

INCREASING ORGANIZATIONAL CAPACITY FOR HEALTH EQUITY WORK: A LITERATURE REVIEW FOR HEALTH NEXUS

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1.0 Background

Health Nexus is a bilingual organization that supports individuals, organizations and communities to strengthen their capacity to promote health and to create healthy, equitable and vibrant communities. The organization has been breaking down silos and bridging across sectors for more than 30 years. In 2016, Health Nexus developed a *Health Equity Strategy* with the goal of strengthening Health Nexus' capacity to develop healthy, equitable communities. The Strategy has three objectives:

1. Embed health equity as a value into organizational procedures and processes;
2. Increase staff confidence and capacity to apply a health equity lens in their work; and
3. Position Health Nexus as a champion in the field of health equity.

To support the strategy, a literature review and an evidence brief on health equity was conducted by a graduate student. The objective of this literature review is to provide evidence from the literature on how to embed health equity into organizational capacity. The discussion section provides health promoters and health promotion organizations with evidence to serve as a foundation for tangible health equity activities.

1.1 Defining Need:

Currently there is a lack of cohesive, comprehensive resources that health promoters can utilize to increase their capacity to promote health equity. A scan of academic research found inadequate evidence on the topic of health equity embedded in organizational capacity. Conversations conducted with health promotion stakeholders echoed the need for a resource to translate theory into action, specifically to answer the question, '*what can I do to promote health equity?*'

The specific research question developed for this literature review is '***What strategies/approaches are used by organizations in Canada or Ontario to increase their health equity capacity?***' As a health promotion organization, Health Nexus views health broadly. Therefore the results include some public health and health care system publications (such as resources from the Wellesley Institute and Health Quality Ontario) in addition to health promotion publications.

1.2 Health Equity Glossary: Key Terms

This section defines key health equity terms and concepts to provide the reader with a better understanding of the subject matter, and allow them to effectively navigate this document. The full Health Equity Glossary is located in **Appendix A**, where terms are supplemented with examples and analogies, critical analyses and additional resources. **Table 1** presents essential health equity terms and concepts that appear throughout this document.

Table 1: Condensed Health Equity Glossary

Term/Concept	Definition(s)
Health Equity	<p>The absence of unfair and avoidable or modifiable differences in health among population groups defined socially, economically, demographically or geographically (Solar & Irwin, 2007).</p> <p>“Equity in health means that peoples’ needs guide the distribution of opportunities for well-being. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences and various social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity, which result in unequal access to health services, nutritious food or adequate housing etc. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life” (PHAC, 2010).</p> <p>NOTE: Different countries and jurisdictions may use the terms ‘equity’ and ‘equality’ interchangeably. In addition, there may be slight differences when translated into different languages.</p>
Health Promotion	<p>“The process of enabling people to increase control over, and to improve their health. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental, political and economic conditions so as to alleviate their impact on public and individual health. The Ottawa Charter for Health Promotion describes five key strategies for health promotion: build healthy public policy; create supportive environments; strengthen community action; develop personal skills; and re-orient health services” (PHAC, 2010).</p>
Organizational Capacity	<p>“The ability of an organization to facilitate, support and fulfill an initiative, program, mandate or common goal” (Carlson, Donahue, and Foster, 2011)</p>
Social Determinants of Health (SDOH)	<p>“The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems” (WHO, 2017).</p> <p>Mikkonen & Raphael (2010) outline the following 14 SDOH: <i>Stress, Bodies, and Illness; Income and Income Distribution; Education; Unemployment and Job Security; Employment and Working Conditions; Early Childhood Development; Food Insecurity; Housing; Social Exclusion; Social Safety Net; Health Services; Aboriginal Status; Gender; Race; and Disability.</i></p>

2.0 Methodology¹

2.1 Search Strategy and Appraisals²³

Health Nexus’ Using Evidence Tool

Health Nexus has developed a Using Evidence Tool for staff members to utilize while developing their products and/or services when a literature search or appraisal process is required. The tool provides a

¹ Detailed review process and methodology found in Appendix.

² The searches are current as of February 2017.

³ Articles were tracked within [Zotero](#) reference management software.

structured format for research, and offers various resources. Additional information about the tool is located in **Appendix C**.

Database Search

The initial, structured search was conducted within the following databases: Summons 2.0; Web of Science; EBSCOHost; and Google Scholar. This search yielded 149 relevant academic articles, but only two met the eligibility criteria. Therefore additional research was conducted in the grey literature, which is where the research was concentrated.

Grey Literature Search

Health Nexus' Using Evidence Tool provided a number of databases. The following were explored for relevant grey literature: PHAC Canadian Best Practices Portal (CBPP); CHNet-Works! Researchers-Practitioners Webinars; Health Evidence; and Turning Evidence into Practice (TRIP). Following this a Google search ensued, which produced thousands of results. The first five pages (ten results per page equating to 50 results) were filtered, because the relevancy to the topic dropped drastically after this point. Specific health promotion websites that appeared often in this initial Google search were explored further. This entailed searching multiple websites of health promotion organizations across Canada (with a focus on Ontario): the BC Centre for Disease Control (BCCDC); National Collaborating Centre for Determinants of Health (NCCDH); National Collaborating Centre for Methods and Tools (NCCMT); Peterborough County-City Health Unit; Public Health Ontario (PHO); Sudbury & District Health Unit; and The Wellesley Institute. Following the screening and eligibility phases, 45 articles (rated strong evidence), and one article (rated moderate evidence) were included. Refer to **Appendix B** for the complete structured review. The searches are current as of February 2017.

2.2 Results⁴

Information from the included articles was categorized broadly, followed by a thorough evidence synthesis. This produced five key themes to produce a framework for increasing health equity work within health promotion organizations outlined in **Table 2**. If themes were discussed in less than ten of the articles they were excluded from the framework. A complete summary of the evidence is located in **Appendix C**.

⁴ Outlined fully in the [Evidence Tool](#).

Table 2: Literature review themes and number of results

Theme	Number of Resources ⁵
Establish Strong and Effective Leadership	n = 24
Continuously Expand the Evidence Base to Support Best Practices and Foster Knowledge Translation and Exchange	n = 18
Collaborate and Partner with Intersectoral Stakeholders and Communities	n = 14
Demonstrate and Increase Competencies (Public Health, Professional, Cultural, Linguistic)	n = 13
Embed Equity into the Organization’s Mandate, Policies and Procedures	n = 11

Once the five themes emerged, the practical implications, barriers, and actions were organized into separate categories within the ‘Using Evidence Tool’. Many of these components overlapped across all the themes. For example, there is an emphasis on evaluation and reporting across the ‘action’ items. In addition, commonly cited barriers were a lack of time and resources. **Table 3** displays the categories for each of the themes. The discussion outlines various barriers because it is crucial to understand and factor these into any planning and implementation phases.

Table 3: Theme implications, barriers, and actions for health equity work

Theme	Implications	Barriers	Actions
Strong and Effective Leadership	<ul style="list-style-type: none"> • Key factor to address social determinants of health (SDOH) • Supports equity work, both operationally and philosophically 	<ul style="list-style-type: none"> • Passion, conviction and resources • ‘Wicked’ problems • Resources (budgets, organizational supports) • Lack of momentum and support 	<ul style="list-style-type: none"> • Clear mandate • Organizational commitment and readiness • Link to evaluation • Performance measurements, evaluation and health equity indicators
Continuously Expand the Evidence Base to Support Best Practices and Foster Knowledge Translation and Exchange	<ul style="list-style-type: none"> • Necessity of equity data collection • “Build knowledge we can act on” • Role of researchers • Knowledge Translation Models 	<ul style="list-style-type: none"> • The existing evidence base and limitations • Insufficient systems • Lack of coordinating systems • Staff capacity • Evaluation • Project management 	<ul style="list-style-type: none"> • Integrate equity into evaluation and reporting • Create and use a strong knowledge base • Theoretical and methodological innovations

⁵ Denotes number of resources found with this theme.

