HEALTH EQUITY INDICATORS

FOR ONTARIO LOCAL PUBLIC HEALTH AGENCIES

USER GUIDE | APRIL 2016

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Disclaimer

The views expressed in this report are those of the research team and do not necessarily reflect those of Public Health Ontario.

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Purpose and Preamble

The purpose of this User Guide is to provide local boards of health and local public health agencies with a comprehensive set of evidence-based, pilot-tested indicators that supports their work to address health inequity as required by the Ontario Public Health Standards (OPHS) and the Ontario Public Health Organizational Standards (OPHOS). The indicators are designed for application at the local level where boards and public health agencies are active and accountable.

Our scope of interest focused on the identification and testing of a set of indicators that could assist in the planning and delivering of public health activities directed at the social determinants of health in a way that would support the public health roles identified by the National Collaborating Centre on the Determinants of Health including 1) assess and report, 2) modify / orient, 3) engage and 4) lead / participate and support (NCCDH, 2011). These roles are seen as fundamental in reducing health inequities across population groups. The 'organizational and system development' role was adopted here as a fifth role.

These evidence-based indicators can be used as an internal tool to guide work in meeting the public health equity mandate effectively established in Ontario's legislative framework. They are not meant to be used in a competitive fashion through provincial comparisons. Among other factors, we acknowledge that there are different governance structures (i.e., autonomous boards of health, semi-autonomous, regional / municipal arrangements) which may influence the progress of health equity work. The indicators are most useful as a way to determine, internally, the extent to which your organization is working towards health equity-related activity in programs and services, where improvements can be made, and the progress made over time. We see this as a shared learning journey.

These indicators could be a first step toward the development of an equity-specific standard or protocol to include in the OPHS. Using this Guide may start or enhance the discussion in your local public health agency about health equity as a priority, any required resources or capacity issues, or help to identify barriers to health equity work.

Please see *Phase 2 Report: A Case Study Approach to Pilot Test Indicators* for further details about how the indicators were developed.

What are Health Equity Indicators for Ontario Local Public Health Agencies?

An indicator is "a thing that indicates the state or level of something" (Oxford University Press, 2016). It can be used to "show what a situation is like" and/or the change in value or level (Cambridge University Press, 2016). The Health Equity Indicators presented in this User Guide provide a way for Ontario local public health agencies to assess their efforts to improve health equity as an organization. These indicators differ from *Health or Health Status Indicators,* which are sets of quantitative or qualitative data that provide information on the health status of individuals, groups or populations (EuroHealthNet, 2016). Although population health status indicators are often used as a measure of health inequity, it is difficult to determine how much of a local public health agency's activities impact a health inequity positively or negatively. Many factors outside of the purview of public health impact on any given health inequity (e.g., minimal wage, affordable housing, etc.). This set of Health Equity Indicators has been developed to measure the process of health equity work within the local public health agency and not it's overall impact on population health. They are indicators to determine how well a local public health agency is meeting the health equity mandate as directed in the Ontario Public Health Standards (MOHLTC, 2008), as well as the NCCDH roles for public health to address the social determinants of health.

How to Use this Guide

This Guide is presented in sections corresponding to each of the five indicator roles:

1. Assess and report
2. Modify / orient
3. Engage in community and multi-sectoral collaboration
4. Lead / participate and support
5. Organization and system development

Within each section, each indicator is accompanied by additional background / rationale information. References and resources are provided at the end of the document.

Also at the end of the document, a glossary of terms and working / operational definitions is provided. Please refer to this list to promote clarity and consistency among team members when applying the indicators within your organization. Logistically, we recommend that multiple staff members become involved in completing the worksheets because organizational knowledge is often spread across individuals. Much of the information may need to be requested from different sources and/or may not be immediately accessible. Your public health agency may already have a team or workgroup assembled that is able to complete these indicators (e.g. SDoH / Health Equity Team or Performance Management Team). In any case, nurturing support for the process from senior staff or management will be important, especially when examining results and determining the next steps for your public health agencies.

Worksheets have been provided for each indicator in Appendix A. **Unless otherwise stated, please note that indicators refer to the previous 12 months of activity.** Once indicators have been completed, results should be reviewed. It is hoped that by completing these indicators, agencies will be provided with insights and opportunities to improve equity activity over time and that actions to improve health equity activity may flow from this assessment / review.

Role 1:
Assess and Report

Assessing and reporting on health status and could be done to improve it:

- Using data collection methods to ensure the needs of marginalized and priority populations are identified
- Engaging the community to seek meaning and understanding of the findings
- Providing results to foster community discussion, problem solving and action

Role 1 Indicator 1

Background/Rationale

The World Health Organization (WHO) recommends creation of “a national health equity surveillance system, with routine collection and data on social determinants of health and health inequity” (recommendation 16.2, WHO, 2008, p. 180). According to the WHO Commission on Social Determinants of Health, a health equity surveillance framework should “include information on health inequities and determinants and the consequences of ill health” and be presented in a stratified manner based on both social and regional variables (WHO, 2008, p. 181). The recommendation itself refers to the development of a national health surveillance system; however, the components are considered relevant to the task of assessing and reporting within local public health context. This recommendation has been taken up in Canada by groups working on the development of the Chronic Disease Indicator Framework, who likewise recommend basic stratification in reporting that reflects adoption of a minimum health surveillance system (Betancourt et al. 2014). In a report entitled *Health for All (*Mobert et al, 2008), the authors describe the importance of stratifying data by socioeconomic status (SES) as one example, rather than controlling for the effect of SES as many analyses do. By stratifying, the differential effect of income on health status becomes apparent. Similar analyses could be undertaken for links between health and unemployment, social exclusion, education, deprivation, and other variables (Sutcliffe et al., 2009).

The *Populations Health Assessment and Surveillance Protocol* of the Ontario Public Health Standards (OPHS) states that “[t]he board of heath shall use population health, determinants of health and health inequities information to assess the needs of local populations, including the identification of populations at risk, to determine those groups that would benefit from public health programs and services (i.e. priority populations)” (MOHLTC, 2008, p. 16). Further, the OPHS states “boards of health shall engage in ongoing population health assessment and surveillance. Information to support this analysis shall be derived from a range of provincial and local indicators using identified data sets and methodologies. These analyses shall use specific information on the following: demographics; burden of disease, including mortality and morbidity rates; reproductive outcomes; risk factor prevalence; cultural and social behaviours related to health; health conditions (including injury and substance misuse); environmental conditions and hazards; health determinants; and other risks to the public’s health)” (MOHLTC, 2008, p. 19).

