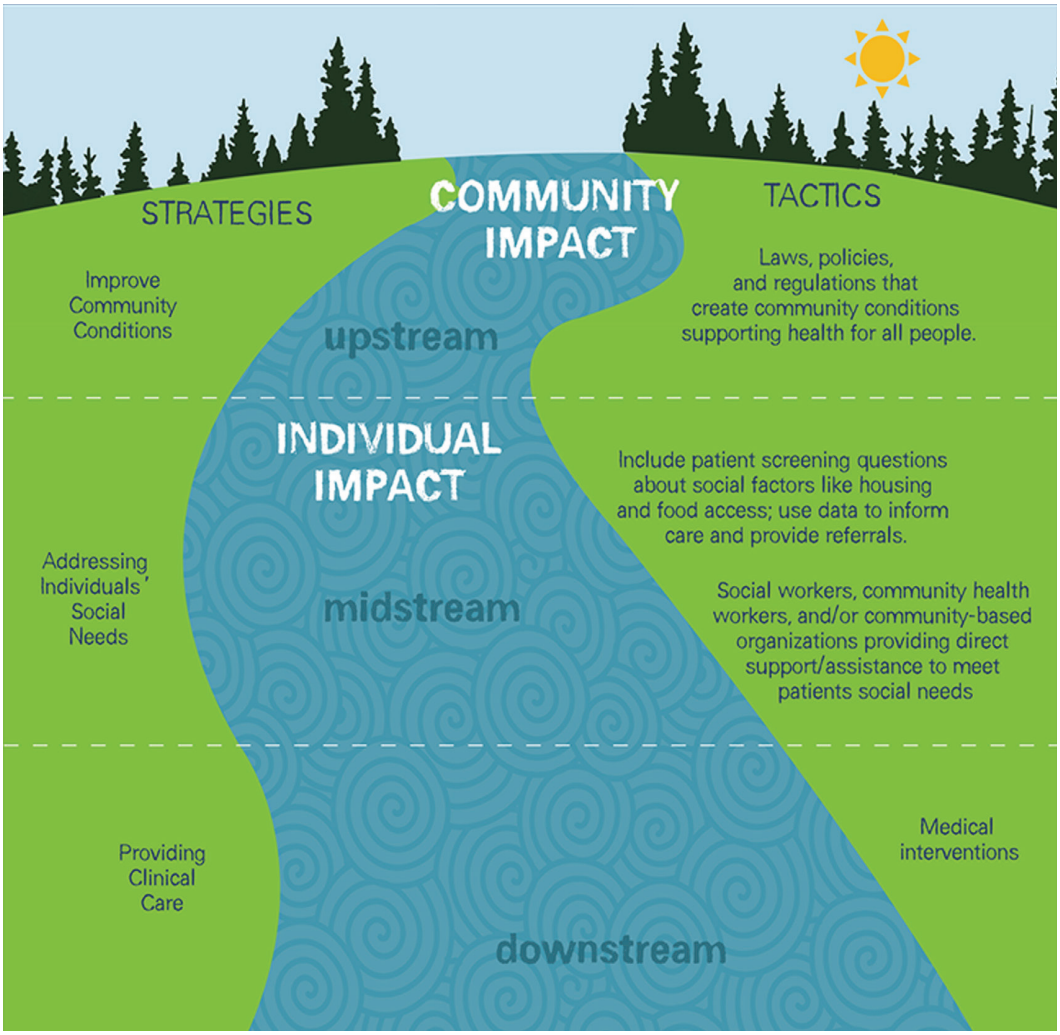


6. KUEHNERT ET AL. DEFINING THE SOCIAL DETERMINANTS OF HEALTH FOR NURSING ACTION TO ACHIEVE HEALTH EQUITY: A CONSENSUS PAPER FROM THE AMERICAN ACADEMY OF NURSING

a) Conceptual framework to guide policy development[23(p13)]

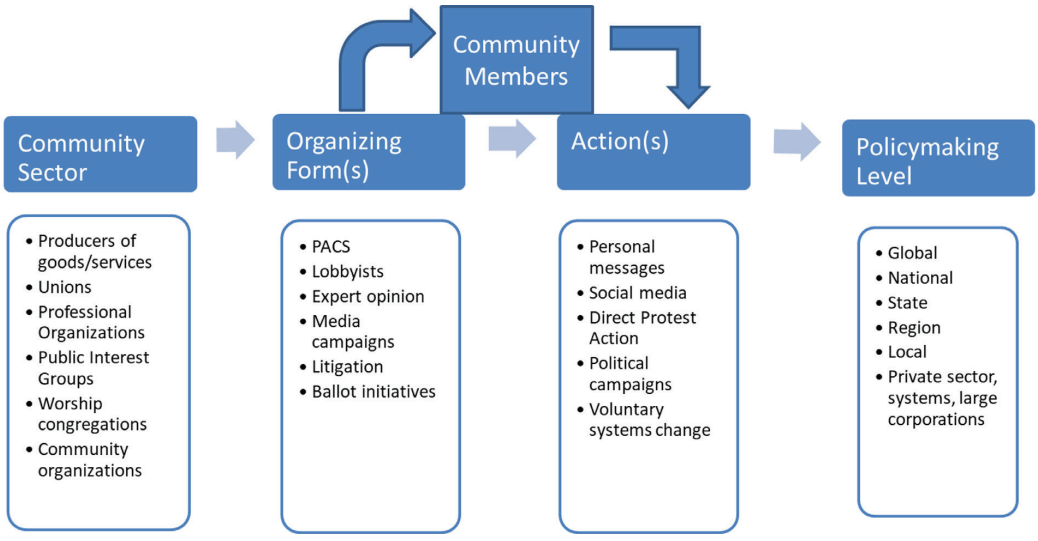


b) Social determinants and social needs: moving beyond midstream[23(p18)]



Note: Original source of graphic is Castrucci and Auerbach.

c) Pathways to policy change[23(p19)]



7. MALAWA ET AL. RACISM AS A ROOT CAUSE APPROACH: A NEW FRAMEWORK

a) Racism as a Root Cause approach: 4 components[24(p2)]

