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Office régional de la santé de Winnipeg
À l'écoute de notre santé

Health Equity Recommendation Synthesis

Final Report

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Background

Health equity[1] has always been an underpinning of universal health care and a founding principle of public health services. However, an overt and deliberate region-wide focus on strategic health equity action in the Winnipeg Health Region (WHR) was not undertaken prior to the fall of 2008. At that time, the Winnipeg Regional Health Authority (WRHA) participated through its membership in the Urban Public Health Network (UPHN), along with the Canadian Institute of Health Information (CIHI), in the creation of a report *Reducing Gaps in Health: A focus on socio-economic status in urban Canada* that was released in November 2008.

The report found that the gaps in health status, as measured by selected hospitalization indicators analyzed by an established deprivation index, were larger in Winnipeg than the Canadian population overall; the gaps appeared wider and the gradient steeper than other Canadian cities. This stimulated two regional commitments: to strike a WRHA committee to explore strategic promotion of health equity action at the regional level and to increase WRHA participation in the newly formed Winnipeg Poverty Reduction Council (WPRC) charged with addressing root causes of inequity. In 2009, WRHA's support for, and participation in, the WPRC increased, and a new WRHA committee was struck with broad representation from programs and sites to explore a WHR disparity reduction strategy.

In April 2009, the first meeting of the then named "Disparity Reduction Accountability Committee" occurred and the committee was immediately renamed the "Promoting Health Equity Oversight Committee" (PHEOC) to reflect a strengths-based approach. Following several meetings and an exploration process determining next steps, a plan was put forward and supported by PHEOC to strike three working groups: a Planning Working Group to strategize inserting health equity consideration into all operational decision making such as planning, finance, logistics and human resources, a Partnership Working Group to identify and maximize partnerships external to the WRHA with key players addressing socioeconomic-related health and social issues, and a Directional Working Group to produce a report describing local health equity status and evidence informed recommendations for action. The latter Directional Working Group, was further divided into three active task teams: an Indicators Working Group, a Recommendation for Action Working Group and a Communications Working Group. Various members with relevant interest and expertise from outside and within the health region were invited to join the groups.

The Recommendations for Action Working Group (RAWG) members agreed that a search of existing health equity recommendations should be conducted prior to the development of local health equity recommendations. Initially, it was hoped that a review of the published literature would result in evidence-based best practice recommendations that could inform the development of local recommendations for Winnipeg. Published best practice intervention literature was inadequate to develop a comprehensive plan to address the broad range of modifiable social and economic factors leading to improved health equity outcomes. Rather, published literature focused on factors in relative isolation, or on health equity gaps, rather than in establishing the evidence for interrelated, multifaceted, complex strategic interventions. As such, the focus of the search turned instead to existing recommendations as it was noted that many extensive reviews on health equity action had been done. Largely grey literature reports from credible sources were selected with the pragmatic, unverified assumption made that they had used the best evidence and expert opinion available in developing their recommendations, recognizing that they had more resources available to gather and critically appraise current information than we would as a local health authority. Verification of the evidence supporting the recommendations was beyond the scope of our work.

[1] "Equity in health can be defined as the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantages/disadvantages—that is, different positions in a social hierarchy. " {Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health. 57(4),* 254-258.}

The plethora of recommendations available was overwhelming to a group such as ours trying to arrive at regional direction for local action expeditiously with minimal time and resources. Additionally, recommendations spanned many levels ranging from international to local and from broadly conceptual to very detailed giving an "apples and oranges" context to this review. Consequently, the objective of the RAWG transitioned to become the collection and synthesis of relevant existing health equity recommendations and then organize the findings into directional themes that could assist in developing the Winnipeg Health Region's strategy to improve health equity. A systemized approach was developed and it's findings are being shared should they be of assistance to groups in a similar stage of health equity planning.

This report presents the findings from a review of health equity promotion recommendations and the subsequent synthesis. The major groupings that arose from the theming and categorization process are outlined. Recommendations are grouped into the areas of 'principles' and 'strategies' as well as 'areas for action' that would promote health equity. High level themes and subthemes are presented, along with counts of how frequently the themes /subthemes appeared. It is anticipated that users of this report would need to undertake a prioritization process to determine what areas of action are most applicable in their local situation, taking a close look at concept details within the theme and subtheme areas to develop specific local action plans based on collaboration.

A conceptual framework was developed that summarizes and builds on the recommendation synthesis. The conceptual framework visually depicts the themes that arose from this work. It represents the common essential elements from the health equity recommendations synthesis that should be addressed in health equity planning. They are assumed to form the basis of interrelated activities that together have the potential to increase population health equity.

In addition, the recommendation synthesis produced summary information based on the categories and themes that were identified in this work. This summary information was compiled into individual sets that can be used as tools to assist health equity planning. For the purpose of this stage of the WHR's health equity planning, the summary tools were limited to the "areas for action" components. These summary tools are provided as appendices. Research on these individual elements and their interactions will be helpful to understanding the complex relationships and integrated approaches required to influence health equity.

Methods & Synthesis Process

Literature Search and Document Selection

A "grey literature" internet search was conducted, followed by a manual reference search for English documents containing either specific recommendations or plans to promote health equity. The documents reviewed were chosen because they contained specific recommendations and/or specific plans that would promote health equity, as well as being relevant in Winnipeg's regional context. The search revealed specific recommendations to promote health equity in Canada, nationally, provincially or in major cities; as well as selected major international documents generated by the World Health Organization, and English speaking countries such as the United Kingdom, and the United States. All of the Canadian content was selected for synthesis as well as major international documents including original and companion work done by the World Health Organization. A key assumption of this work was that the recommendations extracted from the reports were based on some level of evidence. No attempt to validate the evidence behind the reports or to seek primary evidence for the recommendations was made since the resources required to undertake that level of work was out of the scope of this project. It was therefore assumed that themes that appeared consistently in many different reports may represent consensus on the best evidence currently available. This is therefore a synthesis of health equity recommendations currently proposed and assumed to be informed by some level of evidence, and not a critical review of the evidence for health equity interventions.

Recommendation Identification and Extraction

Selected documents were reviewed to identify potential recommendations. Recommendations were selected for extraction if the document:

- clearly labeled the segment as recommendations; or
- language implied that a focused action or strategy was helpful to promote health equity; or
- language was structured to describe intentions to act in a way that would improve health equity.

When one or more of the above mentioned criteria was met, the segment of text was marked for extraction and added to a master recommendation list. When potential recommendations were unclear as to whether they should be included or excluded, the item was discussed between the two coders and consensus reached. A total of 1249 extracted recommendations were considered. Recommendations and sub-recommendations were sometimes considered as one recommendation, and sometimes they were split apart and considered as multiple recommendations. Recommendations duplicated verbatim across more than one report were not coded.

Coding

Once the extraction of recommendations was complete they were entered into a spreadsheet and codes were generated against them. Individual recommendations or segments of recommendations were captured and coded. Each relevant concept represented by a unique word or phrase was extracted and a code was developed. The code concepts were derived from the recommendations and generated by the reviewers. For example, the following recommendation text

> *"raise housing quality standards and improve local environments and quality of life"* was coded as:
>
> housing - quality
> role - improve housing standards
> outcome - quality local environments
> outcome - quality of life
> settings - local environment

Note that recommendations generally had many codes assigned. Each quotation was coded by a primary and secondary coder to ensure coder reliability. Instances of coder disagreement resulted in a discussion until agreement between coders was achieved. As new recommendations were coded, an effort was made to reuse or modify existing codes to avoid unnecessary duplication of identical concepts. New codes were developed as needed when new content was encountered throughout the coding process. Throughout, codes were entered into a data management program (ATLAS ti, v5.2) creating a master list of recommendations as a source for coding subsequent recommendations.

Recommendation Sorting and Categorizing

When recommendations were coded, an alphabetized master code list was created. The master code list was reviewed manually and used to identify major themes and categories of themes (e.g., principles, strategies, areas for action, etc.). Once the themes and subthemes were identified, the two coders hierarchically linked the individual codes to their respective theme and subtheme groups using the ATLAS program. Once each of the codes were linked to their respective theme and subtheme, the coders then organized the themes into major categories and

created summaries of codes representing each of the major themes and subthemes. The following section describes the outcome of the coding and theming process.

Recommendation Synthesis Outcomes

Summary of Health Equity Theming

The 32 documents reviewed resulted in 1249 extracted recommendations (see Appendix A for a list of documents reviewed and included in the recommendation synthesis). Of the 1249 recommendations, 2650 codes were generated and applied using data management software. Essentially, recommendations were broken down into the smallest units of concept and labeled with a code, and then reconstituted back into common themes. Most recommendations were complex and required several unique codes to appropriately capture the recommendations' intent. There were 83 themes or subthemes created to represent all of the codes assigned to the health equity recommendations[2]. Once the 83 themes and subthemes were identified, they were then logically grouped into greater categories (i.e., principles, strategies, areas for action, health equity, and human rights). The subsequent tables shown in this report display the themes by category (i.e., principles, strategies, and areas for action). Some major code themes also have sub-groups representing an additional level of analysis.

Framework for Understanding and Addressing Health Equity

The framework for understanding and addressing, health equity was conceptualized following the initial coding of all recommendations and arose directly from the recommendation synthesis. Major code themes were organized into a multi-layered representation of what could be described as essential elements necessary for achieving health equity. The themes are organized into the following categories: principles, strategies, and areas for action for improving health equity (see Figure 1).

Principles of health equity make up the first/outer essential layer of the conceptual framework. *Principles* represent a basic set of intentions that may facilitate the development of planning and creating recommendations leading to health equity.

The second essential layer represents **strategies.** The three strategies include knowledge, governance, and participation. *Knowledge* represents the need for information (e.g., knowledge, indicators/data) and tools (e.g., health equity assessment, surveillance tools) that are necessary for making informed decisions on action leading to improving health equity. *Governance* represents the authority and power necessary for moving health equity agendas forward. *Participation* represents the relationship and participatory partnership processes that are necessary for achieving effective and lasting results in health equity action.

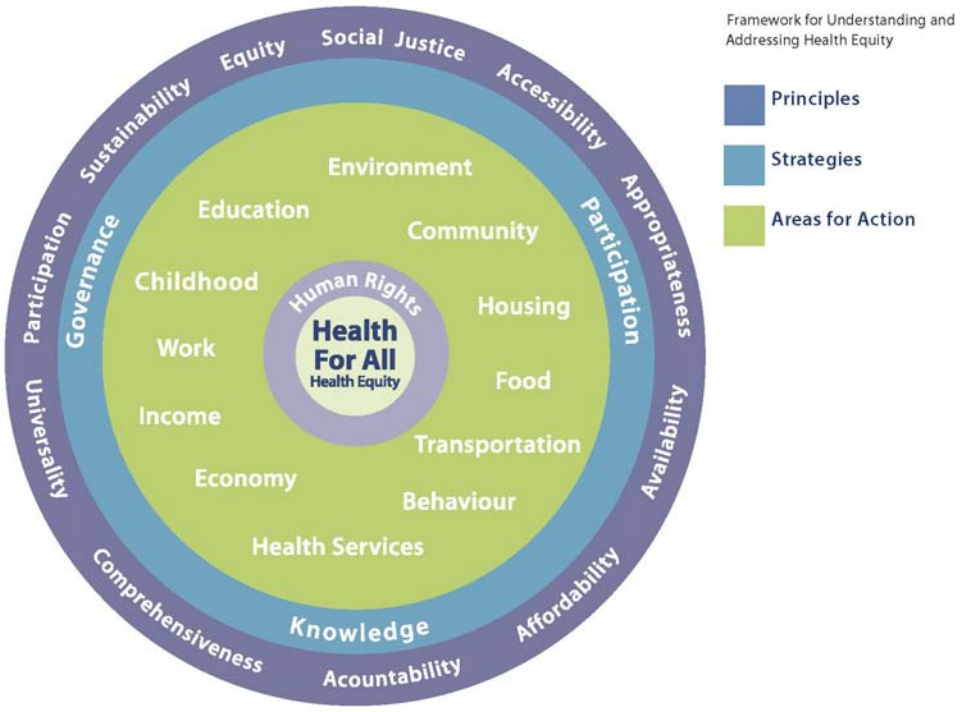
The third essential layer represents the various **areas of action** for improving health equity. Each of the respective factors plays an important role in improving health equity, but it is the combined effect of addressing all the inter-related factors that will likely have the greatest impact on improving health equity.

In the last two inner circles are **human rights** and **health equity**. Health, and access to most of the *factors* identified, are internationally recognized *human rights*. Health equity is the ultimate

[2] Codes representing "groups" and "roles" were captured but not included in the present analysis.

goal of strategically using *principles* and *strategies*, and acting on *factors* to lead to improved and optimum "Health for All".

Figure 1. Framework for Understanding and Addressing Health Equity



Summary of Recommendation Synthesis Themes

The following section provides a detailed summary of the recommendation synthesis analysis. The process of developing, assigning, and grouping codes into themes and/or subthemes was done with the assistance of a computerized data management program (ATLAS v5.2). Using an electronic program for the coding and theming process also provided an opportunity for tracking and counting the number of codes used to represent the original recommendations. In addition, the program also allows the user to develop a query report that will display each of the original source recommendations used to represent any individual theme or subtheme. This process of reporting original source recommendations used to develop a theme or subtheme was an important tool in the overall discussion for developing regional health equity recommendations. Quantifying, or counting the number of original source recommendations that represent any particular theme or subtheme was not a primary objective of this synthesis. However, it was determined by the RAWG group that adding quantifiers such as the number of codes associated with each theme/subtheme, as well as the number of original source recommendations associated with each theme/subtheme would add a level of contextual understanding to how each theme/subtheme was represented in the development of the framework. A complete definition for each of the themes outlined in the table below can be seen in appendix B.

Each major theme within the larger categories (i.e., principles, strategies or areas for action) has two associated counts in the side columns. The **first column** represents the total number of individual codes associated with it. The **second column** represents the total number of original source recommendations that have been linked to each of the themes/subthemes (see Table 1 for the frequencies associate with each of the themes or subthemes). Frequencies should be considered only in the most general manner as an indicator of importance of each theme or subtheme because:

- duplicate recommendations were not coded,
- some recommendations were split into sub-recommendations while others were not, and
- some reports identified very broad recommendations while others had a great number of detailed recommendations focused on specific themes.

Table1: Frequencies for Associated Themes and/or Subthemes

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
Areas of Action for Health Equity		
1. Economy	38	40
2. Income	100	82
3. Work	109	66
4. Childhood	115	103
5. Education	121	74
6. Environment	133	83
7. Community	100	156
8. Housing	80	49
9. Transportation	10	13
10. Food	51	36
11. Behaviours	73	56
12. Health Services	317	233
Strategies to Promote Health Equity		
13. Knowledge	205	173
14. Governance	282	294
15. Participation	117	165
Principles of Health Equity		
16. Accessibility	15	68
17. Accountability	16	31
18. Affordability	4	26
19. Appropriateness	52	66
20. Availability	4	11
21. Comprehensiveness	26	44
22. Equity	39	52
23. Participation	18	35
24. Social Justice	7	7
25. Sustainability	10	43

26. Universality	5	10

In addition to the frequency details that contributed to the development of each subtheme, table 2 provides yet another level of analysis describing the specific content that is associated with each theme/subtheme. The summarized content was extracted from the original source recommendations for each of the framework's twelve 'Areas for Action'. In addition, a packaged set of summarized information for each of the 'Areas for Action' is available in the appendices. Each summary set contains: a definition; summary of content; list of original source recommendations; and references to the source documents. Table 3 provides a list of appendices for each of the 'Areas for Action'.

The scope of this project included a general synthesis and analysis of heath equity recommendations to develop a health equity framework, as well as develop a tool for assisting local health equity planning around the 'Areas for Action'. Although included in the general synthesis analysis, further detailed analysis and summary information for the 'Strategies' and 'Principles' components of the framework were deemed out of scope for this phase of the health region's planning.