Role 1: Assess and Report

Indicator 1

R1-1. Does your public health agency conduct routine data analysis of health outcomes of public health importance stratified by demographic and/or socioeconomic variables?

Yes □ No □

R1-1a. How frequently?

□ Monthly
□ Semi-annually
□ Annually
□ Other (please specify)

R1-1b. Please check each variable for which information is included and stratified (as appropriate). Please note that the list provided is not exhaustive:

□ sex
□ gender
□ age group
□ at least 2 social markers (e.g. education, income, ethnicity, immigrant status, sexual orientation)
□ at least 1 geographical marker (e.g. municipality, urban or rural, neighbourhood),
□ Aboriginal or indigenous identity (where possible)
□ a summary measure of absolute inequity, (e.g. absolute difference slope index of inequality, summary measures of socioeconomic inequalities in health)
□ a summary measure of relative health inequity (e.g. disparity rate ratio, population attributable fraction, relative index of inequality, concentration index)
□ other

R1-1c. Please check which health outcomes of interest are explored:

□ mortality
□ early child development
□ mental health
□ morbidity and disability
□ self-reported physical and mental health
□ cause-specific outcomes (e.g. diabetic renal failure)
□ other

Role 1 – Indicator 2

Background/Rationale

The OPHS defines priority populations as “those populations that are at risk and for which public health interventions may be reasonably considered to have a substantial impact at the population level” (MOHLTC, 2008, p. 4). The OPHS does not distinguish between those at risk due to socially- produced factors (e.g. low income, limited education, unemployed, poor housing, discrimination due to culture, race or sexual orientation) and those at risk for biological or physiological reasons (e.g. genetics, sex, age). This indicator is intended to assess how Public Health Unit’s (PHUs) have interpreted the OPHS’ definition of priority populations.

Identification and planning for priority populations may occur through service plans, program plans or program operational plans.

Role 1: Assess and Report

Indicator 2

R1-2. Does your public health agency identify and plan for priority populations that have experienced (or are at risk for experiencing) health inequities?

Yes □ No □

If yes, what process is used to identify priority populations?

R1-2a. Identification of priority populations

a. Standardized and explicit process (e.g. specified in a policy and procedure for operational planning)

   Yes □ No □

b. Standardized and explicit template (e.g. separate column for priority population).

   Yes □ No □

c. Other (please describe).

   Yes □ No □

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R1-2b. Health unit's definition of priority population (tick all that apply)

a. Based on socially-produced differences in health outcomes or risk factors (e.g. a priority population could be smokers in low income social housing as this group has been shown to have higher rates of daily smoking compared with the general population)

Yes □ No □

b. Based on differences in health outcomes or risk factors, but not necessarily socially-produced (e.g. a priority population could be youth smokers as this group was shown to have higher rates of daily smoking compared to older adults).

Yes □ No □

c. No standard, explicit or agreed-upon interpretation of definition (i.e. inconsistent)

Yes □ No □

d. Other

Yes □ No □ (if yes, please describe)

Role 1-Indicator 3

Background/Rationale

The *Populations Health Assessment and Surveillance Protocol* of the OPHS states that "[t]he board of health shall, collect, manage, and use data and information from multiple sources in order to undertake population health assessment and surveillance. This shall include quantitative and qualitative data and information obtained through various sources" (MOHLTC, 2008, p.7), including "primary data collection (qualitative and quantitative), as well as data and information from other local, regional, provincial, and national sources" (MOHLTC, 2008, p. 7). Training may be provided to community members to "enable them to participate in data collection activities (e.g., community asset mapping, Photovoice, digital storytelling, walking audits). Once data are collected, community members and partners can also be included in interpreting findings, refining priorities, and developing solutions. The perspectives of community members can bring static data to life by revealing the lived experiences behind the data." (Centre for Disease Control and Prevention, 2010, p. 19)

Role 1: Assess and Report

Indicator 3

R1-3. In addition to surveys, have community members from priority populations who are experiencing (or who are at risk for experiencing) health inequities been involved in data collection activities (e.g. using community asset mapping, photovoice, digital storytelling, walking audits, focus group, or other methods) over the past year? This may include data collection opportunities gained through work with partner organizations that may be considered to be supportive of the role played by public health in population health assessment and surveillance as specified by the OPHS.

Yes □ No □

R1-3a. Please list the different types of data collection methods used:

Role 1-Indicator 4

Background/Rationale

The *Populations Health Assessment and Surveillance Protocol* of the OPHS states that "[t]he board of health shall provide population health information, including determinants of health and health inequities to the public, community partners, and health care providers, in accordance with the Population Health Assessment and Surveillance Protocol, 2008" (MOHLTC, 2008, p. 16). Further, the Ontario Public Health Organizational Standards (OPHOS) state that "[t]he board of health shall ensure that the administration develops and implements a community engagement strategy which includes:

• The provision of information to the public on the board of health's mission, processes, programs and activities to improve the health of its community;

• The dissemination of results of population health assessments to its communities;

• Providing all information noted above in formats that are accessible to everyone in local communities and are available through a variety of methods, including a website (MOHLTC, 2011, p. 17).

According to a recent report from the NCCDH (2014), public health activities that are commonly associated with advancing health equity include (in addition to surveillance and research): raising awareness or "raising the red flag" about inequities, reframing what health means in communities, using data and stories to build understanding, and bringing critical issues to light.

Role 1: Assess and Report

Indicator 4

R1-4. Is there an overarching, written plan in place that addresses public health agency reporting to the community?

Yes □ No □

R1-4a. Are there specific plans in place that include dissemination to identified priority populations that have experienced (or are at risk of experiencing) health inequities?

Yes □ No □

R1-4b. Please list the strategies used by your public health agency to disseminate information to priority populations that have experienced health inequities.

Role 2: Modify/Re-orient

Modifying and/or re-orienting public health programs:

- Requires an understanding of needs among populations, which itself requires engagement with community
- Requires an understanding of existing services available in the community, which requires engagement with other providers

Role 2 - Indicator 1

Background/Rationale

The OPHS state that "principle of need acknowledges the importance of using data and information to inform decision-making at the local level regarding program assessment, planning, delivery, management, and evaluation. This principle must be continuously applied at all levels of program and service delivery to ensure optimal performance. In order to be successful in achieving outcomes, boards of health shall continuously tailor their programs and services to address needs that are influenced by differences in the context of their local communities" (MOHLTC, 2008, p. 19).