RRC Approach Component	Description
Precise impact	Precisely impacts the racially marginalized group(s)
Systems change	Focuses on changing policies, systems, or environments, as opposed to changing people
Long-term	Sustainable and/or institutionalized for long-term impact
Reparations	Seeks to repair historical injustices by shifting resources, power, and opportunities to racially marginalized groups

b) Racism as a Root Cause checklist[24(p3)]

How do you know if racism is the root cause of health disparities you are seeking to address? If the population you are engaging with is experiencing at least one of the following, racism is likely at the root of this population's health outcome disparities:
Barriers to wealth accumulation
Educational inequities
Disproportionate burden of displacement and housing insecurity
Disparate treatment in the justice system
Disparities by skin tone and/or color

8. SCOTTISH GOVERNMENT. RACE EQUALITY FRAMEWORK FOR SCOTLAND 2016-2030

a) Race Equality Framework visions and key goals (extract)[25(p82)]

OVERVIEW OF VISIONS AND KEY GOALS

Vision	Key Goals
Overall Vision Our Vision for a fairer Scotland is that by 2030 Scotland is a place where people are healthier, happier and treated with respect, and where opportunities, wealth and power are spread more equally. The Race Equality Framework aims to ensure that this vision is achieved equally for people from all ethnicities, helping to build a Scotland where we all share a common sense of purpose and belonging.	1. An accountable approach to support and drive forward the implementation of the Race Equality Framework is established 2. Strategic work within Scotland's public sector better addresses race equality, including through more effective practice linked to the Scottish Specific Public Sector Equality Duties. 3. Scotland's public sector has improved capacity to tackle racial inequality and meet the needs of minority ethnic people 4. Policy processes in Scotland are based on a robust range of data on ethnicity. 5. Scotland's minority ethnic voluntary sector is stronger, more effective and sustainable

9. SMITH JERVELUND ET AL. RECOMMENDATIONS FOR ETHNIC EQUITY IN HEALTH: A DELPHI STUDY FROM DENMARK

a) Eight overall recommendations on structural and organizational levels to reduce ethnic health inequities[26(p3)]

SECTION 3: PEOPLE EXPERIENCING INEQUITIES

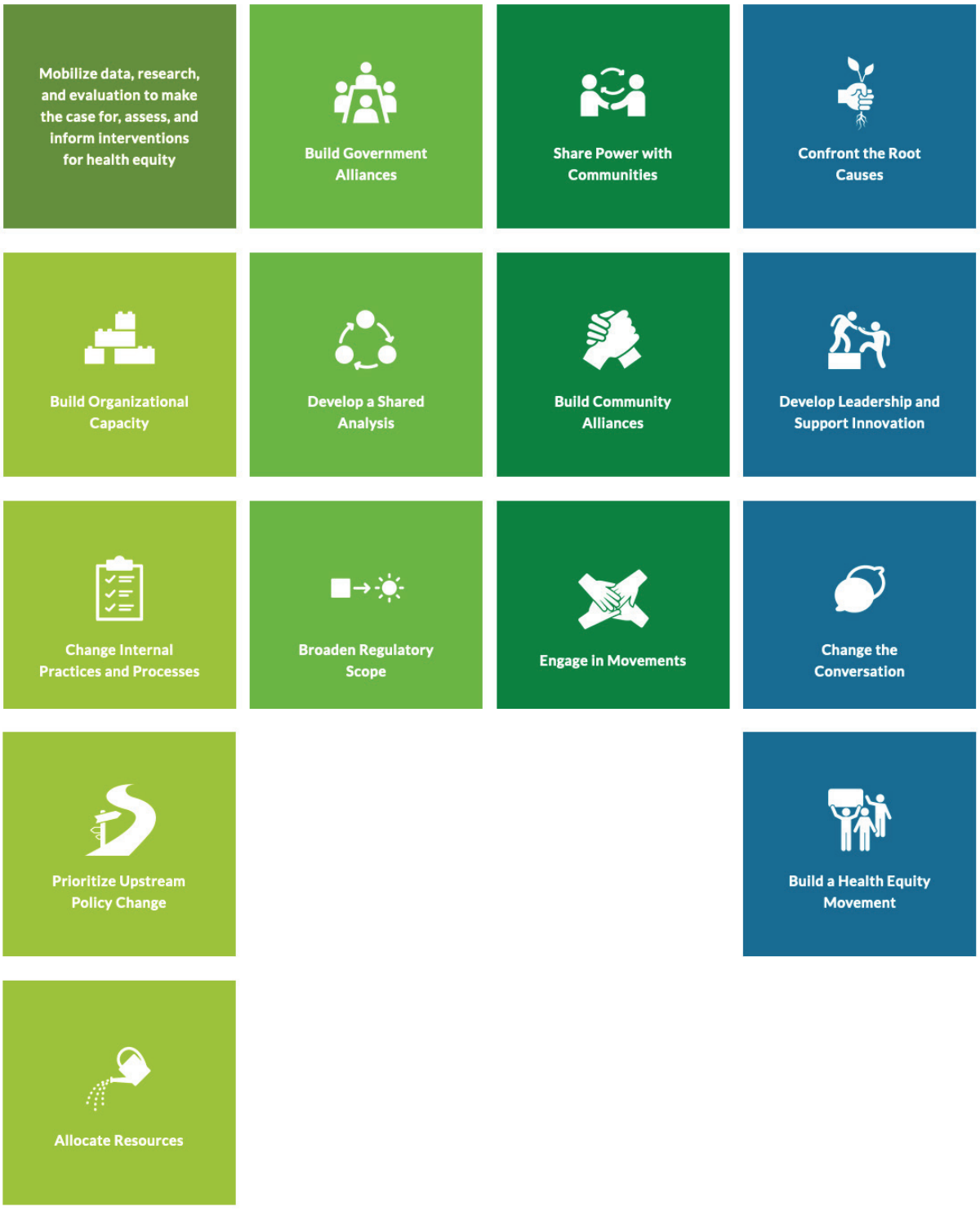
1. ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES. HEALTHY AND EQUITABLE COMMUNITIES STRATEGIC PLAN 2022–2025

a) Alaska Healthy and Equitable Communities logic model[27(p12)]