Table 2: Summarized Content of Original Recommendations for Areas for A

Themes and Sub-Themes
1. Economy
1.1. Economic policy (international, national, regional, local) • Development • Business • Industrial • Procurement • Taxation • Borrowing • Investments (e.g., cap annual growth of health care treatment sector at 5%) • Mitigate the negative impact of business interests on health • Adequate economic base • Economic productivity • Economic security • Workforce planning (skills development, education) • Global trade regulation
1.2. Local economic vibrancy • Local procurement • Sign preferred supplier contracts • Local recruitment • Local employment • Local regeneration • Regeneration of deprived communities
1.3. Improving the economic condition of Aboriginal people and communities

- Business creation
- Address structural impediments (e.g., Indian Act), break the cycle of disadvantage

1.4. Rural economies

- Landlessness
- Viable livelihoods

1.5. Resource management and public reporting of human activities

- Supply of renewable energy
- Electricity
- Mineral supplies, fish stock and other natural resources

2. Income

2.1 Governance

- **Transfer payments**

- **Policy affecting income:** Saving incentives; pathway for moving upwards; reduce rate of households < LICO in five years; fuel; employment; after tax and benefit income sufficient for healthy living; female employment and economic participation; female employment equity; pay equity; Aboriginal income equal to general population; "poverty reduction strategy"

- **Equitable distribution of taxes:** Tax evasion; tax havens; tax credits; progressive taxation of income; taxation of inherited wealth; increase lower limit tax exemption for low income earners and remove lower limit tax exemption for high income earners

- **Employment income:** Special efforts are made to secure jobs with adequate pay for those in the weakest position in the labour market; earned income benefit (payments designed to help low and modest income working families)

- **Minimum wage:** Laws; increase; reflects a living wage; index to the cost of living; raise income of low income people

- **Income and children:** Tax provisions for families with children; reduce rate of children < LICO in five years

- **Social assistance:** Raise rates to LICO then index to inflation; enhanced benefits; income supplements; work earning supplements; remove work earning 'clawbacks'; revise income thresholds and benefits reductions; voluntary withdrawal from social assistance; greater availability of funds to low income families as their work incomes rise

- **Income assistance for those unable to work:** Employment insurance; benefits for the elderly; income support programs; no buffer when moving from benefit to and from work; consolidate income assistance and disability providers into one resource; equalize or make rates equitable between income assistance and disability provider; extend income assistance to after employment found; allowances

- **Benefits:** Disability; parental leave; sick benefits; injury; incapacity to work; unemployment; increasing uptake of benefits

- **Resettled refugees and refugees:** Abolish travel loan repayment; timeliness of Interim Federal Health Program payments

- **Pension:** Earnings-related pension

2.2 Income Adequate for Healthy Living

- **Guaranteed minimum income sufficient for healthy living:** Standards for minimum income for healthy living; sufficient for healthy development; adequate income for life transitions; income associated with improvements in health and life expectancy

- **Eliminate poverty:** Eliminating child poverty; break the cycle of disadvantage; people on social assistance; rural poverty; land tenure; educate about costs of not addressing it; fuel poverty

2.3 Financial management

3. Work

3.1. Employment, Unemployment, and Underemployment

3.1.1. Legislation to support full, fair, and decent employment:

- Reduce long-term employment across the social gradient
- Planning employment for deprived communities
- Full time service jobs
- Year-round employment
- Create vision for healthy and productive work

3.1.2. Creating a sustainable workforce

- Earned income benefit (payments designed to help low and modest income working families)
- Worker health for healthy workforce
- Hiring practices
- Job retention
- Move funding from job search initiatives with limited success to skills enhancement

3.1.3. Training

- Employment training
- Specialty training services for refugees
- Job coaching
- Job placement
- Work-based learning including apprenticeships
- Job supports

3.1.4. Labour market

- Reduce unemployment
- Reduce underemployment
- Employment opportunities

- Timely interventions to reduce long-term unemployment
- Employment rate
- Return to employment
- Employment programs (e.g., work clothing)
- Preserve and create jobs
- Sustainable work
- Voluntary work

3.2. Conditions and Equity

3.2.1. Recognize housework, care work and volunteerism

3.2.2. Conditions

- Employment benefits
- Collective bargaining
- Increase unionization
- Work related counseling
- Healthy living wage
- Employment equality and equal opportunity
- Fair employment
- Fair pay

3.2.3. Flexibility

- Flexibility of retirement age
- Suitable for lone parents, careers and people with mental and physical health problems
- Combining work and care-giving responsibilities of women
- Conflict with family obligations
- Parental leave for sick children

3.2.4. Security

- Work insecurity (informal, temporary, seasonal)
- Formal and informal workers
- Obtain and keep work

3.2.5. Quality

- Psychosocial conditions
- Stress
- Working conditions
- Healthy workplace
- Balance power between employer and employee
- Employee influence on how work is to be performed
- Workplace as a setting for promoting well-being and physical and mental health
- Culturally safe work environments
- Control over work demands
- Disruptive shift changes
- Extended work hours

3.2.6. Safety

- Workplace safety
- Exposure to material hazards
- Exposure to conditions and health damaging behaviours
- Physical hazards
- Prevention of workplace injuries and stress
- Work environment
- Occupational health and safety protection
- Occupational health services that include early warning systems for health hazards at work (including psychosocial)

4. Childhood

4.1. Identification, Prevention and Referral, and Support

- Vision, hearing, speech, dental screening
- FASD diagnosis, developmental delays, behaviour issues, disability, high risk mothers and families, pre/post natal care, family violence, abuse and family distress
- High risk mothers and families
- Immunization, and car safety
- Outreach and progressive support for Early Childhood Development (ECD) across the social gradient
- Easy access to services for children and families (e.g., health, welfare, and social services)
- Comprehensive Developmental Approach
- Language, literacy, physical social, emotional, and cognitive
- Exposure to inappropriate models in the media including violence

4.2. Mothers, Family, and Caregivers: Identification, Prevention and Referral, and Support

- Poverty, food security, pregnant women
- Mother/baby nutrition supplements and programs
- Child benefits and insurance for parental leave
- Income support for low income families
- Teen pregnancy prevention (e.g., sex education and counseling, birth control)
- Pre-natal and post-natal support (breastfeeding, depression, smoking cessation)
- Support for families, parents, and caregivers (e.g., clothing, toy lending, playgrounds, respite child care, and 'family friendly policies'

4.3. Child Care

- Day care, early care and nursery care, affordable care,
- Financial subsidies
- Standards, systems and programs

5. Education

5.1. Addressing Barriers and Facilitators

5.1.1. Adequate financing

- Financial barriers;
- Financing reform;
- Materials;
- Support students in one year programs;
- Finance training for unemployed; waive low income student university tuition;
- Cap university tuition;
- Increase provincial funding for university tuition;
- Loan reduction program

5.1.2. Best practices

- Well-developed curricula;
- Sustainable education;
- Academic support;
- Programs that raise education levels;
- Differing learning abilities and strengths;
- Educational opportunities;
- Literacy skills;
- Ensure cultural competence is embedded in education and training;
- ESL classes for differing learning abilities;
- ESL classes for illiterate persons;
- Incorporating factors leading to success in school (i.e., leadership, school climate, staff, funding & resources, community, programs)

5.1.3. Lifelong learning

- Education and training opportunities;
- Young people not in education, employment or training;
- Increase age that youth can legally stop attending school to 18 unless high school graduation has occurred

5.1.4. Extended schools

- Provide health and social services in schools;
- Use tools including websites, resources and directory of relevant community organizations;
- Schools open on evenings and weekends to provide recreation;
- Healthy schools program;
- Develop school-based workforce to work across school-home boundaries;
- Develop school-based workforce to address social and emotional development, Physical and mental health and well-being;
- Nutrition programs

5.1.5. Social inequalities

- Social inequalities in pupil's educational outcomes is a sustained priority;
- Addressing racism;
- Reduce differences;
- Return to education;
- Aboriginal education to the level of the general population;
- Improve education opportunities for Aboriginal people;
- Equalized access to quality education k-12;
- Closing gaps in education and skills in females

5.1.6. Education goals:

- Enrolment; retention; attendance; attainment; graduation; qualifications and skills;
- Aboriginal;
- Low income children

5.2. Early Childhood Education

- ECD interventions for low income youth;
- Preschool program;
- Daycares;
- Pre-primary school;
- Support transition to school;
- Readiness for school

5.3. Formal Education

5.3.1. Primary and Secondary

- Literacy; physical literacy;
- 'Full service' extended approach;
- Kindergarten program;
- Equalized access to quality education in K-12;
- 'Whole child' approach to education by supporting families and communities;
- Community role; Community schools; Active Transport (cycling, walking) routes;
- Additional resources for serving disadvantaged children;
- On alcohol, on drugs, on relationship, on sex;
- Life skills, personal, social, and health education;
- Gains in student knowledge, attitudes, self-esteem and health behaviour;
- Health promoting;
- Health programs

5.3.2. Post-secondary

- Qualified persons attend college;
- More low-income students attend university;
- Aboriginal people's university;
- Vocational

5.3.3. Professional

- Train planners, engineers, architects and other professionals about the health equity impacts of design and urban planning;
- Standard and compulsory SDH into medical and health training;
- Train 10,000 Aboriginal health professionals over a 10-year period

5.4. Adult Education

- Literacy;
- Skill development, skills training, and skills upgrading;
- Applied learning;
- Non-vocational learning;
- Long-term unemployed

6. Environment

6.1. Physical and Social Infrastructure Development, Maintenance, and Improvement

6.1.1. Planning

- Healthy cities, physical/social
- Rural/urban/isolated/informal
- Zoning/land use, design, improvement
- **Considerations for planning:** migration trends; building for social interaction; for neighbourhood livability; eco-friendly (e.g., energy efficiency, minimize resource use); health focused; for safety; proactive; 'smart growth' & 'new urbanism'; inclusionary/avoiding segregation; mixed land use and proximities (e.g., home to work); anticipate economic, demographic and technological change; coordinate infrastructure and services; lighting; outdoor landscaping and parks; aesthetics; financing

6.1.2. Services

- Water management (e.g., monitoring standards training and certification, potable, quality, fluoridation)
- Sewage management (e.g., drains for waste water),
- Waste management

- Clean pleasant surroundings (e.g., street cleaning)
- Control vector-borne diseases

6.1.3. Built Environment

- Transportation (aesthetics, safety/injury, traffic patterns, paved, multiple forms, options for commute), alternatives to automobile, active, pedestrian (sidewalks, crosswalks), connectivity of streets to enable walking between locations, cycle, public transportation
- Housing, housing the poor, home ownership and rental options including location options, approval process speed for affordable housing
- Slum/informal settlement (upgrading, recognizing legal status, prevent formation)
- Forest areas
- Retail , buildings
- Green spaces, leisure/recreational facilities, park, playground, children's centres
- Water and waste systems
- Health and social services
- Alcohol and tobacco: retail outlets (hours of operation, location, concentration), advertising, ban smoking in public areas, second hand smoke

6.2. Degradation

- Climate, air, soil, water
- Prevention, restoration, mitigation, adaptation
- Pollution and quality (e.g., noise, lead, commercial activity related [petroleum and extractive industries])
- Environment (ecology, climate change, risk)
- Compensation to Aboriginal people

7. Community

7.1. Healthy Communities

7.1.1. Planning

7.1.2. Built environment

- Public spaces that engage people and participation, neighbourhood / local
- Regeneration initiatives
- Recreation / arts and sport facilities, health and fitness, correctional facilities

7.1.3. Social environment

- Social and health services, integrated neighbourhood teams, mental wellness, spiritual wellness, local services and delivery, supporting families, peer support

7.1.4. Priority groups for social inclusion

- Aboriginal (restore Aboriginal culture, language, support networks, decolonization, justice, control, reunite with land)
- Disabled persons and their caregivers (disability supports)
- Mentally ill (stigma)
- Elderly
- Corrections population (transition planning, bridging to release, correctional facility participation in accreditation)
- Immigrants

7.1.5. Rural to urban migration supports (Aboriginal), rural displacement

7.1.6. Community capacity / capital, empowerment / control / self-determination, local norms

7.1.7. Inclusion / cohesion, exclusion / isolation, social development, interaction, networks, dispute resolution, anti-discrimination, resolving intercultural differences, culture

7.2. Safety and Security

- Violence and crime
- Integrated prevention planning
- Prevention / treatment / harm reduction / enforcement
- Recidivism
- Domestic violence (proactive community organization response, support for male perpetrators)
- Neighbourhood watch
- Escort vulnerable people
- Recreation services available evenings and weekends
- Tobacco smuggling

8. Housing

8.1. Housing Characteristics

8.1.1. Problems to address

- Humid / damp; mould; cold; cramped / privacy; poor or no insulation; indoor air quality; home maintenance

8.1.2. Planning

- Density of development
- Supply of affordable housing and choice of affordable housing options (including new)
- Emergency shelters (e.g., homeless)
- Temporary housing; multi-occupant; social housing (consider stigma)
- Eco-friendly neighbourhood and housing design; clean energy alternatives; energy conservation and efficiency; sustainable
- On-reserve
- Local needs
- Supported (e.g., cooperatives or independent apartments with off-site staff or case management; group homes often with on-site staff)

8.2. Housing Governance

8.2.1. Finance

- Micro-financing for housing
- Restore federal housing to funding to levels <1986
- Add 1% of federal spending for affordable housing
- Five year tax abatement for affordable housing projects
- Increase monthly shelter allowance to current rates including utility costs
- Set aside 10% of undeveloped land for affordable housing
- Land trust of surplus land for affordable housing
- National housing standards
- Mechanisms to set rates

8.2.2. Policy considerations

- Housing stability

- Rent to own
- Purchase and renovate abandoned or neglected multi-family buildings
- Convert low income rentals to home ownership opportunities
- Address affordable housing wait lists; mixed housing; transitional
- **Youth homelessness prevention:** Convert and target housing units to supportive housing for at risk and homeless youth
- Set decent housing standards targets
- Transfer title to non-profit housing agencies with goal of transferring title to home owners
- Sweat equity to improve housing; housing repair scheme; housing safety scheme
- Address wait period for "Rental Assistance" (BC)
- Transition period out of "Welcome House" (BC)
- Keep shelter allowances current with inflation
- Construction standards

8.2.3. Safety standards

- Fire safety
- Minimized health risks
- Implement housing health and safety ratings

9. Transportation

- Planning for social inclusion (transportation planning to access key services using affordable public transportation
- Land use planning that promotes mixed use neighbourhoods without reliance on vehicles
- Local participation in planning)
- Policy (e.g., number of strollers allowed on buses)
- Strategy
- Walking and cycling facilities
- Investment
- Mitigate climate change effects of transportation and adapt to climate change in ways that promote equity
- Disability gas tax rebate

10. Food

10.1. Food Production and Distribution

- Agriculture sector, food system, food distribution
- Local control: governance of the local activities of multinational supermarkets and food suppliers, food distribution hubs, food markets, vendors, support for cooperative ventures among small traders
- Economic, environmental, development and food crises

10.2. Food Security and Safety

- **Affordability:** hunger; determine income assistance based on actual cost of food; child food security; routine availability of food in all schools (e.g., 'Food in Schools'); stronger local economies and greater control over the price of food
- **Food self-sufficiency and sustainability:** urban agriculture program; optimal conditions for food security in rich and poor countries; food security initiatives; access to food
- Food deserts
- **Food safety:** protocols appropriate for local conditions

10.3. Food Quality and Fortification

- Nutritional quality of processed food; ban all trans fats; ban sale of soft drinks and junk food in schools
- Promote fortification (e.g., folic acid); reduce salt content requirements; stronger labeling

requirements on all packaged foods; regulation of breast-milk substitutes; regulation of high fat and sugar processed foods
- Food contaminants
- **Incentives:** modify lunch programs to improve nutrition; green markets and grocery stores that sell fresh produce; subsidize nutritional foods; zoning and neighbourhood design to discourage junk food and support grocery stores, farmers markets and restaurants; availability of fruits and vegetables in schools (e.g., 'National Fruit Scheme', '5 a DAY')
- **Disincentives:** increase taxes on junk food; restrict advertisement of junk food