“The determinants of health will often inform the needs of a community. It is evident that population health outcomes are often influenced disproportionately by sub-populations who experience inequities in health status and comparatively less control over factors and conditions that promote, protect, or sustain their health. By tailoring programs and services to meet the needs of priority populations, boards of health contribute to the improvement of overall population health outcomes. Boards of health shall also ensure that barriers to accessing public health programs and services are minimized. Barriers can include, but are not limited to, education; literacy levels; language; culture; geography; economic circumstances; discrimination (e.g., age, sexual orientation, race, etc.); social factors, including social isolation; and mental and physical ability.”

Cultural competence is an integral part of providing quality, equitable, and safe client centred care and services. Culturally competent care is a process that occurs on many levels. It is providing services to families, clients (and populations) in a respectful manner that takes into consideration the diversity of their social, cultural, and linguistic backgrounds and beliefs (Sick Kids, 2014). By recognizing the need to become culturally aware / competent, we can begin to minimize barriers and improve access to services and programs (i.e. understanding youth as a sub-culture and minimizing barriers that would foster health inequities in service access).

Role 2: Modify/Re-Orient

Indicator 1

R2-1. In the past 12 months, has your public health agency assessed program/services provided to priority populations experiencing health inequities to ensure that they are provided in a culturally competent manner?

Yes □ No □

R2-1a. If yes, in what proportion of these programs/services was an assessment of cultural competence conducted? (%)

R2-1b. What form did your assessment take? Please describe.

R2-1c. Did the assessment include an evaluation of participant perception of cultural safety?

Yes □ No □

R2-1d. Please provide an example of the evaluation or assessment used to assess cultural safety from the client perspective:

R2-1e. Do program plans incorporate the information gathered from cultural competence assessments?

Yes □ No □

Please provide an example:

Role 2 - Indicator 2

Background/Rationale

Boards of Health may have layers of operational plans that describe activities of teams within a service area (i.e. dental services), teams within Program Divisions (i.e. health promotion) or broad activity areas (i.e. child health). This indicator assesses whether staff preparing those plans are expected to systematically consider health equity when planning and evaluating public health programs and services. The mechanism could be a prompt within the operational plans to outline equity focused activity or a specification to use a standard equity tool in the planning process.

This question asks about the availability of a tool for public health practice in the organization to help the field understand the baseline routine use of health equity assessment. It does not ask about the nature or quality of the tool's implementation, which are also important. Use of a health equity assessment tool can develop and progress as knowledge, skills, and the number of people dedicated to using the tool grow. In addition, organizations can enable the use of health equity assessment by promoting its use, requiring its use and or allocating financial, human or material resources to support its use. Given the baseline use of health equity assessment determined by this question, the quality of implementation could be surveyed in the future.

The planning cycle includes an expectation to modify programs and services based on evaluations and assessments to meet community needs. Health equity assessment can be part of the actions to ensure that programs and services meet community need. This question allows for submission of qualitative examples of any program changes resulting from the use of a health equity assessment. This can help contribute to the evidence base of the health equity impact assessment.

Role 2: Modify/Re-orient

Indicator 2

R2-2. Does your Public Health Agency employ a mechanism to ensure that operational planning includes a health equity assessment of programs and services provided by the health unit, at least annually (or with any updates)?

Yes □ No □

R2-2a. Does the Public Health Agency provide a standardized health equity assessment tool for staff to use in the assessment of programs and services?

Yes □ No □

Please provide a list of tools used.

R2-2b. Have any Public Health Agency programs or services been modified as the result of a health equity assessment?

Yes □ No □

If yes, please list and describe:

Role 2 - Indicator 3

Background/Rationale

The OPHS under the section on guiding principles notes that “Boards of Health shall foster the creation of a supportive environment for health through community and citizen engagement in the assessment, planning, delivery, management, and evaluation of programs and services. This will support improved local capacity to meet the public health needs of the community” (MOHLTC, 2008, p. 22).

Role 2: Modify/Re-orient

Indicator 3

R2-3. Please indicate (and describe where possible) in which of the following ways members of priority populations experiencing health inequities have participated in the development and delivery of Public Health Agency-led programs and services, over the past year:

□ representatives on committees or boards (please specify)
□ client advisory mechanisms (describe)
□ peer workers
□ volunteers
□ other (please describe)

Role 3:
Engage

Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs:

- Requires an understanding of needs among populations, as well as services from other providers
- Requires collaboration with other service providers to prioritize gaps and identify steps to address them

Role 3 - Indicator 1

Background/Rationale

The OPHS state that Boards of Health shall "foster the creation of a supportive environment for health through community and citizen engagement in the assessment, planning, delivery, management, and evaluation of programs and services" (MOHLTC, 2008, p. 22). In the OPHOS, it is stipulated that each board of health "shall ensure that the administration develops and implements a community engagement strategy" (MOHLTC, 2011, p. 17). Each strategy will include "the recruitment and engagement of community partners and the public to participate in the development of the strategic and operational plans for the board of health, and in the evaluation of programs and services" (MOHLTC, 2011, p. 17).

Role 3: Engage

Indicator 1

R3-1. Does your public health agency have an organizational level community engagement strategy?

Yes □ No □

R3-1a. If so, does this strategy include or address priority populations experiencing health inequities?

Yes □ No □

If yes, please elaborate.

Role 3 - Indicator 2

Background/Rationale

Many of the requirements outlined in the OPHS can be facilitated via extensive partnerships established within "the health sector (e.g., Local Health Integration Networks and primary health care) and other sectors (e.g., education, social services, housing, workplace health and safety system, and environment)" (MOHLTC, 2008, pp 20, 22). Further, "the attainment of desired population outcomes, as identified in the OPHS, is dependent upon the degree of integration of public health programs and services with broader community goals. Collaboration among boards of health, their local community partners, academic institutions, and government is integral to the interpretation and prioritization of needs" (MOHLTC, 2008, p. 20). The quality and scope of local partnerships shall be an essential indicator of success for boards of health in achieving and maintaining the leadership role required to create the conditions necessary for effective change (MOHLTC, 2008, p. 22).

Similarly, the OPHOS direct boards of health to ensure development of a "stakeholder engagement strategy" includes "establishing and participating in collaborative partnerships and coalitions that address public health issues" with the non-health and health sector partners listed above (MOHLTC, 2011, p.17).

Role 3: Engage

Indicator 2

R3-2. Does your public health agency establish and participate in collaborative partnerships and/or coalitions to address health equity and social determinants of health issues?