Inputs	Strategies	Short- and Mid-term Outcomes	Long-term Outcomes
• Healthy Alaskans 2030 • $36 million for Alaska Initiative to Address COVID-19 Among High Risk, Rural, and Underserved Alaskans through June 2023 • Healthy and Equitable Communities Strategic Plan • DPH Healthy and Equitable Communities Unit • Healthy and Equitable Communities Committee • Regional and Local governments • Community, tribal, and regional partners • Community grantmaking organizations	• Work with community partners to fund and implement activities on the Alaska Initiative to Address COVID-19 Among High Risk, Rural, and Underserved Alaskans Work Plan and the Healthy and Equitable Communities Strategic Plan • Work with community partners to develop, fund and implement local Healthy and Equitable Communities plans • Enhance outreach, engagement, and reach of Healthy Alaskans 2030 • Form Healthy and Equitable Communities Committee and begin regular meetings • Develop working partnerships with grant makers, governments, tribal, and community-based organizations to support implementation	• Increased access to COVID-19 testing, vaccination, contact tracing, and prevention among higher risk underserved community groups • Increased capacity and partnership of and among local, regional, tribal, and state organizations to address and prevent COVID-19 and other health concerns among high risk underserved Alaskans • Improved COVID-19 health outcomes among high risk underserved Alaskans	Improved health outcomes among high risk and underserved Alaskans for all HA2030 health objectives

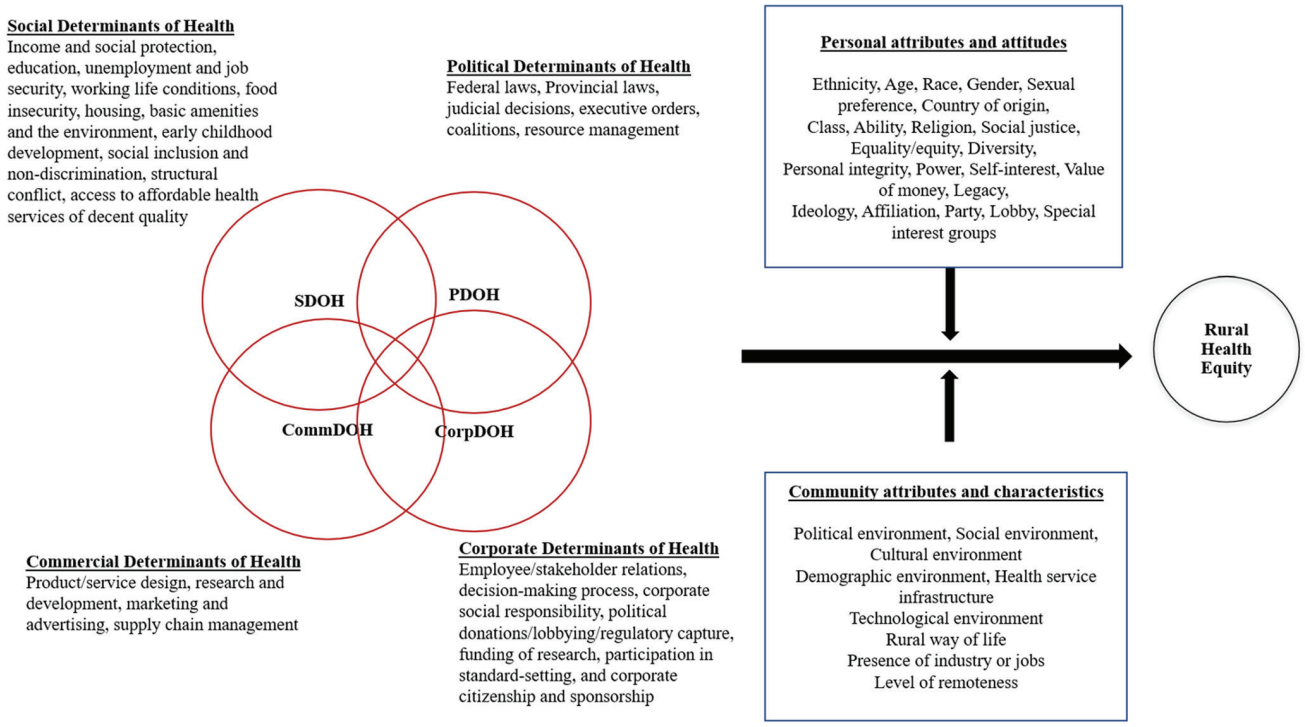
2. STRATEGIC PRACTICES

a) Strategic Practices framework[28]



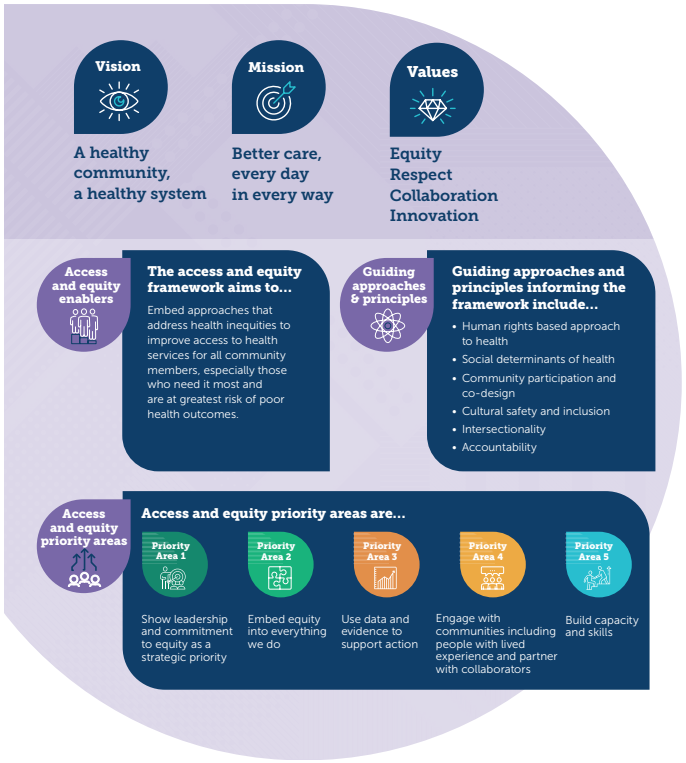
3. LEIMBIGLER ET AL. SOCIAL, POLITICAL, COMMERCIAL, AND CORPORATE DETERMINANTS OF RURAL HEALTH EQUITY IN CANADA: AN INTEGRATED FRAMEWORK

a) Integrated determinants of health framework for rural health equity[29(p752)]