Theme	Implications	Barriers	Actions
Collaborate and Partner with Intersectoral Stakeholders and Communities	<ul style="list-style-type: none"> Better comprehension of the problem under investigation Capacity to address future issues through partnerships and confidence-building 	<ul style="list-style-type: none"> Time, relationship building, evaluation, common language and capacity building Competing agendas, communications and engagement, imbalance of power, managing and diverse expectations 	<ul style="list-style-type: none"> Borrow resources and tools, provide mutual support, network Working groups Community engagement Comprehensive strategies and strategic directions
Demonstrate and Increase Competencies	<ul style="list-style-type: none"> Provide the building blocks for effective public health practice 	<ul style="list-style-type: none"> Resources needed to update current competencies 	<ul style="list-style-type: none"> Ongoing training, supportive learning environment and updated competencies
Embed Equity into the Organization's Mandate, Policies and Procedures	<ul style="list-style-type: none"> Apply a health equity lens Clear duties and expectations 	<ul style="list-style-type: none"> Lack of resources and understanding 	<ul style="list-style-type: none"> Clear mandate and enabling infrastructure

These themes align closely with themes outlined by the NCCDH. The NCCDH (2014) clearly identifies four key roles for public health action on health determinants to reduce health inequities:

- 1. Assess and report** on the health of populations to describe the existence and impact of health inequalities/inequities and effective strategies to address them;
- 2. Modify/orient** public health interventions to reduce inequities including the consideration of the unique needs and capacities of priority populations;
- 3. Engage** in community and multi-sectoral collaboration to address the health needs of these populations through services and programs; and
- 4. Lead/participate** and support other stakeholders in policy analysis, development and advocacy to improve health determinants/inequities.

In addition, participants in an environmental scan conducted by the NCCDH shared a number of elements that are necessary for these roles to be undertaken most effectively:

- Leadership** that is collaborative;
- Organizational and system development** within and outside the health sector;
- Development and application of **information and evidence**;
- Education and awareness** raising for public health staff and the general public;
- Skill development** based on participatory learning; and
- Partnership development** inter- and intra-sectorally.

3.0 Discussion

3.1 Strong and Effective Leadership

From the research findings, it is clear that strong and sustained leadership at all levels within an organization is essential to building organizational capacity for health equity action. Therefore, ‘strong and effective leadership’ serves as the core foundation of the literature review framework.

Theme	Implications	Barriers	Actions
Strong and Effective Leadership	<ul style="list-style-type: none"> • Key factor to address social determinants of health (SDOH) • Supports equity work, both operationally and philosophically 	<ul style="list-style-type: none"> • Passion, conviction and resources • ‘Wicked’ problems • Resources (budgets, organizational supports) • Lack of momentum and support 	<ul style="list-style-type: none"> • Clear mandate • Organizational commitment and readiness • Link to evaluation • Performance measurements, evaluation and health equity indicators

3.1.1 Implications

The NCCDH conducted a survey in 2010 where 75% of respondents identified **leadership** as a key factor on the social determinants of health. Moreover, the NCCDH asserts that leadership not only supports equity work operationally within an organization, but philosophically as well. Organizational and individual public health leadership for health equity is driven by passion and moral belief (NCCDH, 2015).

3.1.2 Barriers

Passion, Conviction and Resources

The research indicates that all too often health equity action takes the backseat on an organization’s agenda. Organizations have limited resources and more often than not have little flexibility to focus on more immediate deliverables and deadlines to secure and ensure continued funding. These barriers reflect the challenges surrounding existing political climates and ideological tensions both internally within the organization and externally (Tyler et al. 2014, McPherson et al. 2016). If there is a limited budget, organizational supports may not be available to support managers in their efforts to be completely committed to pursuing health equity work.

Passion and moral conviction underscore successful organizational and individual public health leadership for health equity, and if either of these components is missing then it poses as an obstacle (NCCDH 2015, Underwood, Harlos & Vivian-Book, 2013). In addition, the NCCDH has found widespread agreement that while health equity work has received more attention in recent years, public health practitioners commonly expressed caution that “the momentum has not yet resulted in significant, concrete actions to reduce health inequities. Without concrete actions, participants voiced concern that public health interest in health equity may become a passing fad or “flavour of the month” (2014).

Since leadership needs vary considerably there is little agreement regarding effectual leadership practices as well as supporting or limiting factors. As a result, the NCCDH argue that leadership competencies of public health professionals in the area of social determinants of health and health equity need to be developed further (2013). Eloquently put, “public health staff’s important leadership contribution is to know when to lead from the front, when to follow and when to be cheerleaders. Staff must be able to function well in each of these roles” (NCCDH, 2015).

Wicked Problems

Becoming a leader is easier said than done, especially in regards to health equity, which is often viewed as a ‘**wicked problem**.’ The NCCDH provide numerous attributes of a ‘wicked problem’, which include no definitive formulation of the problem; every problem could be considered a symptom of another problem; solutions are not true or false, but worse or better; no immediate or ultimate test of a solution; and every solution is a one-shot operation (2015). Often advancing health equity is characterized by numerous and interconnected influences, ways of understanding and potential approaches for action (2014).

Keeping this in mind, health promoters and their organizations may be intimidated by the scope of health equity endeavors, and the breadth of the action required to advance health equity may seem overwhelming (NCCDH, 2015). Furthermore, it can be extremely difficult to communicate key messages and translate health equity theory into practice. Lastly, a lack of discussion about applying health equity tools at the management level and a shortfall of management buy-in could be barriers that illustrate a lack of organizational commitment and readiness (NCCDH, 2015).

In a study conducted with Ontario public health nurses (PHN) McPherson et al. identified how crucial the organizational culture was in acting as a support or barrier for PHN role development and implementation related to the social determinants of health. Organizational culture includes those basic values, assumptions and behaviours that influence the functioning of the organization. The authors argue that these are often taken for granted and represent a powerful force affecting the activities of an organization (2016).

3.1.3 Actions

Health Equity Champions

The BC Centre for Disease Control (BCCDC) maintains that staff members need to take on the role of an “executive equity champion” to help embed equity into their organization’s strategic direction (2016). How is an organization supposed to ‘find’ these champions? Bowen, Botting & Roy (2011) indicate that from their experience an organizational champion must possess credibility with the audience of interest; be knowledgeable about the issue (this does not necessarily equate to being an ‘expert’); be capable to advocate for, as well as support an effective collaborative process (such as working groups) and; be confident that the issue is important enough to champion.

Maintain Leadership and Motivation

By embedding equity within formal and informal leadership structures leaders are able to motivate staff through involvement and keep equity on the organization’s agenda. Through these efforts, leaders are

better able to harness existing health equity momentum and foster an organizational culture of equity. In this way they are better able to cultivate **common ownership** of health equity among all staff members, which should entail building on existing efforts, nurturing champions, as well as creating links between priorities and evidence (NCCDH, 2015). Leaders may be formally designated and supported or informal, self-driven champions; they can be supported in a number of formal and informal ways, including mentorship and training.

Organizational Commitment and Readiness

Leadership must occur at all levels of an organization, not just amongst senior management. McPherson et al. outline three levels of leadership where commitment must occur: **individual**, **organizational/public health unit** and **systems** (2016). There is a multitude of policy and theoretical frameworks that assist in establishing health equity commitment, as well as financial and human resources (Underwood, Harlos & Vivian-Book, 2013).

