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INTERVENTION PROJECT

DRAFT FINAL REPORT

Implementing Local Public Health Practices to Reduce Social Inequities in Health

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Summary

With recent public health renewal initiatives in Ontario, boards of health under the new Ontario Public Health Standards (OPHS) are responsible for public health programs and services that incorporate equity-based expectations. The Sudbury & District Health Unit (SDHU) EXTRA project was developed to respond to our problem statement, "What are evidence-informed local public health practices to reduce social inequities in health and how can this evidence optimally inform SDHU management decision-making about programs and services?"

In order to meet our first short-term objective, "to identify evidence-informed local public health practice to reduce social inequities in health", we conducted an extensive literature search. Our review and analysis of the literature yielded ten promising practices, relevant at the local public health level, with potential to contribute to reductions in social inequities in health. A significant challenge we encountered was the sheer complexity of the problem we were tackling and the vastness of the possible relevant evidence base. We benefitted enormously from the timing of our work relative to the release of the World Health Organization Commission on Social Determinants of Health reports, which were influential to our work on social inequities in health. Along with this release, there were also significant supportive changes and shifts in the province and in the public health environment in Ontario related to social inequities in health.

As a means of meeting our second short-term objective, "to identify evidence-informed strategies to effectively change local public health practice", we conducted an assessment of the organizational context for change, and identified potential strategies for transferring knowledge into action. We determined that the SDHU, as an organization, demonstrates the readiness and support to adopt local practices to reduce social inequities in health. We also identified knowledge brokering as a promising strategy for bringing the evidence to practice.

Knowledge brokering meetings were held with three SDHU program managers and their planners. Participants engaged in a facilitated discussion about how to implement the promising practices and evidence into program planning and logic models. In addition, acknowledging that community support is an essential enabler to achieving organizational change, a community-wide social marketing initiative was launched, which consisted initially of newspaper advertisements about social inequities in health.

The knowledge brokering pilot demonstrated significant promise in building management skills and competencies by providing an intentional way of moving our evidence into action, and was well received for that purpose. Knowledge brokering brought the identified promising practices to the fore and created an opportunity for one-on-one dialogue about program-specific implementation of these practices. The intervention and our EXTRA work leading to the intervention have had a significant impact on the SDHU, including the establishment of a multi-disciplinary Social Inequities in Health Steering Committee, and a program planning process that now incorporates consideration of social inequities in health for all programs.

We have considered the EXTRA intervention as an important step in an extensive process that began before EXTRA and will continue after the formal end of our EXTRA project. Our work has been and will be of significant interest for several audiences: other Ontario health units, provincial ministries and agencies, and public health actors across Canada. Despite the policy initiatives that need to be implemented at levels beyond local public health, health units can and should implement their programs and services in ways that reduce social inequities in health. In the longer term, the work of supporting such local public health action with evidence-informed practices should be lead by a provincial agency combined with significant field partnership.

Report

Anecdote: ***An experience that galvanized our resolve…***

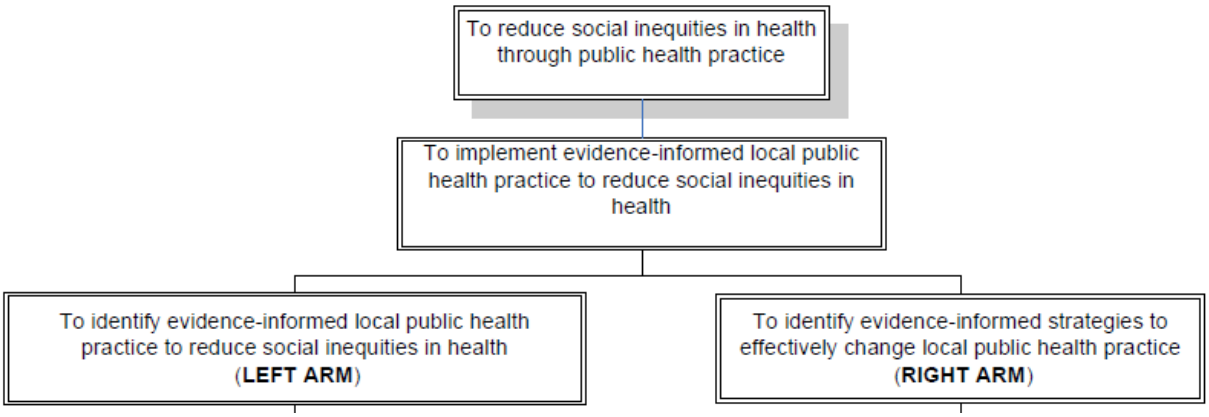
The three authors have had a longstanding interest in reducing social inequities in health. One real life local issue that galvanized and further grew our resolve involved the late Kimberly Rogers. Ms. Rogers was a 40-year-old Sudbury student who was eight months pregnant when she died in August of 2001 while on house arrest for welfare fraud. Her crime was to receive $13,500 of annual social assistance while also in receipt of student loans.

The Sudbury & District Health Unit (SDHU) was called upon to testify at the subsequent coroner's inquest, during which the Medical Officer of Health contributed local data about the cost of nutritious eating. The coroner's verdict included a recommendation that such local data should be used to routinely assess the adequacy of social assistance rates and thus ensure that recipients' basic needs are met.

The SDHU's contribution demonstrated the upstream public health role in both reducing poverty rates and mitigating the health repercussions of poverty and social inequities. Our intervention project was inspired by this example of healthy public policy development through the provision of local evidence.

1. Problem Statement

Our problem statement is: What are evidence-informed local public health practices to reduce social inequities in health and how can this evidence optimally inform SDHU management decision-making about programs and services? Our approach to this problem is depicted in the following excerpt from our overall program logic model (*Appendix A*):



2. Context -Your Place and the Big Picture

The Sudbury & District Health Unit (SDHU) is a progressive, accredited public health agency and part of the Ontario public health system of 36 such agencies. Through a main office and four branch offices, the SDHU delivers provincially legislated public health programs and services to over 200,000 people in 19 municipalities covering a geographic catchment area of approximately 46,121 kilometres. The organization is governed by an autonomous sole purpose Board of Health and is led by the Medical Officer of Health/Chief Executive Officer (MOH/CEO). The 2009 staffing complement was 258 full-time equivalents with a total budget of $24.2 million.

The SDHU has a longstanding history of interest in and action on the social determinants of health and health inequities. (*Appendices B, C and D)* Informing the SDHU work is the recognition that while our population-based public health interventions may successfully improve overall health status or related health behaviours, they may actually *increase* health inequities between income groups. *(Appendix E.)*

Our interest in addressing local health inequities is congruent with emerging global-to-local policy direction including, for example, the World Health Organization Commission on Social Determinants of Health (WHO CSDH), the new Ontario Public Health Standards (OPHS) and local community poverty reduction plans. Recent seminal international, national, provincial and local reports are listed in *Appendix F* and were summarized in our previous Intervention Project Progress Reports (IPPR).

Additionally, with recent public health renewal initiatives in Ontario, boards of health under the new OPHS are responsible for public health programs and services that incorporate equity-based expectations. It is anticipated that the SDHU EXTRA project will contribute to the knowledge base for local action and be relevant for public health practice settings across Ontario.

3. The Evidence – A Critical Review

As noted in Section 1 and depicted in the overall program logic model (*Appendix A*), the SDHU EXTRA project has two short-term outcome objectives: 1) to identify evidence-informed local public health practice to reduce social inequities in health (*left arm)*, and 2) to identify evidence-informed strategies to effectively change local public health practice (*right arm*). In this section, we describe our critical review of the evidence to support the *left arm* outcome objective, as well as our evidence review and process to support the *right arm* objective. The resulting interventions and their implementation are then described in Sections 5 and 6, respectively.

3.1 Evidence for Public Health Practices to Reduce Social Inequities in Health (*left arm*)

The *left arm* program logic model is depicted in *Appendix G.*

3.1.1. Methods

An extensive search of the literature on public health practice and inequities in health was undertaken. We searched approximately 20 databases and the websites of approximately 35 public health, government, non-government and other local/provincial/national/international organizations for relevant published and grey literature (i.e. web content, conference proceedings, documents, reports, and associated web-links or databases). We also identified grey literature through the EXTRA desktop grey literature search function, through references and advice from our EXTRA mentors and other experts, and by a "snowball" approach in which we gathered salient documents listed as references in other literature. Titles and abstracts from approximately 1600 database and grey literature search results were scanned initially for relevance. Of these, 238 documents were determined to warrant further in-depth appraisal. Articles were then more thoroughly reviewed and categorized into three levels. The most

relevant articles were reviewed in full by the EXTRA fellows for the purposes of this project. See previous IPPRs for more detail.

3.1.2. Assessing and Adapting the Evidence

The complexity of the "problem" under study resulted in significant limitations to the evidence base in terms of traditional hierarchies of evidence[1-3]. Evidence was therefore assessed on a fit-for-purpose basis, determining whether it convincingly answered the question asked[4]. Our critical appraisal approach thus focused on assessing relevance and applicability, rather than on a strict appraisal of evidence quality. We based our appraisal on the key questions identified by the National Collaborating Centre for Methods and Tools (NCC-MT)[5].Our approach to critical appraisal was also informed by the work of Pawson and colleagues on *realist reviews*[6]. The realist review concept assisted us to incorporate expert views and contextual factors into our critical appraisal and adaptation of the evidence for our context and purposes.

3.1.3. Findings - Public Health Practices

Evident from our review of the literature is that the levers for action by local public health professionals are poorly understood[7, 8]. The evidence base supporting effective methods of reducing health inequities is limited[9] and the lack of certainty about precise causal pathways means that there is limited guidance, tools, or techniques for integrating equity considerations into policy and programs[10]. Public health research has focused more on the impact of social inequalities than on their causes or realistic strategies to address underlying causes (p. 62)[11]. However, the WHO CSDH notes that while more research is needed, given the importance of the issue, this lack cannot be a barrier to making judgements with the current evidence (p. 42)[12].

Correspondingly, our review and analysis of the literature yielded *promising* public health practices. We identified ten practices, relevant at the local public health level with potential to

contribute to reductions in social inequities in health: 1) Targeting with universalism, 2) Purposeful reporting, 3) Social marketing, 4) Health equity target setting/goals, 5) Equity-focused health impact assessment, 6) Competencies/organizational standards, 7) Contribution to evidence base, 8) Early childhood development, 9) Community engagement, and 10) Intersectoral action. Supporting evidence for each practice was summarized in the IPPR2 and a description of each practice can be found in *Appendix H*.

Although all ten practices are of interest, we decided to focus on three initially: targeting with universalism (TU), social marketing (SM), and equity-focused health impact assessment (EfHIA). (*Appendix I)* At the outset we identified a need to research both lifestyle-focused and policy-focused public health actions to reduce social inequities in health. While we felt that policy solutions (e.g. EfHIA) to social inequities in health held more promise, we also recognized that much public health work involves lifestyle or behaviour change strategies. Ensuring that this work is done in a way that increases health equity (e.g. TU) is therefore important. Social marketing was identified as an enabler to both strategies. Logic models for these three strategies were developed as part of the EXTRA project as an opportunity to lay the groundwork for future work. (*Appendix J*)

3.2 Evidence for Changing Local Public Health Practice (*right arm)*

We engaged in processes to understand our organizational context for change and to identify effective strategies to transfer knowledge into action. The *right arm* program logic model is depicted in *Appendix K.*

3.2.1 Organizational Context for Change

The work of Greenhalgh et al[13] assisted us in assessing our organizational context and readiness for change. As shown in Table 1, we assessed the key elements of *system readiness for*

innovation after reviewing our organizational history, milestone documents and a recent internal "mapping" review[14].

