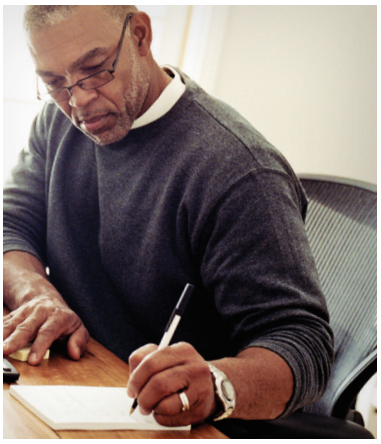
A PRACTITIONER'S GUIDE FOR

ADVANCING HEALTH EQUITY

Community Strategies for Preventing Chronic Disease



FOUNDATIONAL SKILLS FOR PUBLIC HEALTH

National Center for Chronic Disease Prevention and Health Promotion
Division of Community Health

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WWW.CDC.GOV/HEALTHEQUITYGUIDE

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Additionally, *A Practitioner's Guide for Advancing Health Equity* is not intended to serve as step-by-step instructions, as there is no one-size-fits all approach to advancing health equity. Although this document discusses a variety of evidence- and practice-based strategies, it is not exhaustive. Strategies included may not be appropriate for every organization's situation. Communities must decide what is appropriate for their local context. Therefore, strategies and examples in this guide should be considered in accordance with an organization's and, where applicable, its funder's established protocols and regulations.

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LETTER FROM THE DIVISION OF COMMUNITY HEALTH

PUBLIC HEALTH PRACTITIONER,

There is a growing body of literature exploring how environments in this nation shape our health. To address this issue, public health practitioners are implementing chronic disease policy, systems, and environmental improvements where people live, learn, work, and play. Practitioners are also considering how to ensure such improvements are designed to reverse the negative trends of chronic health conditions among vulnerable population groups. In response to the mounting needs of practitioners seeking reliable tools to advance health equity, the Centers for Disease Control and Prevention (CDC) developed *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease (Health Equity Guide)*.

The purpose of the *Health Equity Guide* is to assist practitioners with addressing the well-documented disparities in chronic disease health outcomes. This resource offers lessons learned from practitioners on the front lines of local, state, and tribal organizations that are working to promote health and prevent chronic disease health disparities. It provides a collection of health equity considerations for several policy, systems, and environmental improvement strategies focused on tobacco-free living, healthy food and beverages, and active living. Additionally, the *Health Equity Guide* will assist practitioners with integrating the concept of health equity into local practices such as building organizational capacity, engaging the community, developing partnerships, identifying health inequities, and conducting evaluations. The *Health Equity Guide* is designed for the novice interested in the concept of health equity, as well as the skillful practitioner tackling health inequities.

We encourage you to visit **WWW.CDC.GOV/HEALTHEQUITYGUIDE** for additional tools and resources that promote health and the integration of health equity into everyday practice. We hope you find the information and examples provided to be useful and an impetus in your efforts to reduce health disparities and advance health equity.

Sincerely,

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INTRODUCTION

Heart disease, cancer, diabetes, and stroke are the most common causes of illness, disability, and death affecting a growing number of Americans.[4] Many of these chronic conditions tend to be more common, diagnosed later, and result in worse outcomes for particular individuals,[5-7] such as people of color, people in low-income neighborhoods, and others whose life conditions place them at risk for poor health.

(See Appendix A for list of population groups experiencing chronic disease disparities.)

Despite decades of efforts to reduce and eliminate health disparities, they persist—and in some cases, they are widening among some population groups.[8-11] Such disparities do not have a single cause. They are created and maintained through multiple, interconnected, and complex pathways. Some of the factors influencing health and contributing to health disparities include the following:[12,13]

- **Root causes or social determinants of health** such as poverty, lack of education, racism, discrimination, and stigma.
- **Environment and community conditions** such as how a community looks (e.g., property neglect), what residents are exposed to (e.g., advertising, violence), and what resources are available there (e.g., transportation, grocery stores).
- **Behavioral factors** such as diet, tobacco use, and engagement in physical activity.
- **Medical services** such as the availability and quality of medical services.

INTRODUCTION (Continued)

HEALTH EQUITY MEANS THAT EVERY PERSON HAS AN OPPORTUNITY TO ACHIEVE OPTIMAL HEALTH REGARDLESS OF:

- THE COLOR OF THEIR SKIN
- LEVEL OF EDUCATION
- GENDER IDENTITY
- SEXUAL ORIENTATION
- THE JOB THEY HAVE
- THE NEIGHBORHOOD THEY LIVE IN
- WHETHER OR NOT THEY HAVE A DISABILITY[3]

While health disparities can be addressed at multiple levels, this resource focuses on **policy, systems, and environmental improvement strategies** designed to improve the places where people live, learn, work, and play. Many of the 20th and 21st century's greatest public health achievements (e.g., water fluoridation, motor vehicle safety, food safety) have relied on the use of laws, regulations, and environmental improvement strategies.[14,15] Health practitioners play an important role in these improvements by engaging the community, identifying needs, conducting analyses, developing partnerships, as well as implementing and evaluating evidence-based interventions.

These intervention approaches are briefly described below:

- **Policy improvements** may include "a law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions."[16]
  Example: A voluntary school wellness policy that ensures food and beverage offerings meet certain standards.
- **Systems improvements** may include a "change that impacts all elements, including social norms of an organization, institution, or system."[17]
  Example: The integration of tobacco screening and referral protocols into a hospital system.
- **Environmental improvements** may include changes to the physical, social, or economic environment.[17]
  Example: A change to street infrastructure that enhances connectivity and promotes physical activity.

INTRODUCTION (Continued)

Such interventions have great potential to prevent and reduce health inequities, affect a large portion of a population, and can also be leveraged to address root causes, ensuring the greatest possible health impact is achieved over time. **However, without careful design and implementation, such interventions may inadvertently widen health inequities.** To maximize the health effects for all and reduce health inequities, it is important to consider the following:

- Different strategies require varying levels of individual or community effort and resources, which may affect who benefits and at what rate.
- Certain population groups may face barriers to or negative unintended consequences from certain strategies (see Appendix B for a list of common barriers). Such barriers can limit the strategy's effect and worsen the disparity.
- Population groups experiencing health disparities have further to go to attain their full health potential, so even with equitable implementation, health effects may vary.
- Health equity should not only be considered when designing interventions. To help advance the goal, health equity should be considered in other aspects of public health practice (e.g., organizational capacity, partnerships, evaluation).

A Practitioner's Guide to Advancing Health Equity provides lessons learned and practices from the field, as well as from the existing evidence-base. This resource offers ideas on how to maximize the effects of several policy, systems, and environmental improvement strategies with a goal to reduce health inequities and advance health equity. Additionally, the resource will help communities incorporate the concept of health equity into core components of public health practice such as organizational capacity, partnerships, community engagement, identifying health inequities, and evaluation.

This resource has four major sections:

- Incorporating Health Equity into **Foundational Skills** of Public Health
- Maximizing **Tobacco-Free Living** Strategies to Advance Health Equity
- Maximizing **Healthy Food and Beverage** Strategies to Advance Health Equity
- Maximizing **Active Living** Strategies to Advance Health Equity

TERMINOLOGY

A clear understanding of definitions is important. The following definitions are offered as a starting place as you review this resource:

Health equity: Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.[12]

Health disparities: Health disparities are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.[7]

Health inequalities: Health inequalities is a term sometimes used interchangeably with the term health disparities. It is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual- or group-specific attributes (e.g., income, education, or race/ethnicity).[7]

Health inequities: Health inequities are a subset of health inequalities that are modifiable, associated with social disadvantage, and considered ethically unfair.[7,18,19]

Social determinants of health: Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[20]

SECTION 1

Incorporating Equity into Foundational Skills of Public Health

Every day, decisions are made that have an influence on health equity. These decisions may include who is hired, what activities take place, which populations are served, and how strategies are implemented and evaluated. Considering how every decision will impact your health equity goals is an important step in integrating health equity into everyday practice.

This section includes lessons learned from practitioners across the nation who are working to advance health equity. Additionally, key questions for reflection are proposed to stimulate ideas and help you and your organization think about ways to incorporate the goals of health equity into key foundational skills and practices of public health including:

- Building Organizational Capacity
- Engaging Community Members
- Developing Partnerships and Coalitions
- Identifying and Analyzing Health Inequities
- Selecting, Designing, and Implementing Strategies
- Developing Effective Communication Efforts
- Conducting Evaluations

BUILDING ORGANIZATIONAL CAPACITY TO ADVANCE HEALTH EQUITY

ORGANIZATIONS ENGAGE IN MANY PRACTICES—BOTH WITHIN AND BEYOND THEIR WALLS—THAT CAN INFLUENCE THEIR IMPACT ON HEALTH EQUITY. EACH OF THESE PRACTICES (E.G., HIRING DECISIONS, RESOURCE DISTRIBUTION, STAFF TRAINING) REPRESENTS AN OPPORTUNITY TO IMPROVE HEALTH FOR ALL. CONSIDER THESE IDEAS TO ENHANCE YOUR ORGANIZATION'S CAPACITY TO ADVANCE HEALTH EQUITY.