Cohen et al. produced an extensive work on this topic and argue that commitment to public health equity action (PHEA) is verified in multiple ways (2013). First, an organization expedites and follows through with equity-focused action. Second, they provide sufficient structures and resources needed to support PHEA. Next, they promote participatory processes that fairly distribute power and generate trust and respect. Lastly, ensuring that all levels of the organization have health equity champions will energize and motivate staff to pursue PHEA (Cohen et al. 2013).

'Social justice' was an organizational value commonly promoted throughout many of the articles. Cohen et al. proclaim that when an organization values social justice capacity for public health equity action is strengthened because there is direct attention on the **root causes** of inequities in health in different social groups (2013). This may increase successful community engagement and empowerment in particular.

Link to Evaluation and Reporting

In order to maintain leadership and organizational accountability, **performance measurements**, **evaluation** and **health equity indicators** must be established and utilized regularly. Through activities such as year-end reports on activities, accountability for action is instituted (Betker et al. 2013). In this way health equity targets can be set and offer an organization tangible, concrete goals to aim for. The Ontario Public Health Association (OPHA) created their own [framework](#) and activities to advance health equity that include several indicators. For example, the indicator *'% of OPHA submissions and presentations that include health equity'* is an activity that supports their goal to assess and report on the existence and impact of health inequities; and reduces inequities using effective strategies' (2016).

McPherson et al. (2016) insist that clear **accountability** measures are built into accountability agreements to help ensure that positions are used to meet the intended mandate of increasing organizational health equity capacity. For example, by including explicit deliverables and performance measures there is greater accountability (NCCDH, 2015). In addition, this ensures that a strategic direction of quality and performance is undertaken.

Peterborough County-City Health Unit demonstrates their commitment to accountability through the following [actions](#): develop stronger accountability systems and processes at every level of the organization; build a culture of evaluation with clear accountabilities and; strengthen workplace culture and invest in the leadership potential of every employee (2013). Through the collection of data, organizations can design and evaluate policies, programs, and services to mitigate health inequities. Lastly, organizations will be able to fully utilize equity-focused organizational planning, management and evaluation tools to evaluate the outcomes of health equity actions (intermediate and long-term impacts) (Cohen et al. 2013, BCCDC 2016).

3.2 Continuously Expand the Evidence Base to Support Best Practices and Foster Knowledge Translation and Exchange

Theme	Implications	Barriers	Actions
Continuously Expand the Evidence Base to Support Best Practices and Foster Knowledge Translation and Exchange	<ul style="list-style-type: none"> • Necessity of equity data collection • “Build knowledge we can act on” • Role of researchers • Knowledge Translation Models 	<ul style="list-style-type: none"> • The Existing Evidence Base and Limitations • Insufficient systems • Lack of coordinating systems • Staff capacity • Evaluation • Project management 	<ul style="list-style-type: none"> • Integrate Equity into Evaluation and Reporting • Create and Use a Strong Knowledge Base • Theoretical and Methodological Innovations

3.2.1 Implications

Many of the articles outline the importance of continually adding and updating the evidence and knowledge base for health equity work, in order to exchange with other stakeholders. Gardner (2014) argues that in order to increase health equity organizational capacity successfully, the collection of equity data must take place and he frankly states that practitioners “build knowledge we can act on”. Researchers work in a variety of settings and disciplines; collectively they play an important role in building an understanding of the causes of health inequities and effective interventions. Gradually they help integrate research and data, which eventually results in more effective incorporation of a health equity lens into research and data (NCCDH, 2015). This research and data on inequities will then be utilized to design and evaluate policies, program and services (Cohen et al. 2013).

There are a number of knowledge translation models that can help guide the implementation of knowledge to inform health promotion action to improve health equity (refer to Davison & NCCDH’s 2013 critical examination article on knowledge to action models) . Interestingly, Davison & NCCDH found that the most relevant models are those with principles and values reflective of equity and social justice. Moreover, by using these types of models organizations can: identify equity as a goal; involve stakeholders; prioritize multisectoral engagement; draw knowledge from multiple sources; recognize the importance of contextual factors; and have a proactive or problem-solving approach (2013).

3.2.2 Barriers

The Existing Evidence Base and Limitations

The Public Health Association of Canada (PHAC) indicates that there are a number of data limitations and a lack of supportive tools relating to gaps in the existing evidence base for health equity work (2014). The NCCDH outlines additional limitations:

- **"Insufficient systems**, especially regarding measurement and reporting, e.g. infrastructure; deficiency of data and data linkages, including mechanisms to identify incremental change over time; minimal effort or methods to measure impact of resource shifts (to or away from equity-related foci); equity not being integrated into clinical care performance measures;
- **Lack of coordinating mechanisms** and high level intergovernmental, inter-departmental collaboration; shortage of equity-focused policy, legislation and strategies; few cross-sector/cross-jurisdiction funding models; health equity seen as public health issue, yet drivers rest outside public health and health care systems; and
- **Staff capacity**, (e.g. knowledge, skills and diversity among public health staff and lack of clarity regarding roles and expectations) - making it difficult to mobilize action" (2015).

Evaluation

There are a number of evaluation issues that include: difficulty demonstrating outcomes of interventions; inadequate understanding of how to scale up (vertically and horizontally); limited feasibility to replicate successes (for example between jurisdictions, where context and capacity differs); and the need to focus efforts where a health equity approach will add most value (NCCDH, 2015). These issues influence project management approaches as well. For example, clearly defining approaches, producing detailed information collection strategies and assigning qualified staff to conduct and analyze data are identified as important by facilitators (Tyler et al. 2014). Perhaps one of the most daunting barriers is posed by the NCCDH: ***Can "objective science" values and "social justice" values converge in action?*** (2015).

3.2.3 Actions

Integrate Equity into Evaluation and Reporting

The BCCDC offers a number of recommendations to integrate equity into evaluation and reporting. First, the concept of health equity must be integrated into program plans, organizational strategies and reports. Second, opportunities must be provided to staff so they are able to share their experiences and knowledge with others (such as staff meetings) as well as acknowledge the work of staff members who promote equity. Lastly, opportunities for staff to share equity practices in formal settings such as working groups, conferences, as well as regional and national gatherings should be supported by health promotion organizations (2016).

Create and Use a Strong Knowledge Base

The NCCDH encourages organizations to act on existing evidence and strengthen the knowledge base to support intensive action as well as incorporate equity considerations into regular monitoring,

surveillance and reporting (2016). All too often practitioners are swamped with numerous immediate tasks, and are unable to take the time to share their experiences and lessons learned. The NCCDH recommends that staff document these instances and make them available to others. There are plenty of formats available, such as a one-page summary, a lunch-and-learn presentation, a report, or a peer-reviewed publication (NCCDH, 2013).

In order to increase knowledge exchange, funding must be in place for these initiatives. Information sharing and joint planning will “amplify gains across organizations” if support for knowledge exchange and network development for those in similar roles is in place (McPherson et al. 2016, NCCDH, 2015). As a practical example, the Central East LHIN plans to develop an [online health equity information and knowledge transfer system](#) for service providers.

Theoretical and Methodological Innovations

Due to a variety of factors there have been various theoretical and methodological innovations in knowledge generation, knowledge synthesis and knowledge integration for population and public health. Some of these innovations include the development of web-based determinants of health and health inequity portals. The NCCDH outlines some of these factors below including: overall experience is increasing; existing and developing models of web-based determinants of health and health equity portals; extent of interest within public health; and degree of interest outside public health (2013). Ideally, with this heightened attention there is a greater likelihood of sustained funding for these creative strategies.