11. Behaviours

11.1. Healthy Living
- Diet
- Hygiene, oral, dental
- Rest, stress management, work-life balance
- Injury prevention (intentional and unintentional)
- Sexual expression
- Relationships
- Providing care for others
- Use of primary care, hypertension, preventive health service use, use of allied health services
- Environmental stewardship
- Safe exposure to harmful environmental risks
- Lifelong learning, develop skill

11.2. Active Living
- **Active transportation:** adverse effects of "car society"; cycling and walking; walking buses
- **Physical activity promotion**: cycle training; exercise; play; "Sport in School"

11.3. Substance Use
- Prevention, harm reduction, treatment and enforcement
- Redirect taxes and increase price of alcohol, cigarettes and junk food to public health programs
- Health hazards from commercial activities – alcohol and tobacco
- Tobacco cessation and reduction, tobacco sales to minors, tobacco smuggling, tobacco control programs, education,
- **Alcohol misuse and reduction:** alcohol consumption among high-risk groups; negative health impact of alcohol misuse; social exclusion that triggers problem drinking
- Avoidance of harmful substances and addictions
- Coordinated response to health and social problems faced by injection drug users

12. Health Services

12.1. Finance Strategies
- **Fund**: health promotion, illness prevention, based on need, refugee care, interpretation for medical care, patient transportation
- Avoid per capita funding
- **Redirect funding**: taxes from alcohol, cigarettes and junk food to public health programs
- **Funding health care options:** special 'health' tax on financial speculation, medicare, community initiatives, subsidize high risk individuals, preventing impoverishment when seeking medical treatment
- **Health resources distributed proportionate to need (geographically):** human resources, areas with high health needs have adequate capacity for delivering quality care, avoid gaps and duplication of services

12.2. Comprehensive Programs and Services

- Community information and referral systems
- Shared electronic health records
- **Population focused:** community-based primary care; access 24/7 to follow-up care; home care; dental; support to help young people with mental health needs; integrated mental health and addictions services (e.g., smoking cessation); medical drug treatment; arthritis care; sexual and reproductive; counseling (e.g., coping skills interventions, trauma, social and emotional support); pharmacare; disability services
- **Comprehensive holistic care:** programs of outreach (range of outreach services); holistic approach to health (includes spiritual, physical, mental, emotional, cultural economic, social and environmental); self-management services; patient navigation; integration of alternate therapies; shared guideline for practice; continuum of care (e.g., prevention; health protection; health promotion [e.g., referral schemes for exercise]; curative; rehabilitative)
- Health services are delivered in locations where people congregate (e.g., community centres, outreach organizations, community and social organizations); school nurses; correctional system's health
- Community development; engagement in development, implementation and evaluation of services
- **Culturally and linguistically appropriate**: standards for culturally competent policies, programs and services; culturally proficient systems; cultural competency training; culture integrated into health services; specialty clinics that offer multi-disciplinary services including mental health programs, trauma counselling and social support services of underserved or inappropriately served groups; Aboriginal patient liaison workers or navigators; cultural brokers, interpretation services, language capacity within services, bridge between western and traditional healing practices
- **Refugee health:** specialty clinics for refugees who require enhanced medical support; comprehensive health services for refugees and refugees resettled as permanent residents (Interim Health Program)

12.3. Public Health Promotion and Prevention

- **Guidelines:** for public health practice; for public on use of public health and primary care system for primary and secondary prevention
- Health literacy so clients can better access, understand, communicate, evaluate and act on health
- Communicable disease control and prevention; HIV increase uptake of HAART
- **Continuum of Care - Policy and Strategy (including programs of outreach):**
  1. **Social determinants of health:** early detection of the determinants; determinants underlying HIV, mental illness and other diseases; determinants to maintain health; determinants supporting physical and social well-being; teenage pregnancy
  2. **Primary prevention:** chronic disease (e.g., diabetes); immunization; 'brushing for life'; smoking; increase awareness of arthritis, osteoporosis, exercise, weight control and injury prevention; to address vulnerabilities that can lead to criminal activity
  3. **Early detection:** screening (e.g., Pap and mammography); mental health triage; suicide; Aboriginal equity; adverse outcomes of pregnancy and infancy; smoking cessation
  4. **Early intervention:** mental health early intervention for first episode of psychosis; chronic disease self-management
  5. **Early treatment:** mental health intensive support in first three years after first episode of psychosis; chronic disease management (e.g., diabetes); medically treatable diseases; expert patient program (e.g., self-management for long-term conditions)
- Public health workforce (e.g., inspectors, nurses, medical officers of health (MOH), home visitors, dietitians)
- Enhance public health system capacity

12.4. Health Sector Workforce and Partners

- **Healthcare organizations**: colleges; unions; community organizations; health authorities; departments; nursing homes; partners and external stakeholders
- **Professional competence and capacity**: health professional education; participation in health service design and delivery; about health literacy; to communicate effectively with clients; health literacy is embedded in education of future health professionals
- **System competence and capacity:** to prevent a decline in health due to unemployment; relationships between health and refugee and asylum seeker serving organizations; build Aboriginal leadership at the community level; sufficient skilled staff to tackle health inequities to meet strategic objectives; policies and procedures about sharing personal health information; cultural competency infrastructure; comprehensive primary care and public health services, coordinated with allied health, social and other programs and services including primary care networks
- **Levels of responsibility:** Boards; executive; decision makers; front line staff; clinical workers; community development teams
- **Workforce:** representative workforce (i.e., staffing reflects the diversity of the communities served); recruitment; planning; balance rural urban health-worker density; position description
- **Professional staff**: dentists, clinical epidemiologists; general practitioners; pharmacists; health literacy coordinators; patient navigators; primary care; specialists
- International cooperation

12.5. Addressing Barriers and Opportunities

- **Opportunities:** health services community based and community controlled; national health goals, transferring technology for pharmaceutical production to developing countries; primary care services under Aboriginal control; resources proportionate to size and need of ill population; integrated health and social services; continuity of care; equity as a priority in design and delivery of public health services and programs; staff capacity and skills to improve health equity; democratize health systems; location of health facilities (e.g., pharmacies); regulation of the private medical sector; prescribe and promote exercise; collaborative health networks focused on improving care for specific populations with complex chronic health conditions (e.g., refugees, persons involved in corrections); relationship between corrections and health authorities
- **Barriers:** financial (e.g., medication, transportation to health facilities); service inequities; jurisdictional; medication affordability; costly and ineffective screening, diagnostics and treatments
- **Problems:** inappropriate medication prescribing

12.6. Knowledge and Planning

- **Knowledge**: provide information to underserved groups for the purpose of promoting full participation the planning cycle
- National indicators (e.g., wellbeing, life expectancy, health expectancy [quality of life])
- National guidelines (e.g., falls, osteoporosis)
- **Planning:** developing urban health systems; annual service plans; public health strategic plan; wait times; prioritization system for surgical intervention for people with arthritis; First Nations Health Plan; working effectively with local business to support local regeneration; location of health facilities; plan for innovation
- **Setting goals, objectives and standards:** performance expectations for Aboriginal health policies; equity-oriented workplace health policies; audit, inspection and accountability

Table 3 List of Appendices for Areas for Action Sets

Appendix	Area for Action
Appendix C	Economy
Appendix D	Income
Appendix E	Work
Appendix F	Childhood
Appendix G	Education
Appendix H	Environment
Appendix I	Community
Appendix J	Housing
Appendix K	Transportation
Appendix L	Food
Appendix M	Behaviour
Appendix N	Health Services

Discussion and Next Steps

The health equity recommendation synthesis work had two main objectives. First, the recommendation synthesis work was completed to provide a synthesized understanding of selected current global efforts suggesting directions for health equity work. Secondly, the recommendation synthesis work was summarized and packaged for use to start conversations that facilitates local health equity planning. Essentially, this work provided a valuable tool to the Winnipeg Regional Health Authority to start a comprehensive discussion around regional planning to address health equity. In the absence of direct evidence of the positive benefit of most recommendations considered in isolation, this synthesis may provide an organized foundation for tracking health equity recommendations with outcome research as this evidence continues to surface. The tools developed from this synthesis work may continue to be helpful in sharing health equity knowledge with partners within and outside of the health sector.
It is hoped that others will find this information equally helpful in their efforts to improve health equity.

Acknowledgement

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APPENDIX B: Glossary of Terms for Health Equity Framework

The terms provided in this glossary represent the terms used to describe components of the Health Equity Framework developed as a result of the recommendation synthesis work. The terms in this glossary along with many other health equity related terms is available in a companion document entitled: *Promoting Health Equity: Operational Glossary (Winnipeg Regional Health, 2012)*

Health Equity

Health equity asserts that all people can reach their full health potential and should not be disadvantaged from attaining it because of their social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance.

Adapted from: Whitehead M, Dahlgren G. Concepts and Principles for Tackling Social Inequalities in Health: Leveling Up Part 1.

Human Rights

Human rights are rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. We are all equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible. Basic human rights include freedom; equality; autonomy; access to the necessities of life (i.e., water and food, clothing, and shelter); personal security; rights protected by law; absence of discrimination; recognition as a person; and freedom from arbitrary arrest, imprisonment, torture, or cruel or inhuman punishment. The enjoyment of the highest attainable standard of physical and mental health is also recognized as a fundamental human right.

Adapted from: United Nations, Office of the High Commissioner for Human Rights. What are
human rights?
Last JM. A dictionary of public health. Oxford.

Areas for Action Affecting Health Equity

Behaviour

Behaviour is any personal action that influences health. Behaviour includes but is not limited to substance use, sexual risk-taking and physical activity. Behaviour also includes personal actions associated with other factors that influence health (i.e., food, transportation, housing, environment, community, childhood, education, work, income, economy, health services).

Environment

The physical environment consists of two main components the natural environment (air, water and soil) and the built environment (housing, indoor air quality, community design, transportation and food systems).

Adapted from: Tri-Project Glossary Working Group. Towards an Understanding of Health Equity: Glossary.

Childhood, Early Childhood Development

Childhood development, including early childhood development includes the physical, social/emotional, and language/cognitive domains, each equally important—strongly influencing

well-being, obesity/stunting, mental health, heart disease, competence in literacy and numeracy, criminality, and economic participation throughout life.

Adapted from: (World Health Organization, 2012)

Community
Community arises from the nature and quality of relationships between people with commonalities such as place, culture, experience, interests, beliefs, values and/or norms. Some aspects of community include sharing, commitment, availability, friendliness, cohesion, safety, connection and participation. People can belong to many communities. Within communities there may be great diversity.

Adapted from: (Tri-Project Glossary Working Group, 2011)

Economy
The economy is all the work that humans perform to produce and distribute the goods and services we need and use in our lives.

Adapted from: Stanford J, Biddle T. Economics for everyone a short guide to the economics of capitalism.

Education
Education is a learning process that plays a crucial role in the development of healthy, inclusive and equitable social, psychological and physical environments. It is informed by best practice and is multi-dimensional in its design and learner-centred in its approach. It empowers individuals and communities with knowledge, motivation, skills and confidence (self-efficacy) conducive to positive societal engagement and the benefit of all.

Adapted from: World Health Organization. Health promotion glossary.

Food, Food Security
Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. (Office of Nutrition Policy and Promotion, 2006)

Health Services or Health System
The health services or health system includes all actions whose primary purpose is to promote, restore, or maintain health. (World Health Organization, 2000)

Housing
Housing is any permanent or temporary building or other structure in which people live. Housing structures will have varying qualities; may be self-contained or shared; may be permanent or transient; and may or may not be owned, rented, or occupied without legal rights.

Income
Income is the flow or accumulation of money or its equivalents to allow people to purchase or negotiate goods and services.

Transportation
Transportation is the movement of people or goods. Transportation may be accomplished through human power, motor vehicles or other methods. Transportation-related risks such as injury, noise and pollution may be mitigated. Concerns include affordability and accessibility.

Work
Work is purposeful human activity that may result in the production of goods or services or other meaningful outcomes. Work can be paid or unpaid. It includes production of goods or services in or outside of formal relationships with employers. It includes care-providers who are paid or unpaid. Formal employment is usually regulated. Exposures to, and vulnerabilities and consequences of work-related risks may be considered and addressed.

Strategies to Promote Health Equity

Knowledge

Knowledge is the systematic production, compilation and communication of information to describe, measure, and evaluate health equity and strategies and activities intended to promote health equity, and produce research. Knowledge helps us learn and improve. Knowledge includes systematic processes that:

- Measure and monitor population health status and changes in population health status (i.e., surveillance),
- Determine if interventions and strategies meet their goals or have an effect on health equity (e.g., health equity impact assessments),
- Generate theory and test it (e.g., research), and
- Compile and disseminate this information.

Governance

Governance is concerned with how decisions important to a society or an organization are taken. It helps define who should have power and why, who should have a voice in decision-making, and how accountability is rendered to citizens. (Institute on Governance, 2011)

Participation

Participation means that stakeholders (e.g., affected people, formal or informal organizations and various levels of government) are actively involved in assessing the situation, and/or planning, delivering and evaluating the service, program or strategy. There are many participation models. Participation recognizes the value of varying intensities of involvement from being informed, to providing feedback, to joint planning, to joint management.

By creating participatory processes, we recognize that people and organizations have a deep understanding of their contexts, and that (at the very minimum) they have a right to know, that they have a stake in the outcome, and that they have power to influence or change outcomes. Participation can promote sustainability, generate exponential benefits through synchronized action, and create accessibility, effectiveness, ownership, commitment, increased self-help capacity and skill development, and stronger and more democratic institutions.

Adapted from: Informal Working Group on Participatory Approaches & Methods. What do we mean by participation in development?

Principles to Promote Health Equity

Accessibility

Accessibility is the relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance and cost. (Penchansky & Thomas, 1981)

Accountability

Accountability is the obligation to report on or explain actions and be answerable for policies and use of funds. Accountability applies to public and private organizations and individuals. Accountability implies that measurable goals and a clear path to them have been established. It recognizes that alternative actions or policies should be considered if a goal is not being met or that the goal needs to be changed.

Affordability

Affordability is the relationship of prices of services and providers' insurance or deposit requirements to the clients' income, ability to pay, and existing health insurance. Client

perception of worth relative to total cost is a concern here, as is clients' knowledge of prices, total cost and possible credit arrangements. (Penchansky & Thomas, 1981)

Appropriateness
Appropriateness is defined as suitability for a particular purpose. Appropriateness includes the concepts of cultural proficiency and accommodation.

Availability
Availability is the relationship of the volume and type of existing services, (and resources) to the clients' volume and types of needs. It refers to the adequacy of the supply of physicians, dentists and other providers' of facilities such as clinics and hospitals; and of specialized programs and services such as mental health and emergency care. (Penchansky & Thomas, 1981)

Comprehensive
Comprehensive service or coverage is sufficiently broad in scope to address all recognized need or risk. Comprehensive programs and strategies are those that address not only the problem at hand, but consider factors that contribute to or cause the problem at hand.

Equity
Is an ethical principle that recommends that resources be allocated based on need, not based on underlying social advantage or disadvantage; that is, wealth, power and prestige. (Braveman & Gruskin, 2003)

Social Justice
The organization of society towards an available common good for all, to which all are expected to contribute. To promote and respect social justice means to be part of a society where all members, regardless of their background, have basic human rights (see definition) and equitable access to their community's wealth and resources. (Rasanathan, 2011)

Sustainability and Sustainable Development
A commonly used definition of sustainable development is development which meets the needs of present generation without compromising the ability of future generations to meet their own needs (World Commission on Environment and Development, 1987). For example, the plethora of regeneration and neighbourhood renewal initiatives under way are all intended to provide sustainable changes – that is to say, benefits for the future as well as the present.