Establish an Institutional Commitment to Advance Health Equity

Create or clarify your commitment by writing health equity goals into critical documents such as mission statements and strategic plans. Support your written commitment with action by establishing permanent structures, such as workgroups or staff positions, to improve health equity practices. Create other informal systems to empower staff to identify and contribute to health equity-related improvements. Additionally, consider conducting an organizational assessment (e.g., Bay Area Regional Health Inequities Initiative Organizational Self-Assessment Toolkit[22]) or review your organization's policies and practices for potential modifications.

Where Possible, Align Funding Decisions with Your Commitment to Health Equity

Establish or revise processes for seeking, distributing, and using resources. Establish a clear understanding of community needs before seeking resources. This will ensure the most efficient use of time and resources. Before distributing funds, make health equity a clear component of funding expectations and requirements to guide the actions of those receiving the funds (e.g., require hiring and collaborating with representatives from underserved communities, require health equity training, develop criteria for prioritizing interventions based on need). Also, consider distributing funding opportunities among non-traditional partners and conducting trainings to build capacity of potential applicants.

Be Deliberate in Recruiting and Building Staff Skills to Advance Health Equity

Reexamine and expand recruitment efforts through outreach to members of professional affinity groups and specific cultural networks. Bring in new skills and perspectives by making experience working with underserved populations a priority in job qualifications, and widely distributing job announcements with an aim toward engaging staff with skills addressing health equity. Additionally, facilitate ongoing training and dialogue among staff and management to help make cultural competency and health equity a part of standard operating procedures.

Track and Capture Health Equity Efforts in Training and Performance Plans

Establish expectations that staff and management engage in activities designed to advance health equity (e.g., training requirements, workgroup participation). Hold staff accountable for these activities in training or performance plans. These expectations may help shift the culture and clarify everyone's role in advancing health equity.

Integrate Health Equity Into Your Services and Resources

Get feedback from community members to ensure services and resources are culturally and linguistically appropriate. Modify services, as needed, to make them more convenient for community members (e.g., bundle services to reduce number of visits, adjust service hours). Continually find ways to improve efforts by tracking those who are benefiting from your services and resources. Also, identify those who are not participating and the reasons for this lack of participation. Ensure anticipated improvements are shared with community members to reinforce partnerships and relationships.

Establish Multi-Sector Collaborations and Relationships with Diverse Communities

Addressing the complexities of health inequities is beyond the scope of any one organization or entity. To build the trust needed to advance health equity, develop multi-sector partnerships and relationships with communities affected by health inequities.

> "WE ARE ACTIVELY WORKING TO STRENGTHEN OUR STAFF AND ORGANIZATIONAL CAPACITY TO ADDRESS HEALTH INEQUITIES. THIS INCLUDES ENSURING OUR INTERNAL WORK IS ROOTED IN THE PRINCIPLES OF SOCIAL JUSTICE AND THAT OUR ORGANIZATIONAL CULTURE SUPPORTS STAFF IN BEING INNOVATIVE, CREATIVE, PASSIONATE, AND ACCOUNTABLE. BUILDING OUR INTERNAL CAPACITY HELPS US DEVELOP STRONG PARTNERSHIPS, ENGAGE IN POLICY CHANGE, CONDUCT INNOVATIVE DATA COLLECTION AND ANALYSIS, ENSURE OUR PROGRAMS AND SERVICES MEET THE NEEDS OF COMMUNITIES, AND WORK IN TRUE PARTNERSHIP WITH COMMUNITIES IN ALAMEDA COUNTY."[21]
>
> — *Alameda County Department of Public Health Website*

MPHD Staff members participating in a training on community-based focused conversations.

Changing the Way They Work to Advance Equity—Nashville and Davidson County, TN

Metro Public Health Department

To effectively address existing health inequities, Metro Public Health Department (MPHD) leadership started changing the way they worked. The following highlights some of the actions they took to build their capacity to advance health equity:

- MPHD built health equity into its Departmental Strategic Plan in order to institutionalize such work throughout the organization. Additionally, in 2012, MPHD's Director of Health issued a directive to all staff to incorporate equity as a decision filter in all policy, programmatic, and practice activities.
- MPHD established organizational structures, such as a department-wide Equity Work Group to support the department in attaining its goals and to ensure continued competency and capacity building.
- MPHD instituted various professional development and learning experiences to support and advance individual competencies and organizational capacity to promote health equity. These experiences included assessing individual biases; understanding the impact of individual biases on practice; and understanding how societal and structural biases, racism, and diversity impact health status.
- MPHD worked to build a team of diverse staff who were reflective of and understood the community by incorporating a health equity perspective in its hiring practices. Recruitment and interviewing processes were modified to hire staff who demonstrated an understanding of health equity and how it translated to practice.
- MPHD continues to foster long-standing relationships with organizations that serve and work with communities affected by health inequities. These partnerships are mutually beneficial and have helped MPHD more effectively understand and connect to populations of greatest need.

Through these actions and other efforts, MPHD continues to incorporate a health equity focus in everything they do.

QUESTIONS FOR REFLECTION: Organizational Capacity

1. Where are we now?

- How do our current organizational policies and practices facilitate or inhibit us from advancing health equity?
- What is our organization's stated commitment to health equity? Is this commitment documented and widely understood?

2. How can we institutionalize our organizational commitment to advance health equity?

- What process (e.g., organizational assessment) can we implement to review current policies and practices in relation to our health equity commitment?
- How can our current infrastructure be enhanced to create accountability and provide guidance on our health equity commitment?
- What expectations and opportunities exist for staff to make health equity a part of their daily work?

3. How can funding decisions advance our health equity efforts?

- How do the funds we typically seek align with identified health equity needs in the community?
- When distributing funds, what funding guidelines or requirements need to be in place to ensure recipients address health equity?

4. How can we build a skilled and diverse workforce committed to health equity?

- How do our recruitment efforts support or hinder us in building a diverse staff and management team committed to health equity?
- How can we add or enhance our training activities to ensure staff and management share a common understanding of the complexities of health inequities and have the skills to advance health equity in their work?
- How can we better align staff performance to health equity practice?
- How can we build accountability for advancing health equity into the performance plans of staff and management?

5. How can we integrate health equity into our products and service offerings?

- What are the cultural and linguistic preferences of our community members? How can we revise our services and resources to accommodate those preferences?
- What structural and operational modifications are needed for our services to be more accessible and of better quality?
- How are we tracking and evaluating our efforts to determine if populations experiencing health inequities are benefiting from the services or resources we provide?

6. How can our partnerships and community outreach efforts help to advance health equity?

- What existing partnerships do we have with organizations serving populations experiencing health inequities?
- What new partnerships should we consider exploring to fulfill our commitment to health equity?
- How is our organization perceived in the community?
- How can we build better connections to and collaborations with populations experiencing health inequities?

7. What are our next steps?

- What can we do differently to improve or enhance our organization's capacity to advance health equity?
- What is our plan of action to implement those changes?

MEANINGFUL COMMUNITY ENGAGEMENT FOR HEALTH AND EQUITY

COMMUNITY ENGAGEMENT CAN HARNESS THE SKILLS AND TALENTS OF A COMMUNITY'S MOST IMPORTANT RESOURCE: ITS PEOPLE. INVOLVING COMMUNITY MEMBERS IN HEALTH INITIATIVES CAN FOSTER CONNECTEDNESS AND TRUST, IMPROVE ASSESSMENT EFFORTS, AND BUILD THE CAPACITY OF INDIVIDUALS TO POSITIVELY AFFECT THEIR COMMUNITY. ADDITIONALLY, THIS ENGAGEMENT CAN ENHANCE THE EFFECTIVENESS OF PROPOSED STRATEGIES AND INCREASE THE SUSTAINABILITY OF EFFORTS. CONSIDER THESE IDEAS TO ENHANCE COMMUNITY ENGAGEMENT ACTIVITIES.

Understand the Historical Context Before Developing Your Engagement Strategy

Examine the history of the community as well as past engagement efforts, to understand any issues, and to learn what has worked and what has been less successful. For example, years of neglect and conflict may have contributed to distrust and prevented meaningful engagement between a community and local organizations. Try to get an accurate picture of how your organization and its engagement strategies are perceived, and work with community leaders to address any barriers to engagement.

Build Community Relationships Early On

Authentic community engagement takes time and requires an ongoing commitment from all involved. Establish and maintain strong relationships with communities experiencing health inequities before funding opportunities arise or urgent health issues develop.

Assess and Address Organizational Barriers to Community Engagement

Some organizations may be reluctant to begin an engagement process due to the necessary time commitment, the staff skills needed, and the ability to demonstrate effectiveness. There may also be concerns about the effort becoming unmanageable. To address these concerns, develop engagement plans and principles that provide a systematic approach to conducting engagement activities. Additionally, consider enlisting the help of other trusted organizations to build staff skills and support engagement efforts.

Select Engagement Techniques Appropriate for Your Context

Consider engagement techniques based on the purpose and length of engagement, as well as the resources available to your organization. Examples of engagement activities include interviews with community members, focus groups, community forums, community assessments and mapping, PhotoVoice, community-based participatory research, resident participation on boards or councils, and paid positions for residents within organizations.