3.3 Collaborate and Partner with Intersectoral Stakeholders and Communities

Theme	Implications	Barriers	Actions
Collaborate and Partner with Intersectoral Stakeholders and Communities	<ul style="list-style-type: none"> • Better comprehension of the problem under investigation • Capacity to address future issues through partnerships and confidence-building 	<ul style="list-style-type: none"> • Time, relationship building, evaluation, common language and capacity building • Competing agendas, communications and engagement, imbalance of power, managing and diverse expectations 	<ul style="list-style-type: none"> • Borrow resources and tools, provide mutual support, network • Working groups • Community engagement • Comprehensive Strategies and Strategic Directions

3.3.1 Implications

The World Health Organization (WHO) defines ‘**intersectoral action**’ as actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector (WHO, 2008). There are a multitude of benefits that arise through intersectoral and community collaboration. The NCCDH indicates that organizations which become involved in participatory research projects develop a better comprehension of the problem under investigation and this research can contribute to organizational capacity to address future issues through partnerships and confidence-building (2015). In addition, Gardner argues that community engagement needs to begin from communities and residents through an equity lens, rather than solely with ‘experts’, planners or professionals who define issues and drive system transformation (2013).

3.3.2 Barriers

Time, Power Imbalances, Communication and Capacity Building

There are numerous obstacles that may arise when working intersectorally and with communities. Staff members who have undertaken this type of work may share the sentiment that there are ‘too many cooks in the kitchen’ on any given project. There may be difficulties working intersectorally due to time; relationship building; evaluation; common language; and capacity building (NCCDH, 2014). PHAC shares similar impediments including: competing agendas; communications and engagement; imbalance of power; as well as managing and diverse expectations (2014).

3.3.3 Actions

Collaborative Action

Rideout provides valuable advice for effective collaborative action, which includes borrowing resources and tools, providing mutual support, as well as networking and referrals (2016). McPherson et al. reminds organizations that both internal and external activities serve to bolster their work. This ensures that internal structures are established to bring public health staff together and help minimize ‘internal siloes’ (2016). One may ask how collaborative work should look however opinions vary greatly. Bowen, Botting & Roy (2011) endorse a **working group** arrangement where a suitable group(s) already in existence can take on this role. In this way, collaborative-seeking organization can go where stakeholders are and meet around their activities. There are several advantages for this format which include:

- Increasing the likelihood of participation;
- Minimizing the time required of participants;
- Allowing the flexibility to use varying formats and methods appropriate for each audience;
- Enabling every group can spend more time on its area of concern/expertise; and
- Fostering learning opportunities for project initiators and their organizations.

Community Engagement

Community partners (including government, community organizations and other grass-roots leaders) are crucial for providing evidence and helping to understand its meaning and implications for health equity in the community. This ensures that community partners can be engaged throughout the entire process in order to consider local and political inclinations and appropriate activities. Eventually, community partners help build capacity for leadership and action (NCCDH, 2015).

One of Peterborough County-City Health Unit’s strategic directions is to increase a ‘**Community-Centred Focus**’. The Unit plans to play an active role in championing the establishment of a ‘local data consortium’. These endeavors acknowledge community agencies that collect, produce and analyze population and health data have expressed interest in collaboration (2013). In addition, PHAC advocates that organizations involve marginalized populations in decision-making, including First Nations, Inuit and Métis peoples, to provide **cultural continuity** in enhancing health outcomes, and provide valuable lived experience. As a result, organizations will be better positioned to clearly understand the interests of their community allies and with partners in a participatory, respectful way (2014). These activities

represent actions that can influence social and structural conditions that currently lead to health inequities, such as building capacity within priority populations (community development) and engaging in advocacy with or on behalf of equity-seeking populations (Cohen et al. 2013).

Comprehensive Strategies and Strategic Directions

Strategic directions and process development must be established in order to support efforts to work intersectorally (NCCDH, 2014). Bowen, Botting & Roy (2011) offer relevant suggestions for developing and maintaining a comprehensive strategy:

- **Keep focused on the evidence: Think systematically**
- **Think strategically**
 - Position your issue within a wider policy trajectory
 - Align with ongoing activities
 - Position action as a response to an existing problem
 - Position around emerging events and pressures
 - Build and nurture your coalition
- **Integrate local and research evidence**
 - Integrate local and research evidence
 - Tell a story; tell the best story
 - Send a trusted messenger

3.4 Demonstrate and Increase Competencies

Theme	Implications	Barriers	Actions
Demonstrate and Increase Competencies	<ul style="list-style-type: none"> • Provide the building blocks for effective public health practice 	<ul style="list-style-type: none"> • Resources needed to update current competencies 	<ul style="list-style-type: none"> • Ongoing training, supportive learning environment and updated competencies

3.4.1 Implications

PHAC defines ‘**core competencies**’ as “the essential knowledge, skills and attitudes necessary for the practice of public health. They transcend the boundaries of specific disciplines and are independent of program and topic. They provide the building blocks for effective public health practice and the use of an overall public health approach. Generic core competencies provide a baseline for what is required to fulfill public health system core functions. These include population health assessment, surveillance, disease and injury prevention, health promotion and health protection” (2008).

Underwood, Harlos & Vivien-Book (2013) outline the varying aspects of professional competency that are needed for effective health equity action including:

- **Knowledge about health equity**
 - Inspiring teachers, formal education and expert peers
 - Theoretical frameworks, especially Critical Social theories which refers to a structural view of society/sources of inequality

- Personal study and continual updating regarding best practices, research and current data
 - Work experience
- **Skills**
 - People skills
 - Communication skills that include strategically breaking down issues (e.g., poverty) into manageable activities including advocacy activities
 - Facilitation skills, using multiple strategies to achieve Health Equity goals and adapt approaches to context.
 - Taking advantage of opportunities and working effectively within policy environments to encourage a shift to health equity
- **Attitudes**
 - Moral conviction
 - Risk taking
 - Passion, energy and motivation

3.4.2 Barriers

Resources and Updating Current Competencies

Many organizations lack the resources to ensure continued competency training for their staff members and some believe that official competency guidelines are in dire need of modification. The NCCDH evaluated the current Core Competencies for Public Health in Canada released by PHAC and provided multiple recommendations:

- Include specific determinants of health content in all competency categories and throughout the document;
- Strengthen integration of a determinants of health approach in the competency statements by revising indirect references to the determinants of health and using specific and active language;
- Reflect the values and attitudes that are strongly stated in the preamble through the competency statements, practice examples and glossary of terms;
- Reference an expanded list of determinants of health (e.g., Mikkonen and Raphael, 2010);
- Include explicit wording and relevant examples as modeled in the competency statements from other countries;
- Expand determinants of health content, both the amount and range, in the practice examples and glossary of terms; and
- Review discipline-specific competencies to determine if specific determinants of health content could be used (2012).

3.4.3 Actions

Ongoing Training, Supportive Learning Environment and Updated Competencies

As noted in other themes, there may be a lack of resources available to fully instill professional competencies needed to advance health equity. Oickle & Fish (2016) provide guidance for all levels of an organization in order to strengthen these competencies:

- **Practitioners:** Create learning plans to continue and increase competence, as well as partake in reflective practice;
- **Employers:** Embed equity into human resource processes, job descriptions and continuing professional development;
- **Educators:** Actively integrate equity into their curriculum and course development; and
- **Disciplines:** Strengthen social determinants of health, equity and social justice content, definitions and examples.