Yes □ No □

R3-2a. Please identify with which partners active partnerships or coalitions have been formed:

i. Non-health sector:
- □ community planning organizations
- □ boards of education
- □ social housing authorities
- □ labour organizations
- □ children & youth services
- □ local chambers of commerce
- □ other

ii. Health sector:
- □ CEO of the local health integration network (LHIN)
- □ hospital administrators
- □ long-term care facility administrators
- □ community health centre administrators
- □ community care access centre administrators
- □ other

Role 4:
Lead/ Support/ Participate

Lead, support and participate with others to address policies:

- Requires community and multi-sectoral collaboration
- Supporting community and other stakeholders in policy advocacy for improvement in health determinants and inequities

Role 4 - Indicator 1

Background/Rationale

The OPHS state that boards of health shall contribute to the development or modification of healthy public policy by facilitating community involvement, and engaging in activities that inform the policy development process (MOHLTC, 2008).

Role 4: Lead/Support/Participate

Indicator 1

R4-1. How many position and policy statements, vetted and approved by the board of health (over the past year), reflect advocacy for priority populations experiencing (or at risk for experiencing) health inequities?

Role 4 - Indicator 2

Background/Rationale

The OPHS incorporate determinants of health throughout (both personal and social), and include a broad range of activities intended to promote population health and reduce health inequities by working with community partners (MOHLTC, 2008).

Working with others in order to improve, influence or advocate for improved health and well-being of the public is a core competencies in public health (PHAC, 2008). Partnership and collaboration uses shared resources and responsibilities to pursue a common goal. When used for advocacy the aim is to reduce inequities in health status or access to health services (PHAC, 2008).

Please note that the list of social determinants of health (SDoH) areas provided were based, originally on those discussed in *Social Determinants of Health: The Canadian Facts* (Mikkonen and Raphael, 2010).

Role 4: Lead/Support/Participate

Indicator 2

R4-2. Please indicate in which SDoH area(s) public health unit staff have been engaged in cross-sectoral advocacy for policy development:

- □ Aboriginal status
- □ gender
- □ disability
- □ housing
- □ early life/early childhood development
- □ income and income distribution
- □ education
- □ race
- □ employment and working conditions
- □ unemployment and job security
- □ social exclusion
- □ food insecurity
- □ social safety net
- □ health services (access to care)

Role 5:
Organization and System Development

- One of the additional suggested 'roles' meant to foster achievement of the four public health roles to address health determinants to reduce inequities
- Organizational and system development addressing the policies, structures, procedures and practice of an organization (or system) to be in place to address inequities and managing the required change

Role 5 - Indicator 1

Background/Rationale

According to the former Ontario Council on Community Health Accreditation (OCCHA, a strategic plan is an indicator of good governance because it shows a purposeful approach to planning and priority setting for the organization. Strategic plans are also a key element for an organization to consider its strengths and weaknesses, and to make plans to address these. (OCCHA, 2008). This indicator also addresses the requirement in the OPHS for strategic plans to address health equity, specifically.

According to the OPHOS, each Board of Health "shall have a strategic plan covering a period of 3 – 5 years that describes how equity issues will be addressed in the delivery and outcomes of programs and services. Strategic plans should be reviewed at least every other year and revised as appropriate" (MOHLTC, 2011, p. 14).

Role 5: Organizational and System

Indicator 1

R5-1. Does the Board of Health's (BOH) strategic plan describe how equity issues will be addressed?

Yes □ No □

If yes, please explain.

R5-1a. What time period (in years) does the current strategic plan cover? Please provide dates.

R5-1b. Does the strategic plan include outcome targets?

Yes □ No □

If yes, please provide.

Role 5 - Indicator 2

Background/Rationale

According to the OPHOS, “[t]he Board of Health shall ensure that the administration establishes a human resources strategy, based on a workforce assessment which considers the competencies, composition and size of the workforce, as well as community composition, and includes initiatives for the recruitment, retention, professional development and leadership development of the public health unit workforce” (MOHLTC, 2011, p. 22). Toronto Public Health (TPH) lists strategies to address health inequities that includes creation of a diverse workforce that reflects the communities served by the health unit in order to “leverage the perspectives, experiences and community connections” available within that workforce (TPH, , 2015).

Role 5: Organizational and System

Indicator 2

R5-2. Is there a human resource strategy in place to consider the workforce diversity (e.g. by age, gender, race/ethnicity, disability, Indigenous/Aboriginal identity) within the public health agency?

Yes ☐ No ☐

If yes, please describe?

R5-2a. How does this distribution compare to the overall population diversity of your geographic catchment?

Role 5 - Indicator 3

Background/Rationale

According to the OPHS, Boards of Health shall ensure a competent and diverse public health workforce by providing ongoing staff development and skill building related to public health competencies (MOHLTC, 2008). In addition, the OPHOS also state that a Board shall ensure the development of a plan to identify the training needs of staff that encourages opportunities for the development of core competencies (OPHOS, 2011).

The PHAC (2008) core competency statements stipulate that a public health practitioner should be able to:

- Recognize how the determinants of health (biological, social, cultural, economic and physical) influence the health and well-being of specific population groups;
- Address population diversity when planning, implementing, adapting and evaluating public health programs and policies;
- Apply culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities.

In their Conceptual Framework of Organizational Capacity for Public Health Equity Action, Cohen et al (2013) identified the following equity-specific knowledge / skills required among the workforce as a whole:

- ability to frame, articulate and promote equity concepts in ways that resonate with various specific audiences;
- skilled in education, awareness-raising and social marketing with the public and decision-makers about equity issues;
- uses evidence-based advocacy for policy changes to support health equity;
- possesses relational competencies to establish and manage inter sectoral alliances and meaningful community engagement (particularly with equity seeking populations);
- proficient in community development, including building capacity for social change;
- employs a repertoire of evidence-based policy options and practice and program interventions to create equity within and outside the health system; and
- an ability to use health equity assessment, audit, and program planning and evaluation tools.

Role 5: Organizational and System

Indicator 3

R5-3. Does your public health agency provide health equity training to all staff?

Yes □ No □

R5-3a. If no, what proportion of staff receive training?

R5-3b. Does the training include… (check all that apply)

Type	Which staff receive this training?	How frequently is training offered?
□ health equity		
□ cultural competency		
□ social marketing		
□ impact assessment		
□ community engagement		
□ program planning and evaluation		
□ other (please specify)		

R5-3c. Does your public health agency conduct evaluations of health equity training efforts?