Adapted from: Barnes R, Health Development Agency. Health Impact Assessment (HIA): Glossary of terms used.

Universality
Universality refers to everyone having equal rights to use public social protection systems without any barriers such as user fees.

GLOSSARY REFERENCES
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APPENDIX C: Area for Action (Economy)

Health Equity Recommendation Synthesis

ECONOMY: The economy is all the work that humans perform to produce and distribute the goods and services we need and use in our lives.
Adapted from: Stanford J, Biddle T. Economics for everyone a short guide to the economics of capitalism.

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
1. Economy	38	40

1.1. Economic policy (international, national, regional, local)

- Development
- Business
- Industrial
- Procurement
- Taxation
- Borrowing
- Investments (e.g., cap annual growth of health care treatment sector at 5%)
- Mitigate the negative impact of business interests on health
- Adequate economic base
- Economic productivity
- Economic security
- Workforce planning (skills development, education)
- Global trade regulation

1.2. Local economic vibrancy

- Local procurement
- Sign preferred supplier contracts
- Local recruitment
- Local employment
- Local regeneration
- Regeneration of deprived communities

1.3. Improving the economic condition of Aboriginal people and communities

- Business creation
- Address structural impediments (e.g., Indian Act), break the cycle of disadvantage

1.4. Rural economies

- Landlessness
- Viable livelihoods

1.5. Resource management and public reporting of human activities

- Supply of renewable energy
- Electricity
- Mineral supplies, fish stock and other natural resources

Original Source Document Recommendation Extractions

Economy

1. Manage urban development to ensure greater availability of affordable housing; invest in urban slum upgrading including, as a priority, provision of water and sanitation, electricity, and paved streets for all households regardless of ability to pay. (1)

2. Promote health equity between rural and urban areas through sustained investment in rural development, addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their homes. (1)

3. Counter the inequitable consequences of urban growth through action that addresses rural land tenure and rights and ensures rural livelihoods that support healthy living, adequate investment in rural infrastructure, and policies that support rural-to-urban migrants. (1)

4. Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity. Consider health equity impact of agriculture, transport, fuel, buildings, industry, and waste strategies concerned with adaptation to and mitigation of climate change. (1)

5. Make full and fair employment and decent work a central goal of national and international social and economic policy-making. (1)

6. Governments, where necessary with help from donors and civil society organizations, and where appropriate in collaboration with employers, establish and strengthen universal comprehensive social protection policies that support a level of income sufficient for healthy living for all. (1)

7. International finance institutions ensure transparent terms and conditions for international borrowing and lending to help avoid future unsustainable debt. (1)

8. Canadian decision-makers must reevaluate whether minimizing government intervention is an ethical and sustainable approach to maintaining health, promoting social well-being, and increasing economic productivity. (2)

9. Improve policies on tax and benefits for different sections of the population to strongly favour the poorest groups. (2)

10. Support local enterprise, including social enterprises and business development, and encourage community entrepreneurship to improve local job opportunities and skill development. (2)

11. Continue to develop and implement an integrated and sustainable approach to regional economic development which takes into account the needs of disadvantaged areas and communities. (2)

12. Regional policies, including regional economic and housing strategies can also be assessed for their impact on health and health inequalities. (2)

13. The NHS also has a role alongside other public services in contributing to the local regeneration agenda by being a good 'corporate citizen'. Within the NHS, employment and procurement policies, the capital build, and training and skills programmes provide opportunities to link health with regeneration by supporting local economies and make the

best use of the extra investment in the NHS. (2)

14. As the headquarters of the NHS locally, SHAs need to ensure that tackling health inequalities is a NHS priority and it is addressed strategically. They should highlight action on inequalities in the way the NHS delivers its services, as well as the wider NHS contribution to the regeneration of deprived communities. Health inequalities should be central to their planning and performance management, and they should support NHS organizations in meeting the targets and in contributing to effective partnerships. They should also build the capacity and skills of staff and others throughout SHA public health networks to promote better understanding of inequalities issues and what can be done to address them. (2)

15. The business community will have a major role to play in regeneration and health initiatives from occupational health measures to local employment and procurement and beyond into supporting increased diversity in local recruitment and wider involvement in community development and regeneration - for example, by investing in health and fitness centres accessible to those most in need. Jobcentre Plus can help with recruitment and retention issues but also plays a wider role developing job opportunities for people within local communities, as well as playing its part in LSPs. (2)

16. The business sector has a key role to play in tackling health inequalities. There is a growing understanding that good health is good economics, and good economics leads to better health. By focusing on the "wealth creators" (the business sector) as "health creators" and the "health creators" (NHS and other public services) as "wealth creators", the potential to make an impact positively on health and regeneration in our communities is huge. (2)

17. Support best practice health policies (e.g. mental health) and organizational policies on issues such as recruitment/retention, improving the health of the workforce, and helping to regenerate the community. (2)

18. By leading the development of regional economic strategies and through allocating an integrated pot of funding they provide leadership and practical support in promoting economic regeneration sustained by developing social infrastructure - in areas such as skills development. Sustainable work and education are important determinants of health inequality, and targeting development opportunities at the most deprived communities will be an important way to break the cycle of disadvantage. (2)

19. Local authorities can integrate health care issues into wider regeneration initiatives, such as supporting People strategies and LSP community plans. (2)

20. Work collaboratively to improve housing conditions and economic and educational opportunities for Aboriginal people. (3)

21. Facilitate the removal of structural impediments to economic development in First Nations communities. (3)

22. Encourage public reporting on the impact of human activities on fish stocks, forest areas, mineral supplies, and other natural resources. (3)

23. Examine and review systemic barriers to economic development and make it a priority. (3)

24. Cap the annual growth of the health care treatment sector at 5%, instead of 10%, in order to redistribute financial resources to health enhancing activities like education. (4)

25. Support the creation of Aboriginal owned businesses by signing preferred supplier contracts. (4)

26. Assessing economic policies for their potential health impacts due to unemployment. (5)

27. The development of an adequate economic base and increased participation in mainstream local and regional economies in such a way that is respectful of community values, practices and culture has been identified as antecedent to the improvement of social conditions affecting health. (5)

28. Food security, good nutrition and health of urban people would be enhanced through environmentally-friendly "urban agriculture" programmes and locally controlled distribution hubs that foster food system self-sufficiency and sustainability; these also contribute both to the availability of higher quality food (particularly fruits and vegetables) and local economic vibrancy. (6)

29. Governments and nongovernmental organizations should create opportunities for recreation, physical activity and participation in the arts and other cultural activities to enhance livelihood, social cohesion, health and well-being. (6)

30. Future urban development needs to consider means to reduce unsustainable energy and resource use and supply of renewable energy. The indirect effects on global public health in the long run can no longer be ignored. Current and emerging eco-friendly approaches to town planning; housing design and workplace developments need to be systematically applied in order to minimize health inequalities in the future. (6)

31. These programs and services should be flexible, and meet the developmental, language, literacy and cultural needs of all children. They should also provide additional opportunities for the early identification of developmental delays, disabilities and other risk factors and appropriate referrals, encourage parent participation, enhance parents' understanding of child development through information, support and role modeling, build supportive social networks amongst children and families, and support and enhance the economic security of women and families. (7)

32. Implement equity-based social protection systems and maintain and develop effective publicly provided and publicly financed health systems that address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities. (8)

33. Recognize explicitly the ways in which the current structures of global trade regulation shape health inequalities and deny the right to health. (8)

34. Regulate the private medical sector to mitigate the negative impact of business interests on health and enhance the capacity of the public health system. (8)

35. Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies. As collective goals, good health and well-being for all should be given high priority at local, national, regional and international levels. (9)

36. Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities. (9)

37. Support the efforts of governments to promote capacity and establish incentives to create a sustainable workforce in health and in other fields, especially in areas of greatest need. (9)

38. Support locally developed and evidence based community regeneration programs that:
    - Remove barriers to community participation and action
    - Reduce social isolation. (10)

39. "…Action that will revitalize crumbling neighborhoods and promote their reconstruction from the grass roots upwards." (11)

40. Work and working conditions
    - Enforcing legislation that protects the rights of minority groups, particularly concerning employment rights and anti-discrimination.
    - Assuring access to educational, training and employment opportunities, especially for those such as the long-term unemployed.
    - Supporting improved management practices that lead to increased levels of control, variety and appropriate use of skills into the workforce.
    - Assessing the impact of employment policies on health and inequalities in health.
    - Ensuring accessible and safe cycling and walking routes to workplaces.
    - Enacting smoke-free workplace legislation. (12)

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APPENDIX D: Area for Action (Income)

Health Equity Recommendation Synthesis

Income: Income is the flow or accumulation of money or its equivalents to allow people to purchase or negotiate goods and services.

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
2. Income	100	82

2.1 Governance

- **Transfer payments**
- **Policy affecting income:** Saving incentives; pathway for moving upwards; reduce rate of households < LICO in five years; fuel; employment; after tax and benefit income sufficient for healthy living; female employment and economic participation; female employment equity; pay equity; Aboriginal income equal to general population; "poverty reduction strategy"
- **Equitable distribution of taxes:** Tax evasion; tax havens; tax credits; progressive taxation of income; taxation of inherited wealth; increase lower limit tax exemption for low income earners and remove lower limit tax exemption for high income earners
- **Employment income:** Special efforts are made to secure jobs with adequate pay for those in the weakest position in the labour market; earned income benefit (payments designed to help low and modest income working families)
- **Minimum wage:** Laws; increase; reflects a living wage; index to the cost of living; raise income of low income people
- **Income and children:** Tax provisions for families with children; reduce rate of children < LICO in five years
- **Social assistance:** Raise rates to LICO then index to inflation; enhanced benefits; income supplements; work earning supplements; remove work earning 'clawbacks'; revise income thresholds and benefits reductions; voluntary withdrawal from social assistance; greater availability of funds to low income families as their work incomes rise
- **Income assistance for those unable to work:** Employment insurance; benefits for the elderly; income support programs; no buffer when moving from benefit to and from work; consolidate income assistance and disability providers into one resource; equalize or make rates equitable between income assistance and disability provider; extend income assistance to after employment found; allowances
- **Benefits:** Disability; parental leave; sick benefits; injury; incapacity to work; unemployment; increasing uptake of benefits
- **Resettled refugees and refugees:** Abolish travel loan repayment; timeliness of Interim Federal Health Program payments

- **Pension:** Earnings-related pension

2.2 Income Adequate for Healthy Living

- **Guaranteed minimum income sufficient for healthy living:** Standards for minimum income for healthy living; sufficient for healthy development; adequate income for life transitions; income associated with improvements in health and life expectancy

- **Eliminate poverty:** Eliminating child poverty; break the cycle of disadvantage; people on social assistance; rural poverty; land tenure; educate about costs of not addressing it; fuel poverty

2.3 Financial management

Original Source Document Recommendation Extractions

Income

1. Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity. Consider health equity impact of agriculture, transport, fuel, buildings, industry, and waste strategies concerned with adaptation to and mitigation of climate change. (1)

2. Full and fair employment and decent work should be made a shared objective of international institutions and a central part of national policy agendas and development strategies, with strengthened representation of workers in the creation of policy, legislation, and programmes relating to employment and work. (1)

3. Protect all workers. International agencies should support countries to implement core labour standards for formal and informal workers; to develop policies to ensure a balanced work-home life; and to reduce the negative effects of insecurity among workers in precarious work arrangements (informal, temporary and part-time work). (1)

4. Governments, where necessary with help from donors and civil society organizations, and where appropriate in collaboration with employers, establish and strengthen universal comprehensive social protection policies that support a level of income sufficient for healthy living for all. (1)

5. Build national capacity for progressive taxation and assess potential for new national and global public finance mechanisms. (1)

6. Honour existing commitments by increasing global aid to the 0.7% of GDP commitment, and expand the Multilateral Debt Relief Initiative; enhance action on health equity by developing a coherent social determinants of health focus in existing frameworks such as the Poverty Reduction Strategy Paper. (1)

7. Develop and finance policies and programmes that close gaps in education and skills, and that support female economic participation. (1)

8. Invest in formal and vocational education and training, guarantee pay-equity by law, ensure equal opportunity for employment at all levels, and set up family-friendly policies that ensure that women and men can take on care responsibilities in an equal manner. (1)

9. Income inequality is a key health policy issue that needs to be addressed by governments and policymakers. Increasing the minimum wage and boosting assistance levels for those unable to work would provide immediate health benefits for the most disadvantaged Canadians. (2)

10. Reducing inequalities in income and wealth through progressive taxation is a highly recommended policy option shown to improve health. (2)

11. Government policies must support Canadians' working life so that demands upon workers and their rewards are balanced. (2)

12. Providing support and benefits to families through public policies forms a base for healthy childhood development. Providing higher wages and social assistance benefits would reduce child poverty and be one of the best means to improve early childhood development. (2)

13. Governments must reduce food insecurity by increasing minimum wages and social assistance rates to the level where an adequate diet is affordable. (2)

14. Housing policy needs to be more explicitly linked to comprehensive income (including a jobs strategy), public health, and health services policy. (2)

15. Improving and enforcing pay equity legislation would improve the employment and economic situation of Canadian women. (2)

16. Providing a national affordable high quality childcare program would provide opportunities for women to engage in the workplace and improve their financial situations. (2)

17. Improving access to employment insurance for part-time workers would assist women who combine work and care-giving responsibilities. (2)

18. Creating policies that make it easier for workplaces to achieve collective agreements through unionization would be especially beneficial for Canadian women. (2)

19. The federal government make a 'down payment' on a transfer to enhance the supply of disability supports, and commit to a national program of disability supports. (2)

20. The federal government commit to a study of poverty and disability for exploring an expanded role for the federal government in addressing income needs. (2)

21. Improve policies on tax and benefits for different sections of the population to strongly favour the poorest groups. (2)

22. Ensure more people take up welfare benefits and tax credits. (2)

23. Improve employment prospects in the worst areas by tackling employment rates and addressing the issue of inactivity and incapacity. (2)

24. The NHS also has a role alongside other public services in contributing to the local regeneration agenda by being a good 'corporate citizen'. Within the NHS, employment and procurement policies, the capital build, and training and skills programmes provide opportunities to link health with regeneration by supporting local economies and make the best use of the extra investment in the NHS. (2)

25. Income support (e.g. tax and benefit systems, professional welfare rights advice in health care settings). (3)

26. Set clear, measurable goals for employment, income, and education levels of Aboriginal people equal to those within the general population, along with methods for public reporting of results. (4)

27. Provide adequate income to every household through minimum wage increases. (5)

28. Provide earned income tax credits to reduce the burden on those with less income. (5)

29. Secure pension plans and increase saving incentives. (5)

30. Provide incentives (e.g., tax breaks or low cost business loans) for green markets and grocery stores that sell fresh produce. (5)

31. Reduce poverty itself, which is the first approach (Mackenbach, 1994). This is done by raising

levels of educational attainment, by working to reduce unemployment, and by raising the income of those at the bottom of the social hierarchy. The means for accomplishing this are known: allowances, income supplements, and programs that raise education levels. (6)

32. Reduce Low Income Cut-Off (LICO) households from 17.1% to 10% in five years. (7)

33. Reduce the number of children living below LICO from 20.1% to 2% in five years. (7)

34. Parents with children who are on social assistance should have their shelter allowances and their adult allowances (i.e., food, clothing) doubled in order to raise children to the LICO. (7)

35. Establish a Child Poverty Protection Plan to reduce poverty in children in Saskatchewan. (7)

36. Work earning supplements should be coupled with the removal of work earning claw-backs to transition return to work and promote voluntary withdrawal from social assistance. (7)

37. Social assistance rates should be increased as recommended in policy option #3 and then index future rates to inflation. (7)

38. Change the lower limit tax exemption for low income workers and offset the revenue loss by removing the lower limit tax exemption for higher income earners. (7)

39. Increase the Employment Insurance rate for new parents on parental leave from 55% to 80% of employment income prior to leave. (7)