Table 1: System Readiness for Innovation (adapted from Greenhalgh et al, p. 607–608)[13]

Element of system readiness	SDHU assessment
Tension for change	Staff perceive that the current situation must change, i.e. that there are expectations that we engage in more explicit programming to reduce health inequities[14, 15]
Innovation-system fit	The proposed innovations (practices) fit with the organization's values, norms, strategies, and goals[16].
Assessment of implications	Implications of the practices are anticipated[14]; however, further work must be undertaken to ensure a more detailed review
Support and advocacy	The supporters of these practices are numerous and strategically placed in the organization[17]. Community support may need to be strengthened[18].
Dedicated time and resources	This is an area in which further attention will be required (EXTRA survey of SDHU management on evidence use[19] identified needs in this area)
Capacity to evaluate innovation	The organization has the appropriate skills and capacity to undertake monitoring and evaluation of the practices[20].

As highlighted in Sections 2 and 3 of this report and *Appendix B*, the SDHU has a longstanding history of governance and staff support for work to reduce social inequities in health, including the support and leadership of the Board of Health, CEO and senior management. A review of existing organizational documents, including board motions, strategic planning documents, position statements and conference proceedings reflect this history of leadership and support.

We also have important insights into the level of staff readiness for change from the *Health Equity Mapping Project.* This project was undertaken in 2007–2008 to take a *snapshot* of how our current public health activities did (or didn't) address health inequities. Through the process of the project, much was learned about staff readiness and staff needs as they reflected on their own work and activities: "We want to reduce health inequities but how do we know what works?", "If we change what we're doing, how will we know we're making a difference?", and, most significantly, "This is outside of our comfort zone, where do we start?"[14]. The *Health*

Equity Mapping Project highlighted the challenges that accompany health equity work. It also demonstrated a high degree of staff readiness and enthusiasm to learn about and engage in local actions to reduce social inequities in health.

3.2.2. Transferring Knowledge Into Action

Our investigation into how to most effectively transfer knowledge of social inequities into action was informed primarily by our prior work on this subject[21], the summary work of the National Collaborating Centre for Methods and Tools (NCC-MT)[22, 23] and the related Canadian Health Services Research Foundation (CHSRF) Brokering Digests[24]. We also consulted the work of Dobbins and colleagues[25], a previous EXTRA intervention project report on this subject[26] and other literature[27]. We did not undertake an extensive literature review given our prior work and our time constraints.

Based on this review, the following important messages were identified:

- Public health managers and decision makers will use research evidence when they are aware of it, it is easily understood and it has *clear recommendations*.
- Knowledge transfer is most successful when *interactive engagement* among policymakers, practitioners, researchers and funders takes place (*relationship*).
- Decision makers prefer ideas to hard data. For successful transfer, researchers must be able to *translate results into ideas/recommendations for future policies/activities*.
- Different target audiences require different transfer strategies (*adaptability)*.
- Because evidence is only one component of decision making, to be used it must be *compelling* and transferred by *credible individuals*.

Additionally, we sought to specifically identify the needs of SDHU managers regarding the use of evidence. We drew on prior consultations with the management team as well as the

EXTRA assessment survey[19] conducted in February 2009. This survey revealed a perceived lack of time and skills among managers to critically appraise and apply research evidence. In analyzing our findings from the literature and from our managers in the context of our relatively small organization with well established relationships, we identified that knowledge brokering would be a promising knowledge transfer practice to pilot for our EXTRA intervention.

Knowledge brokering is interactive, face-to-face engagement that provides for two-way dialogue about research and evidence:

> [A knowledge broker] provides a link between research producers and end users by developing a mutual understanding of goals and cultures, collaborates with end users to identify issues and problems for which solutions are required, and facilitates the identification, access, assessment, interpretation, and translation of research evidence into local policy and practice. [25]

In particular, we appreciated the relational aspect of knowledge brokering: that the knowledge broker could engage in interactive sessions with managers to ensure dialogue relevant to specific program areas.

4. The Intervention

Our intervention project is the culmination of our work to identify promising local public health practices to reduce social inequities in health, assess our organizational context for change and identify effective knowledge-to-action strategies. The intervention objectives are: 1) To build management skills and competencies to integrate evidence-informed practice to reduce social inequities in health via knowledge brokering, and 2) To foster a supportive community environment for evidence-informed local public health practice to reduce social inequities in health. *Appendix L* describes process objectives for each of these two short-term outcome objectives.

The second intervention objective acknowledges the fact that evidence-informed decision-making in public health is about more than research evidence and organizational readiness[22].

Community support will be an important enabler for the SDHU's success in changing its practice. As the organization focuses more on reducing social inequities in health, it is likely that the type and quantity of services currently available to the community will change. A process of informing and building community support for such change was therefore identified to be a critical component for our intervention project.

5. Implementation

5.1. Knowledge Brokering

Two-hour knowledge brokering meetings, facilitated by a dedicated knowledge broker, were held individually with three SDHU program managers and associated planners/health promoters in December 2009. Participants were selected based on their expected receptivity to the concepts. These expected *early adopters* covered different program areas of the organization. Follow-up consultations were also held to evaluate the usefulness of the knowledge brokering process, to gather input on the practical implications of implementation, including facilitators and challenges, and to inform next steps in the process.

Key background materials were distributed at least two weeks prior to the knowledge brokering meetings. These materials guided the participants through the ten promising practices identified through the EXTRA literature review. Links were provided to selected readings which had been assessed by the EXTRA team and deemed to be key sources for each of the three focus practices. Participants were asked to review the resources and reflect on their potential application to specific programs and activities prior to the knowledge brokering meeting. (*Appendix M*) The knowledge broker prepared for the meetings by becoming familiar with each program's current situational assessments and proposed program plans. During the knowledge brokering meetings, participants engaged in a facilitated discussion about how to implement the promising practices into their planning and the program logic models for their specific programs.

Detailed field notes were taken of these sessions and of the subsequent individual follow-up consultations.

5.2. Fostering a Supportive Community Environment

Due to time constraints, this component of the intervention project was only partially developed. However, two bilingual full-page newspaper advertisements were developed and published in local newspapers during December 2009. They were supported by web-based resources posted on the SDHU website as well as a dedicated SDHU telephone extension for additional information. (*Appendix N*)

6. Results

We have achieved significant results in our pursuit of the objectives of our overall program logic model (*Appendix A*). Specifically, we identified ten evidence-informed local public health practices to reduce social inequities in health. We then identified evidence-informed strategies to effectively transfer this knowledge into practice. These results enabled the development of the intervention objectives as outlined in Section 4 and Appendix L.

This section reports on the results of objective one of our intervention project (knowledge brokering), and provides some comment on objective two (supportive community environment).

Our intervention objectives were achieved to varying degrees. As the key strategy for the first objective, the knowledge brokering pilot demonstrated significant promise in building management knowledge, skills and competencies. This conclusion is based on field notes from the knowledge brokering sessions, information from the post-session interviews, and data from surveys of participating managers and health promoters.

The knowledge brokering meetings were effective in providing a forum for in-depth discussion of social inequities in health in the context of a particular program area. There was support for the individualized, small group approach to knowledge brokering so that questions

and challenges could be fully explored in a relaxed, open environment. Implications of the practices for program plans were identified, and in some cases, specific actions for implementation were identified through the discussions.

We received very positive comments about the pre-session resources the participants were asked to read. Managers commented that having a manageable, relevant and credible set of resources allowed them to feel that they did not have to start from scratch and go looking for what to read – we had done that selection process for them and they were grateful for that filtering step that directed them easily to the best readings on the topic. Managers provided positive feedback on the sessions themselves. They felt that it was important to carve out time for this kind of discussion and to bring an equity focus to program planning. Although the timing was not specifically aligned with logic model development, the sessions still were reported to be valuable and timely. As one manager said, “The knowledge brokering wasn’t extra work. It helped me with my work”. Additionally, many questions were raised during the meetings about larger directions for the Health Unit as a whole, and how the specific plans of the team would fit into other initiatives that have yet to be determined.

As part of the evaluation of our intervention, the seven participants completed a survey on a 1-5 scale ranging from *1: not at all* to *5: very much*. Questions inquiring about the value of the resources used for the knowledge brokering sessions were rated highly at 4.7. Questions related to learning something new, increasing understanding, and bringing forward new considerations and challenges, were moderately highly rated (between 3.5 and 3.8). A question related to actually changing their assessment of the options for their programs was moderately rated, at 2.8 (with scores ranging from 1 to 4).

From these results, and comments made during the post-knowledge brokering interviews, we can conclude that the provision of information about social inequities in health can be done effectively through knowledge brokering, and that depending on the participant's starting point, the process may also bring forward new ideas and considerations. The process of making changes within programs is clearly more complex than what can be accomplished in a two-hour knowledge brokering meeting, and we would be unlikely to find that the process in and of itself created significant change. However, participants expressed intentions to follow up on possible directions with their teams, and it is through this process, begun through knowledge brokering, that changes to program plans may occur. Overall, support for the knowledge brokering process was very high: all participants rated the question about recommending the process to another manager or team at either 4 or 5.

Another indicator of support relates to feedback about next steps. Managers and planners involved in the knowledge brokering pilot have asked for assistance in translating the social inequities in health practices with their team members. We plan to work with the knowledge brokering participants to do this, thus enlisting their involvement as change agents and holders of knowledge. Additionally, most program managers outside of the pilot support broader organizational engagement in the knowledge brokering sessions.

With respect to our second objective of fostering a supportive community environment, work is well underway and expected to continue in the coming year (see Sections 4 and 5.2) . Informal feedback on the advertising initiative to date has been very positive.

Regarding the results of our engagement in this EXTRA project on our organization as a whole, we have observed some significant impacts. From a process perspective, a multi-disciplinary Social Inequities in Health Steering Committee has been established that is chaired

by the Medical Officer of Health/Chief Executive Officer, our program planning process now incorporates consideration of social inequities in health for all programs, and Board of Health members receive project updates. From a substantive perspective, we are experiencing an attitudinal transition. A sense of "ownership" of work on social inequities in health is spreading to an expanding circle of managers. Responsibility for this work is no longer seen to be restricted to a small core of people as program managers are dialoguing and asking tough questions about how they can adapt and implement the evidence-informed practices in their areas of responsibility.

7. Lessons Learned

7.1. Overall Lessons

Knowledge brokering was an effective strategy for bringing the identified promising practices to the fore and creating an opportunity for one-on-one relationship building about reducing social inequities in health. Through the knowledge brokering process, we provided tangible and specific material that enabled further integration of the practices into program planning processes, and we expect that the relationships established will continue to be valuable conduits for information about effective practices for reducing social inequities in health.

Although we have been engaged in professional development and strategic and operational planning related to social inequities in health for several years, we found through the knowledge brokering process that the actual implementation of these concepts benefit from ongoing review, exploration, and discussion, using concrete examples. For staff not currently engaged in day-to-day focus on social inequities in health, it is important to create frequent, meaningful opportunities for discussion, so that social inequities concepts can become part of the regular lexicon at the Health Unit, and action to reduce social inequities becomes part of established practice. It was also valuable to create an organizational expectation, at least for the

three participating managers, that these practices be applied (as relevant) during the planning process, rather than as optional add-ons.

7.2. Pre-existing Conditions for Success

Our substantive history of governance and organizational support and work in this field as noted earlier was a critical pre-existing condition for success. Our engagement in and implementation of this EXTRA project was also facilitated by our almost 20-year history as a teaching health unit that has resulted in significant experience with and resources for evidence use.