Underwood, Harlos & Vivien-Book (2013) reiterate the need to develop and expand **leadership competencies** of public health professionals, specifically in the area of social determinants of health and health equity. Furthermore, **cultural** and **linguistic competency** is imperative as well. The Wellesley Institute recommends that organizations support staff with cultural competency training and increase the diversity and competency of their workforces (2016).

In order to effectively and continuously train staff members, a supportive learning environment must be in place. This type of environment allows staff to acquire and build upon the skills required to be effective in their roles. This signifies cultivating a healthy organizational culture by:

- Transforming power relationships within and beyond the organization;
- Encouraging access to and free flow of information;
- Fostering innovation and new methods; and
- Creating an engaged learning environment (Community Health Centres of Greater Toronto 2011, Gardner 2012).

3.5 Embed Equity into the Organization’s Mandate, Policies and Procedures

Theme	Implications	Barriers	Actions
Embed Equity into the Organization’s Mandate, Policies and Procedures	<ul style="list-style-type: none"> • Apply a health equity lens • Clear duties and expectations 	<ul style="list-style-type: none"> • Lack of resources and understanding 	<ul style="list-style-type: none"> • Clear mandate and enabling infrastructure

3.5.1 Implications

Embedding equity into an organization’s mandate, policies and procedures looks straightforward on paper. In reality, an entire organizational shift involving internal environment, culture, and practices take place. Health equity becomes structurally embedded within the organization so they are able to incorporate and **apply a health equity lens** in their planning, implementation and evaluation of all program(s), activities and policies (OPHA 2016, McPherson et al. 2016). Adopting such practices provides

organizations and their staff with **clear duties and expectations** so they understand how to factor equity considerations into discretionary decision-making (BCCDC, 2016).

3.5.2 Barriers

Lack of Resources and Understanding

In order to embed health equity, one must understand what health equity actually means. Often there is **confusion** surrounding the language or understanding of health equity. The NCCDH outlines various components underlying this confusion, including: a **lack of evidence** or data and difficulties demonstrating success; and **implementation** issues: values or ideology, lack of resources, training, skills or power to effect change (2012).

When building a **health equity agenda** an organization may experience difficulties. In McPherson et al.'s study the authors identified the context-specific aspect of building a health equity agenda and saw the impact of **early contextual decisions on the role implementation** of SDOH-PHNs:

- Positions health equity as a **priority** issue for the organization;
- **Enhances staff competencies** around health equity; and
- Provides **support for integrating** SDOH and health equity across the organization (2016).

On the other hand, McPherson et al. observe that appointing SDOH positions to **specific** program areas at the **beginning** resulted in an overall **lack of visibility** of equity work at the cross-organizational level. This is because health promoters tend to be immersed in their day-to-day work. The authors note that this was especially harmful in organizations with little or no broader health equity strategy at the beginning.

3.5.3 Actions

Clear Mandate and Enabling Infrastructure

The overall goal is to ensure that all staff are attentive to consistent equity language and processes. This is completed by developing an organizational strategy and/or framework and applying a health equity lens (NCCDH, 2014). Whenever an organization is able to appropriately adopt and communicate their mandate it offers a number of opportunities to produce an effective health equity framework and strategic approaches. A good understanding of the organization's common purpose provides staff with concrete directions, which can promote meaningful and coordinated health equity action. As a result, good working relationships and team dynamics are cultivated, which translate to better project planning and responses (Tyler et al. 2014).

By integrating equity into the organization's mandate, it is applied at a systems level rather than being an "add-on" or specific initiative. Even if funding cuts occur, mandates, policies, and procedures require system-level change, for example, how can [we] strategically realign resources for lasting change?" (BCCDC, 2016) Tackling issues of the SDOH and health equity requires a multidisciplinary approach, such as human resource initiatives that solicit a range of disciplines that benefit from diverse skills and perspectives (McPherson et al. 2016).

This equity integration increases the opportunity to create and support an **enabling environment**. In order to support staff to apply the entire scope of their competencies, McPherson et al. (2016) recommend that organizations: develop and promote **cultural attributes** (such as a shared vision, mission and goals) that prioritize health equity and are understood and valued throughout the organization; and foster a **culture of creativity and responsiveness** that will support staff to practice the full scope of their competencies.

The NCCDH outline multiple components of an **enabling infrastructure**:

- Strategic and operational plans that prioritize health equity;
- Multi-disciplinary, multi-level guiding or steering committees to set supportive policies and procedures and ensure **interaction between and across levels**;
- **Health equity teams**, offices or units supporting SDOH work, either at the organizational level or within selected programs;
- GIS mapping, situational assessments and other elements of “**purposeful reporting**” designed to identify priority populations;
- More **systematic health equity-focused assessments**, monitoring and evaluation to allow programs to focus and shift efforts if required;
- **SDOH tools**, training and other resources to support staff;
- **Support to engage with community partners** through external committees or area-specific efforts (2015).

Underwood, Harlos & Vivien-Book (2013) offer additional actions that organizations may take to deepen their commitment to equity further:

- Create a purpose statement
- Participatory leadership
- Outline relationships and roles
- Summarize core public health functions
- Establish areas of focus
- Demonstrate a commitment to social justice
- Incorporate core competencies

3.6 Distinct Best Practices

Planning, evaluation, and reporting are nuanced, ongoing best practices that presented themselves throughout the themes. **Table 4** illustrates these actions in depth to help guide these health equity actions for Health Nexus.

Table 4: Distinct best practices applicable for all five themes

Theme	Action/Activities	Description
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All Five Themes	Integrate evaluation and reporting to increase accountability	Establish performance measurements, evaluation, and health equity indicators which are regularly utilized
		Ensure clear accountability measures are built into accountability agreements (for example, by including explicit deliverables and performance measures)
		Integrate the concept of health equity into program plans, work plans, organizational strategies, and reports
		Provide and support opportunities for staff to share their experiences and knowledge with others (such as staff meetings) and acknowledge those who promote equity
		Evaluation framework: include activities/indicators from annual Strategy Implementation Plans in the framework; include questions regarding health equity in staff surveys (for example, questions to identify level of knowledge on health) and client surveys (regarding the profile of Health Nexus).
		Planning processes: use a health equity lens and refer to equity when developing and planning activities and initiatives, including proposals and project reports.

4.0 General Limitations

There was varying terminology based on the research topic of interest. For example, the term ‘health equity’ may be coined ‘health equality’ in other countries. As a result, it may be of interest to include both terms if an international literature review on the subject was conducted in the future.

Furthermore, there are no concrete tactics used to measure and increase health equity organizational capacity on a national scale. Consequently, it was difficult to narrow down terminology to a manageable size that could produce results; some of the terms included ‘strategy’, ‘framework’, ‘approach’ and ‘plan’.

4.1 Methodological Limitations

The majority of the evidence outlined in the results was harnessed through the scanning of grey literature, due to a lack of academic articles specific to the research question. As a result, limitations include a lack of reproducibility of the review and search engine restrictions. For example, many documents relating to tools and frameworks that measure and increase health equity organizational capacity may be kept confidential within the organization – thus making it impossible for the general public to access online. If the same search was conducted one year from now, there may be substantial amount of material on the topic that has been published, which would interfere with the replicability of this initial search. Lastly, this literature review does not explore the topic outside of Canada so this would be a future undertaking depending on available resources and funding.

5.0 Implications for Health Promotion Practice and Concluding Remarks

Framework for Our Actions and Goals

In 2016 the Wellesley Institute conducted a literature review titled, [International Review of Health Equity Strategies](#), for Health Quality Ontario. Their report aimed to identify and describe strategies that have been developed by Canadian and international jurisdictions to enhance health equity within and beyond the health sector.