Understand and Address Barriers That May Prevent Community Participation

Consider populations that are experiencing health inequities in your community (e.g., people of color, people with disabilities, LGBT populations) and potential barriers they may face with engagement efforts. Community members often have many demands and may be unclear about the value of their involvement. Respect community members' time and efforts by having a clear and agreed-upon purpose for engagement. When necessary, conduct meetings in native languages or provide interpretation or other services needed to address language and cultural barriers to participation. Conduct engagement activities at times and places that are convenient to the community and provide transportation or childcare services, if needed.

Support and Build the Community's Capacity to Act

Community members are vital assets for broader community improvements and may have a long-term interest in the community's well-being. Choose engagement activities that build on the capacity of community members. These activities can increase their awareness of health inequities and provide skills on how to intervene. Such engagement activities may include cultivating residents as leaders or supporting local coalitions or networks. These efforts can serve a community beyond any one project and can also position community members and organizations to apply for additional funding to help sustain efforts.

Value Both Community Expertise and Technical Expertise

Many communities benefit from engaging individuals and organizations with technical expertise in certain health issues. Such expertise can provide lessons learned from initiatives in other settings, as well as guidance to avoid unnecessary barriers in implementation. However, it is critical that the expertise and perspective of community members—those ultimately impacted by any initiative—be respected and valued when engaging such technical expertise.

> "DON'T LEAVE THE COMMUNITY BEHIND, LET THE COMMUNITY LEAD."[23]
>
> *— Lark Galloway Gilliam Executive Director of Community Health Councils*

A community networker standing adjacent to a community store that supports obesity prevention efforts in Chicago, IL.

Provide Individualized Attention Through Community Networkers—Chicago, IL

Consortium to Lower Obesity in Chicago Children (CLOCC)

In its first decade, the Consortium to Lower Obesity in Chicago Children (CLOCC) decided to focus on 10 Chicago neighborhoods with disproportionate rates of childhood obesity. These communities were referred to as Vanguard Communities and are primarily low-income and communities of color. To make sure the consortium developed and implemented effective strategies to reduce such health inequities, CLOCC sought out meaningful ways for organizations and individuals in the Vanguard Communities to be involved in the design, implementation, and evaluation of obesity-focused initiatives.

Five community networkers (employed as full-time staff members) served as a direct link to five of the Vanguard Communities. Other staffing and partnering models were developed for the remaining five neighborhoods. These community networkers served as liaisons between communities and CLOCC, and spent the majority of their time in the field engaged in their assigned communities. They brought the needs and strengths of the communities to the attention of the consortium. Because the community networkers had deep ties to their communities, they understood the context in which activities took place. They were able to provide community partners and members with resources, technical assistance, and other relevant information from the consortium.

This model was highly successful in connecting CLOCC to the community and developing a portfolio of effective community-based strategies for obesity prevention. As a result, CLOCC refined the staffing model and now deploys community program coordinators to serve several regions throughout the city. These individuals coordinate resources and bring intervention approaches to many neighborhoods throughout Chicago.

QUESTIONS FOR REFLECTION: Community Engagement

1. Where are we now?

- What existing relationships do we have with populations experiencing health inequities?
- What is our current process/plan for engaging community members, particularly those experiencing health inequities?
- Are we using language that facilitates or creates barriers to engaging the intended communities?

2. What approaches can we use to effectively engage community members?

- What type of engagement techniques do we typically use? Have they had the effect we intended?
- Are we using techniques that build community capacity and leadership? If not, what techniques could be pursued?

3. What barriers to community engagement should we consider?

- What is our organization's history with the community?
- What organizational barriers exist for meaningful community engagement activities? How can we overcome these barriers?
- How will we identify barriers to community participation? How can we overcome these barriers?

4. How can we engage and balance both community and technical expertise in our efforts?

- How do we show that we value and recognize the expertise of community members?
- Do any strained relationships exist in the community? Why do they exist?
- How can our engagement process best leverage both community and technical expertise?

5. What are our next steps?

- What can we do differently to improve or enhance our community engagement?
- What is our plan of action to implement those changes?

DEVELOPING PARTNERSHIPS AND COALITIONS TO ADVANCE HEALTH EQUITY

PARTNERSHIPS AND COALITIONS CAN HELP ORGANIZATIONS AMPLIFY THE OFTEN UNHEARD VOICES OF POPULATIONS MOST DIRECTLY AFFECTED BY HEALTH INEQUITIES. PARTNERSHIPS AND COALITIONS CAN ALSO WORK TO ACHIEVE EQUITABLE OUTCOMES BY LEVERAGING A DIVERSE SET OF SKILLS AND EXPERTISE. CONSIDER THE FOLLOWING IDEAS TO ENHANCE YOUR PARTNERSHIP AND COALITION EFFORTS AROUND ADVANCING HEALTH EQUITY.

Engage Partners from Multiple Fields and Sectors that Have a Role in Advancing Health Equity

Health inequities do not have a single cause, and public health alone cannot address such inequities. Partner with community, education, housing, media, planning and economic development, transportation, and business partners, and engage these sectors in your coalition. Such multi-sector partnerships can work to improve the underlying community conditions that make healthy living easier, particularly in underserved communities.

Include Partners Working with Population Groups Experiencing Health Inequities

Organizations dedicated to serving these various populations (e.g., people of color, the elderly, people with disabilities, LGBT individuals) may or may not have health-related expertise. However, such organizations often have substantial expertise on the norms, culture, and needs of the populations they serve and can contribute significantly to your efforts.

Establish Mechanisms to Ensure New Voices and Perspectives are Added

Groups that have been collaborating for a long time should be mindful not to exclude potential new partners. Periodically assess membership composition and participation, and evaluate decision-making processes. It may also be necessary to periodically adjust meeting times and locations to accommodate new partners. While important to ensure a diverse partnership, do not assume that individuals from a specific population group can speak for all members of that group. Additionally, be cautious of including community representatives as a symbolic gesture rather than as fully engaged partners.

Develop a Common Language Among Partners from Different Sectors and Backgrounds

Early in the process, establish a shared vision and understanding for the partnership. Plan discussions or trainings to build a common understanding about health equity and the strategies needed to address it. Additionally, establish guidelines for communication, such as spelling out acronyms and avoiding potentially confusing terminology or jargon.

Acknowledge and Manage Turf Issues

Turf struggles may arise over conflicts in ownership, recognition, or resources between organizations. Partners should acknowledge and commit to manage tensions that may arise by anticipating potential turf issues, cultivating trust and respect, and shaping a collective identity. If turf issues arise, a strong, established relationship can create a safe space for partners to address complex issues, competing agendas, and difficult decision making.

Recognize and Address the Power Dynamics in a Partnership

All partners should have an equal opportunity to define issues, create strategies, implement solutions, and make decisions. The different contributions, resources, and expertise each partner brings to the table could be a source of tension or could be leveraged to improve collaborative efforts and outcomes. For instance, without additional resources, some partners may not be able to participate on an ongoing basis due to limited staff and organizational resources. Finding ways to compensate partners (e.g., funding, continuing education credit, travel cost reimbursement, certificates of appreciation) may help provide opportunities for longer-term engagement for some partners. Additionally, partners may be able to cross train each other to build skills in unfamiliar areas, or they may have complementary resources that can be shared.

> "OUR PARTNERSHIPS WILL HAVE TO BE STRONGER IF WE ARE TO HAVE AN IMPACT. WE MUST REACH OUT TO NONTRADITIONAL PARTNERS IN THE PRIVATE SECTOR, INDUSTRY, AND OTHER PARTS OF GOVERNMENT IN THE TRANSPORTATION, EDUCATION, AND JUSTICE SECTORS, FOR EXAMPLE."[24]
>
> — *Dr. David Satcher, Director, Satcher Health Leadership Institute and the Center of Excellence on Health Disparities, Morehouse School of Medicine*

Diverse set of community partners who worked together to increase smoke-free protections for vulnerable populations by implementing a smoke-free campus at Women's Treatment Center in Chicago.

Intentional Recruitment of Partners Working with Underserved Populations—Chicago, IL

Respiratory Health Association of Metropolitan Chicago (RHAMC)

To address tobacco-related health inequities, the Respiratory Health Association of Metropolitan Chicago (RHAMC) and Chicago Department of Public Health have used various strategies to establish diverse partnerships. As part of the partnership process for CDC's *Communities Putting Prevention to Work* program, they took the following actions:

- Established a competitive request for proposals (RFP) process to identify and select appropriate partners. The RFP process was designed to select partners in diverse geographical areas that demonstrated experience in serving populations with disproportionate smoking rates.
- Promoted the RFP beyond traditional channels, including circulating it among current partners and coalitions serving the priority communities.
- Collaborated with city agencies like the Chicago Park District, Chicago Public Schools, and Chicago Housing Authority, as well as community-based social service organizations and community health clinics.
- Established a system to maintain strong partnerships, tracking efforts in underserved communities, and building capacity of community-based organizations through various trainings and technical assistance so they could address tobacco use in the future.

The diverse partnerships developed through this process helped the organization design appropriate strategies to address tobacco-related health inequities.

QUESTIONS FOR REFLECTION: Partnerships and Coalitions

1. Where are we now?

- How do our current partnerships/coalitions reflect the populations experiencing inequities in our community?
- What is the current commitment to advancing health equity among these partners/coalitions? How does this commitment translate into identifiable and measurable activities?