7.3. Success Factors Built Into the Project

Throughout the EXTRA project, we were helped significantly by having direct involvement of the organizational leader (MOH/CEO) so that buy-in from the top was never in question. This involvement also led to ease of decision making related to human and financial resource (re)allocation to support the project. Having EXTRA team fellows from different disciplines, divisions and levels in the management hierarchy brought a variety of perspectives and spheres of influence that helped to advance our project within the organization. These enabling factors led to tangible supports for the knowledge brokering initiative including the assignment of a full-time knowledge broker for three months in addition to the staff person already established as a resource person for social inequities in health. Further, having a Social Inequities in Health Steering Committee provided a structure that allowed for effective involvement of people outside the EXTRA team and kept the focus on this topic despite competing priorities.

7.4. Problems/Challenges/Opportunities

Although we knew at the outset that the evidence base related to local public health practice to reduce social inequities in health was limited, we had to struggle to define the nature of the evidence that would be relevant for our work. Rather than finding definitive evidence for effective action, we were faced with evidence that was often suggestive, speculative, and

informed by experience rather than by randomized controlled trials. The benefit to our expanded definition of "evidence" is that the process of adapting the evidence to our local context happened organically as we digested our findings, such that a constant filtering of the evidence through experience and expertise was our analytic process.

A significant challenge we encountered was the sheer complexity of the problem we were tackling and the vastness of the possible relevant evidence base. Along with this inherent challenge, we also faced challenges of competing priorities, both foreseeable and unexpected, over the two-year period. Losses in key human resources had implications for workloads, particularly that of the MOH/CEO, and the pandemic response in mid-2009 created changes in team member availability for EXTRA work and the availability of others in the Health Unit to participate in our intervention.

The timing of this intervention was not optimal, given that the existing program planning process and program logic model development was delayed due to the pandemic response that required intensive involvement across the Health Unit. Our original intention was to deliver the knowledge brokering intervention in conjunction with program logic model development, and then to look to the resulting logic models for evidence of the impact of the knowledge brokering. However, we chose to proceed with the intervention in late 2009 in order to provide some pilot data for our EXTRA report and to inform our next steps for other related initiatives.

While working as a multi-level team brought many strengths, it also created the need to negotiate within the team regarding roles in the project, and at some points acknowledging that, given our different decision latitudes within the organization, some roles were pre-defined. Although having the involvement of the MOH/CEO as a fellow was clearly advantageous, there

were also challenges encountered, such as competing priorities, and the inherent authority that comes with the position.

7.5. External Environment

We benefitted enormously from the timing of our work relative to the release of the WHO CSDH reports. There were also significant changes and shifts in the provincial public health environment related to social inequities in health. Colleagues expressed great interest in and support for our work on identifying effective local public health practices and welcomed our reports. Thus, although the timing of our intervention was not optimal, the timing of our larger endeavour related to identifying evidence-informed practices to reduce social inequities in health was excellent and will create conditions for effective next steps.

7.6. Integrating Evidence and Information Into Action

The knowledge brokering process provided an intentional way of moving our evidence into action, and was well received for that purpose. Clearly, applying evidence to practice will happen over time and will need to be maintained; within the time frames of this report, we feel we have created meaningful advances in this regard.

Given the questions raised at the knowledge brokering sessions about how the practices would fit in with other processes and practices at the Health Unit, we can conclude that it is important for knowledge brokering related to social inequities in health to be integrated into the existing planning process, rather than seen as an add-on to the planning process. The existing process already has an explicit equity focus, but as we move to the specifics of team actions to reduce social inequities in health, the connections between the equity objectives and the planning process must be made explicit and seamless. One way of addressing this need will be to closely involve staff with expertise in social inequities in health in the program logic model phase of program planning so that equity issues are considered as part of the fabric of planning. However,

as we undertake to provide these supports on an ongoing basis, we will also need to manage expectations and ensure that this is seen as part of a long-term process.

8. Implications for Policy and Spreading the Change

There are policy implications from our EXTRA project for our own organization, other local public health agencies and provincial organizations and ministries. We have previously described the very vibrant policy context for this work and we feel that we are "asking the right questions at the right time" given the number of requests we have already received to share our work.

However, we are aware that actions to address social inequities in health are not simple and their policy implications are challenging. The WHO CSDH has described this as a "wicked problem" that is not easily resolved (if at all) through the traditional policy infrastructure[10] . The challenges are summarized in Table 2.

Table 2: Characteristics and Policy Challenges of Social Inequities in Health

"Wicked" Characteristic of Social Inequities	Policy Implications
Multi-faceted phenomena with multiple causes requiring the action in multiple sectors at multiple levels	No clear pathway towards policy development and implementation;
Life course perspective required	Serious challenges to policy-making timescales
Complex concepts for constituents to grasp (e.g. requires sophistication of understanding differences even between health and health *care)*	Difficult to engage policy makers
Values base of social inequities	May challenge policy status quo

Despite these challenges, there is significant interest among local public health actors. Our project has demonstrated that concrete strategies and tools for action are essential for engaging such actors, and our work to define these strategies and tools is a significant contribution. Although there are many policy initiatives that would need to be implemented at levels beyond local public health, health units can and should play a role through their programs and services, and dissemination of the practices meets an expressed need in the field to "know what we should be doing" to address inequities at the local public health level.

The objectives of our overall EXTRA project are broad and generalizable to other Ontario public health units. The findings related to the promising practices (left arm) and change strategies (right arm) are likely applicable to Ontario public health units given the relative similarity of our programs and services and professional workforces. However, we would observe that our work was completed in the context of relatively strong familiarity with and support for this work, in addition to our history as a teaching health unit. The right preconditions are likely an important feature of any generalizability of the knowledge brokering process.

We have shared our research and findings with colleagues through many channels, including presentations at Canadian Public Health Association conferences; consultations with other health units and interested parties about our work on social inequities in health (both pre-EXTRA and the EXTRA work), and sharing with many strategic tables in the province, including the Ontario Public Health Association(OPHA)/Association of Local Public Health Agencies (alPHa)/Council of Ontario Medical Officers of Health(COMOH) Determinants of Health Working Group and the Ontario Ministry of Health Promotion Guidance Document Steering Committee.

In addition to the dissemination as described above, we have developed plans for the further development of the practices at the SDHU. We have considered the EXTRA intervention as an important step in an extensive process that began before EXTRA and will continue after the formal end of our EXTRA project. The logic models developed as part of our EXTRA work will guide next steps over the coming months and years. Specific next steps include extending the knowledge brokering to other program managers, developing materials to use with program teams so as to establish a shared knowledge base across the organization, addressing any internal and external implementation challenges and further developing our social marketing initiative. Ideally, our organization would develop so that knowledge- and resource-seeking related to

social inequities in health would become natural and organic – a way of doing business. As Greenhalgh et al (p. 593)[13] describe, introducing an innovation can begin with "making it happen", followed in time by "helping it happen" and then "letting it happen". As we continue with the work described above, we hope to evolve to the "letting it happen" stage as it relates to our work on social inequities in health.

Internally, important sustainability measures must be put in place. We will need to also reflect on the larger direction for the Health Unit as a whole to ensure that there is clear alignment of practices. As we take on these activities, it will be important to maintain existing committee structures that support social inequities in health work, create management expectations and planning tools, and continue to explicitly allocate human and financial resources to the social inequities in health portfolio. It is also important that we spread the knowledge about the promising practices and this process beyond our organization to assist in creating expectations and "pressure" on us to keep up the work.

Although many in public health are committed to the need to reduce social inequities in health, they do not have tangible evidence-informed strategies for this work. The public health field requires such strategies along with supports to translate evidence and develop sustainable implementation strategies. Local public health leadership needs to be intimately engaged in this work.

The investment of time, energy and resources in this project was worthwhile and rewarding. It required us to leverage our organizational interest and momentum and our financial and human resources to complete the work. In the longer term, however, the work of supporting local public health action on social inequities in health with evidence-informed practices would benefit from the leadership of a central provincial agency combined with significant field partnership. This

work should be taken to another level so that it can be sustained, developed further and engage all health units. Our preliminary discussions with the Ontario Agency for Health Protection and Promotion regarding their social inequities in health mandate may be influential in this regard.

Our experience with this intervention project has demonstrated to us the importance of evidence in advancing the goal of reducing social inequities in health through local public health action. We understand that evidence is an essential but not sufficient basis for policy action. Combining evidence with important environmental considerations such as community health issues, local and organizational context, public health resources and community and political preferences, is expected to result in effective practice[10, 23]. The EXTRA project has assisted us to be explicitly mindful of these elements as we continue our journey to reduce social inequities in health through effective local public health action.

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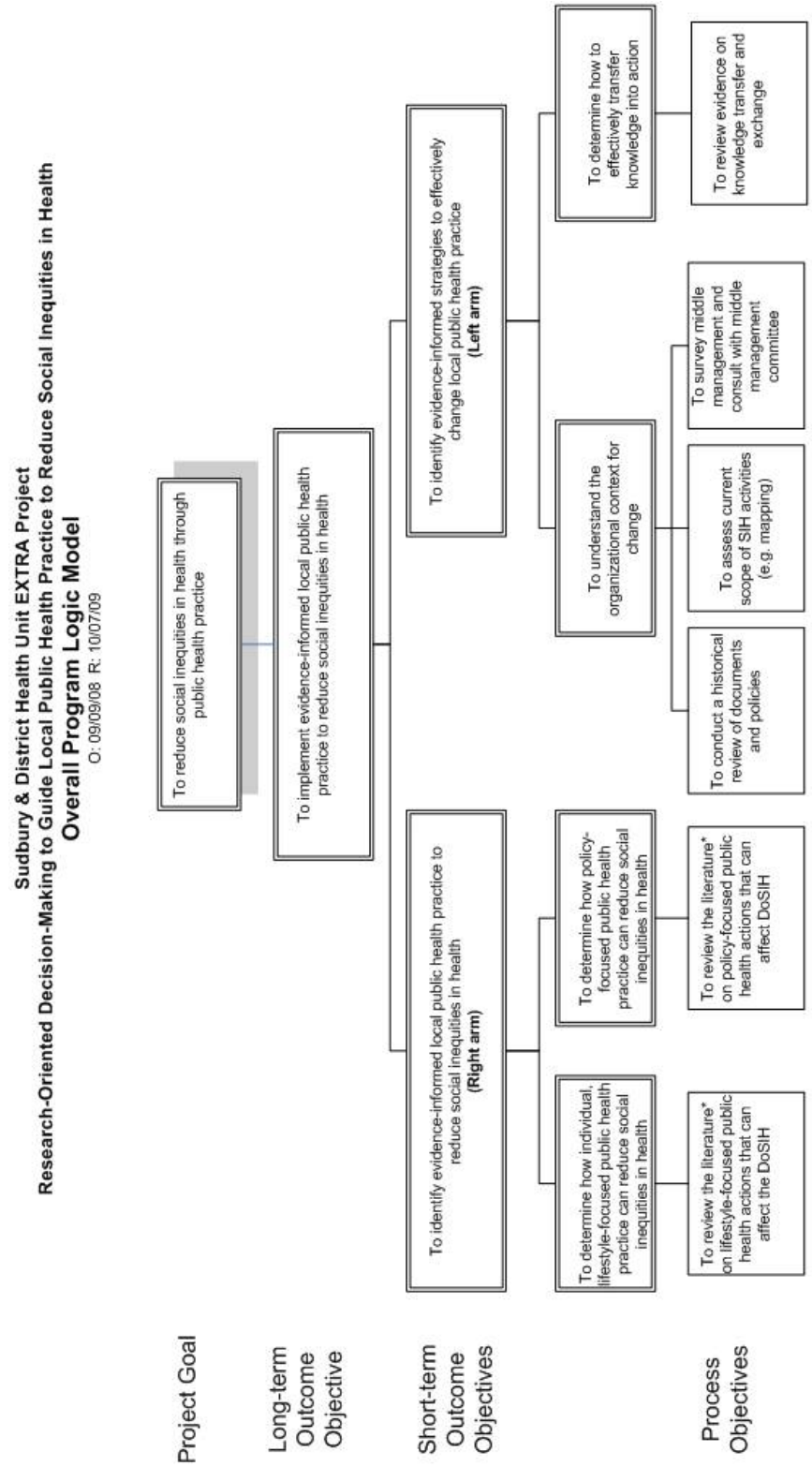
Appendix A: Overall Program Logic Model