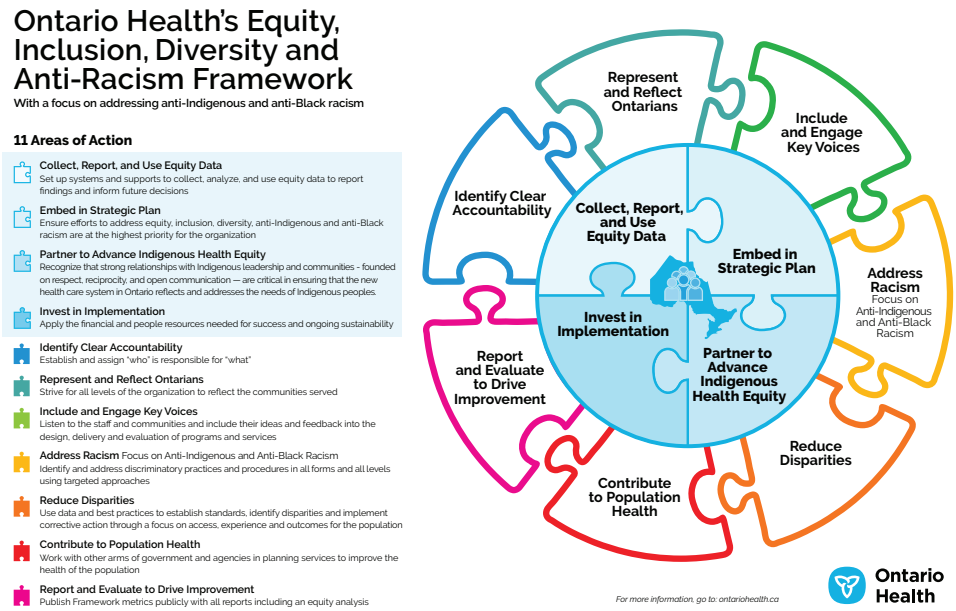
4. NORTH WESTERN MELBOURNE PRIMARY HEALTH NETWORK. ACCESS AND EQUITY FRAMEWORK: A FRAMEWORK FOR IMPROVING HEALTH EQUITY IN THE NORTH WESTERN MELBOURNE PHN REGION, JULY 2021 TO JUNE 2024

a) Access and Equity Framework[30(p6)]



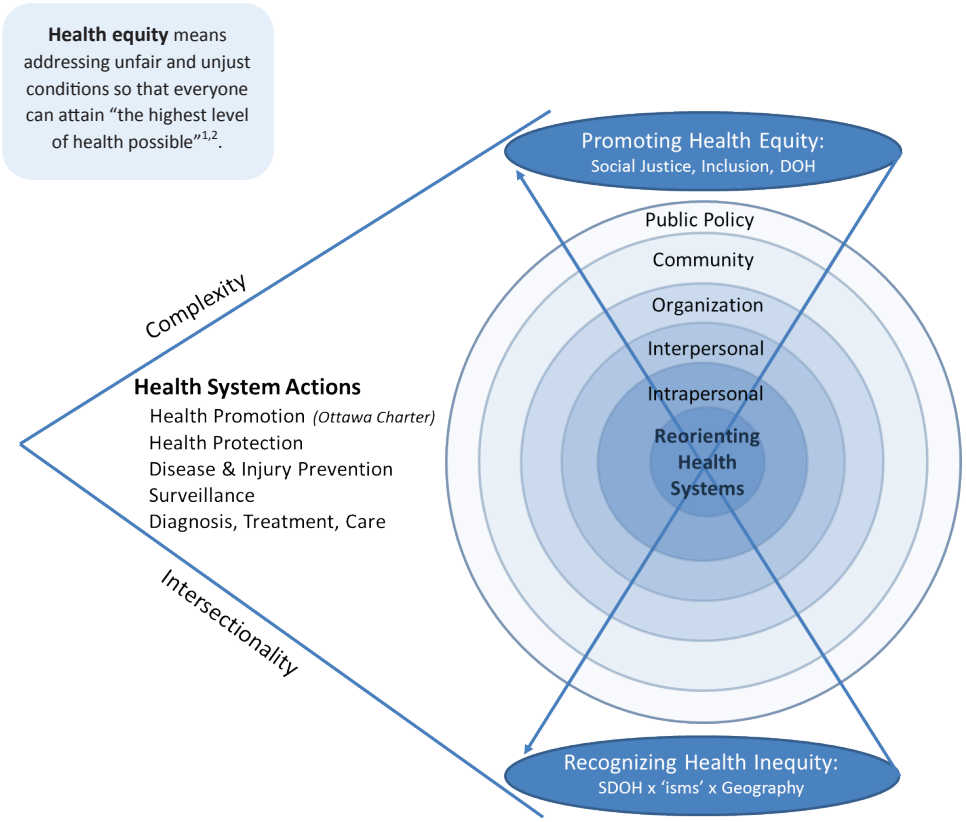
5. ONTARIO HEALTH. ONTARIO HEALTH'S EQUITY, INCLUSION, DIVERSITY AND ANTI-RACISM FRAMEWORK

a) Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework[31(p1)]