2. How can we build diverse and inclusive partnerships/coalitions?

- What partners are we missing in our network/coalition that should be included?
- What partners do we need to engage in order to address the major social determinants of health impacting our community (e.g., housing, transportation, education, urban planning, business)?
- What are the commonalities in the priorities of potential partners that can serve as levers for collaboration?
- What is each partner's role in addressing health equity?

3. How can we work to engage new partners in a meaningful way?

- What process can we develop to regularly assess our partnerships/coalitions to see who else should be invited to help advance our goals of achieving health equity?
- How can we improve efforts to engage new members in meaningful ways?
- How can we strengthen communication and understanding among partners?

4. How can we anticipate and address group dynamics that may arise?

- What are some of the challenges in collaborating with different partners? Once identified, what steps can be taken to address these challenges?
- What potential issues concern our partners? What issues can be anticipated?
- How can we ensure that all partners meaningfully participate and influence decision making?

5. What are our next steps?

- What can we do differently to improve or enhance our partnerships/coalitions?
- What is our plan of action to implement those changes?

IDENTIFYING AND UNDERSTANDING HEALTH INEQUITIES

WITHOUT A CLEAR UNDERSTANDING OF EXISTING HEALTH INEQUITIES, WELL-INTENTIONED STRATEGIES MAY HAVE NO EFFECT ON OR COULD EVEN WIDEN HEALTH INEQUITIES. IT IS CRITICAL TO HAVE A CLEAR UNDERSTANDING OF WHAT INEQUITIES EXIST, AND THE ROOT CAUSES CONTRIBUTING TO THEM. CLEARLY IDENTIFY AND UNDERSTAND HEALTH INEQUITIES TO ESTABLISH BASELINES AND MONITOR TRENDS OVER TIME, INFORM PARTNERS ABOUT WHERE TO FOCUS RESOURCES AND INTERVENTIONS, AND ENSURE STRATEGIES ACCOUNT FOR THE NEEDS OF POPULATIONS EXPERIENCING HEALTH INEQUITIES. CONSIDER THESE IDEAS TO ENHANCE YOUR ORGANIZATION'S EFFORTS TO IDENTIFY AND UNDERSTAND HEALTH INEQUITIES.

Do Not Rely on Assumptions About What Health Inequities Exist in Your Community

The health inequities in your community may differ from national and state data or other surrounding communities. Utilize the best available data to understand what is happening in your community. As feasible, follow a thorough process to identify existing health inequities, and assess community assets, needs, and challenges.

Gain a Comprehensive Understanding of the Identified Health Inequities

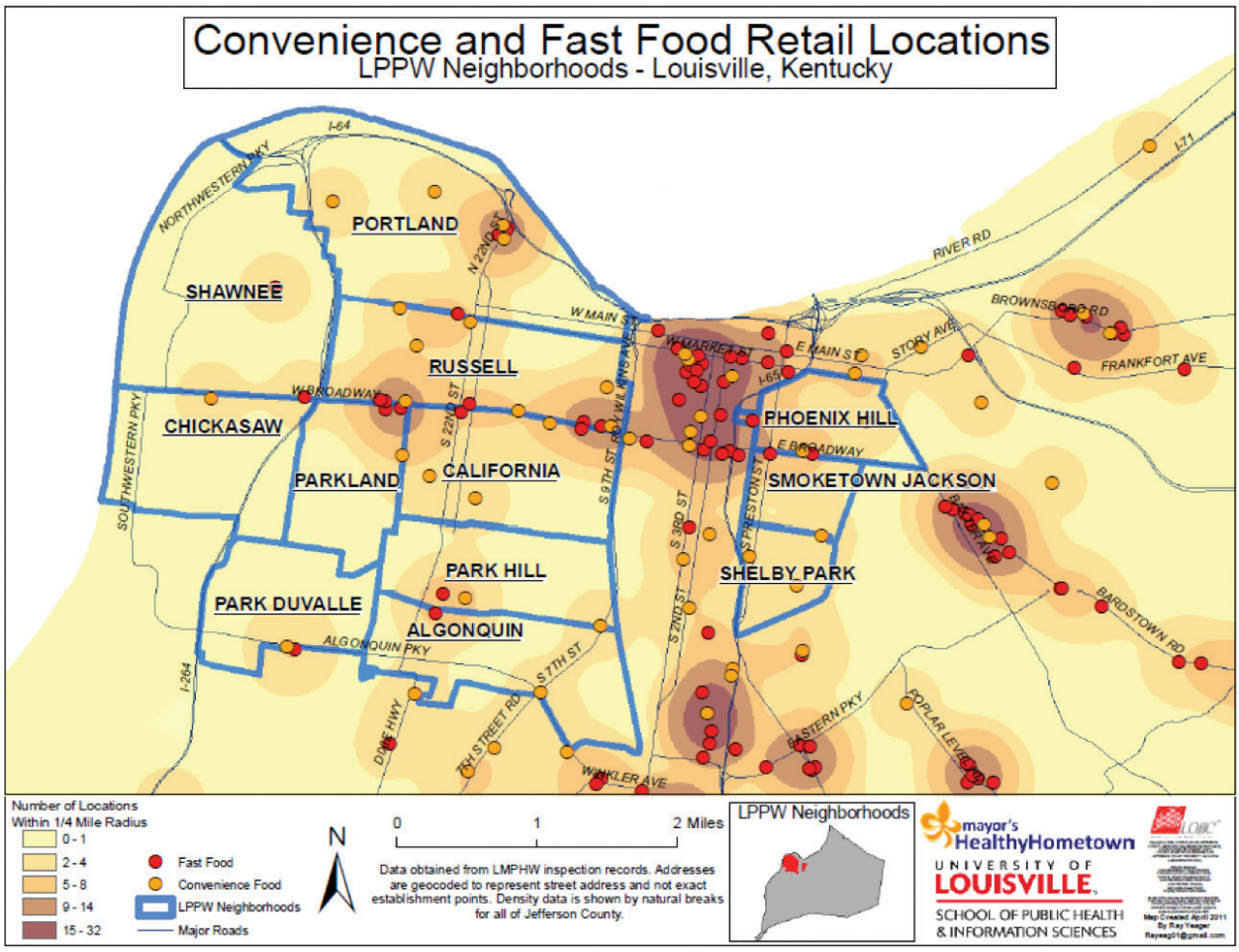
Examine multiple aspects of health in your community to get a clearer picture of health inequities. For example, identify health risk behaviors and disease outcomes according to characteristics such as income, disability status, gender identity, geography, race/ethnicity, and sexual orientation. Additionally, gain insight into the social (e.g., discrimination), economic (e.g., poverty), and physical (e.g., availability of healthy food retail) environments to develop a deeper understanding of health inequities. A community's history and context (e.g., long-standing policies, cultural norms, values) can also be helpful in understanding inequities and identifying effective strategies.

Use Appropriate Tools to Identify Health Inequities

National databases, health departments, and institutions, such as universities and hospitals, are prime sources for finding local data on health outcomes. While these data sets are a good starting place, you may not want to rely solely on this information for understanding health inequities. Partners such as local public works, transportation, and police departments may have access to other data sources (e.g., water quality, street conditions, crime statistics) which may reveal inequities related to social, economic, and physical environments. Where possible, use data sources that allow you to stratify indicators by factors such as age, disability status, race, and sexual orientation. See Appendix C for a list of online resources for identifying and understanding health inequities.

Engage Community Members and Partners in Data Collection and Interpretation

Provide training 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.



Map of Louisville, KY used as a tool to identify inequities.

Using Multiple Factors to Pinpoint Health Inequities—Louisville, KY

Louisville Metro Public Health and Wellness

The Louisville Metro Public Health and Wellness (LMPHW) Department is committed to reducing obesity-related health inequities. To identify areas with higher rates of obesity, the department analyzed data related to the social determinants of health including income, violence, access to transportation, and access to healthy food (including proximity to fast food restaurants). It also used GIS mapping to identify and locate relevant indicators by ZIP code.

These strategies revealed that obesity rates and environments that did not support healthy eating and physical activity in Louisville were disproportionately higher in 12 low-income neighborhoods—most of which were also predominantly African American. These neighborhoods are characterized as food deserts, where affordable, healthy food is difficult to obtain. These neighborhoods also have higher rates of violence and poverty and low levels of education. Having a clear emphasis on areas experiencing health inequities helped the department to design its initiatives and focus their efforts accordingly.

1. Where are we now?

- [ ] What are our organization's current practices for identifying and understanding health inequities?
- [ ] Can we clearly articulate health inequities related to the health issues we are trying to prevent and/or address? If so, list those health inequities.

2. What types of information can we use to identify health inequities in our community?

- [ ] What process can we set up to get a full understanding of health inequities in our community?
- [ ] What type of information do we need to ensure we have a full understanding of health inequities in our community?
- [ ] Have we looked beyond basic health risk behaviors and standard outcome data to examine social, economic, and physical indicators that may contribute to or maintain health inequities?
- [ ] Have we examined community context and historical factors that may help our understanding of existing health inequities?