Appendix B: SDHU Social Inequities in Health Highlights

Sudbury & District Health Unit
Service de santé publique

Social Inequities in Health
Sudbury & District Health Unit Highlights from the Last Decade

2000-04

- Multiple community and staff presentations on social determinants of health (e.g. Social Planning Council, Rotary Club, Registered Nurses Association of Ontario, workplaces, Romanow Commission, etc.)
- Testimony at the Inquest into the death of Kimberly Rogers (house arrest for welfare fraud)

2005

- Board of Health Determinants of Health Position Statement
- SDHU OPHA/alPHa conference stream, November 2005
  Determinants of Health: Developing an Action Plan for Public Health
- Resulting alPHa AGM resolution A05-4, November 2005
  Determinants of Health as a Mandatory Public Health Program
- Resulting OPHA AGM resolution, November 2005
  Determinants of Health
- SDHU Working Poor Needs Assessment and Conference
- Board of Health motion 73-05: *Equity Based Planning*

2006

- SDHU discussion paper:
  A Framework to Integrate Social and Economic Determinants of Health into the Ontario Public Health Mandate
- Board of Health motion 63-06: *Cost shared operation budget with a focus on health equity*

2007

- Advocacy Paper:
  Social Inequalities in Health and Ontario Public Health
- Review of Ontario's public health programs/mandate: specific equity-focused recommendations for the new Ontario Public Health Standards

2008

- Internal scan: *Health Equity Mapping Project*
- CHSRF EXTRA Program Fellowship: intervention project on social inequities and public health practice (2008-2010)
- Board of Health endorsement of the Greater Sudbury Community Strategy for Poverty Reduction (Social Planning Council of Sudbury)
- SDHU coordination: *Social Inequities in Health Steering Committee*
- Mayor's Expert Panel on Health Cluster Development: formal liaison with health sector leaders on opportunities for action on poverty

Appendix C: Glossary

Health inequality	**Health inequalities** are differences in health status experienced by various individuals or groups in society. These can be the result of genetic and biological factors, choices made or by chance, but often they are because of unequal access to key factors that influence health like income, education, employment and social supports. [Source: Health Disparities Task Group. (December, 2004). *Reducing Health Disparities - Roles of the Health Sector: Discussion Paper*.]
Health inequity (a.k.a. Social inequities in health)	Health inequities refers to those health inequalities that are systematic, socially produced (and therefore modifiable by society's actions), and are judged to be unfair and unjust [PHAC (2007). *Canada's Response to the WHO Commission on Social Determinants of Health*.] *Thus, not all health inequalities are health inequities.
Health equity (Levelling Up)	Health equity is the condition where everyone could attain their full health potential and are not disadvantaged due to their social position or other socially determined circumstances. [Brennan, R, Baker EA, Metzler M. (2008) *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008.] The Rainbow Model (above) is used at the SDHU to guide program efforts to work as far "upstream" as possible. Levelling up means bringing "up the health status of less privileged socioeconomic groups to the level already reached by their more privileged counterparts" (Levelling Up (part 2), 2006, p. 2). This implies that the overall goal is *improving* health, **not** reducing the health of any group for the sake of achieving equal (but lower) health status across the population.
Equity oriented health policies	These are policies that aim to reduce or eliminate **social inequities in health.** Whitehead, M. & Dahlgren, G., 2006

Source: Sudbury & District Health Unit. (2009). *OPHS Planning Path*. Sudbury, ON: Author.

Appendix D : SDHU Determinants of Health Position Statement

Sudbury & District Health Unit / Service de santé publique

Sudbury & District Board of Health
Determinants of Health Position Statement 2005

Position

The Sudbury & District Board of Health uses a population health approach to improve the health of the entire population in its catchment area and to reduce health inequities among population groups. Health improvements are achieved through effective action on the broad range of factors and conditions that determine health. Health inequities are reduced by focusing on vulnerable populations. The broad determinants of health are addressed in each life stage: childhood and youth, mid-life and later life. The Sudbury & District Board of Health recognizes that efforts to improve population health require evidence-based strategies, strong partnerships within and outside of the traditional health sector, and flexibility in the face of complex challenges.

Background

Why are some Canadians healthy and others not? There is a growing body of evidence about what makes and keeps people healthy. In 1974 the landmark Health and Welfare Canada, *Lalonde Report,* described a framework of key factors that determine health status: lifestyle, environment, human biology and health services. Since that time, this simple framework has been refined and expanded. The *population health approach* builds on the Lalonde framework and recognizes that health depends on more than access to a good health care system. Excellent scientific research has established that factors such as living and working conditions and how we share wealth in our societies are crucially important for a healthy population.

Commonly referred to as the *determinants of health*, these broad factors impact on individual and population health. The determinants of health are each important in their own right, however, they interact to forcefully influence health and well being across the lifespan.

Although the determinants of health can be described in many ways, the Sudbury & District Board of Health uses the Public Health Agency of Canada categorization of the twelve major determinants.

The 12 Determinants of Health

1. Income and social status: There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health.
2. Social support networks: The health effects of social relationships may be as important as established risk factors such as smoking, physical activity, obesity, and high blood pressure.

3. Education and literacy: People with higher levels of education have better access to healthy physical environments for their families. Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy.
4. Employment/Working conditions: employment provides not only money but also a sense of identity and purpose, social contacts and opportunities for personal growth. Unemployed people have a reduced life expectancy and suffer significantly more health problems.

   Conditions at work, both physical and psychosocial, can have a profound effect on people's health and emotional wellbeing.
5. Social environments: Effective social and community responses can add resources to an individual's choices of strategies to cope with changes and foster health.
6. Physical environments: At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects. In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being.
7. Personal health practices and coping skills: There is growing recognition that personal health choices are greatly influenced by the socioeconomic environments in which people live, learn, work and play.
8. Healthy child development: The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful. Positive stimulation early in life improves learning, behaviour and health into adulthood.
9. Biology and genetic endowment: The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide range of responses that affect health status and appears to predispose certain individuals to particular diseases or health problems.
10. Health services: Health services designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health.
11. Gender: Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. "Gendered" norms influence the health system's practices and priorities.
12. Culture: Some persons or groups may face additional health risks largely due to a socio-economic environment which is determined by dominant cultural values that may perpetuate conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally sensitive appropriate health care and services.

Reference

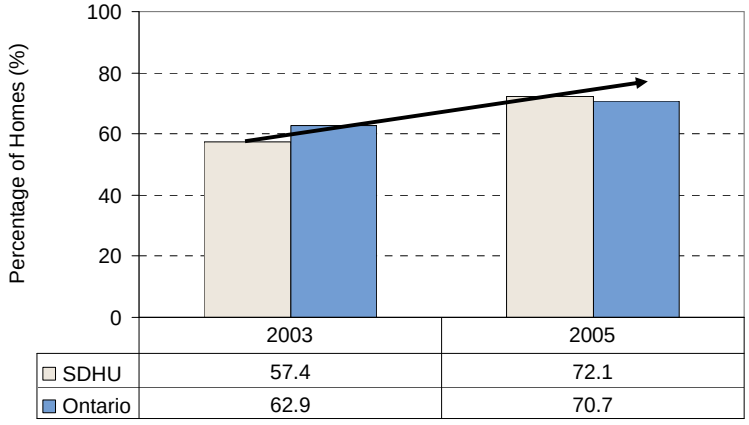
Public Health Agency of Canada http://www.phac-aspc.gc.ca/ph-sp/phdd/

Appendix E: SDHU Experience with Increasing Inequities

Sudbury & District Health Unit Experience With Smoke-free Homes: Increasing Inequities

Smoke-free Homes

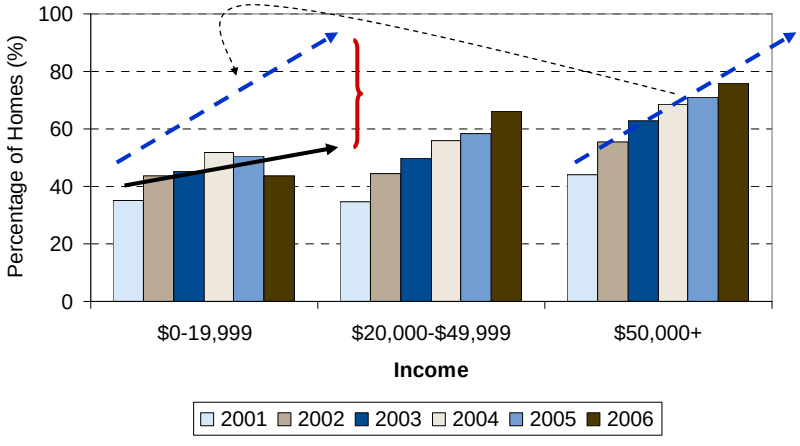
Figure 5.2: Smoke-free Homes (%), SDHU vs. Ontario, 2003 and 2005



Source: Canadian Community Health Survey, 2003 and 2005

Smoke-free Homes

Figure 5.3: Smoke-free Homes (%), by Household Income, SDHU, 2001-2006



Source: Rapid Risk Factor Surveillance System, 2001-2006

Appendix F: Social Inequities in Health in Context

Social Inequities in Health in the International, National, Provincial, Local and Organizational Policy Context

The following are key reports and sources related to social inequities in health, which were described in our IPPR1.

International Policy Contexts:

Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health.* Geneva, Switzerland: World Health Organization. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

World Health Organization. (2008). *Final reports and additional documents of the Knowledge Networks.* Retrieved December, 2008, from http://www.who.int/social_determinants/knowledge_networks/final_reports/en/index.html

The European Union's related work as described in the *Determine project, a*n EU consortium for action on the socio-economic determinants of health. http://www.health-inequalities.eu/)

National Policy Contexts*:*

Sweden:

Agren, G. (2003). *Sweden's new public health policy: National public health objectives for Sweden*. Page 5. SNIPH, Sweden. http://www.fhi.se/shop/material_pdf/newpublic0401.pdf

Swedish National Institute of Public Health. (2005). *The 2005 public health policy report: Summary*. Page 1. SNIPH, Sweden. http://www.fhi.se/upload/ar2005/rapporter/r200544fhprsummary0511.pdf

United Kingdom:

Department of Health (2003). *Tackling health inequalities: A programme for action.* London, UK: Author. Retrieved December, 2008, from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268

Department of Health and Social Security. (1980). *Inequalities in health: report of a research working group*. ('Black report'). London, UK: Department of Health and Social Security.

Acheson, D. (1998). *Independent inquiry into inequalities in health: Report.* Retrieved December, 2008, from http://www.archive.official-documents.co.uk/document/doh/ih/ih.htm

Department of Health. (2000). *The NHS plan: A plan for investment, a plan for reform.* London, UK: The Stationery Office. Retrieved December, 2008, from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4002960

Department of Health. (2002). *Tackling health inequalities – 2002 cross-cutting review*. London, UK: The Stationary Office. Retrieved December, 2008, from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4098280

Department of Health. (2007). *Tackling health inequalities: 2007 status report on the programme for action*. London, UK: The Stationary Office. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083471

The UK has also developed valuable web-based tools:

London Health Observatory. (2008). *Health inequalities intervention tool*. London, UK: Association of Public Health Observatories. Retrieved December, 2008, from http://www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx

Norway:

Norwegian Ministry of Health and Care Services. (2006-2007). *National strategy to reduce social inequalities in health.* Report No. 20 (2006-2007) to the Storting. http://ec.europa.eu/health/ph_determinants/socio_economics/documents/norway_rd01_en.pdf

Canada:

Public Health Agency of Canada. (2008). *The Chief Public Health Officer's report on the state of public health in Canada, 2008.* Minister of Health. Retrieved December, 2008, from http://www.phac-aspc.gc.ca/publicat/2008/cphorsphc-respcacsp/index-eng.php

Senate Subcommittee on Population Health. (2009). A healthy, productive Canada: A determinant of health approach. Ottawa, ON: The Standing Senate Committee on Social Affairs, Science and Technology.