40. Consolidate income assistance and disability providers into one resource with identical and equitable assistance rates for those unable to work. (7)

41. Provide health and social services to schools in low income neighbourhoods in order to prevent school drop-out, encourage academic achievement, increase graduation rates and improve health. (7)

42. Learning institutions like SIAST should allocate 10% of their existing skills training vacancies to adults who have been on social assistance for more than one year to take the program at no cost. (7)

43. The Saskatchewan government should consider increasing monthly shelter allowances for all households receiving income assistance to match the 2008 average monthly rental rate and also include the total monthly cost for utilities. (7)

44. In addition, shelter allowance rates should be reviewed bi-annually and compared to current average monthly rates and brought up to market standards when necessary. (7)

45. The minimum wage should be increased to $10 per hour in order to encourage employment, make work more attractive than employment assistance, and lower the amount of children living in poverty. (7)

46. Use Social Assistance as a transition to work when possible with enhanced benefits that are time sensitive (i.e., five years) to ensure that they achieve their intended results. (7)

47. Maintaining financial support of unemployment benefits, and maintaining or strengthening active wage policies, where special efforts are made to secure jobs with adequate pay for those in the weakest position in the labour market. (8)

48. Upstream Interventions - At the population level, improvements in income a conditions have

been associated with improvements in health and life expectancy (Drev & Whitehead, 1997). A scan of the international literature suggests that income support programs all have an impact on poverty (e.g., programs and tax provisions that benefit families with children; benefits for the elderly; social assistance programs; earnings-related pension; disability; maternal/parent leave; sickness, injury and unemployment benefits; and regulations regarding minimum-wage laws). That impact is uneven across demographic groups. (8)

49. Downstream Interventions - there are many examples of evidence-based community-level interventions and demonstration projects that have had positive effects on both poverty and health status. Many of these interventions focus on children and families in general, tackling child poverty by giving high priority to early medical, social and educational support to disadvantaged children and by enhancing income support and assistance to poor families and single parents are strategies that have been successful improving health. When combined with broader, more universal policies and programs, these kinds of strategies are expected to reduce health inequalities (Dahlgren & Whitehead, 2006). (8)

50. Simplify the IFH processes and improve timeliness of the payment system. (9)

51. Enhance level of income assistance. (9)

52. Extend income assistance period for refugees, after they find employment. (9)

53. Abolish travel loan repayment. (9)

54. Measures to ensure the provision of safe and healthy working environments, particularly in relation to cottage-based industries, need to be an integral component of initiatives to reduce health inequity. The exposure of the local population, often the poorest, to pollutants emitted from workplaces is another concern for health equity. Urban planning needs to consider how the environment, poverty, health and time to care for children are affected by travel distances and travel modes for commuting to work. In addition, insufficient income from work to cover the cost of living is a key social determinant. (10)

55. Minimum Wage - Increasing the minimum wage and indexing it to the annual cost of living. It is important that the minimum wage reflect a 'living wage' in order to eliminate the situation faced by the working poor - people working full time but still facing poverty. (9)

56. Earned Income Benefit - Ensuring that federal and provincial earned income benefits work to augment the incomes of people who are normally in the paid labour force. (11)

57. Federal Child Benefit - Combining the Canada Child Tax Benefit base benefit and National Child Benefit Supplement into a single refundable benefit and making it available to all low-income families, with no reduction of other benefits to offset the increase. Considering revising income thresholds and benefit reductions to avoid undue hardship on lower-income families as their work incomes rise. (11)

58. Income Assistance - Increasing welfare rates and indexing the rates to annual increases in the cost of living. About half of the increase will be required to make up for the erosion in purchasing power since 1994. Considering a mechanism to improve the income status of pregnant women. (11)

59. Ensuring income assistance rates are determined with consideration for the actual cost of food. (11)

60. Use progressive taxation, wealth taxes and the elimination of tax evasion to finance action on the social determinants of health. (12)

61. Implement appropriate international tax mechanisms to control global speculation and eliminate tax havens. (12)

62. Use of progressive taxation, wealth taxes and the elimination tax evasion to finance action on the social determinants of health. (12)

63. Support families to achieve progressive improvements in early child development, including:
    - Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
    - Providing paid parental leave in the first year of life with a minimum income for healthy living
    - Providing routine support to families through parenting programs, children's centres and key workers, delivered to meet social need via outreach to families
    - Developing programs for the transition to school.

    (13)
64. Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies. (13)

65. Reduce the cliff edges faced by people moving between benefits and work. (13)

66. Remove 'cliff edges' for those moving in and out of work and improve flexibility of employment. (13)

67. Review and implement systems of taxation, benefits, pensions and tax credits to provide a minimum income for healthy living standards and pathways for moving upwards. (13)

68. Prioritize policies and interventions that reduce both health inequalities and mitigate climate change, by:
    - Improving active travel across the social gradient.
    - Improving the availability of good quality open and green spaces across the social gradient.
    - Improving the food environment in local areas across the social gradient.
    - Improving energy efficiency of housing across the social gradient. (13)

69. National target for social inclusion It is proposed that there be a national target that progressively increases the proportion of households that have an income, after tax and benefits, that is sufficient for healthy living. (13)

70. Improve the incomes of the poorest people. (14)

71. Income, employment, and socio-economic status
    - Provide a guaranteed minimum income; a living wage as the minimum wage
    - Improving pay equity
    - Restoring and improving income supports for those unable to gain employment
    - Reducing inequalities in income and wealth within the population through progressive taxation of income and inherited wealth.
    - Preserving and creating jobs
    - Directing attention to the health needs of immigrants and to the unfavourable socio-economic position of many groups, including the particular difficulties many New Canadians face in accessing health and other care services.
    - Restoring employment benefits and eligibility to previous levels
    - Requiring that provincial social-assistance programs be accessible and funded at levels to assure health, especially for women of child-bearing age, children and seniors.

- Assuring that supports are available to citizens through critical life transitions, possibly by increasing the uptake of benefits in entitled groups. (15)

72. Promote health equity between rural and urban areas through sustained investment in rural development, addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their homes. (1)

73. Counter the inequitable consequences of urban growth through action that addresses rural land tenure and rights and ensures rural livelihoods that support healthy living, adequate investment in rural infrastructure, and policies that support rural-to-urban migrants. (1)

74. Governments, where necessary with help from donors and civil society organizations, and where appropriate in collaboration with employers, establish and strengthen universal comprehensive social protection policies that support a level of income sufficient for healthy living for all. (1)

75. Progressively increase the generosity of social protection systems towards a level that is sufficient for healthy living. (1)

76. Governments and international institutions set up within the central administration and provide adequate and long-term funding for a gender equity unit that is mandated to analyze and to act on the gender equity implications of policies, programmes, and institutional arrangements. (1)

77. Develop and finance policies and programmes that close gaps in education and skills, and that support female economic participation. (1)

78. Invest in formal and vocational education and training, guarantee pay-equity by law, ensure equal opportunity for employment at all levels, and set up family-friendly policies that ensure that women and men can take on care responsibilities in an equal manner. (1)

79. Reducing inequalities in income and wealth through progressive taxation is a highly recommended policy option shown to improve health. (2)

80. Unemployed Canadians must be provided access to adequate income, training, and employment opportunities through enhanced government support. (2)

81. The social safety net provided by Canadian federal, provincial/territorial, and municipal governments needs to be strengthened. Canada's spending in support of citizens lags far behind many other developed economies. Current benefits do not provide adequate income for life transitions. (2)

82. Improving and enforcing pay equity legislation would improve the employment and economic situation of Canadian women. (2)

83. The federal government commit to a study of poverty and disability for exploring an expanded role for the federal government in addressing income needs. (2)

84. Explore a further role for the federal government in addressing poverty, by meeting individual costs of disability through an expenditure program, perhaps modeled after the National Child Benefit. (2)

85. Reduce further the number of children in low-income households and tackling child poverty. (2)

86. Health professionals can make referrals to energy efficiency programmes to address fuel poverty. (2)

87. Focus on underlying factors that lead to illness, such as poverty, family distress, child abuse, inadequate housing, and untreated mental illness. (4)

88. Reduce poverty itself, which is the first approach (Mackenbach, 1994). This is done by raising levels of educational attainment, by working to reduce unemployment, and by raising the income of those at the bottom of the social hierarchy. The means for accomplishing this are known: allowances, income supplements, and programs that raise education levels. (6)

89. Develop an effective plan to reduce poverty and health inequality for Saskatoon and Saskatchewan that includes a multi-year approach with concrete measurable targets, broad support and an evaluation plan. (7)

90. Establish a legislative requirement in Saskatchewan to eliminate child poverty. (7)

91. Enhance the understanding of the general public about the determinants of health and the economic costs of not proactively addressing poverty. (7)

92. The minimum wage should be increased to $10 per hour in order to encourage employment, make work more attractive than employment assistance, and lower the amount of children living in poverty. (7)

93. Efforts to reduce differences in education or income between socio-economic groups are likely to have a positive effect. (8)

94. Upstream Interventions - At the population level, improvements in income a conditions have been associated with improvements in health and life expectancy (Drev & Whitehead, 1997). A scan of the international literature suggests that income support programs all have an impact on poverty (e.g., programs and tax provisions that benefit families with children; benefits for the elderly; social assistance programs; earnings-related pension; disability; maternal/parent leave; sickness, injury and unemployment benefits; and regulations regarding minimum-wage laws). That impact is uneven across demographic groups. (8)

95. Downstream Interventions - there are many examples of evidence-based community-level interventions and demonstration projects that have had positive effects on both poverty and health status. Many of these interventions focus on children and families in general, tackling child poverty by giving high priority to early medical, social and educational support to disadvantaged children and by enhancing income support and assistance to poor families and single parents are strategies that have been successful improving health. When combined with broader, more universal policies and programs, these kinds of strategies are expected to reduce health inequalities (Dahlgren & Whitehead, 2006). (8)

96. Raising financial and other supports given to low-income families with children, to make it more possible for them to choose a healthier diet (Acheson, 1998). (8)

97. Ensuring adequate incomes and access to affordable, nutritious food. (11)

98. Make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. (16)

99. Give special attention to gender-related aspects as well as early child development in public policies and social and health services. (16)

100. Support families to achieve progressive improvements in early child development, including:
- Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
- Providing paid parental leave in the first year of life with a minimum income for healthy living
- Providing routine support to families through parenting programs, children's centres and key workers, delivered to meet social need via outreach to families
- Developing programs for the transition to school. (13)

101. Establish a minimum 1 income for healthy living for people of all ages. (13)

102. Develop and implement standards for minimum income for healthy living. (13)

103. Review and implement systems of taxation, benefits, pensions and tax credits to provide a minimum income for healthy living standards and pathways for moving upwards. (13)

104. The Toronto board of Health send this report to the Premier of Ontario and strongly urge the government to maintain its stated commitment to poverty reduction in Ontario as a public health measure. (17)

105. Income, employment, and socio-economic status:
- Provide a guaranteed minimum income; a living wage as the minimum wage;
- Improving pay equity
- Restoring and improving income supports for those unable to gain employment
- Reducing inequalities in income and wealth within the population through progressive taxation of income and inherited wealth. (15)

106. Income Preserving and creating jobs:
- Directing attention to the health needs of immigrants and to the unfavourable socio-economic position of many groups, including the particular difficulties many New Canadians face in accessing health and other care services.
- Restoring employment benefits and eligibility to previous levels.
- Requiring that provincial social-assistance programs be accessible and funded at levels to assure health, especially for women of child-bearing age, children and seniors.
- Assuring that supports are available to citizens through critical life transitions, possibly by increasing the uptake of benefits in entitled groups. (15)

107. Child Development:
- Ensuring that families have sufficient income to provide their children with the means for healthy development.
- Providing high-quality preschool education.
- Developing a high-quality, national day-care program.
- Implementing policies that increase the prevalence of breast-feeding.
- Providing social and emotional support to expectant parents and parents with young children via social and health services. (15)

108. Economic distribution: Poverty must be tackled as a matter of priority)1)

109. A commonly mentioned ingredient for tackling poverty and associated low socioeconomic status is through investment in education, more particularly that of children. Investment in

education was also seen as a critical ingredient in strengthening Indigenous populations. (1)

APPENDIX D: REFERENCES

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APPENDIX E: Area for Action (Work)

Health Equity Recommendation Synthesis

Work: Work is purposeful human activity that may result in the production of goods or services or other meaningful outcomes. Work can be paid or unpaid. It includes production of goods or services in or outside of formal relationships with employers. It includes care-providers who are paid or unpaid. Formal employment is usually regulated. Exposures to, and vulnerabilities and consequences of work-related risks may be considered and addressed.

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
3. Work	109	66

3.1. Employment, Unemployment, and Underemployment

3.1.1. Legislation to support full, fair, and decent employment:

- Reduce long-term employment across the social gradient
- Planning employment for deprived communities
- Full time service jobs
- Year-round employment
- Create vision for healthy and productive work

3.1.2. Creating a sustainable workforce

- Earned income benefit (payments designed to help low and modest income working families)
- Worker health for healthy workforce
- Hiring practices
- Job retention
- Move funding from job search initiatives with limited success to skills enhancement

3.1.3. Training

- Employment training
- Specialty training services for refugees
- Job coaching
- Job placement
- Work-based learning including apprenticeships
- Job supports

3.1.4. Labour market

- Reduce unemployment
- Reduce underemployment
- Employment opportunities
- Timely interventions to reduce long-term unemployment
- Employment rate
- Return to employment
- Employment programs (e.g., work clothing)
- Preserve and create jobs
- Sustainable work
- Voluntary work

3.2. Conditions and Equity

3.2.1. Recognize housework, care work and volunteerism

3.2.2.Conditions

- Employment benefits
- Collective bargaining
- Increase unionization
- Work related counseling
- Healthy living wage
- Employment equality and equal opportunity
- Fair employment
- Fair pay

3.2.3.Flexibility

- Flexibility of retirement age
- Suitable for lone parents, careers and people with mental and physical health problems
- Combining work and care-giving responsibilities of women
- Conflict with family obligations
- Parental leave for sick children

3.2.4.Security

- Work insecurity (informal, temporary, seasonal)
- Formal and informal workers
- Obtain and keep work

3.2.5.Quality

- Psychosocial conditions
- Stress
- Working conditions
- Healthy workplace
- Balance power between employer and employee
- Employee influence on how work is to be performed
- Workplace as a setting for promoting well-being and physical and mental health
- Culturally safe work environments
- Control over work demands
- Disruptive shift changes
- Extended work hours

3.2.6.Safety

- Workplace safety
- Exposure to material hazards
- Exposure to conditions and health damaging behaviours
- Physical hazards
- Prevention of workplace injuries and stress
- Work environment
- Occupational health and safety protection
- Occupational health services that include early warning systems for health hazards at work (including psychosocial)

Original Source Document Recommendation Extractions

Work

1. Make full and fair employment and decent work a central goal of national and international social and economic policy-making. (1)

2. Full and fair employment and decent work should be made a shared objective of international institutions and a central part of national policy agendas and development strategies, with strengthened representation of workers in the creation of policy, legislation, and programmes relating to employment and work. (1)

3. Achieving health equity requires safe, secure, and fairly paid work, year-round work opportunities, and healthy work-life balance for all. (1)

4. Protect all workers. International agencies should support countries to implement core labour standards for formal and informal workers; to develop policies to ensure a balanced work-home life; and to reduce the negative effects of insecurity among workers in precarious work arrangements (informal, temporary and part-time work). (1)

5. Include the economic contribution of housework, care work, and voluntary work in national accounts. (1)

6. Invest in formal and vocational education and training, guarantee pay-equity by law, ensure equal opportunity for employment at all levels, and set up family-friendly policies that ensure that women and men can take on care responsibilities in an equal manner. (1)

7. National and international institutions need to be legally mandated to make agreements that provide basic standards of employment and work for everyone. (2)