3. What tools and resources can we use to identify and understand health inequities?

- [ ] What combination of data sources do we need to better understand experiences of populations affected by health inequities?
- [ ] What sources or partners may already have the data we need for assessing community environments or health behaviors?
- [ ] Where can we go to understand the historical context of health inequities in the community?

4. How can we engage community members in gathering and analyzing data?

- [ ] How do we currently engage community members in our data collection and analysis process?
- [ ] What process can we put in place to routinely engage populations affected by health inequities in collecting and analyzing data?

5. What are our next steps?

- [ ] What can we do differently to improve or enhance our ability to identify and understand health inequities?
- [ ] What is our plan of action to implement those changes?

HEALTH EQUITY-ORIENTED STRATEGY SELECTION, DESIGN, AND IMPLEMENTATION

WITHOUT A DELIBERATE FOCUS ON HEALTH EQUITY IN THE STRATEGY DEVELOPMENT PROCESS, STRATEGIES MAY UNINTENTIONALLY WIDEN HEALTH INEQUITIES. WELL-DESIGNED STRATEGIES CAN INCLUDE SUPPORTIVE ACTIVITIES TO ADDRESS BARRIERS OR UNINTENDED CONSEQUENCES UNDERSERVED POPULATIONS MAY FACE DURING IMPLEMENTATION. SUCH EFFORTS CAN HELP ENSURE MAXIMUM EFFECTS ACROSS COMMUNITIES EXPERIENCING HEALTH INEQUITIES. CONSIDER THESE IDEAS TO ENHANCE STRATEGY DEVELOPMENT EFFORTS.

Balance Community Input and Best Available Evidence

Without community input, there can be challenges with strategy design, implementation and enforcement. Build community ownership in the very beginning of this process to increase the effectiveness and sustainability of strategies. Additionally, examine the best available evidence to ensure that your community is investing resources and time in strategies that are most likely to have the intended impact.

Establish a Process to Ensure Strategies are Linked to Identified Inequities

Given the multiple factors involved in developing and implementing strategies, efforts can sometimes unintentionally shift away from identified population groups. Ensure strategies are aligned with desired outcomes by writing goals that outline identified inequities. Consider developing criteria or questions to be used as a guide for examining all strategies. This ensures the criteria and strategies align with the established health equity goals. (See Appendix D for a sample *Health Equity Checklist*.[25])

Select a Comprehensive Set of Approaches

Consider selecting a comprehensive set of strategies that work together, as one strategy in isolation only goes so far. For instance, while a policy improvement can be impactful, it may need to be supported by educational activities or organizational improvements to have the intended effect on populations experiencing health inequities.

Account for the Diversity Within the Community

Understand the diversity within your community (e.g., age, disability status, geographic area, race/ethnicity, sexual orientation, socioeconomic status). Populations may have different needs that should be considered and accounted for in strategy selection, design, and implementation (e.g., financial incentives, language translation, mobility assistance). Such diversity may also reveal the need for a wide set of partners in the design process.

Recognize that Everyone is Not Starting at the Same Place

Populations experiencing health inequities may have further to go to fully benefit from a given strategy. Identify and account for different levels of existing resources, capacity, and support across population groups when designing strategies to help avoid widening health inequities.

Identify Barriers and Potential Negative Unintended Consequences that Populations Experiencing Inequities May Face

When designing strategies, consider and account for possible barriers to full implementation, enforcement, and benefit for populations experiencing health inequities. Additionally, anticipate negative unintended consequences of any strategy and incorporate solutions early in the design phase. Common barriers may include cost, transportation challenges, safety concerns, lack of capacity or resources, lack of awareness, differing social or cultural norms, and limited health literacy. Potential unintended consequences may include stigma or displacement. Work with partners and community members to identify potential barriers and negative consequences and build in support to address them. (See Appendix B for a description of potential barriers and unintended consequences.)

Use a Tool to Ensure Health Equity is Part of Strategy Selection and Design

Using tools or frameworks can help you think through health equity considerations in each step of strategy selection and design. Such tools can also ensure consistency in planning and help align strategies with health equity goals. You can use an existing tool (e.g., Health Impact Assessment[26] and Health Equity Impact Assessment[27]) or you can work with partners and the community to develop your own tool.

Establish Processes to Identify and Address Implementation Challenges

It can be difficult to fully measure the effect of a strategy until it is completed. However, you can build in opportunities to monitor progress at different stages of implementation to identify issues and assess how well populations experiencing health inequities are being reached. Identify issues early in the process to provide an opportunity to make adjustments that can support equitable outcomes. Be prepared to address potential challenges and provide additional supports throughout a strategy's implementation.

CONSIDER THE FOLLOWING OVERARCHING QUESTIONS WHEN DESIGNING STRATEGIES TO ADVANCE HEALTH EQUITY:

- Are those most affected by the issue actively involved in defining the problem and shaping the solution?
- How does this strategy improve the conditions for those communities most in need?
- Will those most negatively affected by the problem benefit the same, less so, or more so?
- What barriers or unintended consequences should be accounted for to make this strategy effective in underserved communities?
- How can we ensure effective implementation and enforcement of identified strategies across population groups or communities?

Nice Ride bike kiosk located at Farview Park in north Minneapolis, MN—an area with high rates of obesity and physical inactivity.

A Concentrated, Place-Based Approach to Address Health Inequities—Minneapolis, MN

Minneapolis Department of Health and Family Support (MDHFS)

With support from CDC's *Communities Putting Prevention to Work* program, the Minneapolis Health Department (MHD) developed a series of strategies focused in North Minneapolis to address disproportionate rates of obesity and limited access to physical activity and healthy food resources. The Health Department and partners implemented the complementary initiatives listed below:

- Placed bike share kiosks next to parks where MHD outreach workers encouraged families to use neighborhood parks for physical activity.
- Located the kiosks and the new bike walk center near mass transit as well as bike lanes and walking paths to link residents to major community destinations including farmers markets, community gardens, and commercial districts.
- Implemented Safe Routes to School in the same areas to increase opportunities for students to walk and bike to school.
- Used targeted media, advertising, and outreach to increase residents' awareness of biking and walking resources and how the strategies connected to other health initiatives.
- Implemented Electronic Benefit Transfer (EBT) systems and a Market Bucks incentive program at farmers' markets in the area, allowing residents to use EBT cards to purchase fresh fruits and vegetables and providing customers with up to a $5 match in Market Bucks coupons.
- Established a local food resource hub and network in four neighborhoods, including North Minneapolis.

In this place-based approach, each strategy complemented the other, resulting in a focused effort to impact health inequities.

QUESTIONS FOR REFLECTION: Strategy Selection, Design, and Implementation

1. Where are we now?

- What is our current process, if any, for integrating health equity into strategy selection, design, and implementation?

2. How can we address health equity goals when selecting strategies?

- What are the diverse needs we should consider when selecting strategies that will have the greatest impact on populations experiencing health inequities?
- How can we balance community input with evidence-based strategies to select the most effective strategies to reduce health inequities?
- How can we verify that selected strategies align with the needs of populations experiencing health inequities?
- How can we ensure selected strategies build on one another to form a comprehensive approach that advances the achievement of health equity in our community?

3. How can we address our health equity goals when designing strategies?

- What are the diverse needs we should consider when designing strategies that will have the greatest impact on populations experiencing health inequities?
- How can we account for different levels of existing resources, capacity, and supports across population groups when designing strategies?
- What process can we establish to identify and address barriers to, and potential unintended consequences of strategies that populations experiencing health inequities may face?

4. What tools can we use to select and design strategies to advance health equity?

- What existing processes, frameworks, and/or tools can we use to systematically incorporate the goal of health equity into strategy selection and design?
- What processes or tools can we create to systematically incorporate the goal of health equity in all of our strategy selection and design efforts?

5. How can we address our health equity goals when implementing strategies?

- How can we work with partners to anticipate needs among populations experiencing inequities and provide necessary supports to advance equitable outcomes?
- What methods have we put in place to monitor progress in implementation, identify issues early in the process, and assess how well populations experiencing health inequities are being reached?
- What agreements have we reached with our partners on the long term plans and results?

6. What are our next steps?

- What can we do differently to improve or enhance our strategy development process to advance health equity?
- What is our plan of action to implement those changes?

MAKING THE CASE FOR HEALTH EQUITY

THERE ARE VARYING IDEAS ABOUT WHAT IT MEANS TO "ADVANCE HEALTH EQUITY." EFFECTIVELY MAKING THE CASE FOR HEALTH EQUITY REQUIRES AN UNDERSTANDING OF THE COMMUNITY CONTEXT AND INTENDED AUDIENCES, AN APPROPRIATELY FRAMED MESSAGE THAT APPEALS TO CORE VALUES, AND INCREASED AWARENESS OF EXISTING HEALTH INEQUITIES AMONG STAKEHOLDERS. CONSIDER THESE IDEAS TO ENHANCE EFFORTS IN MAKING THE CASE FOR HEALTH EQUITY:

Assess the Community Context Before Developing Messaging Around Health Equity

Without a proper understanding of the community context, messages around health equity can go unnoticed or may lead to unfavorable actions. It is important to consider the needs, assets, and priority issues of both community members and key stakeholders. Also, consider their receptiveness to the concept of health equity before developing any messaging. Understanding these issues may provide insight into common values, competing demands, fiscal priorities, and related efforts, which may help in refining messages.