Canadian Institute for Health Information. (2008). *Reducing gaps in health: A focus on socio-economic status in urban Canada.* Ottawa, ON: Author. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_1690_E&cw_topic=1690&cw_rel=AR_2509_E

Provincial Policy Contexts:

Government of Newfoundland and Labrador. (2006). *Reducing poverty: An action plan for Newfoundland and Labrador*. St. John's, NFLD: Author. http://www.hrle.gov.nl.ca/hrle/poverty/poverty-reduction-strategy.pdf

Nova Scotia. (2008). *Poverty reduction strategy.* Retrieved December, 2008, from http://www.gov.ns.ca/coms/specials/poverty/PovertyReductionStrategy.html

New Brunswick. (2008). *Developing a poverty reduction plan.* Retrieved December, 2008, from http://www.gnb.ca/0017/Promos/0001/index-e.asp

Quebec. (2006). Lutte contre la pauvreté et l'exclusion sociale. Retrieved December, 2008, from http://www.mess.gouv.qc.ca/grands-dossiers/lutte-contre-la-pauvrete/loi.asp

Quebec. (2001). Article 54 Public Health Act. Retrieved December, 2008, from http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html

Ministère de la Santé et des Services sociaux du Québec. (2007). Troisième rapport national sur l'état de santé de la population du Québec : Riches de tous nos enfants – la pauvreté et ses répercussions sur la santé des jeunes de mois de 18 ans. Gouvernement du Québec. http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/961885cb24e4e9fd85256b1e00641a29/9c0ddc879f714b0585257399006ef57b?OpenDocument

Ontario. (2008). *Ontario's poverty reduction strategy.* Retrieved December, 2008, from http://www.growingstronger.ca/english/default.asp

Population Health and Wellness Ministry of Health Services. (2005). *Public health renewal in British Columbia: An overview of core functions in public health.* BC: Author. http://www.health.gov.bc.ca/prevent/pdf/phrenewal.pdf .

Health Officers Council of BC. (2008). *Health inequities in British Columbia: Discussion paper*. Public Health Association of British Columbia. http://www.bchealthyliving.ca/node/398

Local Policy Contexts:

Toronto Public Health. (2008). *The unequal city: Income and health inequalities in Toronto*. Toronto, ON: Author. http://www.toronto.ca/health/map/pdf/unequalcity_20081016.pdf

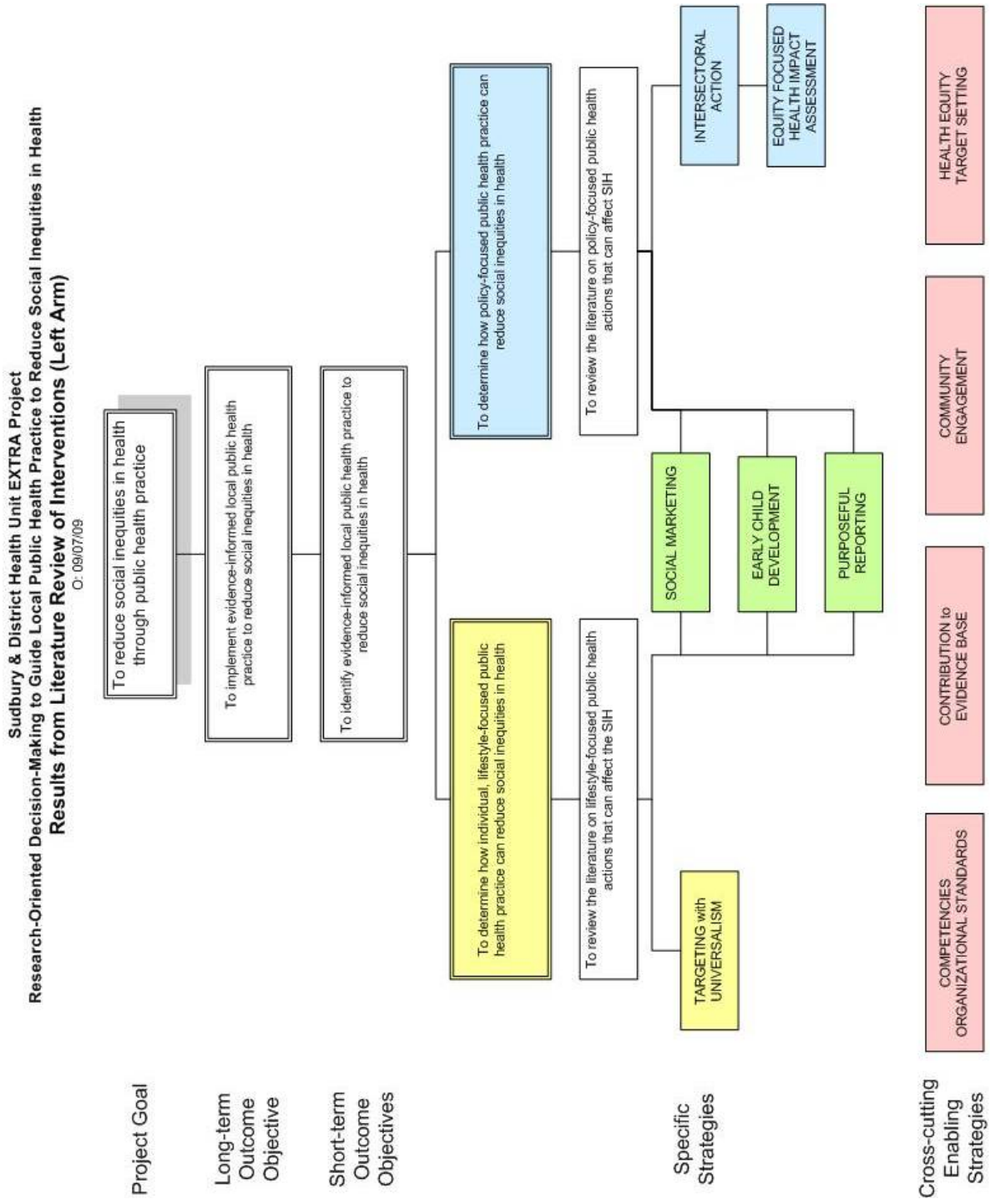
Lemstra, M., & Neudorf, C. (2008). *Health disparity in Saskatoon: Analysis to intervention*. Saskatoon, SASK: Saskatoon Health Region. http://www.uphn.ca/doc/public/HealthDisaparitiesinSaskatoonExecutiveSummary.pdf

The City of Greater Sudbury has adopted a healthy community model and has been designated by the United Nations University as a Regional Centre of Expertise in Education for Sustainable Development:

United Nations University. (no date). Regional Centres for Expertise. Retrieved December, 2008, from http://www.ias.unu.edu/sub_page.aspx?catID=108&ddlID=661

Social Planning Council of Sudbury. (2008). *Community strategy to reduce poverty in the City of Greater Sudbury*. Sudbury, ON: SPC Sudbury. http://communities.mysudbury.ca/Sites/Social%20Planning%20Council%20of%20Sudbury/Lists/Announcements/Attachments/47/Community%20Poverty%20Reduction%20Strategy%20English.pdf

Appendix G : Left Arm Program Logic Model



Appendix H: Ten Promising Practices to Reduce Social Inequities in Health in Local Public Health

1. Targeting with universalism

Dahlgren and Whitehead[1, 2] describe the need to improve disproportionately the health of more disadvantaged groups through targeting, while at the same time improving the health of the entire population. To make strides in reducing health inequities, public health practice must strive to balance selective or targeted approaches with universal strategies.

2. Purposeful reporting

Through reporting purposefully on health inequities in a way that presents, rather than masks, the effect of social inequities in health, evidence of progress or lack thereof, can be brought to the fore and can guide future interventions.

3. Social marketing

Social marketing is "the systematic application of marketing alongside other concepts and techniques, to achieve specific behavioural goals, for a social good" (National Social Marketing Centre 2007 as quoted in Farr p. 451)[3]. Target audience segmentation and tailored interventions, including health communications, are key steps within the social marketing process. This approach is considered a promising practice for creating positive social change and improving the health of vulnerable populations.

4. Health equity target setting

Target setting appears to hold some promise as part of a strategy for reducing health inequities, and may have a role at the local public health level. It seems important to focus those targets on areas shown to be remediable, as opposed to setting lofty but perhaps unattainable targets.

5. Equity-focused health impact assessment[1]

Health Impact Assessment (HIA) is a structured method to assess the potential health impacts of proposed policies and practices. When applied correctly, HIA enables decision-makers to highlight and enhance the positive elements of a proposal, and minimize the aspects that may result in negative health outcomes[4]. With the goal of reducing social inequities in health, knowledge about the winners and losers of policies can assist decision-makers to minimize negative health outcomes, compensate those affected with other benefits, and/or ensure that those affected are not already disadvantaged[5].

6. Competencies/organizational standards:

The skills base required to work effectively on social inequities in health includes community planning and partnership and coalition building, among other skills[6, 7]— not a common knowledge or experience base for most public health staff.

Public health organizations will have to make social inequities work a priority, and commit to working intersectorally and with community engagement as a foundation, something that may amount to a paradigm shift for public health.

7. Contribution to evidence base

It is important that the burgeoning knowledge base on addressing social inequities through local public health action be strengthened by intentional dissemination of knowledge, whether through traditional mechanisms such as journal publications, through reports, or through other knowledge exchange mechanisms such as communities of practice.

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[1] This section draws extensively on Stephanie Lefebvre's (Sudbury & District Health Unit, 2009) unpublished summary of the literature on equity-focused health impact assessment.

8. Early childhood development

That early child experiences establish the foundational building blocks for development across the life stages is widely recognized[8, 9]. Furthermore, with the greatest gains experienced by the most deprived children, investments in early child development have been referred to as powerful equalizers[9].

9. Community engagement

Community engagement is a key cross-cutting strategy in reducing social inequities in health. Frohlich and Potvin[10] emphasize in particular the participation of members of vulnerable populations in problem identification, intervention development and evaluation.

10. Intersectoral action

Intersectoral action is critical, as many of the solutions to addressing social inequities in health lie outside of the health sector. Public health has a longstanding history of providing leadership on health issues and working through coalition structures.Building strong and durable relationships between public health and other sectors (e.g. education, municipal, transportation, environment, finance, etc.) will be necessary for effective action (p. 62)[11].