8. Power inequalities between employers and employees need to be reduced through stronger legislation governing equal opportunity in hiring, pay, training, and career advancement. (2)

9. Unemployed Canadians must be provided access to adequate income, training, and employment opportunities through enhanced government support. (2)

10. Workers, employers, government officials, and researchers need to develop a new vision of what constitutes healthy and productive work. (2)

11. Facilitating mothers' employment through job supports, making available affordable childcare, and providing employment training would serve to reduce food insecurity among the most vulnerable Canadian families. (2)

12. Housing policy needs to be more explicitly linked to comprehensive income (including a jobs strategy), public health, and health services policy. (2)

13. Governments at all levels must revise laws and regulations and develop programs that will allow new Canadians to practice their professions in Canada. (2)

14. Providing a national affordable high quality childcare program would provide opportunities for women to engage in the workplace and improve their financial situations. (2)

15. Governments must enact laws and regulations that allow foreign-trained immigrants to practice their occupations in Canada. (2)

16. Expand early intervention services so that every young person with a first episode of psychosis be treated promptly and receive the intensive support they need during the first three years of their illness with the aim to keep them in or helping them to return to education or employment. (2)

17. Improve basic skills and provide improved workforce training and education. (2)

18. Improve employment prospects in the worst areas by tackling employment rates and addressing the issue of inactivity and incapacity. (2)

19. Improve the job prospects of black and ethnic minority groups. (2)

20. Develop consistent transport and land use planning policies that improve people's ability to access work and key services, and encourage greater exercise. (2)

21. Local authority transport planners will conduct accessibility planning in partnership with PCTs and other local bodies to improve access to jobs and services for disadvantaged groups and areas in Local Transport Plan areas. (2)

22. The modernisation of the NHS will lead to new ways of working and create employment opportunities across the country, including in some of the most deprived areas. NHS Trusts and PCTs should work with other agencies to ensure that local unemployed people are equipped for these opportunities. (2)

23. The business community will have a major role to play in regeneration and health initiatives from occupational health measures to local employment and procurement and beyond into supporting increased diversity in local recruitment and wider involvement in community development and regeneration - for example, by investing in health and fitness centres accessible to those most in need. Jobcentre Plus can help with recruitment and retention issues but also plays a wider role developing job opportunities for people within local communities, as well as playing its part in LSPs. (2)

24. Support best practice health policies (e.g. mental health) and organizational policies on issues such as recruitment/retention, improving the health of the workforce, and helping to regenerate the community. (2)

25. Encourage the use of planning conditions and other mechanisms to work with major employers to ensure that the employment opportunities afforded by growth delivers benefits to deprived communities. (2)

26. By leading the development of regional economic strategies and through allocating an integrated pot of funding they provide leadership and practical support in promoting economic regeneration sustained by developing social infrastructure - in areas such as skills development. Sustainable work and education are important determinants of health inequality, and targeting development opportunities at the most deprived communities will be an important way to break the cycle of disadvantage. (2)

27. Employers can examine hiring practices to ensure equality of opportunity. (3)

28. Set clear, measurable goals for employment, income, and education levels of Aboriginal people equal to those within the general population, along with methods for public reporting of results. (3)

29. Invest in adult education opportunities, skills upgrading, work and work clothing, child care, and stable, affordable housing. (3)

30. Continue to improve the socio-economic status of the Aboriginal population by creating more educational and job opportunities. (3)

31. Reduce poverty itself, which is the first approach (Mackenbach, 1994). This is done by raising levels of educational attainment, by working to reduce unemployment, and by raising the income of those at the bottom of the social hierarchy. The means for accomplishing this are known: allowances, income supplements, and programs that raise education levels. (4)

32. Re-allocate funding from job search initiatives with limited success to skills enhancement programs. (5)

33. Evidence Based Policy Option #33 - Setting Measurable Goals: More Work for Aboriginal People. (5)

34. Aboriginal representation in the workforce should increase to 15% of full time service jobs, 15% of management positions and 15% of professional workplaces within 10 years; or by 2017. (5)

35. More control for Aboriginal people over their own employment and academic programs. (5)

36. Return to work programs should include a comprehensive combination of adapted skills training, job search, job placement, on the job experience and life skills training in order to increase chances of transitional return to work. Health services should augment the return to work process when required. (5)

37. Use Social Assistance as a transition to work when possible with enhanced benefits that are time sensitive (i.e., five years) to ensure that they achieve their intended results. (5)

38. Increasing high-quality training and education opportunities for people most at risk-in particular, long-term unemployed people. (6)

39. Assessing economic policies for their potential health impacts due to unemployment. (6)

40. Maintaining financial support of unemployment benefits, and maintaining or strengthening active wage policies, where special efforts are made to secure jobs with adequate pay for those in the weakest position in the labour market. (6)

41. Improving the competence and capacity of the health sector to prevent a decline in health due to unemployment; for example, through outreach mental health services (Dahlgren & Whitehead, 2006; Acheson, 1998). (6)

42. Introducing comprehensive support programs (including day care) for children in less privileged families to promote healthy early childhood development is considered an important way to reduce health inequalities. A systematic review of day care programs for low-income families found that providing enhanced access to day care provides better educational, employment and financial achievement for mothers of children in day care. Even more than two decades later, children who experienced day care programs had less unemployment and higher earnings than those children who did not attend day care (Zoritch & Roberts, 1998). (6)

43. Tackling upstream causes of alcohol misuse in society- for example, the unemployment and social exclusion that triggers problem drinking. (6)

44. Implement employment equity policies and plans for the recruitment and retention of health system staff that reflect the diversity of the population. (7)

45. Ensure that laws and regulations under Employment Standards and WorkSafe BC are complied to by employers of migrant workers. (7)

46. Develop job coaching, counselling and specialty training services for refugees. (7)

47. Interventions for improving safety and security at the community level often involve engagement of local leaders in dispute resolution, investing in lighting and neighbourhood watch initiatives, educational and recreational activities (including job training opportunities), and licit and illicit drug-use prevention and harm reduction, but there are local contexts where other approaches are needed. (8)

48. Enact policies that progressively ensure full employment of the working-aged population, healthy working environments and secure conditions of employment. (9)

49. Make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. (10)

50. Support the efforts of governments to promote capacity and establish incentives to create a sustainable workforce in health and in other fields, especially in areas of greatest need. (10)

51. Increase access and use of quality lifelong learning opportunities across the social gradient, by:
    - Providing easily accessible support and advice for 16-25 year olds on life skills, training and employment opportunities.
    - Providing work-based learning, including apprenticeships, for young people and those changing jobs/careers
    - Increasing availability of non-vocational lifelong learning across the life course.

    (11)

52. Improve access to good jobs and reduce long-term unemployment across the social gradient. (11)

53. Make it easier for people who are disadvantaged in the labour market to obtain and keep work. (11)

54. Prioritize active labour market programs to achieve timely interventions to reduce long-term unemployment. (11)

55. Income, employment, and socio-economic status:
    - Provide a guaranteed minimum income; a living wage as the minimum wage; Improving pay equity
    - Restoring and improving income supports for those unable to gain employment
    - Reducing inequalities in income and wealth within the population through progressive

taxation of income and inherited wealth.
- Preserving and creating jobs
- Directing attention to the health needs of immigrants and to the unfavourable socio-economic position of many groups, including the particular difficulties many New Canadians face in accessing health and other care services.
- Restoring employment benefits and eligibility to previous levels
- Requiring that provincial social-assistance programs be accessible and funded at levels to assure health, especially for women of child-bearing age, children and seniors.
- Assuring that supports are available to citizens through critical life transitions, possibly by increasing the uptake of benefits in entitled groups. (12)

56. Work and working conditions
    - Enforcing legislation that protects the rights of minority groups, particularly concerning employment rights and anti-discrimination.
    - Assuring access to educational, training and employment opportunities, especially for those such as the long-term unemployed.
    - Supporting improved management practices that lead to increased levels of control, variety and appropriate use of skills into the workforce.
    - Assessing the impact of employment policies on health and inequalities in Health.
    - Ensuring accessible and safe cycling and walking routes to workplaces.
    - Enacting smoke-free workplace legislation. (12)

57. Make full and fair employment and decent work a central goal of national and international social and economic policy-making. (1)

58. Full and fair employment and decent work should be made a shared objective of international institutions and a central part of national policy agendas and development strategies, with strengthened representation of workers in the creation of policy, legislation, and programmes relating to employment and work. (1)

59. Achieving health equity requires safe, secure, and fairly paid work, year-round work opportunities, and healthy work-life balance for all. (1)

60. Provide quality work for men and women with a living wage that takes into account the real and current cost of healthy living. (1)

61. Protect all workers. International agencies should support countries to implement core labour standards for formal and informal workers; to develop policies to ensure a balanced work-home life; and to reduce the negative effects of insecurity among workers in precarious work arrangements (informal, temporary and part-time work). (1)

62. Improve the working conditions for all workers to reduce their exposure to material hazards, work related stress, and health-damaging behaviours. (1)

63. Include the economic contribution of housework, care work, and voluntary work in national accounts. (1)

64. A greater degree of unionized workplaces would most likely reduce income and wealth inequalities in Canada. Unionization helps to set limits on the extent of profit-making that comes at the expense of employees' health and wellbeing. (2)

65. National and international institutions need to be legally mandated to make agreements that provide basic standards of employment and work for everyone. (2)

66. Power inequalities between employers and employees need to be reduced through stronger legislation governing equal opportunity in hiring, pay, training, and career advancement. (2)

67. Workers, employers, government officials, and researchers need to develop a new vision of what constitutes healthy and productive work. (2)

68. More policy-relevant research must be pursued to support government's decision-making and to have an accurate and up-to-date picture of job security in Canada. (2)

69. Special focus should be on improving conditions of employees in high-strain low-income jobs. (2)

70. Collective and organized action through unionization of workplaces is an important means of balancing power between employers and employees. (2)

71. Working conditions can be made better when employees are provided with opportunities to influence their work environment. (2)

72. More quantitative and qualitative research on working conditions in Canada is urgently needed. (2)

73. Improving access to employment insurance for part-time workers would assist women who combine work and caregiving responsibilities. (2)

74. Creating policies that make it easier for workplaces to achieve collective agreements through unionization would be especially beneficial for Canadian women. (2)

75. Comprehensive prevention strategies should address the social and built environments of the priority settings of everyday living:
    - Neighbourhoods
    - Homes
    - Daycares and schools
    - Workplaces
    - Public places (restaurants, entertainment venues, grocery stores, retail stores, recreation facilities, spiritual settings)
    - Transportation settings (cars, buses, bicycle access)
    - Special community circumstances (urban built environment, rural areas, isolated communities) (13)

76. Create a better and safer working environment which reduces the risk of accidents and illness among the workforce. (2)

77. Develop consistent transport and land use planning policies that improve people's ability to access work and key services, and encourage greater exercise. (2)

78. Local authority transport planners will conduct accessibility planning in partnership with PCTs and other local bodies to improve access to jobs and services for disadvantaged groups and areas in Local Transport Plan areas. (2)

79. The business community will have a major role to play in regeneration and health initiatives from occupational health measures to local employment and procurement and beyond into supporting increased diversity in local recruitment and wider involvement in

community development and regeneration - for example, by investing in health and fitness centres accessible to those most in need. Jobcentre Plus can help with recruitment and retention issues but also plays a wider role developing job opportunities for people within local communities, as well as playing its part in LSPs. (2)

80. Encourage employers to take responsibility for health in the workplace through better access to information on health matters at work. (2)

81. Invest in adult education opportunities, skills upgrading, work and work clothing, child care, and stable, affordable housing. (3)

82. Limit exposure to physical hazards, chemicals, and psychosocial strains in workplaces. (14)

83. Increase opportunities for control over work demands. (14)

84. Reduce disruptive shift changes and extended work hours. (14)

85. Provide working parents with sufficient leave time to attend to children when they are sick. (14)

86. Minimize work-family conflict. (14)

87. Reduce the exposure of disadvantaged groups to conditions (food insecurity, pollution, and unsafe environments, for example) and health damaging behaviours (poor diet, tobacco use, etc.), while keeping the contexts of the target groups in mind. (4)

88. Return to work programs should include a comprehensive combination of adapted skills training, job search, job placement, on the job experience and life skills training in order to increase chances of transitional return to work. Health services should augment the return to work process when required. (5)

89. Use Social Assistance as a transition to work when possible with enhanced benefits that are time sensitive (i.e., five years) to ensure that they achieve their intended results. (5)

90. Maintaining financial support of unemployment benefits, and maintaining or strengthening active wage policies, where special efforts are made to secure jobs with adequate pay for those in the weakest position in the labour market. (6)

91. Include legislation and actions that remove physical hazards at work, improve psychosocial conditions, strengthen the possibilities to secure a healthy workplace and develop the workplace as a setting for health promotion. (6)

92. Intensifying interventions to reduce occupation-related health problems, such as back pain. Supporting occupational health services that emphasize primary and secondary prevention of workplace injuries and stress, including early warning systems for health hazards at work (including psychosocial risk factors). (6)

93. Working with companies and organizations to enhance the possibilities for employees to influence how the work is to be performed, especially in high-stress workplaces. A review of international case studies on improving psychosocial health in the workplace found that it was possible to make improvements by tailoring changes to specific workplaces. For example, changes made in the workplace included increased variety and understanding of the different tasks in a production process, workforce participation in identification of problems and their solutions, and altered shift patterns to make them less

tiring and disruptive to workers' personal lives (Karasek, 1992). (6)

94. Working toward equity-oriented workplace health policies within the health sector (Dahlgren & Whitehead, 2006), including those policies that build culturally-safe work environments. (6)

95. To reduce the additional negative health impact of alcohol misuse typically experienced among lower socio-economic groups, support systems can be developed in work settings and in the community, both for prevention of alcohol misuse among children and youth and for adults. (6)

96. Implement employment equity policies and plans for the recruitment and retention of health system staff that reflect the diversity of the population. (7)

97. Ensure that laws and regulations under Employment Standards and WorkSafe BC are complied to by employers of migrant workers. (7)

98. Develop job coaching, counselling and specialty training services for refugees. (7)

99. Create safe and healthy workplaces. (8)

100. Measures to ensure the provision of safe and healthy working environments, particularly in relation to cottage-based industries, need to be an integral component of initiatives to reduce health inequity. The exposure of the local population, often the poorest, to pollutants emitted from workplaces is another concern for health equity. Urban planning needs to consider how the environment, poverty, health and time to care for children are affected by travel distances and travel modes for commuting to work. In addition, insufficient income from work to cover the cost of living is a key social determinant. (8)

101. Future urban development needs to consider means to reduce unsustainable energy and resource use and supply of renewable energy. The indirect effects on global public health in the long run can no longer be ignored. Current and emerging eco-friendly approaches to town planning, housing design and workplace developments need to be systematically applied in order to minimize health inequalities in the future. (8)

102. Enact policies that progressively ensure full employment of the working-aged population, healthy working environments and secure conditions of employment. (9)

103. Strengthen occupational health safety and health protection and their oversight and encourage the public and private sectors to offer healthy working conditions so as to contribute to promoting health for all. (10)

104. Make it easier for people who are disadvantaged in the labour market to obtain and keep work. (11)

105. Improve quality of jobs across the social gradient. (11)

106. Encourage, incentivize and, where appropriate, enforce the implementation of measures to improve the quality of jobs across the social gradient, by:
- Ensuring public and private sector employers adhere to equality guidance and legislation
- Implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work. (11)

107. Develop greater security and flexibility in employment, by:
- Prioritizing greater flexibility of retirement age
- Encouraging and incentivizing employers to create or adapt jobs that are suitable for lone parents, careers and people with mental and physical health problems. (11)

108. Remove 'cliff edges' for those moving in and out of work and improve flexibility of employment. (11)

109. Income, employment, and socio-economic status:
- Provide a guaranteed minimum income; a living wage as the minimum wage;
- Improving pay equity
- Restoring and improving income supports for those unable to gain employment
- Reducing inequalities in income and wealth within the population through progressive taxation of income and inherited wealth.
- Preserving and creating jobs
- Directing attention to the health needs of immigrants and to the unfavourable socio-economic position of many groups, including the particular difficulties many New Canadians face in accessing health and other care services.
- Restoring employment benefits and eligibility to previous levels
- Requiring that provincial social-assistance programs be accessible and funded at levels to assure health, especially for women of child-bearing age, children and seniors.
- Assuring that supports are available to citizens through critical life transitions, possibly by increasing the uptake of benefits in entitled groups. (12)

110. Work and working conditions:
- Enforcing legislation that protects the rights of minority groups, particularly concerning employment rights and anti-discrimination.
- Assuring access to educational, training and employment opportunities, especially for those such as the long-term unemployed.
- Supporting improved management practices that lead to increased levels of control, variety and appropriate use of skills into the workforce.
- Assessing the impact of employment policies on health and inequalities in Health.
- Ensuring accessible and safe cycling and walking routes to workplaces
- Enacting smoke-free workplace legislation. (12)

APPENDIX E: REFERENCES

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Childhood, Early Child Development: Childhood development, including early childhood development includes the physical, social/emotional, and language/cognitive domains, each equally important—strongly influencing well-being, obesity/stunting, mental health, heart disease, competence in literacy and numeracy, criminality, and economic participation throughout life.