Leverage Opportunities to Advance Health Equity Efforts

Become aware of health equity-related work in your area and around the country. If health equity-oriented efforts are underway, connect with those efforts to heighten the visibility of your efforts and to reinforce your message. Additionally, identify partners or coalitions with complementary goals (e.g., community- and faith-based organizations) as they may be able to support your message.

Support the Case for Health Equity with Relevant Data

Use data on health inequities to complement your overall message and raise the awareness of key stakeholders. For example, visual and experiential data (e.g., mapping, digital storytelling) can provide vivid examples of the real experiences of communities affected by health equities. Cost data can also be used to reveal the significant financial implications of existing inequities (e.g., unnecessary health care costs, costs associated with premature death among populations experiencing inequities).

Highlight Solutions When Framing Your Messages Around Health Equity

Lengthy descriptions of the existence of health inequities may detract from actionable solutions. The description of the problem should not overshadow potential solutions. Establish which inequities exist in your community; however, ensure the message focuses on actions to address health inequities.

Ensure Health Equity Messages are Appropriately Disseminated

It is important that everyone from staff and community members to partners and stakeholders have a shared understanding of your health equity goals. Provide trainings to equip staff members with a clear understanding of health equity as they are the voices for advancing your organization's efforts. Create opportunities for dialogue among community members and stakeholders to share concerns and develop skills to advance health equity in their communities. Identify ways to connect your partners' broader networks to ensure diverse perspectives are contributing to solutions for health equity. Use a variety of communication methods (e.g., earned media, radio spots) to both broadly disseminate and appropriately tailor your messages.

Mapping Our Voices for Equality—Seattle and King County, WA

Public Health Seattle & King County (PHSKC) and Partners

Mapping our Voices for Equality (MOVE)[28] uses media to promote health equity in Seattle and King County. MOVE combines over 100 community-developed multilingual digital stories and features a local map showing both the impact of place on health and some place-based changes that will improve health in King County. To implement MOVE, Public Health Seattle & King County (PHSKC) with support of CDC's *Communities Putting Prevention to Work* program, did the following:

- Engaged community members in dialogue about health equity issues and provided workshops on digital storytelling to gather stories, empower community members, and promote positive health changes in King County.
- Invited local stakeholders to community meetings and forums where community members could showcase their videos and have a discussion.
- Posted over 100 multilingual digital stories to a website with widespread reach, encouraging other community members to get involved.
- Created templates and worksheets to foster dialogue among key stakeholders and community groups when holding meetings and health equity discussions.
- Successfully contributed to multiple policy, systems, and environmental improvements including enhanced school nutrition policies, increased hours to a local community center, and increased access to healthy food in a local "food desert."

The MOVE media initiative is empowering community members to identify and raise awareness of the health inequities impacting them.

QUESTIONS FOR REFLECTION: Making the Case for Health Equity

1. Where are we now?

- How do we currently frame our efforts regarding health equity; what are our messages?

2. How can we assess the community context to develop our health equity messages?

- How receptive are our key stakeholders toward adopting a health equity approach?
- What are the views and perceptions of our key stakeholders as they relate to health inequities? How should we consider those views in our messaging?
- Are other activities and ongoing efforts occurring in our community that could support or inhibit a health equity-based approach? How can we build on these supportive activities and overcome challenges to implementing a health equity-based approach?
- How can we identify and connect with potential partners/coalitions currently engaged in health equity-focused work?

3. What type of data can we use to support the case for health equity?

- What are some creative ways to capture and highlight the lived experience of health inequities in our community?
- What combinations of data can we use to help make the case for health equity?

4. How can we share our message about health equity?

- How can we ensure our staff and partners have a common understanding of our work to advance health equity?
- What are the key messages needed to tell the health equity story in our community?
- How can we create a dialogue around health equity among community members and other key stakeholders?
- Which communication methods will be most effective to reach our intended audiences?
- How can we identify and communicate our health equity success stories?

5. What are our next steps?

- What can we do differently to improve or enhance our ability to make the case for health equity?
- What is our plan of action for implementing those changes?

ADDRESSING HEALTH EQUITY IN EVALUATION EFFORTS

WITHOUT A FOCUS ON HEALTH EQUITY IN EVALUATION EFFORTS, THE EFFECTS OF AN INTERVENTION ON ADDRESSING HEALTH DISPARITIES AND INEQUITIES CAN GO UNNOTICED. FOR EXAMPLE, AN EVALUATION MAY REVEAL OVERALL IMPROVEMENTS IN HEALTH, BUT OVERLOOK THE FACT THAT HEALTH DISPARITIES OR INEQUITIES ARE WIDENING. HEALTH EQUITY-ORIENTED EVALUATIONS CAN BE DESIGNED TO UNDERSTAND WHAT WORKS, FOR WHOM, UNDER WHAT CONDITIONS, AND REVEAL WHETHER HEALTH INEQUITIES HAVE DECREASED, INCREASED, OR REMAINED THE SAME. INTEGRATE HEALTH EQUITY CONSIDERATIONS THROUGHOUT EACH STEP OF AN EVALUATION TO MORE ACCURATELY INTERPRET FINDINGS AND EFFECTIVELY FOCUS INTERVENTIONS. CONSIDER THESE IDEAS TO INTEGRATE HEALTH EQUITY GOALS INTO YOUR EVALUATION EFFORTS.

Develop a Logic Model That Includes Health Equity Activities and Goals

Guide implementation and evaluation efforts by documenting your health equity-related process activities and outcome goals in your logic model. Include these goals and activities to provide clarity on your intended effects on health equity. Secure buy-in and participation by engaging diverse stakeholders, including community members experiencing health inequities, in the development of the logic model. Also include them in every other step of the evaluation process.

Incorporate Health Equity into Evaluation Questions and Design

Since evaluation questions guide the evaluation process, it is critical that your health equity goals are reflected in them. Such questions may help you determine what has worked for whom and under what conditions. Additionally, consider indicators of success at all stages of the logic model to assess whether an intervention reached the intended population, was implemented correctly, and had the intended outcome(s).

Identify Appropriate Variables to Track Populations Experiencing Inequities

Appropriate variables and strategic sampling plans are needed to assess differential effects of interventions across population groups or settings. Choose relevant variables (e.g., income, race, zip code) early in the process to ensure sufficient data on populations experiencing inequities will be gathered, tracked, and analyzed. In addition, carefully select sites/settings or participants that are to be included in the sampling frame.

Use Culturally Appropriate Tools and Methodologies

Evaluations may be planned and carried out by individuals with different educational backgrounds, primary languages, and cultural identities than the populations experiencing health inequities. Therefore, gather the best possible data by using culturally appropriate tools and methodologies that consider factors such as the population's language needs, literacy levels, and facilitator preferences.

Use Multiple Approaches to Understand an Intervention's Effect on Health Inequities

One approach may not sufficiently account for the complexities of health inequities or reflect issues and successes identified as important by the community. Consider multiple approaches (e.g., GIS analysis, focus groups, assessment of environmental improvements) to understanding an intervention's effect to broaden the range of credible evidence, create new measurement models, and integrate new voices into the understanding of a strategy's effects. Additionally, consider a long-term plan for data collection, as it takes time to change the underlying factors that contribute to health inequities.

Include Health Equity Indicators Into Performance Monitoring Systems

Performance monitoring systems may be revised or developed to track whether changes occur in places where they are most needed, as well as other efforts to advance equity. Such tracking provides an opportunity to monitor progress, identify necessary mid-course corrections in underserved communities, and answer questions that may emerge as the evaluation proceeds.

Use Process and Outcome Evaluations to Understand the Effect on Health Inequities

Use process evaluation to gather information about the planning, engagement, and implementation of a strategy. These data may later help explain successful (or unsuccessful) outcomes as they relate to health inequities. Outcome evaluations can be used to understand the effect of an initiative across different populations and indicate whether health inequities have decreased, increased, or remained the same. Incorporating health equity implications in both process and outcome components of an evaluation can help explain an intervention's effect on health inequities.

Widely Disseminate the Results of Equity-Oriented Evaluations

Knowing what works, what does not work, and what may have promise is essential to expand the type of interventions being used to advance health equity. Contribute to the evidence-base by sharing findings, particularly if results identified disparate effects, such as an increase in health inequities. Additionally, build capacity and increase awareness among community members and stakeholders by sharing findings and providing the data they need to decide on next steps.

> "UNLESS THERE IS A DELIBERATE INTENTION TO ADDRESS HEALTH INEQUALITIES AND TO BUILD UP EVALUATIONS THAT PURPOSEFULLY USE EQUITY AS A VALUE CRITERION, THE FIELD OF HEALTH PROMOTION MAY GO ASTRAY REGARDING ITS UNDERLYING COMMITMENTS TO EQUITY IN HEALTH."[29]
>
> *— Louise Potvin, Université de Montréal*

Setting Up Systems to Understand Who Was Affected—Boston, MA

Boston Public Health Commission (BPHC)

The Boston Public Health Commission (BPHC) worked to ensure their *Communities Putting Prevention to Work* (CPPW) efforts were effective in reaching the populations experiencing obesity and tobacco-related health inequities. BPHC implemented the following steps in developing their evaluation plan:

- Developed evaluation questions to gauge their impact on health inequities.
- Required partners to routinely collect data on race/ethnicity, age, gender, and zip code for all of their initiatives. The data documented how activities benefitted the community in general, as well as population groups/areas experiencing health inequities.
- Increased sample size for the *CPPW* Behavioral Risk Factor Surveillance System in order to ensure sufficient power to assess neighborhood-level changes over time.
- Designed an analysis plan to assess the overall effect of the selected strategies, as well as the effect(s) across population groups.
- Set up their performance monitoring to identify areas where additional efforts may be needed to enhance intervention effects in underserved communities.