Yes ☐ No ☐

If yes, please describe your evaluation process.

Role 5 - Indicator 4

Background/Rationale

According to the OPHOS, Boards of Health should establish and implement human resource policies and procedures for all staff that include the evaluation of performance with regard to core competencies in public health (MOHLTC, 2011). These would include those related to health equity and cultural competence.

Role 5: Organizational and System

Indicator 4

R5-4. Do performance appraisals or your organization's equivalent processes for your public health agency's staff require health equity goals be included?

Yes ☐ No ☐

R5-4a. If no, what other mechanisms are being used to reflect or appraise staff member's health equity goals?

R5-4b. Do performance appraisals or your organization's equivalent process for your public health agency's management require the inclusion of health equity goals?

Yes ☐ No ☐

R5-4c. If no, what other mechanisms are being used to reflect or appraise management's health equity goals?

Glossary

Aboriginal or indigenous identity: In a recent (2013) report provided by the National Collaborating Centre for Aboriginal Health, the authors provide the following definition for the term 'aboriginal': Individuals who identify with at least one Aboriginal group, i.e. First Nations(North American Indian), Métis or Inuit, and/or those who report being a Treaty Indian or a Registered Indian as defined by the Indian Act of Canada and/or who are members of an Indian Band or First Nations (Reading and Wien, 2013).

Advocacy: Speaking, writing or acting in favour of a particular cause, policy or group of people (PHAC, 2008)

Cause-specific outcomes: "The measurement of health is a field of research developed by epidemiologists, who measure health outcomes or conditions related to death, illness, disease, injury, disability and expectation of years of life." A health outcome is referred to as "cause-specific" when it can be attributed to one particular cause (Schofield, 2015, p.7). Examples of cause-specific outcomes include renal failure resulting from diabetes, disability resulting from an injury, lowered rates of a disease resulting from widespread immunization in a population.

Collaboration: Collaboration is defined as a "recognized relationship among different sectors or groups, which have been formed to take action on an issue in a way that is more effective or sustainable than might be achieved by the public health sector acting alone" (PHAC, 2008)

Community asset mapping: A positive approach to building strong communities, developed by John Kretzmann and John McKnight (1993). Community asset mapping is a process of inventorying the resources or assets available to a specified neighborhood or community and includes the identification of community assets for individual development and the inventorying of public capital and cultural resources (Michigan State University, 1999).

Community Engagement: As cited in the National Collaborating Centre for Determinants of Health Guide to Community Engagement Frameworks for Action on the Social Determinants of Health and Health Equity (2013) "Community engagement is a process, not a program. It is the participation of members of a community in assessing, planning, implementing, and evaluating solutions to problems that affect them. As such, community engagement involves interpersonal trust, communication, and collaboration. Such engagement, or participation, should focus on, and result from, the needs, expectations, and desires of a community's members." This definition was provided by the Minnesota Department of Health (2013).

The process of community engagement is to be used in a variety of planning areas including operational planning, strategic planning, program planning, and service planning. The Sudbury District Health Unit defines community engagement as a process of working collaboratively and interactively with communities to identify and address issues affecting their well-being, and working together to improve the health of the community and to reduce health inequities (SDHU, 2011). Some examples of best practices for implementing a community engagement strategy include: being transparent about the goals, motivations and limitations of the effort and the population/communities to be engaged throughout the process; taking the time to know the community, including its norms and values, culture, socio-economic conditions, and experience with engagement efforts; and building trust and relationships in the community and seek commitments from formal and informal leaders.

Community engagement has many levels as identified in the International Association for Public Participation's (IAP2, 2007). According to the IAP2, the spectrum of community engagement ranges from informing the public to collaborating with and empowering communities.

Cross-sector collaboration: This refers to partnerships involving government, business, non-profits and philanthropies, communities and/or the public as a whole. "It is engaging multiple areas of a community to work together to deal with a shared social issue or problem." (Bryson, 2006)

Cultural Competence: The Aboriginal Nurses Association (2009) defines cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals, and enables...[them] to work effectively in cross-cultural situations".

Culturally-relevant: "Recognizing, understanding and applying attitudes and practices that are sensitive to and appropriate for people with diverse cultural socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities" (PHAC, 2008 p.10)

Cultural Safety: "Cultural safety takes us beyond cultural awareness and the acknowledgement of difference. It surpasses cultural sensitivity, which recognizes the importance of respecting difference. Cultural safety helps us to understand the limitations of cultural competence, which focuses on the skills, knowledge, and attitudes of practitioners. Cultural safety is predicated on understanding power differentials inherent in health service delivery and redressing these inequities through educational processes" (Spence, 2001).

Digital Storytelling: A relatively new form of storytelling that has developed along with the emergence of more accessible technology and production hardware and software (e.g. digital cameras, digital voice recorders, video recording devices, animation software, sound and music production software). Digital stories are often multimedia productions that combine still photography with video production, music and a narrative voice (Pilgrim Projects, 2007).

Disability: covers a broad range and degree of conditions, some visible and some not visible. A disability may have been present from birth, caused by an accident, or developed over time. There are physical, mental and learning disabilities, mental disorders, hearing or vision disabilities, epilepsy, drug and alcohol dependencies, environmental sensitivities, and other conditions (OHRC, 2011).

Dissemination: Methods/tools that involve/facilitate one-way transmission of messages, the transfer or spread of information from one party to other parties, or the distribution of information from sender to recipients; "Dissemination involves identifying the appropriate audience, and tailoring the message and medium to the audience. Dissemination activities can include such things as summary/briefings to stakeholders, educational sessions with patients, practitioners and/or policy makers, engaging knowledge users in developing and executing dissemination/ implementation plan, tools creation, and media engagement" (Canadian Institutes of Health Research, 2015).

Diversity: The demographic characteristic of populations attributable to perceptible ethnic, linguistic, cultural, visible or social variation among groups of individuals in the general population (PHAC, 2008).

Evaluation: Efforts aimed at determining as systematically and objectively as possible the effectiveness and impact of health-related (and other) activities in relation to objectives, taking into account the resources that have been used (PHAC, 2008).

Food insecurity: Inadequate or insecure access to food because of financial constraints. It indicates deprivation in terms of basic human need: access to nutritious food in sufficient quantities and of sufficient quality to maintain good health (United Nations Food and Agriculture Organization, 1996).