Adapted from: (World Health Organization, 2012)

APPENDIX F: Area for Action (Childhood)

Health Equity Recommendation Synthesis

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
4. Childhood	115	103

4.1. Identification, Prevention and Referral, and Support

- Vision, hearing, speech, dental screening
- FASD diagnosis, developmental delays, behaviour issues, disability, high risk mothers and families, pre/post natal care, family violence, abuse and family distress
- High risk mothers and families
- Immunization, and car safety
- Outreach and progressive support for Early Childhood Development (ECD) across the social gradient
- Easy access to services for children and families (e.g., health, welfare, and social services)
- Comprehensive Developmental Approach
- Language, literacy, physical social, emotional, and cognitive
- Exposure to inappropriate models in the media including violence

4.2. Mothers, Family, and Caregivers: Identification, Prevention and Referral, and Support

- Poverty, food security, pregnant women
- Mother/baby nutrition supplements and programs
- Child benefits and insurance for parental leave
- Income support for low income families
- Teen pregnancy prevention (e.g., sex education and counseling, birth control)
- Pre-natal and post-natal support (breastfeeding, depression, smoking cessation)
- Support for families, parents, and caregivers (e.g., clothing, toy lending, playgrounds, respite child care, and 'family friendly policies'

4.3. Child Care

- Day care, early care and nursery care, affordable care,
- Financial subsidies

- Standards, systems and programs

Original Source Document Recommendation Extractions
Childhood

1. Set up an interagency mechanism to ensure policy coherence for early child development. (1)

2. Commit to and implement a comprehensive approach to early life, building on existing child survival programmes and extending interventions in early life to include social/emotional and language/ cognitive development starting in pre-primary school. (1)

3. Make sure that all children, mothers, and other caregivers are covered by a comprehensive package of quality early child development programmes and services, regardless of ability to pay. (1)

4. Expand the provision and scope of education to include the principles of early child development (physical, social/emotional, and language/cognitive development). (1)

5. Early childhood development. (2)

6. Initiatives to address social, education, health, and housing needs, including the training of 10,000 health professionals over a 10-year period, the establishment of an Aboriginal peoples' university, and recognition of Aboriginal nations' authority over child welfare. (3)

7. Manitoba Government's departments of Health and Healthy Living, Youth and Seniors should work with relevant partners and stakeholders to develop a framework to analyse and improve the conditions of the settings of everyday life, establish guidelines for healthy settings, and develop strategies to implement these guidelines. (4)

8. For infant mortality, the interventions are:
    a. improving the quality and accessibility of antenatal care and early years support in disadvantaged areas - building on the lessons of Sure Start. (3)

9. Brushing for Life scheme to reduce inequalities in dental health of young children in sure start areas without water fluoridation. (3)

10. Early identification referral and tracking systems for identifying children at risk and supporting communication within and between agencies. (3)

11. Local authorities and PCTs will work together more closely on the delivery of Sure Start local programmes and Children's Centres. (3)

12. Social services can provide early access to support services for families experiencing challenging behaviour in their children. (3)

13. Develop better methods for preventing, diagnosing, and tracking the occurrence of fetal alcohol spectrum disorder. (5)

14. Continue to promote awareness of how to prevent sudden infant death syndrome. (5)

15. Continue to improve immunization coverage. (5)

16. Promote car safety including appropriate child seats. (5)

17. Tackle the larger issues that affect children's health and development: Poverty, food security, and social conditions. (5)

18. Focus on underlying factors that lead to illness, such as poverty, family distress, child abuse, inadequate housing, and untreated mental illness. (5)

19. We should set a goal to reduce the number of children not in school from 690 children under the age of 19 to no more than 100 children under the age of 19 by 2010. (6)

20. The KidsFirst program should include children and families that are in most need. (6)

21. Downstream Interventions - there are many examples of evidence-based community-level interventions and demonstration projects that have had positive effects on both poverty and health status. Many of these interventions focus on children and families in general, tackling child poverty by giving high priority to early medical, social and educational support to disadvantaged children and by enhancing income support and assistance to poor families and single parents are strategies that have been successful improving health. When combined with broader, more universal policies and programs, these kinds of strategies are expected to reduce health inequalities (Dahlgren & Whitehead, 2006). (7)

22. Introducing comprehensive support programs (including day care) for children in less privileged families to promote healthy early childhood development is considered an important way to reduce health inequalities. A systematic review of day care programs for low-income families found that providing enhanced access to day care provides better educational, employment and financial achievement for mothers of children in day care. Even more than two decades later, children who experienced day care programs had less unemployment and higher earnings than those children who did not attend day care (Zoritch & Roberts, 1998). (7)

23. Ensuring that children are provided as many advantages as possible for optimal development. (2)

24. These programs and services should be flexible, and meet the developmental, language, literacy and cultural needs of all children. They should also provide additional opportunities for the early identification of developmental delays, disabilities and other risk factors and appropriate referrals, encourage parent participation, enhance parents' understanding of child development through information, support and role modeling, build supportive social networks amongst children and families, and support and enhance the economic security of women and families. (2)

25. Healthier Families - Improving the health of children and families through policies that promote comprehensive, quality and affordable early childhood development and parenting services and programs ensuring that priority is given to those neighbourhoods and communities with the highest numbers of vulnerable children. Particular consideration should be given to the following components of early childhood development that have been shown to be successful and are recommended by First Call: BC Child and Youth Advocacy Coalition. (2)

26. Early Childhood Development (ECD) public health initiatives (e.g., home visits of all

newborns by community health nurses, and vision, hearing, dental and speech screening). (2)

27. Targeted early intervention strategies and services (e.g., supports for high-risk mothers during the pre and post-natal period, and specific supports for children with developmental delays, disabilities, and behavioural issues). (2)

28. Community based information and referral services (e.g., well-resourced information and referral resources). (2)

29. In order to maximize effectiveness, it is further recommended that these services be delivered by an ECD Central hub and co-located with child and family-friendly agencies (e.g., family resource centres, schools, libraries, neighbourhood houses, community centres). Consideration should be given to prorating charges according to family income with low or no fees required for low income families. (2)

30. Give special attention to gender-related aspects as well as early child development in public policies and social and health services. (8)

31. Reduce inequalities 1 in the early development of physical and emotional health, and cognitive, linguistic, and social skills. (9)

32. Build the resilience and well-being of young children across the social gradient. (9)

33. Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient. (9)

34. Support families to achieve progressive improvements in early child development, including:
    1. Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
    2. Providing paid parental leave in the first year of life with a minimum income for healthy living
    3. Providing routine support to families through parenting programs, children's centres and key workers, delivered to meet social need via outreach to families
    4. Developing programs for the transition to school. (9
)
35. Make sure that all children, mothers, and other caregivers are covered by a comprehensive package of quality early child development programmes and services, regardless of ability to pay. (1)

36. Invest in formal and vocational education and training, guarantee pay-equity by law, ensure equal opportunity for employment at all levels, and set up family-friendly policies that ensure that women and men can take on care responsibilities in an equal manner. (1)

37. Early childhood development. (2)

38. Providing support and benefits to families through public policies forms a base for healthy childhood development. Providing higher wages and social assistance benefits would reduce child poverty and be one of the best means to improve early childhood development. (3)

39. Initiatives to address social, education, health, and housing needs, including the training of 10,000 health professionals over a 10-year period, the establishment of an Aboriginal peoples' university, and recognition of Aboriginal nations' authority over child welfare. (3)

40. Improving access to employment insurance for part-time workers would assist women who combine work and caregiving responsibilities. (3)

41. Improving the quality and accessibility of antenatal care and early years support in disadvantaged areas - building on the lessons of Sure Start. (3)

42. Reducing smoking and improving nutrition in pregnancy and early years, including increasing the number of mothers who breastfeed. (3)

43. Preventing teenage pregnancy and supporting teenage parents. (3)

44. Maternity and Child Health and Child Development. (3)

45. Focus on early ante-natal booking and take up rates for women from low income backgrounds. (3)

46. Increase take-up and duration breastfeeding for new mothers, especially those in low income groups through training health professionals and encouraging peer support programs. (3)

47. Ensure that women and young children from low income families have access to healthy diet and provide increased support for breastfeeding mothers. (3)

48. Reducing teenage pregnancy and supporting teenage mothers. (3)

49. Provide early antenatal booking and smoking cessation services in suitable settings for teenage mothers and their partners. (3)

50. Improve nutrition of families and children and other groups in disadvantaged areas by increasing access to and consumption of fruits and vegetables and by increasing uptake and duration of breastfeeding. (3)

51. Local authorities and PCTs will work together more closely on the delivery of Sure Start local programmes and Children's Centres. (3)

52. PCTs can encourage low-income mums to initiate and continue breastfeeding by targeting support at low income and black and minority ethnic groups, using link workers and community mothers schemes. (3)

53. Schools can participate in the Food in Schools programme improving the diet and nutrition of children. (3)

54. PCTs can work closely with local authorities on the delivery of Sure Start local programmes and other local strategies in their areas. (3)

55. Work with Aboriginal communities to develop culturally appropriate reproductive care programs, including better prenatal access, outreach, and nutrition programs for mothers and infants. (5)

56. Continue to monitor the birth weights of Status Indian infants, to better understand the factors that affect it. (5)

57. Develop culturally sensitive and supportive programs to address the root cause of alcohol and substance use and to help achieve better health outcomes for mothers and their infants. (5)

58. Tackle the larger issues that affect children's health and development: Poverty, food security, and social conditions. (5)

59. Offer income supports to families for newborns. (10)

60. Reduce child poverty. (3)

61. Parents with children who are on social assistance should have their shelter allowances and their adult allowances (i.e., food, clothing) doubled in order to raise children to the LICO. (6)

62. Establish a Child Poverty Protection Plan to reduce poverty in children in Saskatchewan. (6)

63. The minimum wage should be increased to $10 per hour in order to encourage employment, make work more attractive than employment assistance, and lower the amount of children living in poverty. (6)

64. Maintaining financial support of unemployment benefits, and maintaining or strengthening active wage policies, where special efforts are made to secure jobs with adequate pay for those in the weakest position in the labour market. (7)

65. Strengthening family-friendly employment policies, including the availability of child care. (7)

66. Downstream Interventions - there are many examples of evidence-based community-level interventions and demonstration projects that have had positive effects on both poverty and health status. Many of these interventions focus on children and families. In general, tackling child poverty by giving high priority to early medical, social and educational support to disadvantaged children and by enhancing income support and assistance to poor families and single parents are strategies that have been successful improving health. When combined with broader, more universal policies and programs, these kinds of strategies are expected to reduce health inequalities (Dahlgren & Whitehead, 2006). (7)

67. Federal Child Benefit - Combining the Canada Child Tax Benefit base benefit and National Child Benefit Supplement into a single refundable benefit and making it available to all low-income families, with no reduction of other benefits to offset the increase. Considering revising income thresholds and benefit reductions to avoid undue hardship on lower-income families as their work incomes rise. (2)

68. Income Assistance - Increasing welfare rates and indexing the rates to annual increases in the cost of living. About half of the increase will be required to make up for the erosion in purchasing power since 1994. Considering a mechanism to improve the income status of pregnant women. (2)

69. These programs and services should be flexible, and meet the developmental, language, literacy and cultural needs of all children. They should also provide additional opportunities for the early identification of developmental delays, disabilities and other risk factors and appropriate referrals, encourage parent participation, enhance parents' understanding of child development through information, support and role modeling, build supportive social networks amongst children and families, and support and enhance the economic security of women and families. (2)

70. Healthier Families - Improving the health of children and families through policies that promote comprehensive, quality and affordable early childhood development and parenting services and programs ensuring that priority is given to those neighbourhoods and communities with the highest numbers of vulnerable children. Particular consideration should be given to the following components of early childhood development that have been shown

to be successful and are recommended by First Call: BC Child and Youth Advocacy Coalition. (2)

71. Adequately resourced and well-coordinated supports for parents, families and other caregivers (e.g., information, resources and workshops about child development and parenting, clothing exchanges and toy lending, drop-in, emergency and respite childcare, and outreach through mobile drop-in programs and playground programs). (2)

72. In order to maximize effectiveness, it is further recommended that these services be delivered by an ECD Central hub and co-located with child and family-friendly agencies (e.g., family resource centres, schools, libraries, neighbourhood houses, community centres). Consideration should be given to prorating charges according to family income with low or no fees required for low income families. (2)

73. Ensure gender equity and the promotion and protection of early childhood development in all policies. (11)

74. Ensure high quality maternity services, parenting programs, childcare and early years education to meet need across the social gradient. (9)

75. Support families to achieve progressive improvements in early child development, including:
    1. Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
    2. Providing paid parental leave in the first year of life with a minimum income for healthy living
    3. Providing routine support to families through parenting programs, children's centres and key workers, delivered to meet social need via outreach to families
    4. Developing programs for the transition to school.
    (9)
76. Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people. (9)

77. Child Development:
    -Ensuring that families have sufficient income to provide their children with the means for healthy development.
    -Providing high-quality preschool education.
    -Developing a high-quality, national day-care program
    -Implementing policies that increase the prevalence of breast-feeding.
    -Providing social and emotional support to expectant parents and parents with young children via social and health services.
    (12)
78. Governments must guarantee that affordable and quality child care is available for all families. (3)

79. Providing affordable housing and childcare would reduce other family expenses and leave more money for acquiring an adequate diet. (3)

80. Facilitating mothers' employment through job supports, making available affordable childcare, and providing employment training would serve to reduce food insecurity among the most vulnerable Canadian families. (3)

81. Providing a national affordable high quality childcare program would provide opportunities for women to engage in the workplace and improve their financial situations. (3)

82. Comprehensive prevention strategies should address the following priority health related

behaviours:
• appropriate care and support for children and others who are in need at any stage of the life course
• healthy relationships at home, school, work and in all community settings (self-respectful, mutually respectful, caring, and supportive; free from abuse, violence, intolerance, exploitation, sexism, and racism)
• healthy sexuality (mutually respectful and consenting, using appropriate disease prevention and contraception)
• healthy hygiene practices (hand washing, cough etiquette, food handling)
• protection and sustainability of the natural environment (protection of our water, soil, air, ecology; sustainable management of non-renewable resources and greenhouse gases)
• safety and injury prevention (seatbelt use, other motor-vehicle safety, bicycle helmet use, falls prevention, workplace safety, safety in other settings)
• mental, emotional and spiritual well-being (lifelong learning, work-life balance, personal stress management), balancing active living (adequate and regular physical activity), sedentary activities (television, video games, computers), and adequate relaxation and sleep
• healthy diet (recommended levels of adequate nutrients, fiber, vitamins, calories, saturated fats, refined carbohydrates, alcohol, and salt); oral and dental hygiene
• avoidance of harmful substances (tobacco, illicit drugs) and addictions (including alcohol, prescription drugs); safe levels of exposure to harmful environmental risks (radon, asbestos, ultraviolet radiation)
• appropriate use of preventive health services (vaccinations, screening); harm reduction programs (safe use of injection drugs, sexually transmitted disease prevention); healthcare (primary care, prenatal care); and other services (addictions treatment, dental care, dieticians, personal and family counseling, other allied health services) (4)