Based on their review and synthesis of their collected documents and information, the Wellesley Institute grouped their strategies into two categories based on whether they present an **intersectoral** or a **health system** approach. The **intersectoral** approach is most relevant to the work carried out at Health Nexus and is utilized in the development of the literature review framework.

The literature review findings are closely aligned with the Wellesley report’s intersectoral strategic goals and actions. A framework was created (**Table 5**) to increase health equity organizational capacity for health promotion organizations, based on the literature review findings, and Wellesley’s approach. This framework could potentially be utilized by organizations outside the health promotion sphere.

Table 5: Framework: Health Equity Organizational Capacity for Health Promotion Organizations

Evidence Base, Knowledge Translation and Exchange	Collaborate	Competencies	Embed Equity
Core Foundation: Strong and Effective Leadership			

Health equity work takes time to be fully implemented and integrated within an organization. The sheer amount of information outlined in this literature review may seem daunting at first glance. Health promoters may be alarmed by the vast amount of health equity information provided in this literature review. Although health equity work is urgent, it is crucial for health promotion organizations to consider a phased implementation approach of health equity activities. In this way, staff members and the organization as a whole will not feel overwhelmed completing this work all at once.

The evidence has clearly articulated that effective health equity work begins with strong and effective leadership. Beginning with this core foundation of the literature framework would serve as an ideal first step for health promotion organizations to adopt in their pursuit to increase their capacity to increase meaningful health equity work.

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Appendices

Appendix A: [Health Equity Glossary – Continued](#)

Appendix B: Resources Health Promoters Can Utilize

Tools and Toolkits	<ul style="list-style-type: none"> • Achieving the Vision of an Inclusive Peel Region: A Diversity, Equity, and Inclusion Organizational Self-Assessment Tool • Health Equity Impact Assessment (HEIA) - Ministry Programs - Health Care Professionals - MOHLTC • Health Equity Tools Inventory • Overview HEIA – Community of Interest • Equity-Focused Knowledge Translation Toolkit Resource Details National Collaborating Centre for Methods and Tools. • Health & Health Equity in the GTA. • The Organizational Capacity Assessment Tool (OCAT)⁶ • Promoting Action on Equity Issues: A Knowledge-to-Action Handbook • Public health planning toolkit • Templates and User Guides for Equity-Focused Impact Assessment • Tools and approaches for assessing and supporting public health action on the social determinants of health and health equity • Toward Health Equity: A Practice Tool • Toward Health Equity: A Tool for Developing Equity-Sensitive Public Health Interventions
Health Equity Glossaries and Fact Sheets	<ul style="list-style-type: none"> • Building Health Equity Capacity in the Mississauga Halton LHIN: Health Equity Glossary. • “Let’s Talk: Health Equity.” NCCDH, 2013. • Towards an Understanding of Health Equity: Glossary • Why Health Equity Matters: Fact Sheet
Collaborations and Partnerships	<ul style="list-style-type: none"> • Collaborative Leadership in Practice – Leadership collaboratif en pratique (CLiP – LCP)
Examples of Equity Initiatives	<ul style="list-style-type: none"> • A Snapshot of Equity Initiatives on LHIN Websites–Toronto Central LHIN.
International Frameworks	<ul style="list-style-type: none"> • “Equity Focused Health Impact Assessment Framework.” The Australasian Collaboration for Health Equity Impact Assessment (ACHEIA) • Whānau Ora Health Impact Assessment
Online Learning Opportunities	<ul style="list-style-type: none"> • Online Courses: Social Determinants of Health & Health Equity • Recommended Online Learning Opportunities Related to Health Equity and Social Determinants of Health, for Public Health Practitioners in Canada
Webinars and Videos	<ul style="list-style-type: none"> • “NCCDH Webinar: Intersectionality & Health Equity.” • “NCCDH Webinar: Strengthening Organizational & Health System Performance to Report and Act on SDH.” • Let’s Start a Conversation About Health...and Not Talk About Health Care at All (Voice-Over)

⁶ A free online tool that helps non profits assess their operational capacity and identify strengths and areas for improvement.

Additional Resources	<ul style="list-style-type: none">• Sudbury & District Health Unit - 10 Promising practices• HC Link - Health Equity• Let's Start a Conversation About Health . . . and Not Talk About Health Care at All: USER GUIDE• Resources, Principles, and the Practice of Health Equity A compilation of training resources for community health care service providers in the Champlain region• WCH Women's Xchange Addressing Issues of Equity in Research• Building Organizational Capacity to Advance Health Equity
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Appendix C: Literature Review – Detailed Methodology and Tools

Evidence Tool Background:

Health Nexus developed a ['Using Evidence Tool'](#) for staff to utilize while developing products and/or services when a literature search or appraisal process is required. This tool allows the researcher to track all their information in one document that can easily be audited at a later date. **Step 1** defines the 'need and search criteria'. **Step 2** provides an extensive list of databases. The databases explored for this literature review include: PHAC Canadian Best Practices Portal (CBPP); CHNet-Works! Researchers-Practitioners Webinars; Health Evidence; and Turning Evidence Into Practice (TRIP). **Step 3** tracks the resource appraisals, while **Step 4** documents those that contribute to the project. **Step 5** tracks the evidence to support key messaging in the product. For the purposes of this literature review the tool was revised slightly. Refer to **Figure 1** for an illustration of the initial process.

Step 1	Step 2	Step 3	Step 4	Step 5
Define Need	Identify Sources	Appraise Sources	Document Contributors	Track Messaging

Figure 1: [Evidence Tool](#) created for internal Health Nexus Use

Consultation with a member of the 'Using Evidence Working Group' that created the evidence tool occurred. Through this engagement, steps of the tool were clarified. In addition, feedback was encouraged since this tool has not been utilized fully by all Health Nexus staff.

Evidence Tool Revisions:

During consultation, the working group contact advised that the tool could be revised and utilized based on the needs of the literature review. Through the process revisions were made for the purposes of this literature review. These revisions enabled better tracking and synthesis of the information gathered. Refer to **Figure 2** for the revised process for this literature review.

Step 1	Step 2	Step 3	Step 3A	Step 3B	Step 4
Define Need	Identify Sources	Appraise Sources ⁷	Synthesis of Findings	Identifying Categories	Document Contributors

Figure 2: Revised ['Using Evidence Tool'](#) steps created for this literature review.

⁷ Steps 3, 3a and 3b were completed simultaneously for each included article. Step 5: Tack Messaging was omitted due to the creation of steps 3a and 3b.

Methodology

Search Strategy and Results:

Section B - Criteria: Evidence	Questions to ask	Comments
Topic Relevancy	Is it relevant to stated topic and audience?	<i>Topic:</i> Health Equity and Organizational Capacity
		<i>Audience:</i> Health promoters, health promotion organizations
Focus/Type	What sources of evidence are needed? (e.g., practice, program, community based, research-based, best practice, guideline, evaluation)	Any
Date/Year	What are the time limits or date ranges? (e.g., 2010-2016)	2007-2017 (10 year period)
Geography/place	What geography is needed or preferred? (regional - municipality, county/region; provincial; Canada; North America; international or world-wide)	<i>Needed:</i> Canada <i>Preferred:</i> Ontario
Issue or Approach	What approach(es) are needed, if any? (e.g., community engagement, health equity, planning, policy, etc.)	Any
Language	What languages? (e.g., English, French, bilingual, multi-lingual)	English

Qualitative and Quantitative Literature Searches:

Quantitative	Population, Intervention or Exposure, Comparison, Outcomes (PICO)	Comments (if applicable)
Population	Describe the population that is relevant to the resource/service (e.g., age, SES, risk status, community type)	<i>Search 1: What strategies/approaches are used by organizations in Canada or Ontario to increase their health equity capacity?</i> Population: Health Promotion Organizations/Staff, NOT primary care
Intervention or Exposure	Describe the intervention or exposure.	Intervention: organizational strategies that increase health equity capacity
Comparison	Describe the comparison (if any).	Comparison: no intervention or other intervention types
Outcomes	Describe key outcomes.	Outcome: Staff and organizational health equity capacity will be increased
Key words for search	Identify the key words for the search.	health equity organizational capacity Canada OR Ontario

Qualitative		Comments (if applicable)
Population	Describe the population that is relevant to the resource/service (e.g., age, SES, risk status, community type)	Health Promotion Organizations/Staff NOT primary care
Situation	Describe the situation.	How do we measure and increase health equity organizational capacity?
Key words for search		health equity organizational capacity Canada OR Ontario

Inclusion and Exclusion Criteria:

Inclusion	Exclusion
I. Relevancy: Health equity specific to organizational capacity in Canada II. Currency: 2007-2017 III. Boolean Terms: Health equity, organizational capacity, Canada OR Ontario IV. Language of Publication: English V. Type: <i>Primary</i> literature (original research results in journals, conference proceedings), <i>Secondary</i> literature (systematic reviews, meta-analysis, practice guidelines)	I. Relevancy: <ul style="list-style-type: none"> Specific settings such as primary care, chronic disease prevention, global health, and mental health Outside of Canada II. Currency: Prior to 2007 III. Boolean Terms: business*, econ*, primary health care OR primary healthcare IV. Language of Publication: Anything other than English V. Type: Tertiary Literature (textbooks, encyclopaedias, newspapers) and videos

Database	Keywords	Hits
Web of Science	TITLE: (health equity) AND TITLE: (organizational capacity) AND TOPIC: (health equity) OR TOPIC: (organizational capacity) NOT TOPIC: (health care*) NOT TOPIC: (healthcare*) NOT TOPIC: (business*) NOT TOPIC: (econ*) NOT TOPIC: (primary healthcare*) NOT TOPIC: (primary health care*) NOT TOPIC: (primary care*) NOT TOPIC: (medic*) Refined by: COUNTRIES/TERRITORIES: (CANADA) AND LANGUAGES: (ENGLISH)	7
EBSCOHost	health equity AND organizational capacity AND CY canada OR CY ontario, canada NOT business* NOT econ*	1
Google Scholar	With all the words: health equity, organizational capacity, Canada With the exact phrase: health equity Without the words: business, bank, econ, primary care	141
Google	health equity, organizational capacity, Canada	757,000 (Went through the first 50 results)
Health Promotion Organizations	<ul style="list-style-type: none"> BC Centre for Disease Control (n = 31) National Collaborating Centre for Determinants of Health (n = 28) 	452

	<ul style="list-style-type: none"> • National Collaborating Centre for Methods and Tools⁸ (n = 198) • Peterborough County-City Health Unit⁹ (n = 5) • Public Health Ontario (n = 45) • Sudbury & District Health Unit (n = 4) • The Wellesley Institute (n = 141)¹⁰ <p>Search Terms: health equity, organizational capacity</p>	
Databases Provided by Evidence Tool	<ul style="list-style-type: none"> • PHAC Canadian Best Practices Portal (CBPP) (n=2) • CHNet-Works! Researchers-Practitioners Webinars (n = 35) • Health Evidence (n = 33) • Turning Evidence Into Practice (TRIP) (n =14) 	84

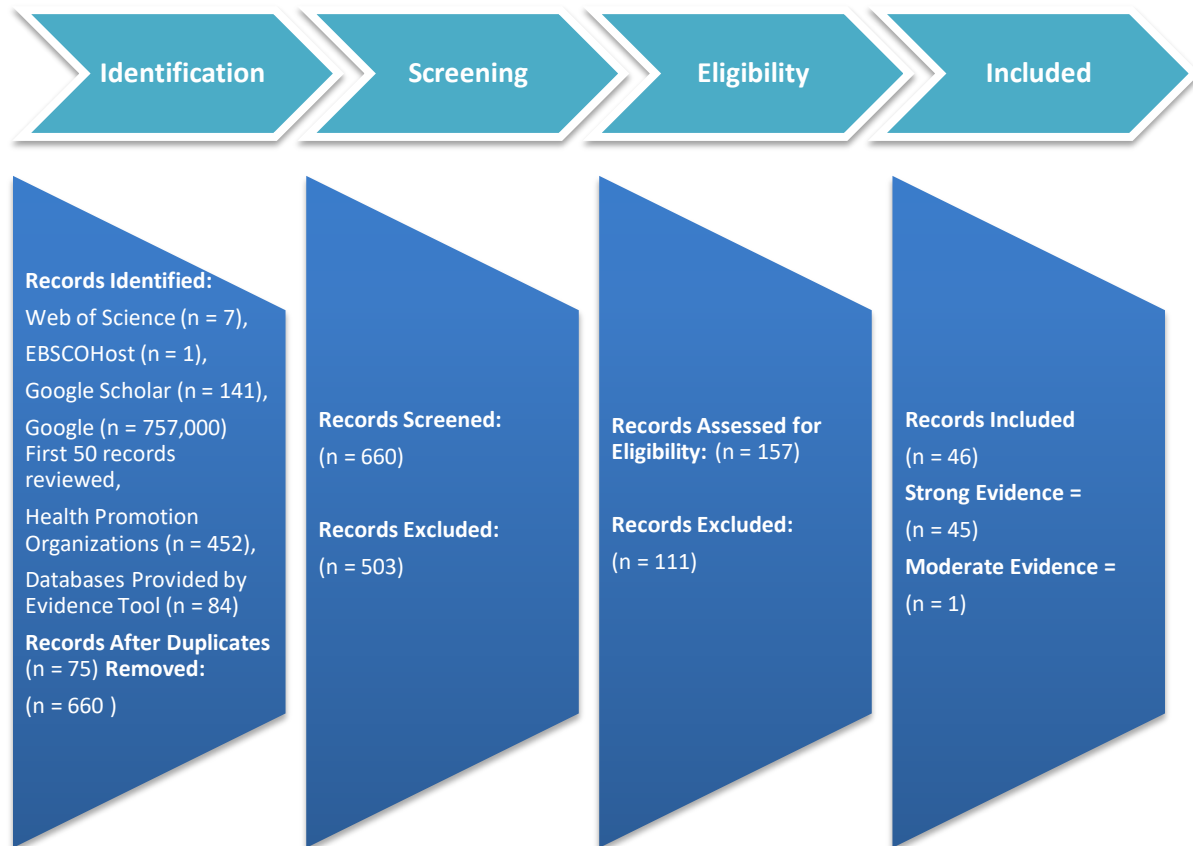
⁸ Filtered through Registry of Methods and Tools

⁹ Using 'health equity'

¹⁰ Filtered through 'health equity' publications

Appraisals of Eligible Articles

Structured Review Process (PRISMA)¹¹



¹¹ [The PRISMA Group 2009](#)