Gender:

- Gender identity is each person's internal and individual experience of gender. It is their sense of being a woman, a man, both, neither, or anywhere along the gender spectrum. A person's gender identity may be the same as or different from their birth-assigned sex. Gender identity is fundamentally different from a person's sexual orientation.
- Gender expression is how a person publicly presents their gender. This can include behaviour and outward appearance such as dress, hair, make-up, body language and voice. A person's chosen name and pronoun are also common ways of expressing gender.
- Trans or transgender is an umbrella term referring to people with diverse gender identities and expressions that differ from stereotypical gender norms. It includes but is not limited to people who identify as transgender, trans woman (male-to-female), trans man (female-to-male), transsexual, cross-dresser, gender non-conforming, gender variant or gender queer (OHRC, 2014).

Health Equity Impact Assessment / Equity-focused Health Impact Assessment (HEIA / EfHIA): Uses health impact assessment (HIA) methodology to create a structured and transparent process of determining the potential differential impacts of a policy or program on the health of the population, and how these impacts are distributed among population groups. EfHIA or HEIA are specifically concerned with determining whether differential impacts are inequitable (i.e. relate to underlying social disadvantage; and are remediable / avoidable by policy or program directions). Although early models of HIA were intended to assess the differential impact of public policies on different population groups, there is evidence that this is not always the case. In response to this, the Australasian Collaboration for Health Equity Impact Assessment (Mahoney et al, 2004) developed a framework for 'Equity focused Health Impact Assessment', which was recently piloted in Manitoba. HIA was originally intended to assess the impact of public policies and private/public development projects outside of the health care system. Several frameworks have, in turn, been developed to integrate an equity lens within the health care system (e.g. Equity Audit, Equity Effectiveness Loop, Health Equity Assessment Tool). (Winnipeg Regional Health Authority, 2012)

Health inequity: is a sub-set of health inequality and refers to differences in health associated with social disadvantages that are modifiable, and considered unfair. Health equity means all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions (NCCDH, 2014, pp. 2).

Health Inequities vs. Health inequalities: From the OPHS (MOHLTC, 2008) – It is important to distinguish between inequality in health and inequity. "Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. Some health inequalities are attributable to biological variations or free choice, and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. It may be impossible or ethically or ideologically unacceptable to change these health determinants, and so the health inequalities are unavoidable. Health inequities are differences in health status between groups/populations that are unfair or unjust (e.g. differences due to poverty, access to services, etc.). The uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequity in health." "Health equity" represents the steps we take to address health inequities.

Measures of absolute and relative health inequity: To best interpret patterns of inequity, the WHO commission recommended that at least one summary measure of absolute health inequity and one summary measure of relative health inequity between social groups be included (WHO, 2008). These measures are complementary and further aid in the interpretation of patterns of inequity within the community (WHO, 2008).

- Summary measure of absolute inequity: "the difference in the rates of health outcomes between the lowest income group and the highest income group" (TPH, 2008, p. 24).
- Summary measure of relative health inequity: "the ratio of the rate of health outcomes in the lowest income group compared to the highest income group" (TPH, 2008, p. 24).

An example of both measures of absolute and relative health inequities can be found in *The Unequal City: Income and Health Inequities in Toronto (*TPH, 2008). An example of relative health inequities may also be found in Opportunity for All (SDHU, 2013).

Morbidity and Disability: Morbidity is another term for illness. A person can have several co-morbidities simultaneously. So, morbidities can range from Alzheimer's disease to cancer to traumatic brain injury. Prevalence is a measure often used to determine the level of morbidity in a population (New York State Department of Health, 1999) Disability covers a broad range and degree of conditions, some visible and some not visible. A disability may have been present from birth, caused by an accident, or developed over time. There are physical, mental and learning disabilities, mental disorders, hearing or vision disabilities, epilepsy, drug and alcohol dependencies, environmental sensitivities, and other conditions (OHRC, 2011).

Mortality: Mortality is another term for death. A mortality rate is the number of deaths due to a disease divided by the total population (New York State Department of Health, 1999).

Operational plans: are the documents used by staff to ensure that public health programs and services have been systematically identified with associated activities and resourced for a period against defined outputs or outcomes (MOHLTC, 2011).

Partnership: From the Public Health Agency of Canada (PHAC, 2008), partnership is defined as "collaboration between individuals, groups, organizations, governments or sectors for the purpose of joint action to achieve a common goal. The concept of partnership implies that there is an informal understanding or a more formal agreement (possibly legally binding) among the parties regarding roles and responsibilities, as well as the nature of the goal and how it will be pursued".

Performance (appraisal) standards: The criteria, often determined in advance, e.g., by an expert committee, by which the activities of health professionals or the organization in which they work, are assessed (PHAC, 2008).

Photovoice: A specific data collection process using a photographic technique through which people can 1) record and reflect community strengths and challenges, 2) promote dialogue and support knowledge exchange about issues identified as important to the community and 3) reach policymakers (Wang and Burris, 1997).

Policy: A course or principle of action adopted or proposed by a government, party, business, or individual: the written or unwritten aims, objectives, targets, strategy, tactics and plans that guide the actions of a government or an organization. Policy includes the decisions and actions that maintain or change what would otherwise occur. Policy sets priorities and guides resource allocation to achieve a desired objective (Winnipeg Regional Health Authority, 2012).

Priority Populations: "Those populations that are at risk and for which public health interventions may be reasonably considered to have a substantial impact at the population level" (MOHLTC, 2008). The OPHS does not distinguish between those at risk due to socially-produced factors (e.g. low income, limited education, unemployed, poor housing, discrimination due to culture, race or sexual orientation) and those at risk for biological or physiological reasons (e.g. genetics, sex, age).

Qualitative data: is often collected by naturalistic methods such as observation, in-depth interviewing or focus groups. Resulting data often consists of narratives produced with key individuals or groups, as well as the researcher's field notes and observations.

Race: The Ontario Human Rights Commission describes communities facing racism as "racialized." Race is a social construct. This means that society forms ideas of race based on geographic, historical, political, economic, social and cultural factors, as well as physical traits, even though none of these can be used to justify racial superiority or racial prejudice (OHRC, 2012).

Social determinants of health (SDoH): The interrelated social, political and economic factors that create the conditions in which people live, learn, work and play. The intersection of the SDoH causes these conditions to shift and change over time and across the life span, impacting the health of individuals, groups and communities in different ways (NCCDH, 2015).