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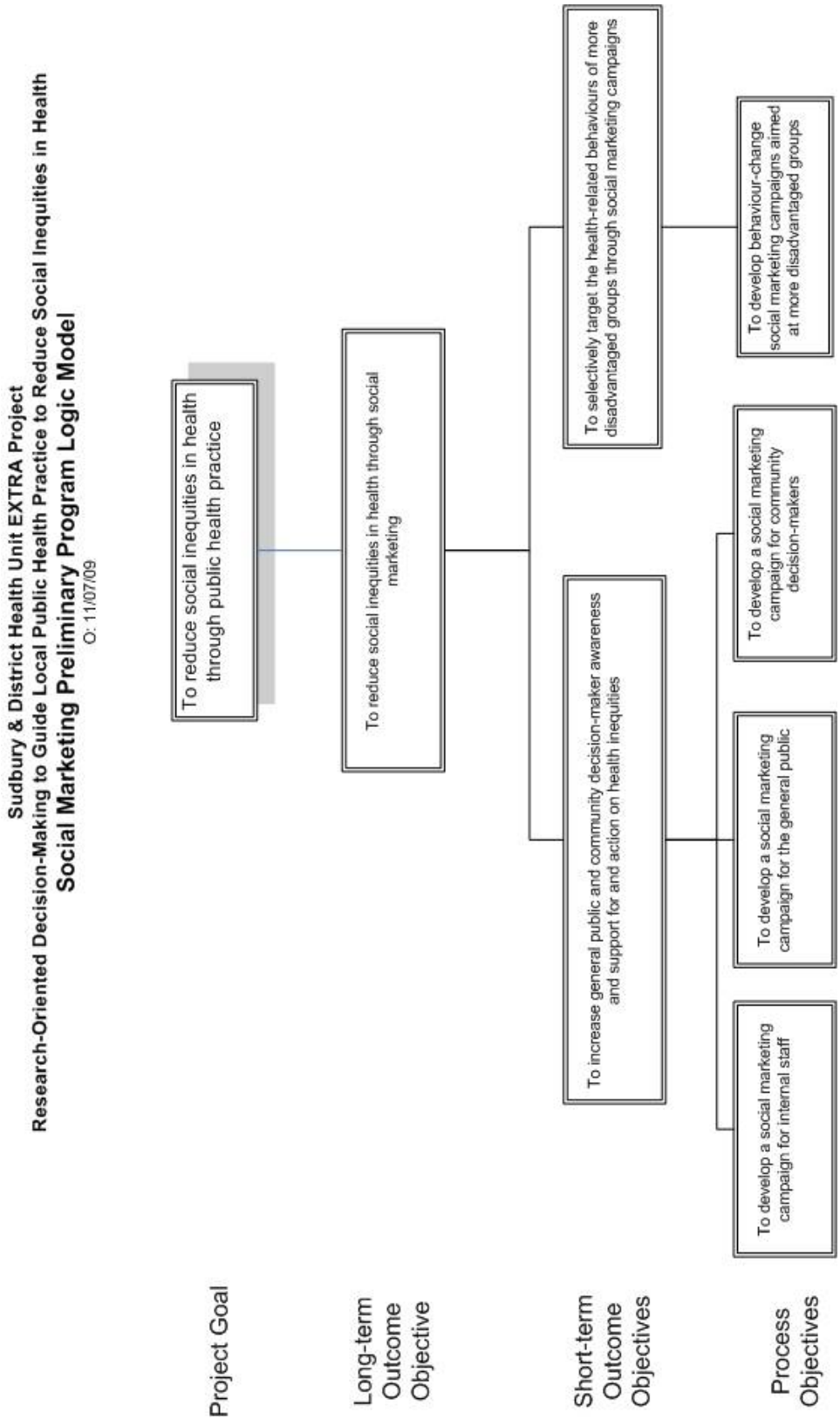
Appendix I: Focus on Three Promising Practices

Ee used the guiding questions listed below (informed by the principles of need, impact, capacity and partnership/collaboration of the Ontario Public Health Standards, 2008) to select three focus practices.

Guiding Questions Used to Select Practices for Our Intervention

Question	**Details**	**Applicability**
Is this a new area of practice? (*need*)	Represents a new area of practice such that unless it was adopted, there would be no activity in this area	• Yes for SM and EfHIA • Partial for TU
Does the practice leverage existing knowledge and practice? (*capacity*)	The practice builds on staff competencies and practices, making adoption more feasible	• Yes for SM and TU • Partial for EfHIA
Is there organizational capacity for the practice? (*capacity*)	Includes aspects of financial resources, leadership support, internal staff champions, workload assessment	• Yes for SM, EfHIA and TU • Workload will need to be reviewed regarding competing priorities
Is the practice within the scope of programming expected of boards of health? (*impact*)	Falls within the legislated mandate of boards of health, community expectations and organizational direction	• Yes for TU and SM • Yes for EfHIA with a progressive interpretation of scope
Together, do the practices incorporate lifestyle- *and* policy-focused public health practices? (*need*)	Having prioritized these two areas in our overall program logic model, we should ensure that the intervention project includes both categories of practice	• Yes (SM=both; TU=lifestyle; EfHIA=policy)
Is there potential for significant impact? (*impact*)	Practice will either be relevant to the work of many staff and program areas and/or will have significant community impact	• Yes for TU regarding relevance to many staff and program areas • Yes for SM and EfHIA regarding potential for significant community impact
Is there potential for building or enriching community partnerships? (*partnership and collaboration*)	The practice will involve other non-health partners and involve community engagement (a cross-cutting strategy as per results of our literature review)	• Yes for SM and EfHIA • Potential for TU

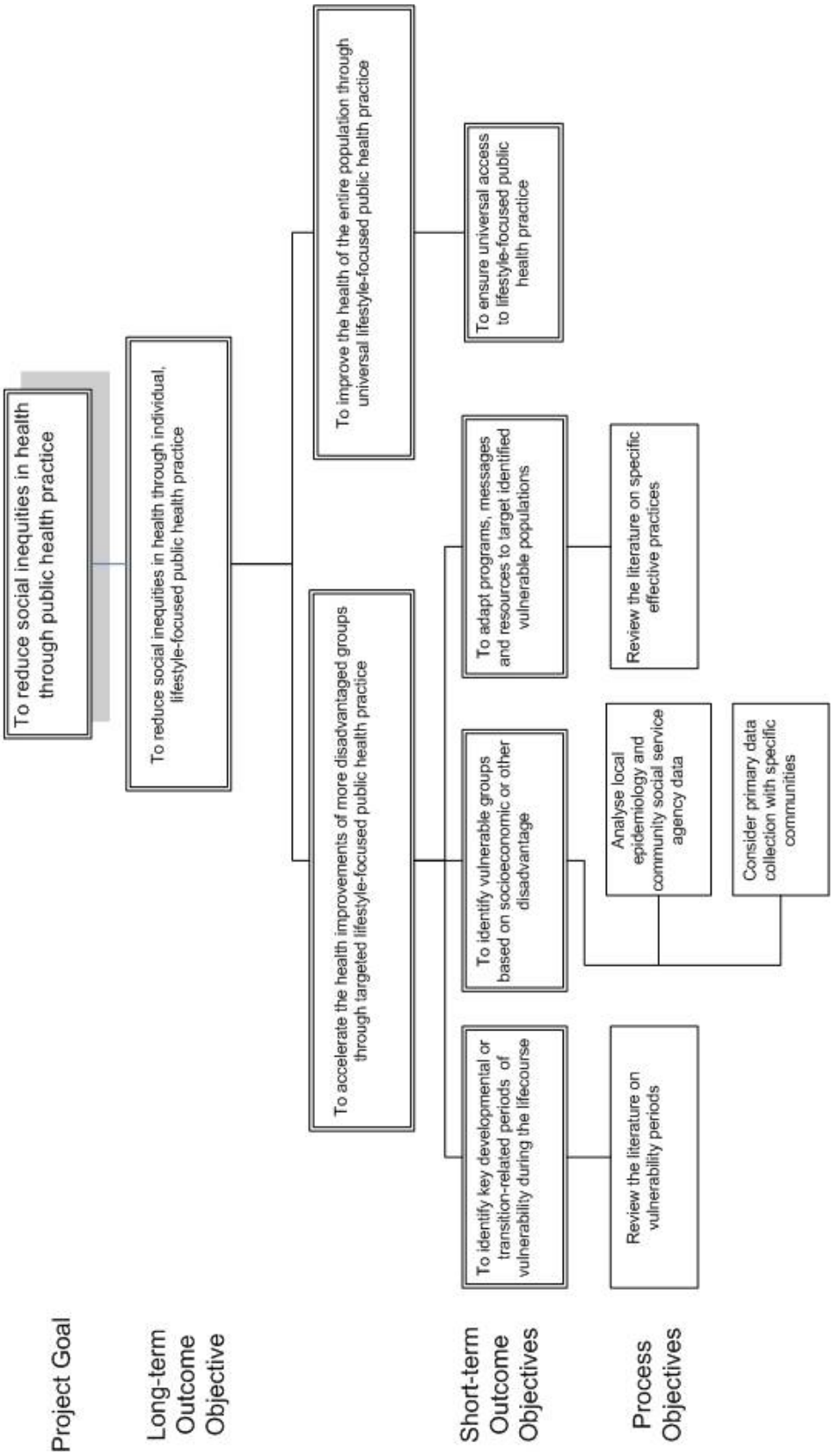
Appendix J: Three Focused Program Logic Models



Sudbury & District Health Unit EXTRA Project
Research-Oriented Decision-Making to Guide Local Public Health Practice to Reduce Social Inequities in Health