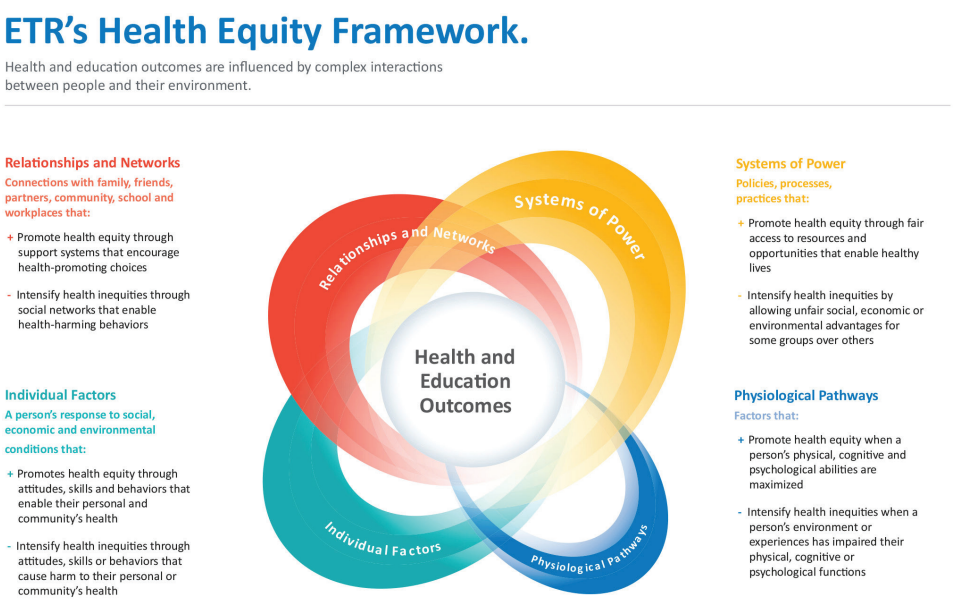
6. PAULY ET AL. REORIENTING HEALTH SYSTEMS TOWARDS HEALTH EQUITY: THE SYSTEMS HEALTH EQUITY LENS

a) Systems Health Equity Lens (SHEL)[32(p1)]



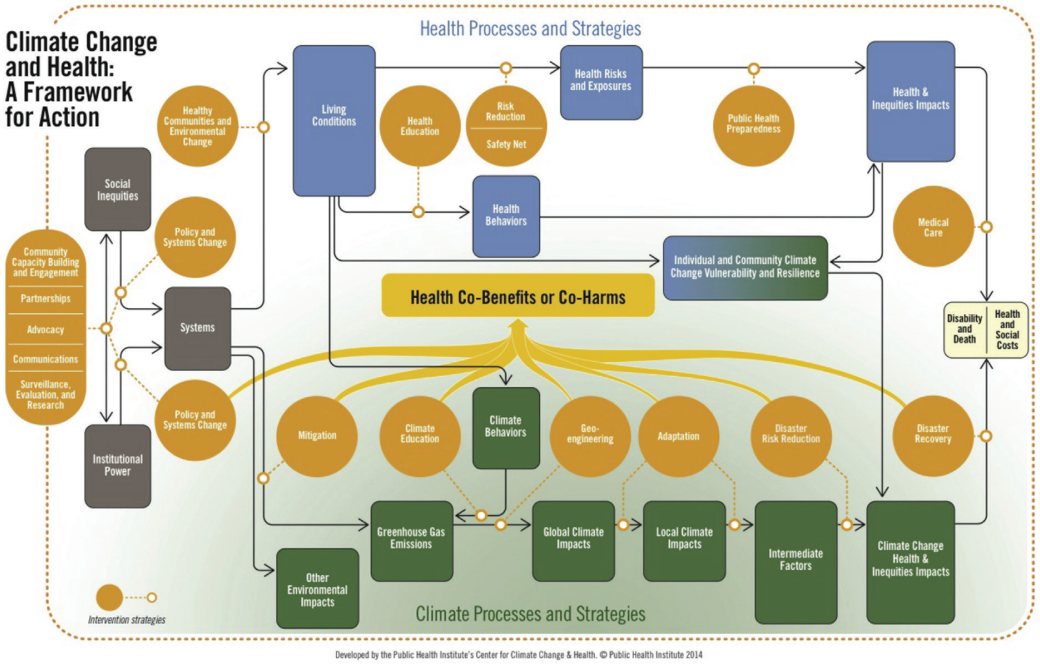
7. PETERSON ET AL. THE HEALTH EQUITY FRAMEWORK: A SCIENCE- AND JUSTICE-BASED MODEL FOR PUBLIC HEALTH RESEARCHERS AND PRACTITIONERS

a) Health Equity Framework[33(p743)]



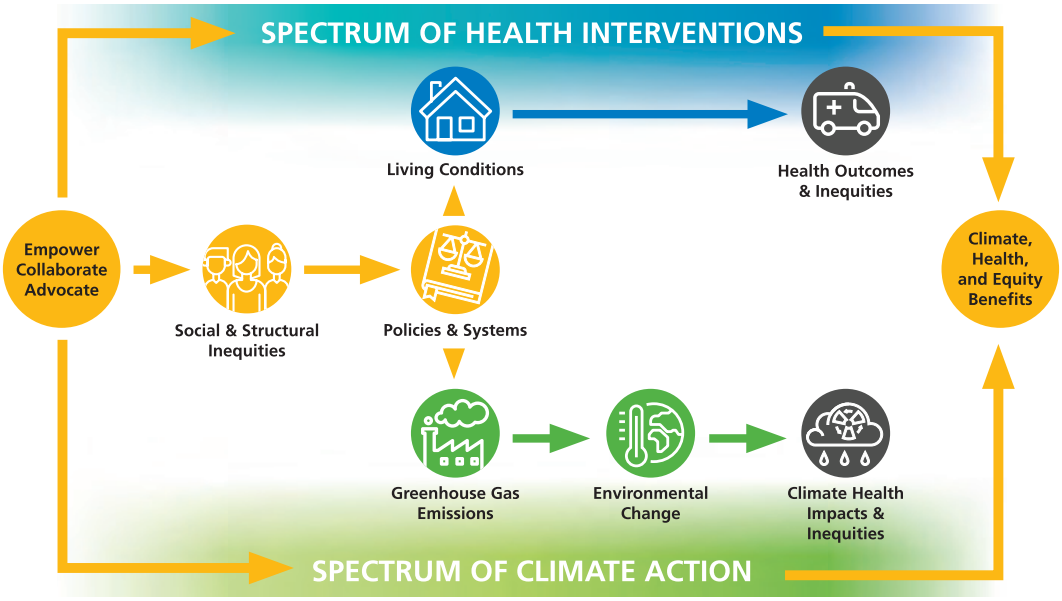
8. RUDOLPH ET AL. CLIMATE CHANGE AND HEALTH INEQUITIES: A FRAMEWORK FOR ACTION

a) Pathways for health inequities and climate change health effects[34(p435)]