Social exclusion: The WHO describes exclusion as consisting of dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions - economic, political, social and cultural - and at different levels including individual, household, group, community, country and global levels. It results in a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which leads to health inequalities (WHO, 2008).

Social Safety Net: Refers to a range of benefits, programs, and supports that protect citizens during various life changes that can affect their health. These life changes include normal life transitions such as having and raising children, attaining education or employment training, seeking housing, entering the labour force, and reaching retirement (Mikkonen & Raphael, 2010; pp. 35).

Strategic Plan: An organizational document that generally covers a period of 3 – 5 years, presents the organization's mission and vision, describes the relationship of programs to community needs and established priorities for action within a specific time-frame and with specific resources (OCCHA, 2008).

Surveillance: is the systematic and ongoing collection, collation, and analysis of health- related information that is communicated in a timely manner to all who need to know, so that action can be taken. Surveillance contributes to effective public health program planning, delivery, and management (MOHLTC, 2008).

Walking audits: An assessment of the walkability or pedestrian access of the built environment in a community. Walkability is a measurement of how inviting an area is to pedestrians. Examining the walkability of a neighbourhood, town or city is an important factor to consider when thinking about issues such as social inclusion or connectedness, healthy lifestyles and safety, for example. They can be undertaken by a range of different stakeholders and often collect both quantitative and qualitative data on the walking environment (Jane`s Walk, 2014, Leyden, 2003).

Workforce Diversity: "We define diversity as inclusion of all groups at all levels in the company. Diversity requires a special corporate culture in which every employee can pursue his or her career aspirations without being inhibited by gender, race, nationality, religion, or other factors that are irrelevant to performance" (Bryan, 1999).

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APPENDIX A
WORKSHEETS

Role 1: Assess and Report
Indicator 1

Date:	Completed by:

R1 – 1. Does your public health agency conduct routine data analysis of health outcomes of public health importance stratified by demographic and/or socioeconomic variables?

Yes ☐ No ☐

R1-1a. How frequently?

☐ Monthly
☐ Semi-annually
☐ Annually
☐ other (please specify)

R1-1b. Please check each variable for which information is included and stratified (as appropriate). Please note that the list provided is not exhaustive.

☐ sex
☐ gender
☐ age group
☐ at least 2 social markers (e.g. education, income, ethnicity, immigrant status, sexual orientation)
☐ at least 1 geographical marker (e.g. municipality, urban or rural, neighbourhood)
☐ Aboriginal or indigenous identity (where possible)
☐ a summary measure of absolute inequity (e.g. absolute difference slope index of inequality, summary measures of socioeconomic inequalities in health)
☐ a summary measure of relative health inequity (e.g. disparity rate ratio, population attributable fraction, relative index of inequality, concentration index)
☐ other (please specify)

R1-1c. Please check which health outcomes of interest are explored:

- ☐ mortality
- ☐ early child development
- ☐ mental health
- ☐ morbidity and disability
- ☐ self-reported physical and mental health
- ☐ cause-specific outcomes (e.g. diabetic renal failure)
- ☐ other (please specify)

Sources/contacts required to complete indicator:

ROLE 1 – INDICATOR 1

Possible areas for review or recommendations for action:

Other notes:

Role 1: Assess and Report
Indicator 2

Date:	Completed By:

R1-2. Does your public health agency identify and plan for priority populations that have experienced (or are at risk for experiencing) health inequities?

Yes ☐ No ☐

If yes, what process is used to identify priority populations?

R1-2a. Identification of priority populations

a. Standardized and explicit process (e.g. specified in a policy and procedure for operational planning)

Yes ☐ No ☐

b. Standardized and explicit template (e.g. separate column for priority population).

Yes ☐ No ☐

c. Other (please describe). Yes ☐ No ☐

R1-2b. Health unit's definition of priority population (tick all that apply)

a. Based on socially-produced differences in health outcomes or risk factors (e.g. a priority population could be smokers in low income social housing as this group has been shown to have higher rates of daily smoking compared with the general population)
Yes ☐ No ☐

b. Based on differences in health outcomes or risk factors, but not necessarily socially-produced (e.g. a priority population could be youth smokers as this group was shown to have higher rates of daily smoking compared to older adults).
Yes ☐ No ☐

c. No standard, explicit or agreed-upon interpretation of definition (i.e. inconsistent)
Yes ☐ No ☐

d. Other
Yes ☐ No ☐ (if yes, please describe)

Sources/contacts required to complete indicator:

Role 1 - Indicator 2

Possible areas for review or recommendations for action:

Other notes:

Role 1: Assess and Report
Indicator 3

Date: **Completed By:**

R1-3. In addition to surveys, have community members from priority populations who are experiencing (or who are at risk for experiencing) health inequities been involved in data collection activities (e.g. using community asset mapping, photovoice, digital storytelling, walking audits, focus group, or other methods) over the past year? This may include data collection opportunities gained through work with partner organizations that may be considered to be supportive of the role played by public health in population health assessment and surveillance as specified by the OPHS.

☐ Yes

☐ No

R1-3a. Please list the different types of data collection methods used:

Sources/contacts required to complete indicator:

Role 1 - Indicator 3

Possible areas for review or recommendations for action:

Other notes:

Role 1: Assess and Report
Indicator 4

Date:	Completed By:

R1-4. Is there an overarching, written plan in place that addresses public health agency reporting to the community?

☐ Yes

☐ No

R1-4a. Are there specific plans in place that include dissemination to identified priority populations that have experienced (or are at risk of experiencing) health inequities?

☐ Yes

☐ No

R1-4b. Please list the strategies used by your public health agency to disseminate information to priority populations that have experienced health inequities.

Sources/contacts required to complete indicator:

Role 1 - Indicator 3

Possible areas for review or recommendations for action:

Other notes:

Role 2: Modify/Re-Orient
Indicator 1

Date:	Completed By:

R2-1. In the past 12 months, has your public health agency assessed program/services provided to priority populations experiencing health inequities to ensure that they are provided in a culturally competent manner?

☐ Yes

☐ No

R2-1a. If yes, in what proportion of these programs/services was there an assessment of cultural competence conducted? ____ %

R2-1b. What form did your assessment take? Please describe.

R2-1c. Did the assessment include an evaluation of participant perception of cultural safety?

Yes ☐ No ☐

R2-1d. Please provide an example of the evaluation or assessment used to assess cultural safety from the client perspective:

R2-1e. Do program plans incorporate the information gathered from cultural competence assessments?