Targeting with Universalism Preliminary Program Logic Model

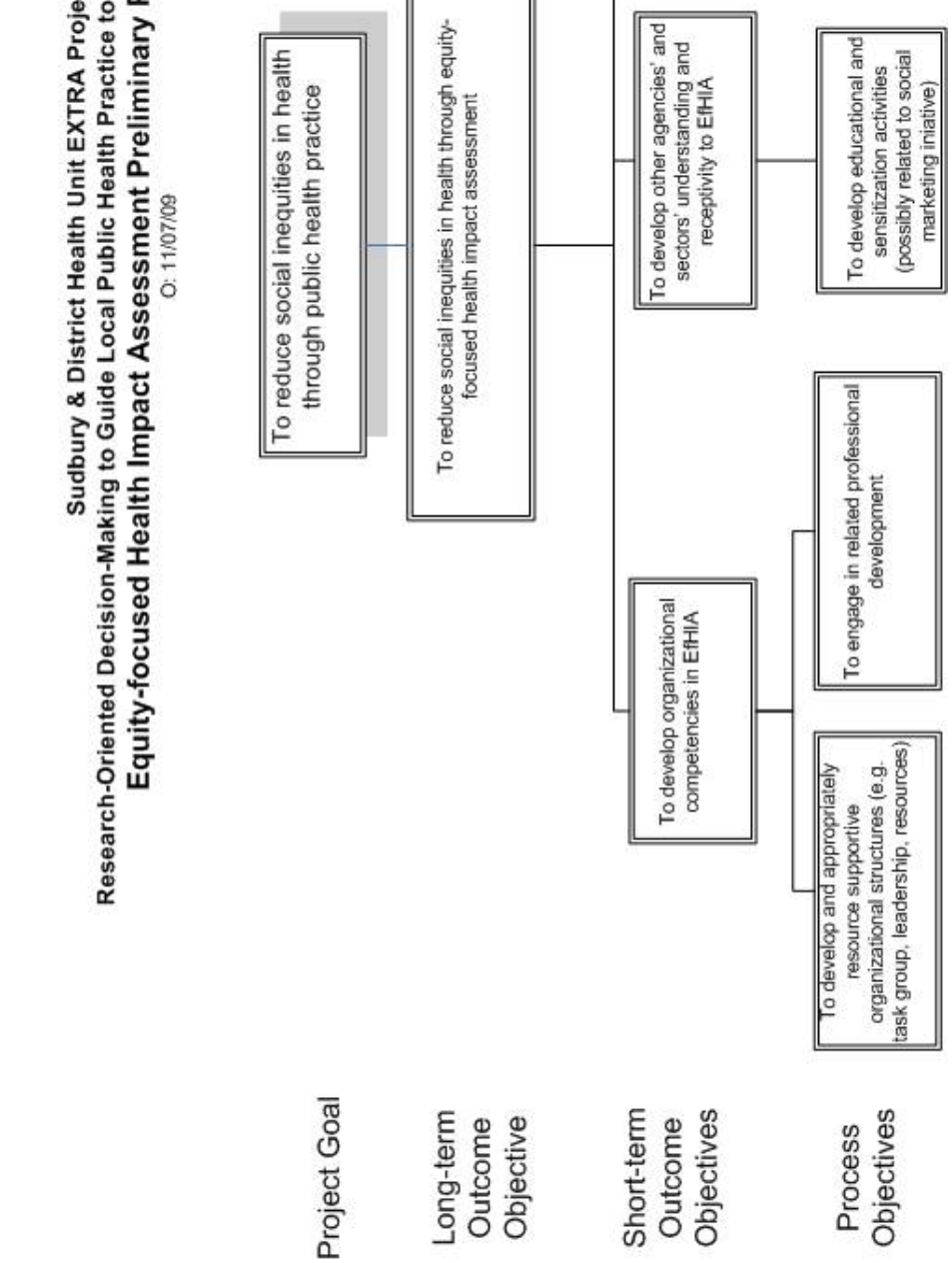
O: 11/07/09



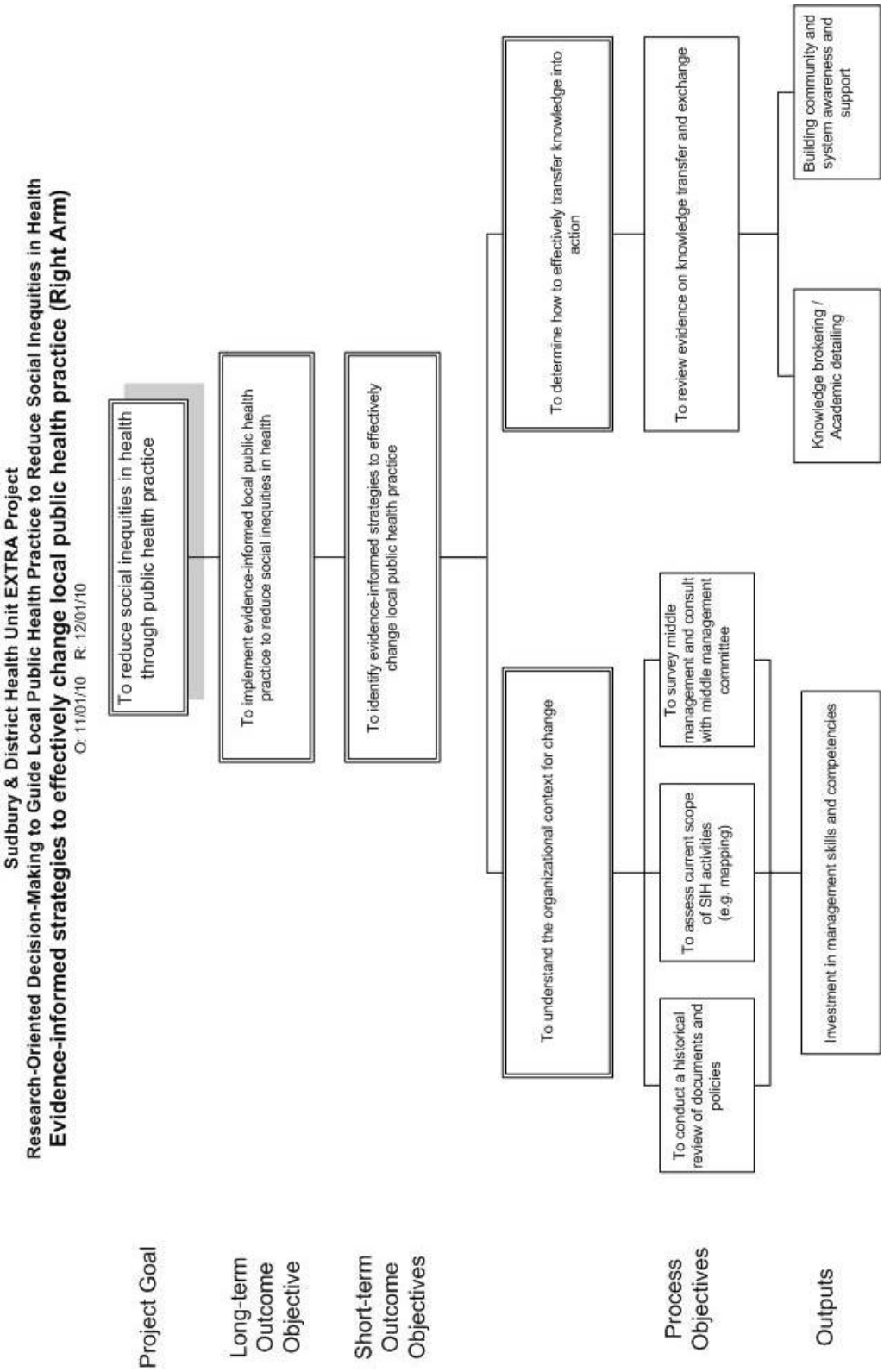
Sudbury & District Health Unit EXTRA Project
Research-Oriented Decision-Making to Guide Local Public Health Practice to Reduce Social Inequities in Health

Equity-focused Health Impact Assessment Preliminary Program Logic Model

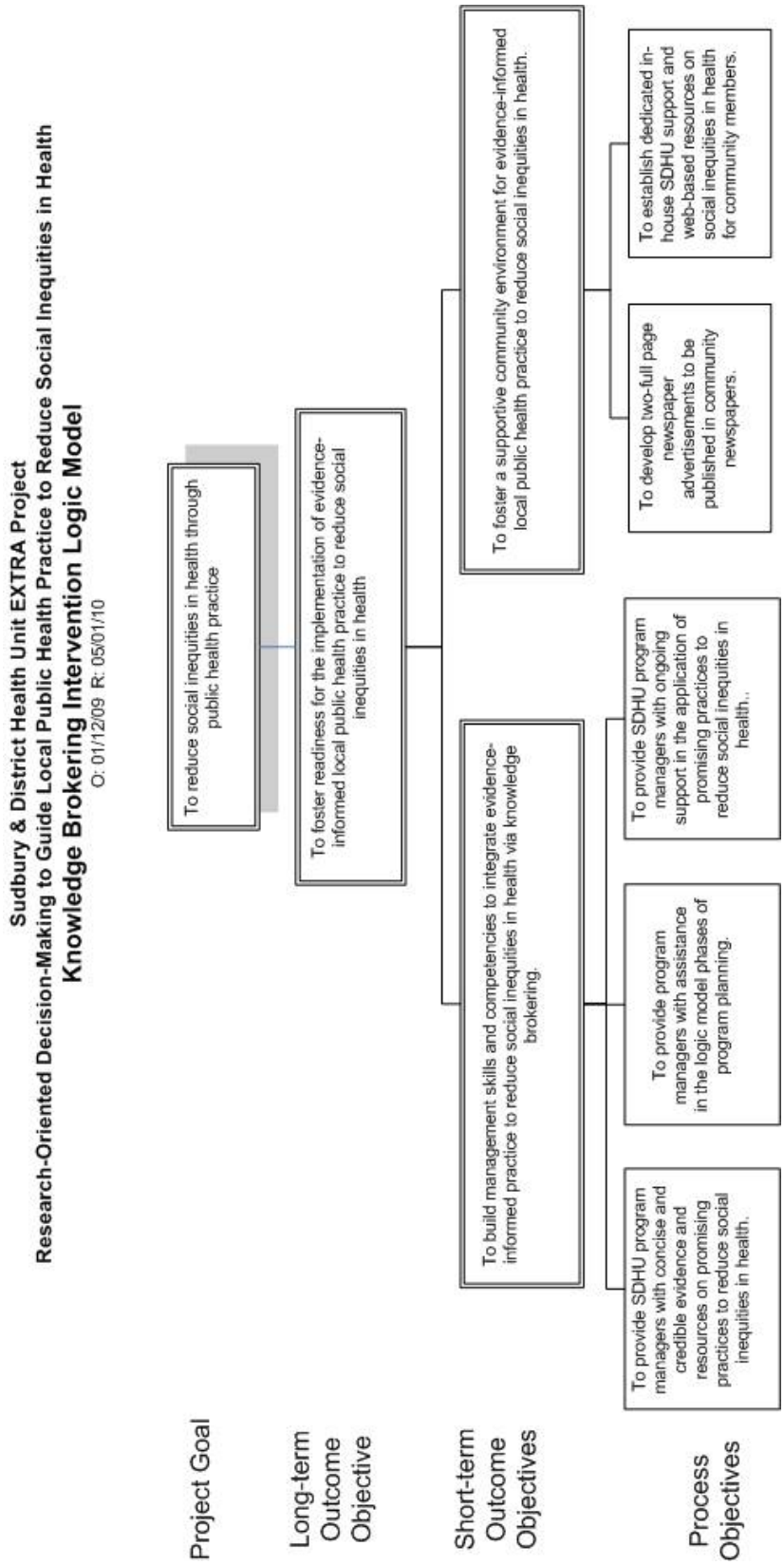
O: 11/07/09



Appendix K : Right Arm Program Logic Model

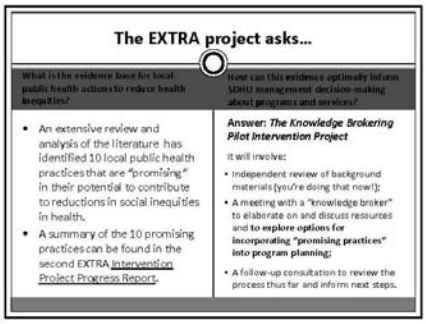


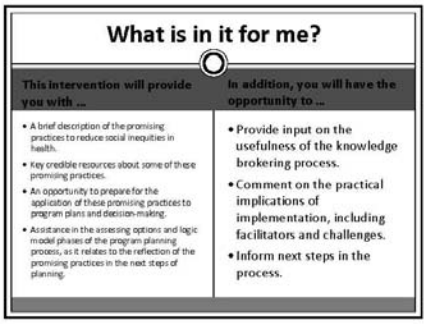
Appendix L : Intervention Program Logic Model

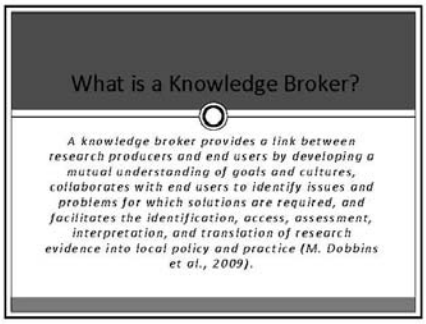


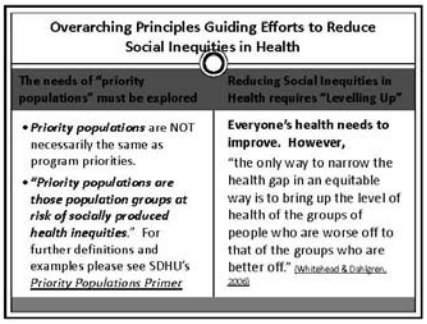
Appendix M: Knowledge Brokering PowerPoint Presentation

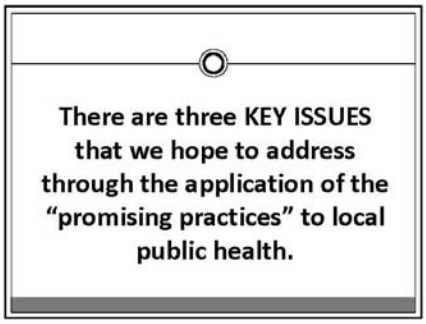
Knowledge Brokering to Support Sudbury & District Health Unit Implementation of Promising Practices to Reduce Social Inequities in Health











1

Issue #1

THE INVERSE LAW OF CARE

What do we mean by the "Inverse Law of Care"?