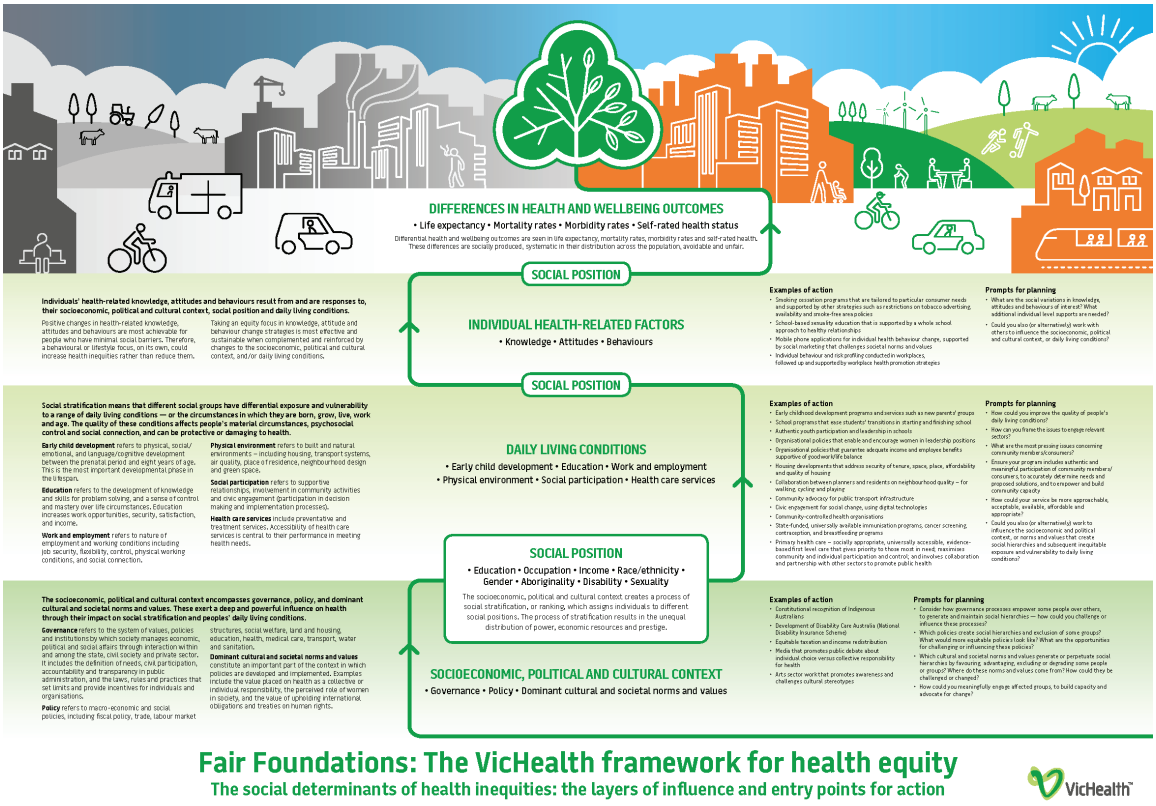
9. RUDOLPH, ET AL. CLIMATE CHANGE, HEALTH, AND EQUITY: A GUIDE FOR LOCAL HEALTH DEPARTMENTS

a) Climate Change, Health, and Equity framework[35(p5)]



10. VICTORIAN HEALTH PROMOTION FOUNDATION. FAIR FOUNDATIONS: THE VICHEALTH FRAMEWORK FOR HEALTH EQUITY

a) VicHealth Framework for Health Equity[36(p3)]



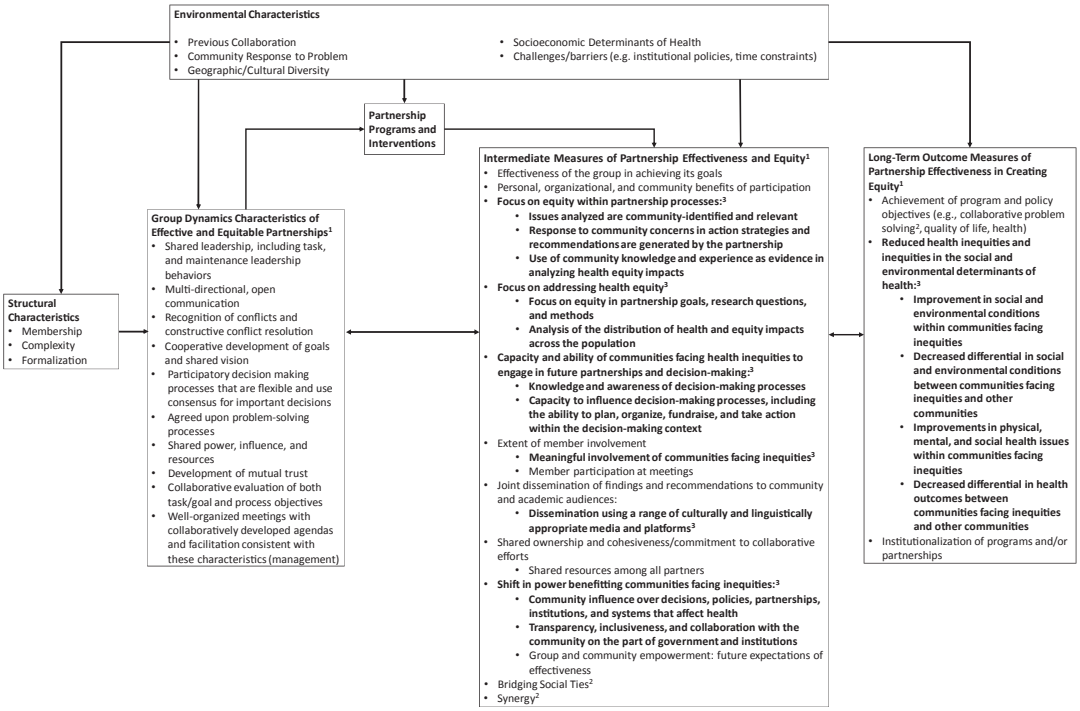
Fair Foundations: The VicHealth framework for health equity