Yes ☐ No ☐

R2-1f. Please provide an example:

Sources/contacts required to complete indicator:

Role 2 - Indicator 1

Possible areas for review or recommendations for action:

Other notes:

Role 2: Modify/Re-Orient
Indicator 2

Date:	Completed By:

R2-2. Does your public health agency employ a mechanism to ensure that operational planning includes a health equity assessment of programs and services provided by the health unit, at least annually (or with any updates)?

Yes ☐ No ☐

R2-2a. Does the public health agency provide a standardized health equity assessment tool for staff to use in the assessment of programs and services**?**

Yes ☐ No ☐

If yes, please provide a list of tools used.

R2-2b. Have any public health agency programs or services been modified as the result of a health equity assessment?

Yes ☐ No ☐

If yes, please list and describe:

Sources/contacts required to complete indicator:

ROLE 2 – INDICATOR 2

Possible areas for review or recommendations for action:

Other notes:

Role 2: Modify/Re-Orient
Indicator 3

Date:	Completed By:

R2-3. Please indicate (and describe where possible) in which of the following ways members of priority populations experiencing health inequities have participated in the development and delivery of public health agency-led programs and services, over the past year:

☐ representatives on committees or boards (please specify)

☐ client advisory mechanisms (e.g. surveys, focus groups, social media, story sharing strategies, established client advisory committees or advisory groups)

☐ peer workers

☐ volunteers

☐ other (please describe)

Sources/contacts required to complete indicator:

ROLE 2 – INDICATOR 3

Possible areas for review or recommendations for action:

Other notes:

Role 3: Engage
Indicator 1

Date:	Completed By:

R3-1. Does your public health agency have an organizational level community engagement strategy?

Yes ☐ No ☐

R3-1a. If so, does this strategy include or address priority populations experiencing health inequities?

Yes ☐ No ☐

If yes, please elaborate.

Sources/contacts required to complete indicator:

Role 3 – Indicator 1

Possible areas for review or recommendations for action:

Other notes:

Role 3: Engage
Indicator 2

Date:	Completed By:

R3-2. Does your public health agency establish and participate in collaborative partnerships and/or coalitions to address health equity and social determinants of health issues?

Yes ☐ No ☐

R2-2a. Please identify with which partners active partnerships or coalitions have been formed, over the past year. (Note that this list is not intended to be exhaustive)

i. Non-health sector

- ☐ local government
- ☐ provincial ministries
- ☐ federal departments
- ☐ broader public sector
- ☐ education sector (including colleges and universities)
- ☐ First Nations organizations
- ☐ Other (Please Specify) _____

ii. Health sector

- ☐ primary care
- ☐ community care
- ☐ acute care
- ☐ long-term care
- ☐ non-governmental organizations
- ☐ Health Canada
- ☐ Public Health Agency of Canada
- ☐ First Nations organizations
- ☐ Other (Please Specify) _____

Sources/contacts required to complete indicator:

Role 3 - Indicator 2

Possible areas for review or recommendations for action:

Other notes:

Role 4: Lead/Support/Participate
Indicator 1

Date:	Completed By:

R4-1. How many position and policy statements, vetted and approved by the Board of Health (over the past year), reflect advocacy for priority populations experiencing (or at risk for experiencing) health inequities?

Sources/contacts required to complete indicator:

Role 3 - Indicator 2

Possible areas for review or recommendations for action:

Other notes:

Role 4: Lead/Support/Participate
Indicator 2

Date:	Completed By:

R4-2. Please indicate in which SDoH area(s) public health unit staff have been engaged in cross-sectoral advocacy for policy development:

- ☐ Aboriginal status
- ☐ gender
- ☐ disability
- ☐ housing and homelessness
- ☐ early life/early childhood development
- ☐ income and income distribution
- ☐ education
- ☐ race
- ☐ immigration status
- ☐ employment and working conditions
- ☐ unemployment and job security
- ☐ social exclusion
- ☐ food insecurity
- ☐ social safety net
- ☐ health services (access to care)

Sources/contacts required to complete indicator:

Role 4 - Indicator 2

Possible areas for review or recommendations for action:

Other notes:

Role 5: Organization and System Indicator 1

Date:	Completed By:

R5-1. Does the Board of Health's (BOH) strategic plan describe how health equity issues will be addressed?

Yes ☐ No ☐

If yes, please explain.

R5-1a. What time period (in years) does the current strategic plan cover? Please provide dates.

R5-1b. Does the strategic plan include outcome targets?

Yes ☐ No ☐

If yes, please provide.

Sources/contacts required to complete indicator:

Role 5 - Indicator 1

Possible areas for review or recommendations for action:

Other notes:

Role 5: Organization and System Indicator 2

Date:	Completed By:

R5-2. Is there a human resource strategy in place to consider the workforce diversity (e.g. by age, gender, race/ethnicity, disability, Indigenous/Aboriginal identity) within the public health agency?

Yes ☐ No ☐

If yes, please describe:

R5-2a. How does this distribution compare to the overall population diversity of your geographic catchment?

Sources/contacts required to complete indicator:

Role 5 - Indicator 2

Possible areas for review or recommendations for action:

Other notes:

Role 5: Organization and System
Indicator 3

Date:	Completed By:

R5-3. Does your public health agency provide health equity training to all staff?

Yes ☐ No ☐

R5-3a. If no, what proportion of staff receive training?

R5-3b. Does your health equity training include… (check all that apply)

	Which staff receive this training?	How frequently is training offered?
4☐health equity		
☐ cultural competency		
☐social marketing		
☐impact assessment		
☐community engagement		
☐program planning and evaluation		
☐other (please specify)		

R5-3c. Does your public health agency conduct evaluations of health equity training efforts?

Yes ☐ No ☐

If yes, please describe your evaluation process.

Sources/contacts required to complete indicator:

Role 5 - Indicator 3

Possible areas for review or recommendations for action:

Other notes:

Role 5: Organization and System Indicator 4

Date:	Completed By:

R5-4. Do performance appraisals or your organization's equivalent processes for your public health agency's staff require health equity goals be included?

Yes ☐ No ☐

R5-4a. If no, what other mechanisms are being used to reflect or appraise staff member's health equity goals?

R5-4b. Do performance appraisals or your organization's equivalent process for your public health agency's management require the inclusion of health equity goals?

Yes ☐ No ☐

If no, what other mechanisms are being used to reflect or appraise management's health equity goals?

Sources/contacts required to complete indicator:

Role 5 – Indicator 4

Possible areas for review or recommendations for action:

Other notes:

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