Those who benefit most from "universal" programs and services are those who have:

- More money
- More time
- More social support
- More education/literacy
- ***Better health to begin with!***

In some cases, universal programs may *increase* health inequities. The health of those who are socially advantaged improves more/faster than the health of those who are socially disadvantaged.

The Promising Practice... Targeting with Universalism

Key elements	Implications for SDHU Program Planning
• Universal policies/ programs are "fine-tuned" so that those who are at greater risk receive the greatest benefit. • The health of the entire population improves but the health of *priority populations* improves more/faster.	• Identification of local *priority populations* is not always straightforward. • Work with *priority populations* may require new approaches/ partnerships. • *Priority populations* may be "targeted" by multiple SDHU program areas.

Essential Resources Targeting with Universalism

Transcending the known in public health practice: The inequality paradox: The population approach and vulnerable populations (Frohlich & Potvin 2008)

Nutrition and physical activity interventions for low-income populations (Chaudhary & Kreiger 2007)

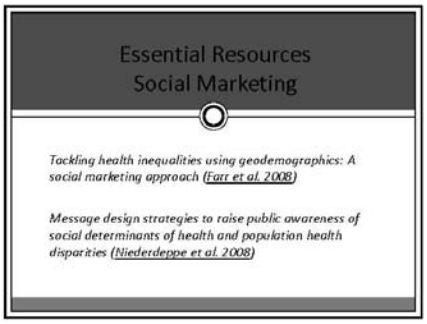
Issue #2

DIFFERENT POPULATIONS EXPERIENCE DIFFERENT MOTIVATORS & BARRIERS TO BEHAVIOUR CHANGE

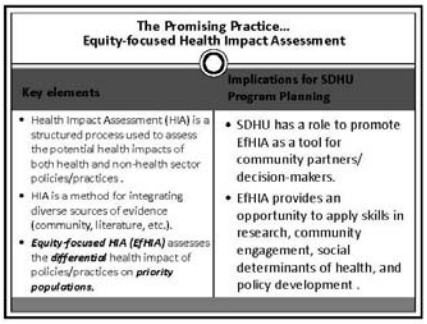
The Promising Practice... Social Marketing

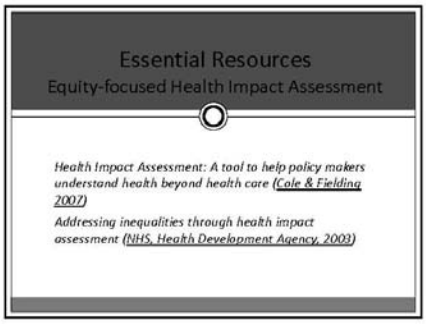
Key elements	Implications for SDHU Program Planning
• A "marketing approach" used to achieve specific behaviour change among *priority populations*. AND • A process used to influence decision-maker support for action to improve the social determinants of health inequities.	• Social marketing (SM) provides a great opportunity to involve/ engage *priority populations* in SDHU activities. • SM requires a large investment of time "up-front" (research, etc.). • Does asking about the needs of *priority populations* require that we respond?

2


Essential Resources
Social Marketing
Tackling health inequalities using geodemographics: A social marketing approach (Farr et al. 2008)
Message design strategies to raise public awareness of social determinants of health and population health disparities (Niederdeppe et al. 2008)


Issue #3
POLICIES, PROGRAMS & PRACTICES IMPACT DIFFERENT PEOPLE IN DIFFERENT WAYS


The Promising Practice...
Equity-focused Health Impact Assessment
Key elements
Implications for SDHU Program Planning
Health Impact Assessment (HIA) is a structured process used to assess the potential health impacts of both health and non-health sector policies/practices.
HIA is a method for integrating diverse sources of evidence (community, literature, etc.).
Equity-focused HIA (EfHIA) assesses the differential health impact of policies/practices on priority populations.
SDHU has a role to promote EfHIA as a tool for community partners/ decision-makers.
EfHIA provides an opportunity to apply skills in research, community engagement, social determinants of health, and policy development.

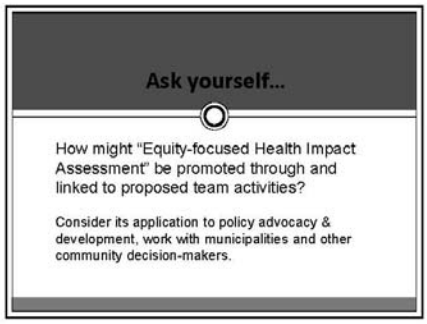

Essential Resources
Equity-focused Health Impact Assessment
Health Impact Assessment: A tool to help policy makers understand health beyond health care (Cole & Fielding 2007)
Addressing inequalities through health impact assessment (NHS, Health Development Agency, 2003)

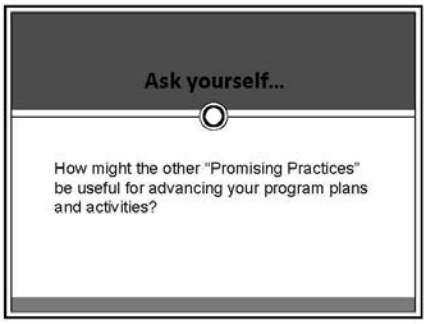

Other Promising Practices to Explore
Purposeful reporting
Reporting evidence that highlights social inequities in health.
Health equity target setting
Careful development and monitoring of indicators to measure success.
Competencies/ organizational standards
Enhancing the skill set of the public health workforce.
Contribution to evidence base
Knowledge exchange via journals, reports, etc.
Early childhood development
Investment in policies, programs, services to support healthy ECD.
Community engagement
Involvement of diverse communities in program development and implementation.
Intersectoral action
Necessary to address many root causes of SIH.


Ask yourself...
How can I best prepare for the knowledge brokering session?
How might "Targeting with Universalism" be applied to the options - (1d) - that my team presented as part of the Planning Path Assessment/Workshop process?
Consider possible changes to approach, venue, target population, communication strategies, staff involved in proposed activities.

3


Ask yourself...
How might "Social Marketing" be used to advance the options - (1d) - that my team presented as part of the Planning Path Assessment/Workshop process?
Consider possible changes to messaging and audiences, community partners, project timelines.


Ask yourself...
How might "Equity-focused Health Impact Assessment" be promoted through and linked to proposed team activities?
Consider its application to policy advocacy & development, work with municipalities and other community decision-makers.


Ask yourself...
How might the other "Promising Practices" be useful for advancing your program plans and activities?

4

Appendix N : Newspaper Advertisements

The most important things you need to know about *your health* may not be as obvious as you think.

Health = A rewarding job with a living wage
Little control at work, high stress, low pay, or unemployment all contribute to poor health.
Your job makes a difference.

Health = Food on the table and a place to call home
Having access to healthy, safe, and affordable food and housing is essential to being healthy.
Access to food and shelter makes a difference.

Health = Having options and opportunities
The thing that contributes most to your health is how much money you have. More money means having more opportunities to be healthy.
Money makes a difference.

Health = A good start in life
Prenatal and childhood experiences set the stage for lifelong health and well-being.
Your childhood makes a difference.

Health = Community belonging
A community that offers support, respect, and opportunities to participate helps us all be healthy.
Feeling included makes a difference.

How can you make a difference?
Action to improve the things that make
ALL of us healthy depends on ALL of our support.

Start a conversation.
Share what you know.

To learn more, call the
Sudbury & District Health Unit
at (705) 522-9200, ext. 515
or visit www.sdhu.com.

Make it a Healthy *Day!*
Sudbury & District Health Unit
Service de santé publique de Sudbury et du district

Les choses les plus importantes que vous devriez connaître à propos de *votre santé* ne sont peut-être pas aussi évidentes que vous le croyez.

La santé = un emploi gratifiant et un salaire adéquat
Peu de contrôle au travail, un niveau de stress élevé, un bas salaire ou le chômage : tout cela a un effet négatif sur la santé.
Votre emploi compte pour beaucoup.

La santé = de la nourriture sur la table et un endroit où demeurer
Il est essentiel pour la santé d'avoir accès à de la nourriture et à un logement sains, sécuritaires et abordables.
L'accès à de la nourriture et à un logement compte pour beaucoup.

La santé = avoir des choix et des opportunités
Ce qui contribue le plus à la bonne santé, c'est le montant d'argent dont on peut disposer. Plus d'argent signifie plus d'occasions d'être en bonne santé.
L'argent compte pour beaucoup.

La santé = un bon départ dans la vie
Les expériences avant la naissance et durant l'enfance préparent à une vie saine et au bien-être.
Votre enfance compte pour beaucoup.

La santé = le sens d'appartenance à une communauté
Une communauté qui offre du soutien, du respect et des opportunités de participation nous aide à être en santé.
Le sentiment d'inclusion compte pour beaucoup.

Vos actions comptent pour beaucoup.
Les actions pour améliorer les choses qui favorisent notre santé à TOUS dépendent de TOUT notre soutien.

Engagez une conversation.
Partagez vos connaissances.

Pour en savoir davantage, appelez le Service de santé publique de Sudbury et du district, (705) 522-9200, poste 515 ou visitez notre site Web au www.sdhu.com.

Visez Santé dès aujourd'hui!
Service de santé publique de Sudbury et du district
Sudbury & District Health Unit

The most important things you can do for *your health* may not be as obvious as you think.

Learn

Eating well and exercising are important, but the things that contribute MOST to our health are how much money we have and our status within our community.

Health = Having options and opportunities
Health = A rewarding job with a living wage
Health = Food on the table and a place to call home
Health = A good start in life
Health = Community belonging

Listen

Everyone has a story to tell. Listen and consider the ways in which people's stories shape their ability to be healthy.

"I've just lost my job."
"There is mould in my apartment."
"I wish I had friends to hang out with."
"I can't find good daycare."
"I sometimes go to school hungry."

Make your voice be heard.

Action to improve the things that make
ALL of us healthy depends on ALL of our support.

Start a conversation.

Share what you know.

To learn more, call the Sudbury & District Health Unit at (705) 522-9200, ext. 515 or visit our website at www.sdhu.com.

Make it a Healthy Day!
Sudbury & District Health Unit
Service de santé publique de Sudbury et du district

Les choses les plus importantes que vous devriez faire pour *votre santé* ne sont peut-être pas aussi évidentes que vous le croyez.

Apprenez

Bien manger et faire de l'exercice sont importants, mais ce qui contribue LE PLUS à notre santé sont le montant d'argent à notre disposition et le statut que nous occupons dans la communauté.

La santé = avoir des choix et des opportunités
La santé = un emploi gratifiant et un salaire adéquat
La santé = de la nourriture sur la table et un endroit où demeurer
La santé = un bon départ dans la vie
La santé = le sens d'appartenance à une communauté

Écoutez

Chacun a une histoire personnelle à raconter. Écoutez et songez aux façons dont ces histoires influencent la capacité de ces personnes à se maintenir en santé.

« Je viens de perdre mon emploi. »
« Il y a de la moisissure dans mon appartement. »
« J'aimerais tant avoir des amis proches. »
« Je ne peux pas trouver un bon service de garderie. »
« Parfois, je me rends à l'école et j'ai faim. »

Faites-vous entendre.

Les actions pour améliorer les choses qui favorisent notre santé à TOUS dépendent de TOUT notre soutien.

Engagez une conversation.

Partagez vos connaissances.

Pour en savoir davantage, appelez le Service de santé publique de Sudbury et du district, (705) 522-9200, poste 515 ou visitez notre site Web au www.sdhu.com.

Visez Santé dès aujourd'hui!
Service de santé publique de Sudbury et du district
Sudbury & District Health Unit