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

VicHealth

11. WARD ET AL. A CONCEPTUAL FRAMEWORK FOR EVALUATING HEALTH EQUITY PROMOTION WITHIN COMMUNITY-BASED PARTICIPATORY RESEARCH PARTNERSHIPS

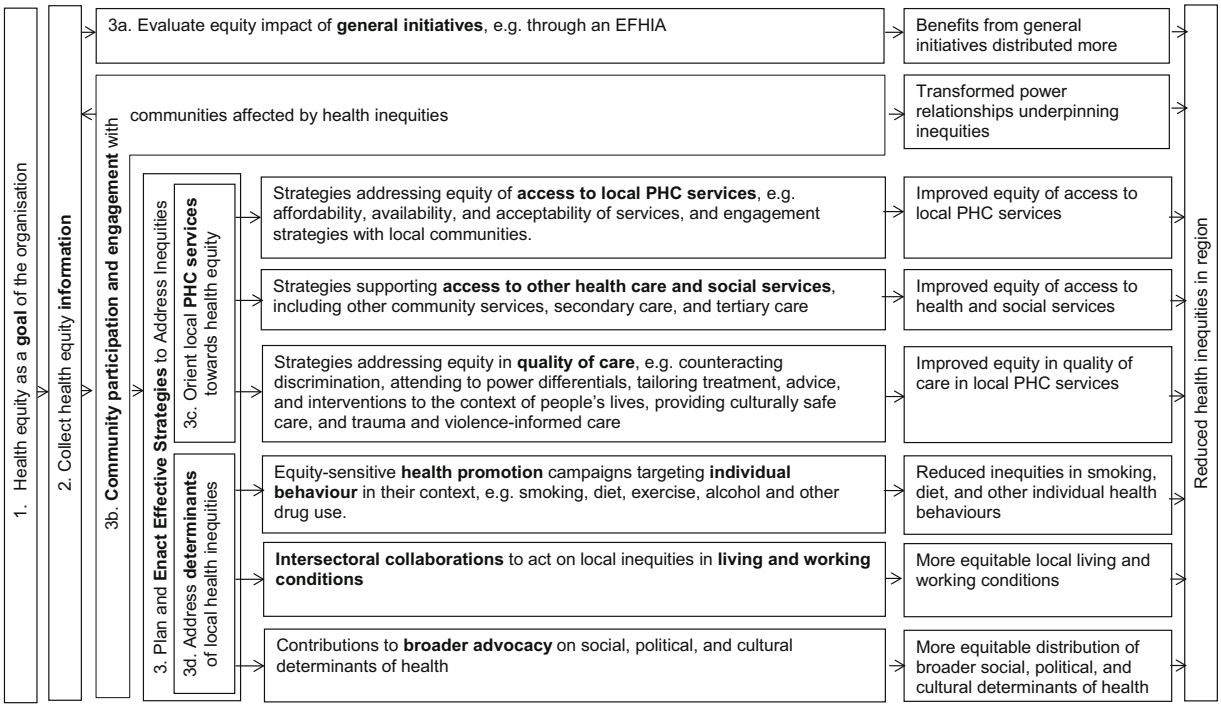
a) Conceptual model for evaluating equity within community-based participatory research partnerships[37(p28)]



SECTION 4: BROAD POPULATION FOCUS WITH REFERENCE TO MULTIPLE DIFFERENT EQUITY-DENIED GROUPS

1. FREEMAN ET AL. A FRAMEWORK FOR REGIONAL PRIMARY HEALTH CARE TO ORGANISE ACTIONS TO ADDRESS HEALTH INEQUITIES

a) Framework for assessing regional primary health care organizations' actions on health equity[38(p570)]



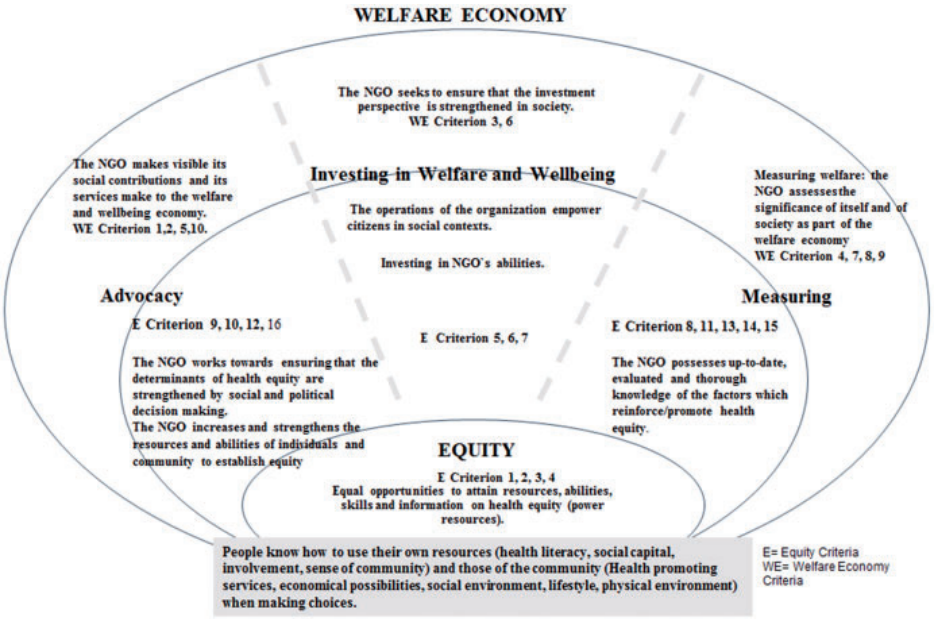
2. GUICHARD ET AL. ADAPTING A HEALTH EQUITY TOOL TO MEET PROFESSIONAL NEEDS (QUÉBEC, CANADA)

a) Reflex-ISS tool for considering social inequalities in health (SIH) in population health interventions[39(pe72)]