Summary of the Evidence

Themes	Articles
Establish Strong Leadership and Health Equity Champions (n = 24)	<ol style="list-style-type: none"> 1. BCCDC. Equity and EPH Handbook. 2. Rideout, Mah, & Cook (2016) 3. BCCDC (2016) Taking Action on Health Equity in Environmental Public Health: Five Strategies for Organizational Change 4. Cohen et al. (2013) 5. Betker et al. (2013) 6. Fish, Norris, & Braunstein Moody (2013) 7. Underwood, Harlos, & Vivian-Book (2013) 8. McPherson, Ndumbe-Eyoh, Betker, Oickle, & Peroff-Johnston (2016) 9. NCCDH (2014) Leadership for Health Equity: Working Intersectorally and Engaging the Community in Western Health 10. NCCDH (2015) Advancing Provincial and Territorial Public Health Capacity for Health Equity: Proceedings 11. NCCDH (2014) Boosting Momentum: Applying Knowledge to Advance Health Equity 12. NCCDH (2012) Bridging the Gap between Research and Practice: Making the Case for Health Equity Internally: Winnipeg's Experience 13. Betker & Ndumbe-Eyoh (2013) 14. NCCDH (2016) Common Agenda for Public Health Action on Health Equity 15. NCCDH (2015) Equity-Integrated Population Health Status Reporting: Action Framework 16. NCCDH (2011) Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice: Environmental Scan 2010 17. NCCDH (2015) Learning to Work Differently 18. NCCDH (2013) Let's Talk: Public Health Roles for Improving Health Equity 19. NCCDH (2015) The Path Taken: Developing Organizational Capacity for Improving Health Equity in Four Ontario Health Units 20. NCCDH (2013) What Contributes to Successful Public Health Leadership for Health Equity? An Appreciative Inquiry 21. Peterborough County-City Health Unit (2013) 22. PHAC (2014) 23. Wellesley Institute for Health Quality Ontario (2016) 24. Bowen, Botting, & Roy (2011)
Continuously Expand the Evidence Base to Support Best Practices, Support Knowledge Translation and Exchange Network (n = 15)	<ol style="list-style-type: none"> 1. NCCDH (2015) Advancing Provincial and Territorial Public Health Capacity for Health Equity: Proceedings 2. NCCDH (2012) Assessing the Impact and Effectiveness of Intersectoral Action on the Social Determinants of Health and Health Equity: An Expedited Systematic Review 3. NCCDH (2016) Common Agenda for Public Health Action on Health Equity 4. NCCDH (2013) Let's Talk: Public Health Roles for Improving Health Equity 5. NCCDH & CIHR (2012) 6. NCCDH (2015) The Path Taken: Developing Organizational Capacity for Improving Health Equity in Four Ontario Health Units 7. NCCDH (2011) Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice: Environmental Scan 2010 8. Davison & NCCDH (2013) 9. PHAC (2014) 10. BCCDC (2016) Taking Action on Health Equity in Environmental Public Health: Five Strategies for Organizational Change

	<ol style="list-style-type: none"> 11. McPherson, Ndumbe-Eyoh, Betker, Oickle, & Peroff-Johnston (2016) 12. Peterborough County-City Health Unit (2013) 13. Wellesley Institute for Health Quality Ontario (2016) 14. Cohen et al. (2013) 15. Simcoe Muskoka District Health Unit (2012)
Collaborate and Partner with Intersectoral Stakeholders and Communities (n = 14)	<ol style="list-style-type: none"> 1. BCCDC (2016) Taking Action on Health Equity in Environmental Public Health: Five Strategies for Organizational Change 2. Cohen et al. (2013) 3. McPherson, Ndumbe-Eyoh, Betker, Oickle, & Peroff-Johnston (2016) 4. NCCDH (2015) Advancing Provincial and Territorial Public Health Capacity for Health Equity: Proceedings 5. NCCDH (2011) Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice: Environmental Scan 2010 6. NCCDH & CIHR (2012) Researcher-Practitioner Health Equity Workshop: Bridging the Gap - Proceedings & Highlights 7. NCCDH (2014) Leadership for Health Equity: Working Intersectorally and Engaging the Community in Western Health 8. NCCDH (2012) Assessing the Impact and Effectiveness of Intersectoral Action on the Social Determinants of Health and Health Equity: An Expedited Systematic Review 9. NCCDH. Learning to Work Differently (2015) 10. Peterborough County-City Health Unit (2013) 11. Simcoe Muskoka District Health Unit (2012) 12. Gardner (2013) Acting on Social Determinants and Health Equity: Opportunities and Promising Practices for Public Health 13. Community Health Centres of Greater Toronto (2011) 14. Wellesley Institute for Health Quality Ontario (2016)
Increase Competencies (Public Health, Professional, Cultural, Linguistic) (n = 13)	<ol style="list-style-type: none"> 1. Betker et al. (2013) 2. Oickle & Fish (2016) 3. Underwood, Harlos, & Vivian-Book (2013) 4. McPherson, Ndumbe-Eyoh, Betker, Oickle, & Peroff-Johnston (2016) 5. NCCDH (2014) Boosting Momentum: Applying Knowledge to Advance Health Equity 6. Betker & Ndumbe-Eyoh (2013) 7. NCCDH (2012) Core Competencies for Public Health in Canada: An Assessment and Comparison of Determinants of Health Content 8. NCCDH (2015) Learning to Work Differently 9. NCCDH (2014) Public Health Speaks: The Power of People and Systems 10. NCCDH (2015) The Path Taken: Developing Organizational Capacity for Improving Health Equity in Four Ontario Health Units 11. Peterborough County-City Health Unit (2013) 12. Sudbury & District Health Unit (2011) 13. Wellesley Institute for Health Quality Ontario (2016)
Embed Equity into the Organization's Mandate, Policies, and Procedures (n = 11)	<ol style="list-style-type: none"> 1. BCCDC (2016) Taking Action on Equity Using Policy Levers in Environmental Public Health Practice 2. McPherson, Ndumbe-Eyoh, Betker, Oickle, & Peroff-Johnston (2016) 3. NCCDH (2015) The Path Taken: Developing Organizational Capacity for Improving Health Equity in Four Ontario Health Units 4. NCCDH (2013) Let's Talk: Public Health Roles for Improving Health Equity 5. NCCDH (2014) Public Health Speaks: The Power of People and Systems 6. OPHA (2016) 7. Ingrid, Amare, Hyndman, & Manson (2014)

	<ol style="list-style-type: none"> 8. Underwood, Harlos, & Vivian-Book (2013) 9. Betker & Ndumbe-Eyoh (2013) 10. Community Health Centres of Greater Toronto (2011) 11. Wellesley Institute for Health Quality Ontario (2016)
Utilize Performance Measurement, Evaluation, Health Equity Indicators and Establish Health Equity Targets (n = 9)	<ol style="list-style-type: none"> 1. BCCDC (2016) Taking Action on Health Equity in Environmental Public Health: Five Strategies for Organizational Change 2. Cohen et al. (2013) 3. NCCDH (2015) Advancing Provincial and Territorial Public Health Capacity for Health Equity: Proceedings 4. NCCDH (2015) The Path Taken: Developing Organizational Capacity for Improving Health Equity in Four Ontario Health Units 5. NCCDH (2013) Let's Talk: Public Health Roles for Improving Health Equity 6. PHO (2016) 7. Community Health Centres of Greater Toronto (2011) 8. Central East LHIN (2010) 9. Wellesley Institute for Health Quality Ontario (2016)
Create Supportive and Enabling Environment (n = 7)	<ol style="list-style-type: none"> 1. BCCDC (2016) Taking Action on Equity Using Policy Levers in Environmental Public Health Practice 2. Cohen et al. (2013) 3. McPherson, Ndumbe-Eyoh, Betker, Oickle, & Peroff-Johnston (2016) 4. NCCDH (2014) Leadership for Health Equity: Working Intersectorally and Engaging the Community in Western Health 5. NCCDH (2013) Public Health Speaks: Organizational Standards as a Promising Practice for Health Equity 6. NCCDH (2015) The Path Taken: Developing Organizational Capacity for Improving Health Equity in Four Ontario Health Units 7. PHAC (2014)