This strategic evaluation design enabled BPHC to make mid-course adjustments and enhanced their ability to contribute to the evidence-base regarding the influence of their initiative on advancing health equity.

QUESTIONS FOR REFLECTION: Addressing Health Equity in Evaluation Efforts

1. Where are we now?

- [ ] How are we currently assessing the effect(s) of our efforts to address health equity?

2. How do we start the evaluation process with health equity in mind?

- [ ] Do we have the expertise to develop, implement, and assess an equity-oriented evaluation plan?
- [ ] What process can we establish to routinely engage community stakeholders, including those experiencing health inequities, in all aspects of our evaluation efforts?
- [ ] What are our current health equity strategies, activities and goals?
- [ ] How can our logic model be modified to reflect our health equity activities and goals?

3. How can we consider health equity in evaluation questions and design?

- [ ] How can we reframe or create new evaluation questions to better understand our effect on health inequities?
- [ ] What are the key variables we should use to track the influence of our efforts on populations experiencing health inequities?
- [ ] How can our sampling plan be designed or modified to answer our health equity-oriented evaluation question(s)?

4. How can we integrate health equity principles in the data gathering process?

- [ ] What processes do we have in place to determine when culturally appropriate tools or methodologies are needed?
- [ ] If modifications are needed, how can we ensure our evaluation tools meet the needs of populations experiencing health inequities (e.g., language and literacy needs)?
- [ ] Are the data we are collecting reflective of the real experience of the populations experiencing inequities? Are other approaches needed?
- [ ] Does our performance monitoring system allow us to track and identify needs that may arise when implementing efforts in underserved communities?
- [ ] How can we structure our evaluation processes to understand the long-term effects of our efforts on health inequities?

5. How can we understand our effect on health equity through our analysis plan?

- [ ] Does our analysis plan allow us to answer the following:
  - What worked?
  - For whom?
  - Under what conditions?
  - Is there any differential impact?
  - Have inequities decreased, increased, or remained the same?
- [ ] If not, how can we modify the analysis plan to answer these questions?
- [ ] Does our outcome evaluation allow us to determine differential effects across population groups?
- [ ] Does our process evaluation allow us to understand the key factors that influenced the outcomes of our efforts in underserved communities?
- [ ] What actions do we need to take to improve or enhance our evaluation plan to understand our effects on health equity (e.g., have inequities decreased, increased, or remained the same)?

6. How can we share our evaluation efforts with diverse stakeholders?

- [ ] How and where do we typically disseminate our evaluation findings?
- [ ] What commitment can we develop to ensure we share findings, even if negative?
- [ ] How can we ensure we share our findings in plain and clear language that can be understood by stakeholders, partners, and community members?
- [ ] How can our findings be used to support more action in communities of greatest need?
- [ ] How can we revise the ways in which we share lessons learned to help others concerned with addressing health inequities?

7. What are our next steps?

- [ ] What can we do differently to improve or enhance our ability to conduct health equity-oriented evaluations?
- [ ] What is our plan of action to implement improvements in our evaluation efforts?

APPENDICES

APPENDIX A
Health Disparities in Chronic Disease Risk Factors by Population Group

APPENDIX B
Considerations for Health Equity-Oriented Strategy Selection, Design, and Implementation

APPENDIX C
Example Resources for Identifying and Understanding Health Inequities

APPENDIX D
Health Equity Checklist: Considering Health Equity in the Strategy Development Process

APPENDIX A

HEALTH DISPARITIES IN CHRONIC DISEASE RISK FACTORS BY POPULATION GROUP

Despite decades of effort to reduce and eliminate health disparities, they have largely persisted—and in some cases are widening.[9-11] Specifically related to chronic diseases, there is a concentrated, disproportionate burden of chronic disease in many underserved populations and communities. The table below describes disparities in chronic disease risk factors by various population groups.

PEOPLE OF COLOR (RACIAL/ETHNIC MINORITIES)	According to the 2010 Census, approximately 16% of Americans identified themselves as Hispanic or Latino, 13% as Black, 5% as Asian, 1% as American Indian and Alaska Native, and 0.2% as Native Hawaiian and other Pacific Islander.[231] On a variety of health indicators, significant disparities among these racial and ethnic minorities continue to exist.[7,232] For example, adult obesity rates in the U.S. are higher among non-Hispanic African Americans (50%) and Mexican Americans (40%) than among non-Hispanic Whites (35%), and they are highest among African American women, at 59%.[233] In 2011, cigarette smoking among adults was highest among American Indian/Alaska Native populations (32%), compared to other racial/ethnic groups.[234]
PEOPLE WITH MENTAL OR SUBSTANCE USE DISORDERS	In the United States, adults with mental or substance use disorders comprise approximately 25% of the population. However, this population accounts for an estimated 40% of all cigarettes smoked resulting in a disproportionate burden from the health consequences of smoking.[235]
PEOPLE LIVING IN RURAL COMMUNITIES	Approximately 19%, or 60 million Americans, live in rural areas.[236] Rural residents are more likely to be elderly, in poverty, in fair or poor health, and to have chronic health conditions.[48] For example, the prevalence of obesity is higher in rural adults (40%) than urban adults (33%).[237] Adults living in non-metropolitan counties also have a higher average annual percentage of smoking (27%) than adults living in large metropolitan counties (18%).[238]
PEOPLE WITH DISABILITIES	Approximately 20% of U.S. adults have a disability.[239] Approximately 28% of adults with disabilities smoke, compared to 16% of those without a disability.[31] Adults with disabilities are more likely to be physically inactive (22%) than are adults without disabilities (10%).[240] Obesity is also higher among adults with a disability (38%) compared to those without a disability (24%), according to self-reported data.[241]

PEOPLE WITH LOW-INCOME AND THOSE EXPERIENCING POVERTY

In 2011, an estimated 15% of the U.S. population lived below the federal poverty level.[152] Poverty is correlated with perceived and actual poor health outcomes. People living in poverty are five times more likely to report their health as "poor" compared to high-income individuals.[242] People with a household income below the poverty line (29%) have a much higher prevalence of smoking compared to people with household incomes at or above the poverty line (18%).[234] Healthy eating (specifically fruit and vegetable consumption) is also lower among low-income populations compared to higher income populations.[243]

PEOPLE WITH LESS THAN A HIGH SCHOOL EDUCATION

Approximately 15 % of Americans 25 years old and older have not earned a high school diploma.[244] Those with undergraduate degrees have a lower prevalence of smoking (9%), compared to those with less than a high school education (25%) or only a high school diploma (24%).[234] Additionally, those with a GED have the highest prevalence of smoking (45%). Regarding obesity, college graduates or above had the lowest rate of obesity (28%) in 2009-2010, compared to those with less than a high school education (38%).[245]

OLDER ADULTS

The proportion of our nation's population aged 65 years and older is expected to increase from approximately 13% of the population in 2010 to an estimated 19% in 2030.[246] In 2009–2010, 45% of adults aged 65 and over were diagnosed with two or more chronic conditions.[247] Regarding inequities, older adults living in poverty and isolation may be particularly vulnerable.[248]

PEOPLE WHO IDENTIFY AS LESBIAN, GAY, BISEXUAL, OR TRANSGENDER (LGBT)

The lesbian, gay, or bisexual population is estimated at 3.5% in the United States, with an additional 0.3% identifying as transgender.[249] Regarding sexual orientation, use of any tobacco products have been found to be higher among lesbian, gay, bisexual, and transgender populations (38.5%) compared to the heterosexual/straight population (25.3%).[61] Obesity prevalence has also been noted among the LGBT community, particularly among lesbians who have been shown to have a higher prevalence of being overweight and obese than heterosexual women who are overweight and obese.[250]

NOTE: This list is not exhaustive and the groups are not mutually exclusive; individuals may belong to more than one population group.

APPENDIX B

CONSIDERATIONS FOR HEALTH EQUITY-ORIENTED STRATEGY SELECTION, DESIGN, AND IMPLEMENTATION

Policy, systems, and environmental improvement strategies have great potential to prevent and reduce health inequities, affect a large portion of a population, and can also be leveraged to address the underlying social determinants of health. **However, without careful design and implementation, such interventions may inadvertently widen health inequities.** Collaborate with partners and community members, including those experiencing health inequities, to identify possible barriers or negative unintended consequences that may limit a strategy's effectiveness. Then, account for identified challenges in strategy development to maximize the health effects for all and reduce health inequities. Consider the following barriers, unintended consequences, and questions when selecting, designing, and implementing equity-oriented strategies:

1 LIMITED COMMUNITY CAPACITY AND RESOURCES

Variability in community capacity and resources can influence decisions about which communities and community organizations to partner with, especially if resources are limited. While there are benefits to funding and collaborating with partners that can "hit the ground running," it is also important to build the capacity of other groups through training and additional support.