Areas	Key discussion elements
Planning	• Identifying SIH issues, the target subgroups, the problems faced, the context and social determinants of health(SDH) involved • Searching for sources of information • Framing the intervention objectives in terms of an action plan to address SDH • Involving target subgroups and stakeholders
Implementation	• Adopting work methods that encourage participation of target subgroups and stakeholders • Defining roles, tasks and responsibilities • Sharing leadership • Supporting the acquisition of knowledge and competencies • Adapting the intervention and making it accessible according to the different levels of literacy of target subgroups
Evaluation	• Integrating the evaluation plan into all phases of the intervention • Ensuring participation at all stages of the evaluation • Establishing a process to assess long-term effects and undesirable outcomes
Sustainability	• Activities to ensure the intervention results are sustainable • Putting in place human, organizational, and financial resources to support the intervention in the long term
Empowerment	• Activities aimed at developing self-esteem, critical awareness, competencies and participation of target subgroups and stakeholders

3. ROUVINEN-WILENIUS ET AL. FINNISH NGOS PROMOTING HEALTH EQUITY IN THE CONTEXT OF WELFARE ECONOMY

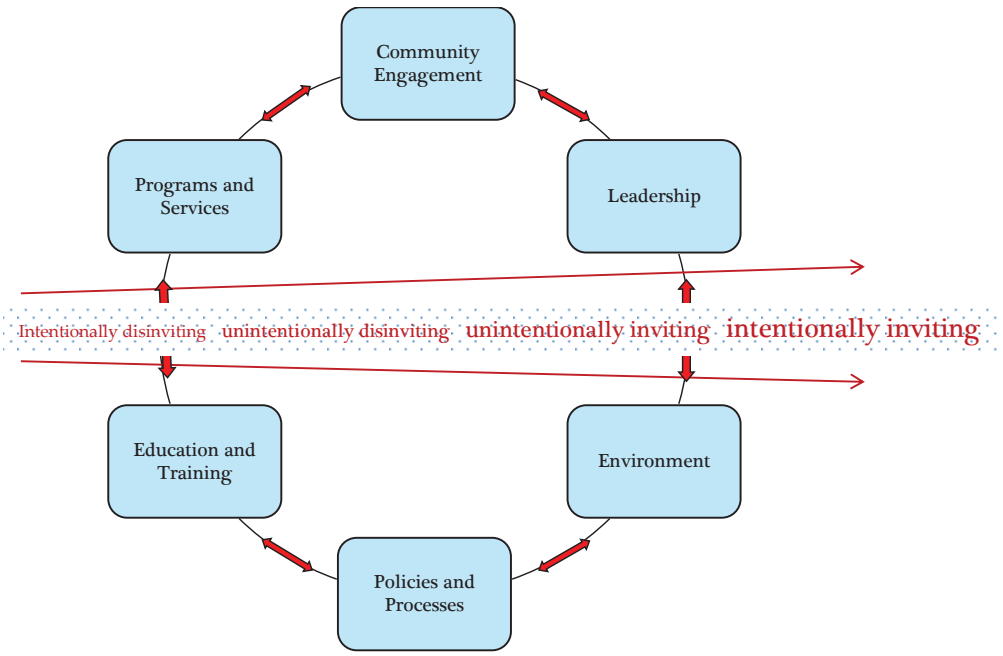
a) Equity and welfare economy criteria within the resource-oriented paradigm for health equity[40(p653)]



SECTION 5: GENDER IDENTITY AND/OR SEXUAL ORIENTATION

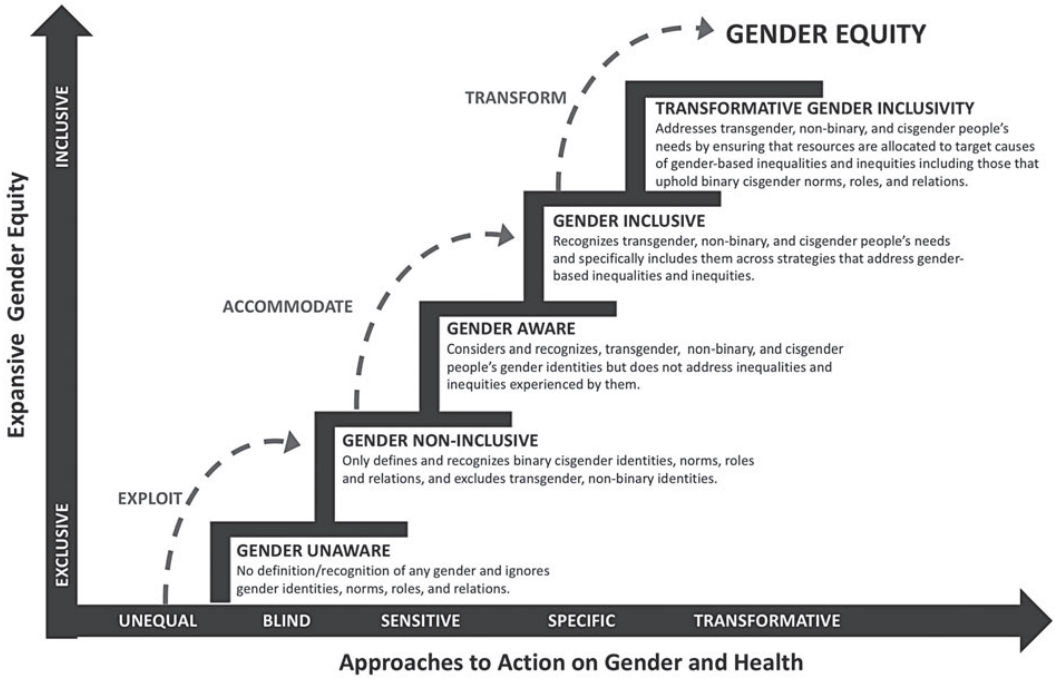
1. DALEY ET AL. A FRAMEWORK FOR ENHANCING ACCESS TO EQUITABLE HOME CARE FOR 2SLGBTQ+ COMMUNITIES

a) Two-Spirit, lesbian, gay, bisexual, transgender, queer, non-binary, and intersex (2SLGBTQ+) home care access and equity framework[41(p8)]



2. RESTAR ET AL. EXPANDING GENDER-BASED HEALTH EQUITY FRAMEWORK FOR TRANSGENDER POPULATIONS

a) Expansive gender equity continuum[42(p3)]



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