- Has lack of capacity or resources kept critical partners away?
- What training opportunities can build the capacity of residents or organizations to make community improvements?
- Are the same organizations repeatedly benefiting from funds distributed in the community? What steps can you take to engage other organizations?

2 VARIABILITY IN HEALTH LITERACY

Addressing health literacy means ensuring that all members of the community have the capacity to access and understand the information they need to engage in health improvement strategies or reap their health benefits.

- Will the improvements be understood by all community members?
- Is training needed to support and sustain the improvements?
- How will language, culture, and other differences be accommodated?

3 LACK OF COMMUNITY ENGAGEMENT, AWARENESS, AND PARTICIPATION

A well-designed effort may fail to reach its full potential if residents are unaware of the improvements or were not invited to participate in the planning and implementation process. Community residents and stakeholders should be consulted and engaged from the very start, and this engagement should be sustained throughout the process.

- How will stakeholders representative of the community's diversity be engaged?
- What steps will be taken to engage community members in planning, implementation, and evaluation?

4 **COST, RESOURCES, AND OTHER FISCAL CONSIDERATIONS**	There may be costs related to strategy implementation, either for the institutions making the improvements, or for the people who are the intended beneficiaries of these improvements. Examine how budget constraints may hinder implementation or uptake in underserved communities.	• Will costs prevent underserved populations from fully benefitting from the strategy? How can affordability be ensured for all? • Which partners might be able to help provide required resources (e.g., funding, materials, staff, other assets) to implement the strategy?
5 **TRANSPORTATION CHALLENGES**	Lack of personal transportation, unaffordable or unreliable public transportation, or inadequate infrastructure may reduce access to goods, services, or environmental improvements, including tobacco cessation services and other health care services. Explore whether transportation issues such as access, cost, and proximity exist.	• Is lack of transportation a problem for the intended beneficiaries of the strategy? • Are the locations where services are provided too distant, inconvenient, inaccessible, or unsafe?
6 **POTENTIAL DISPLACEMENT EFFECTS**	Changing community conditions may contribute to cycles of displacement. It is important to ensure that improvements will benefit residents rather than create conditions that displace them. Identify factors that may drive displacement and protections that can prevent it.	• How might community improvement strategies lead to displacement in the future? • What protections can be put in place to preserve affordable housing and prevent displacement? • How might concerns about displacement prevent residents from engaging in community improvements?
7 **VARIABILITY IN IMPLEMENTATION**	Uneven implementation of a policy or systems improvement may worsen inequities. Explore the factors (including those listed in this table) that might prevent consistent implementation of a strategy and develop solutions early in the planning process.	• Once your strategy is adopted or implemented, what steps will ensure proper implementation? • How will you ensure implementation occurs where it's needed most? • Which institutions need additional support to implement the improvements?
8 **CRIME/SAFETY INFLUENCES (BOTH REAL AND PERCEIVED)**	Even if effective strategies are put in place, fear of crime at locations where the intervention or service is being delivered may keep residents from using the new resources. Assess safety conditions and residents' perceptions of these conditions, and, if necessary, take steps to ensure participants' safety.	• How might concerns about safety prevent the community from benefitting from the strategy? • Are there visible signs of crime and violence?
9 **LACK OF AWARENESS OF DIVERSE NORMS AND CUSTOMS**	Understanding the diversity in culture, norms, and customs among population groups can ensure that strategies are designed to be inclusive. Institutions also have their own customs and norms, and these should also be considered, as they might affect decision making.	• How will community members with different norms and customs be engaged in strategy design? • Are differences in culture and norms understood in ways that result in respectful strategy development?

APPENDIX C

EXAMPLE RESOURCES FOR IDENTIFYING AND UNDERSTANDING HEALTH INEQUITIES

This table describes several online resources that you may be able to use to identify and understand health inequities in your area. This list is not exhaustive and you should determine what best fits your local needs.

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)[251]	A state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.
CENSUS DATA[252]	A database that provides demographic information on income, education, race/ethnicity, housing, and other factors that are viewable at multiple levels: national, state, county, and smaller geographic areas. Interactive features also allow cross tabulation of indicators and population groups.
COMMUNITY COMMONS[253]	An online interactive mapping tool that provides free geographic information systems (GIS) data from the state level to the block group level. The Commons is linked to the National Prevention Strategy and provides a peer learning network and other resources.
COMMUNITY HEALTH ASSESSMENT & GROUP EVALUATION (CHANGE): BUILDING A FOUNDATION OF KNOWLEDGE TO PRIORITIZE COMMUNITY NEEDS[17]	A tool to help community teams develop a community action plan. This tool provides steps for community team members to use in an assessment process. It also helps define and prioritize possible areas of improvement to address the root causes of chronic diseases, as well as related risk factors.
COUNTY HEALTH RANKINGS: MOBILIZING ACTION TOWARD COMMUNITY HEALTH[254]	A ranking of counties in each of the 50 states according to summaries of a variety of health measures. Summary measures include health outcomes (mortality and morbidity) and health factors (health behaviors, clinical care, social and economic aspects, and physical environment).

COMMUNITY HEALTH STATUS INDICATORS (CHSI)[255]	A report that contains over 200 measures for each of the 3,141 U.S. counties. The report presents indicators for deaths due to heart disease and cancer as well as on behavioral factors such as tobacco use, diet, physical activity, alcohol and drug use, sexual behavior, and others that substantially contribute to these deaths.
DATA SET DIRECTORY OF SOCIAL DETERMINANTS OF HEALTH AT THE LOCAL LEVEL[256]	A directory that contains an extensive list of existing data sets that can be used to address social determinants of health. The data sets are organized according to 12 dimensions (broad categories) of the social environment.
HEALTHY COMMUNITIES NETWORK (HCN)[257]	A network that tracks over 200 health and quality-of-life indicators. It also provides guidance on 1,800-plus community-level interventions. Local information is collected and combined with other data.
HEALTH DISPARITIES CALCULATOR[258]	Statistical software from the National Cancer Institute that imports population-based health data and calculates different disparity measurements.
HEALTH EQUITY INDEX[259]	An online tool created by the Connecticut Association of Directors of Health that outlines and measures the social determinants of health with specific health outcomes. The index produces scores as well as GIS maps.
HEALTH INDICATORS WAREHOUSE[260]	A Web site maintained by CDC's National Center for Health Statistics. This resource provides data on communities' health status as well as different determinants. There are over 1,000 indicators that can be categorized by geography, initiative, or topic.
THE TOOL FOR HEALTH AND RESILIENCE IN VULNERABLE ENVIRONMENTS (THRIVE)[261]	A tool intended to help people understand and prioritize the factors within their own communities in order to improve health and safety. The tool identifies key factors around equitable opportunity, people, and place, and allows users to rate how important each factor might be in their community.

APPENDIX D

HEALTH EQUITY CHECKLIST: CONSIDERING HEALTH EQUITY IN THE STRATEGY DEVELOPMENT PROCESS

The Health Equity Checklist provides questions for consideration when designing a strategy to ensure health equity remains central to all aspects of an initiative.

STEP 1: IDENTIFY

Clearly identify health inequities and protective factors in both health outcomes and community conditions across population groups and geographic areas through the use of existing data, community input, and environmental assessments.

STEP 2: ENGAGE

Include and meaningfully engage representatives of population(s)/area(s) defined in Step 1 in your partnerships, coalitions, or on leadership teams.

STEP 3: ANALYZE

Ensure the selection, design, and implementation of strategies are linked to the inequities identified in Step 1, and will work to advance health equity. Consider the following:

Is the strategy TARGETED to a population group(s)/area(s) experiencing health inequities?

- Is the outcome written in a way that allows you to measure the effect of efforts?
- Is it culturally tailored to the unique needs of population group(s)/area(s) experiencing health inequities, and are potential barriers addressed?

Does the strategy rely on SITE SELECTION (e.g., selecting X number of sites for smoke-free cessation services, creating X number of farmers' markets)?

- Do selection criteria for sites reflect populations/areas with the highest burden?
- If not, are selection criteria logical and justified?
- Are there additional supports provided for selected sites that might require them to be successful?

Is the strategy POPULATION-WIDE?

- Have population(s)/area(s) experiencing health inequities been engaged in efforts to identify possible barriers and unintended consequences of the proposed strategy?
- Are identified barriers regarding implementation and enforcement being addressed?
- Have potential unintended consequences been considered and accounted for in proposed activities?

STEP 4: REVIEW

Review evaluation and monitoring plans to ensure health equity-related efforts will be measured. Additionally, ensure appropriate data will be collected to conduct sub-analyses. These data will help in assessing the differential effects of each strategy across population group(s)/area(s), as well as the overall impact of strategies on reducing health inequities.

SUGGESTED CITATION: Centers for Disease Control and Prevention - Division of Community Health. *Health Equity Checklist*: Considering Health Equity in the Strategy Development Process. Atlanta, GA: US Dept of Health and Human Services; 2010.

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