83. Ensure that women and young children from low income families have access to healthy diet and provide increased support for breastfeeding mothers. (3)

84. Access to high quality nursery and childcare in disadvantaged areas. (3)

85. Specialist health care staff can work from outreach centres including schools and neighbourhood nurseries. (3)

86. Invest in adult education opportunities, skills upgrading, work and work clothing, child care, and stable, affordable housing. (5)

87. Introducing comprehensive support programs (including day care) for children in less privileged families to promote healthy early childhood development is considered an important way to reduce health inequalities. A systematic review of day care programs for low-income families found that providing enhanced access to day care provides better educational, employment and financial achievement for mothers of children in day care. Even more than two decades later, children who experienced day care programs had less unemployment and higher earnings than those children who did not attend day care (Zoritch & Roberts, 1998). (7)

88. Provide childcare for two years post-arrival. (13)

89. Measures to ensure the provision of safe and healthy working environments, particularly in relation to cottage-based industries, need to be an integral component of initiatives to reduce health inequity. The exposure of the local population, often the poorest, to pollutants emitted from workplaces is another concern for health equity. Urban planning needs to consider how the environment, poverty, health and time to care for children are affected by travel distances

and travel modes for commuting to work. In addition, insufficient income from work to cover the cost of living is a key social determinant. (14)

90. Child Care Subsidy Program - Reinvesting in the Child Care Subsidy Program. (2)

91. Affordable High Quality Child Care and Other Early Learning Programs - Developing an affordable, accessible, high quality child care system and early learning opportunities for British Columbia (e.g., full-day kindergarten options for children aged three to five, such as those being explored by BC's provincial government). (2)

92. Designated resources for access and participation (e.g., proactive outreach strategies such as resources for transportation, translation, interpretation, literacy assistance, or provision of food and childcare as part of programs in order to address barriers to access). (2)

93. Reduce inequalities 1 in the early development of physical and emotional health, and cognitive, linguistic, and social skills. (9)

94. Ensure high quality maternity services, parenting programs, childcare and early years education to meet need across the social gradient. (9)

95. Support families to achieve progressive improvements in early child development, including:
    1. Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
    2. Providing paid parental leave in the first year of life with a minimum income for healthy living
    3. Providing routine support to families through parenting programs, children's centres and key workers, delivered to meet social need via outreach to families
    4. Developing programs for the transition to school.
    (9)
96. Provide good quality early years education and childcare proportionately across the gradient. This provision should be:
    1. Combined with outreach to increase the take-up by children from disadvantaged families
    2. Provided on the basis of evaluated models and to meet quality standards.
    (9)
97. Child Development
    -Ensuring that families have sufficient income to provide their children with the means for healthy development.
    -Providing high-quality preschool education.
    -Developing a high-quality, national day-care program
    -Implementing policies that increase the prevalence of breast-feeding.
    -Providing social and emotional support to expectant parents and parents with young children via social and health services.
    (12)

APPENDIX F: REFERENCES

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APPENDIX G: Area for Action (Education)

Health Equity Recommendation Synthesis

Education: Education is a learning process that plays a crucial role in the development of healthy, inclusive and equitable social, psychological and physical environments. It is informed by best practice and is multi-dimensional in its design and learner-centred in its approach. It empowers individuals and communities with knowledge, motivation, skills and confidence (self-efficacy) conducive to positive societal engagement and the benefit of all.
Adapted from: World Health Organization. Health promotion glossary.

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
5. Education	121	74

5.1. Addressing Barriers and Facilitators

5.1.1. Adequate financing

- Financial barriers;
- Financing reform;
- Materials;
- Support students in one year programs;
- Finance training for unemployed; waive low income student university tuition;
- Cap university tuition;
- Increase provincial funding for university tuition;
- Loan reduction program

5.1.2. Best practices

- Well-developed curricula;
- Sustainable education;
- Academic support;
- Programs that raise education levels;
- Differing learning abilities and strengths;
- Educational opportunities;
- Literacy skills;
- Ensure cultural competence is embedded in education and training;
- ESL classes for differing learning abilities;
- ESL classes for illiterate persons;
- Incorporating factors leading to success in school (i.e., leadership, school climate, staff, funding & resources, community, programs)

5.1.3. Lifelong learning

- Education and training opportunities;
- Young people not in education, employment or training;
- Increase age that youth can legally stop attending school to 18 unless high school graduation has occurred

5.1.4. Extended schools

- Provide health and social services in schools;
- Use tools including websites, resources and directory of relevant community organizations;
- Schools open on evenings and weekends to provide recreation;
- Healthy schools program;
- Develop school-based workforce to work across school-home boundaries;
- Develop school-based workforce to address social and emotional development, Physical and mental health and well-being;

- Nutrition programs

5.1.5. Social inequalities

- Social inequalities in pupil's educational outcomes is a sustained priority;
- Addressing racism;
- Reduce differences;
- Return to education;
- Aboriginal education to the level of the general population;
- Improve education opportunities for Aboriginal people;
- Equalized access to quality education k-12;
- Closing gaps in education and skills in females

5.1.6. Education goals:

- Enrolment; retention; attendance; attainment; graduation; qualifications and skills;
- Aboriginal;
- Low income children

5.2. Early Childhood Education

- ECD interventions for low income youth;
- Preschool program;
- Daycares;
- Pre-primary school;
- Support transition to school;
- Readiness for school

5.3. Formal Education

5.3.1. Primary and Secondary

- Literacy; physical literacy;
- 'Full service' extended approach;
- Kindergarten program;
- Equalized access to quality education in K-12;
- 'Whole child' approach to education by supporting families and communities;
- Community role; Community schools; Active Transport (cycling, walking) routes;
- Additional resources for serving disadvantaged children;
- On alcohol, on drugs, on relationship, on sex;
- Life skills, personal, social, and health education;
- Gains in student knowledge, attitudes, self-esteem and health behaviour;
- Health promoting;
- Health programs

5.3.2. Post-secondary

- Qualified persons attend college;
- More low-income students attend university;
- Aboriginal people's university;
- Vocational

5.3.3. Professional

- Train planners, engineers, architects and other professionals about the health equity impacts of design and urban planning;
- Standard and compulsory SDH into medical and health training;
- Train 10,000 Aboriginal health professionals over a 10-year period

5.4. Adult Education

- Literacy;
- Skill development, skills training, and skills upgrading;
- Applied learning;
- Non-vocational learning;
- Long-term unemployed

Original Source Document Recommendation Extractions
Education

1. Provide quality compulsory primary and secondary education for all boys and girls, regardless of ability to pay. Identify and address the barriers to girls and boys enrolling and staying in school and abolish user fees for primary school. (1)

2. Build quality health-care services with universal coverage, focusing on Primary Health Care. (1)

3. Develop and finance policies and programmes that close gaps in education and skills, and that support female economic participation. (1)

4. Invest in formal and vocational education and training, guarantee pay-equity by law, ensure equal opportunity for employment at all levels, and set up family-friendly policies that ensure that women and men can take on care responsibilities in an equal manner. (1)

5. Educational institutions and relevant ministries act to increase understanding of the social determinants of health among non-medical professionals and the general public. (1)

6. Elected representatives must commit themselves to adequately funding the Canadian education system so that schools are able to provide well-developed curricula for students. (2)

7. Tuition fees for university and college education must be better controlled by Canadian governments so that fees do not exclude children of low-income families from higher education. (2)

8. Unemployed Canadians must be provided access to adequate income, training, and employment opportunities through enhanced government support. (2)

9. Initiatives to address social, education, health, and housing needs, including the training of 10,000 health professionals over a 10-year period, the establishment of an Aboriginal peoples' university, and recognition of Aboriginal nations' authority over child welfare. (2)

10. Canadians institutions must recognize the existence of racism in Canada and develop awareness and education programs that outline the adverse effects of racism. (2)

11. Narrow the gap in education attainment for young people from disadvantaged backgrounds through improved targeting. (2)

12. Reduce truancy. (2)

13. Use culture and creativity to increase engagement and improve school attendance among pupils at risk of low educational attainment in disadvantaged areas. (2)

14. Expand early intervention services so that every young person with a first episode of psychosis be treated promptly and receive the intensive support they need during the first three years of their illness with the aim to keep them in or helping them to return to education or employment. (2)

15. As well as their vital role in raising educational attainment and the delivery of personal, social and health education (PSHE), schools will be involved in supporting the health inequalities

agenda through:
- Extended Schools
- National Healthy Schools Programme

(2)

16. By leading the development of regional economic strategies and through allocating an integrated pot of funding they provide leadership and practical support in promoting economic regeneration sustained by developing social infrastructure - in areas such as skills development. Sustainable work and education are important determinants of health inequality, and targeting development opportunities at the most deprived communities will be an important way to break the cycle of disadvantage. (2)

17. Work collaboratively to improve housing conditions and economic and educational opportunities for Aboriginal people. (3)

18. Schools can provide strategies that will incorporate the factors that are linked to success in school. These factors fit into six categories: Leadership, school climate, staff, funding and resources, community, and programs. (3)

19. Set clear, measurable goals for employment, income, and education levels of Aboriginal people equal to those within the general population, along with methods for public reporting of results. (3)

20. Continue to improve the socio-economic status of the Aboriginal population by creating more educational and job opportunities. (3)

21. Focus on implementing demonstrated best practices so that Aboriginal children can fully benefit from educational opportunities. (3)

22. Reform school financing to equalize access to quality education in K through 12. (4)

23. Reduce financial barriers that prevent qualified students from attending college. (4)

24. Increase access to recreational facilities through construction support and policies to open up schools and other institutions evenings or weekends. (4)

25. Reduce poverty itself, which is the first approach (Mackenbach, 1994). This is done by raising levels of educational attainment, by working to reduce unemployment, and by raising the income of those at the bottom of the social hierarchy. The means for accomplishing this are known: allowances, income supplements, and programs that raise education levels. (5)

26. We should set a goal to reduce the number of children not in school from 690 children under the age of 19 to no more than 100 children under the age of 19 by 2010. (6)

27. We should set a goal that 90% of Aboriginal children graduate from high school within 10 years (or by 2017) up from the current graduation rate of 48%. (6)

28. Provide health and social services to schools in low income neighbourhoods in order to prevent school drop-out, encourage academic achievement, increase graduation rates and improve health. (6)

29. The skills training sessions should be adapted to include academic support and if required support from health services (i.e., mental health). (6)

30. Cap the student portion of university tuition fees while increasing the provincial portion in funding. The student portion for low income students should be waived altogether. (6)

31. Increase the age that a youth can legally stop attending school from 16 years old to 18 years old; unless high school graduation has already been obtained. (6)

32. Efforts to reduce differences in education or income between socio-economic groups are likely to have a positive effect. (7)

33. Given the significant influence of education on population health status, programs and policies that help to "narrow the gap" by providing educational opportunities (usually for low-income individuals and families) are considered crucial for reducing health inequalities. For instance, identifying and reducing economic, social and other barriers to gaining access to education at all levels (and at all life stages), and increasing access to education and training for disadvantaged groups are recommended strategies (Acheson, 1998). There is also a need to provide culturally relevant and acceptable curricula to ethnic populations, particularly Aboriginal populations. (7)

34. Comprehensive Healthy Schools Programs (delivered with a focus on equity) offer another opportunity to reduce health inequalities over the long-term. An evaluation of health-promoting schools found that this approach to health promotion can lead to gains in students' knowledge, attitudes, self-esteem and health behaviours, particularly in elementary schools (Hamilton & Saunders, 1997). However, there is no evidence yet that these approaches differentially improve health among disadvantaged children or are particularly effective in low-income areas (Acheson, 1998). For Healthy Schools Programs to effectively decrease inequalities in health; there must be attention paid to the particular needs of children experiencing disadvantage. (7)

35. Develop partnerships with universities and colleges to ensure health literacy is embedded within the education of future health care professionals. (8)

36. Develop linkages with English as a Second Language (ESL) classes to support the introduction of health literacy curricula. (8)

37. Introduce health promotion and education materials in a variety of formats, such as pictorial flashcards and role playing, tailored to a different learning abilities and strengths. (8)

38. Partner with universities and colleges to ensure cultural competence is embedded in medical education and training. (8)

39. Utilize existing websites created for primary care teams and health care providers to provide information on best practices in providing care for diverse populations. Include tools, resources, and a directory of relevant community organizations. (8)

40. Increase diversity of types of English as a second language classes, including programs for illiterate people, different learning abilities, locations, rates of learning, etc. (8)

41. Increasing access to education, improving educational outcomes, and enhancing literacy skills. (9)

42. Strong Start Program - Enhancing the Strong Start program so that it is based on evidence of what works, is appropriately funded, and has a strong evaluation component. (9)

43. Community Links - Enhancing the Community Links program, that provides resources to students. (8)

44. BC Loan Reduction Program - Reinvesting in the BC Loan Reduction Program to encourage

more low-income students to attend university. (9)

45. Support for Low-Income Students - Strengthening support for low income students by extending financial support to students in one-year programs. (9)

46. Reduce the social gradient 1 in skills and qualifications. (10)

47. Improve the access and use of quality lifelong learning across the social gradient. (10)

48. Ensure that reducing social inequalities in pupils' educational outcomes is a sustained priority. (10)

49. Prioritize reducing social inequalities in life skills, by:
    - Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education
    - Consistently implementing 'full service' extended school approaches
    - Developing the school-based workforce to build their skills in working across school-home boundaries and addressing social and emotional development, physical and mental health and well-being.

    (10)
50. Increase access and use of quality lifelong learning opportunities across the social gradient, by:
    - Providing easily accessible support and advice for 16-25 year olds on life skills, training and employment opportunities
    - Providing work-based learning, including apprenticeships, for young people and those changing jobs/careers
    - Increasing availability of non-vocational lifelong learning across the life course.

    (10)
51. National targets for child development across the social gradient
    It is proposed that national targets should cover:
    - Readiness for school (to capture early years development)
    - Young people not in education, employment or training (to capture skill development during the school years and the control that school leavers have over their lives).

    (10)
52. Education
    - Further developing the concept of "health-promoting schools", including improved nutrition programs at schools.
    - Providing additional resources for schools serving children from less-well-off groups.
    - Ensuring safe cycling and walking routes to schools.

    (11)
53. Dealing with racism: Complementing courses in cross cultural understanding and communication, the relevance of measures to combat racism was also identified. These might take the form of specific training and public education, as well as through direct intervention by state and other authorities. (12)

54. Commit to and implement a comprehensive approach to early life, building on existing child survival programmes and extending interventions in early life to include social/emotional and language/ cognitive development starting in pre-primary school. (1)

55. Early childhood development. (9)

56. Comprehensive prevention strategies should address the social and built environments of the priority settings of everyday living:
    - Neighbourhoods

- Homes
- Daycares and schools
- Workplaces
- Public places (restaurants, entertainment venues, grocery stores, retail stores, recreation facilities, spiritual settings)
- Transportation settings (cars, buses, bicycle access)
- Special community circumstances (urban built environment, rural areas, isolated communities)

(13)

57. Improve school health programs that include education on drugs, alcohol and tobacco and sex and relationship education. (2)

58. Reduce truancy. (2)

59. Use culture and creativity to increase engagement and improve school attendance among pupils at risk of low educational attainment in disadvantaged areas. (2)

60. Develop clear guidance on arrangements for all homeless families and their children to ensure that their health, education and social service needs are met. (2)

61. Help teenage parents secure access to education through government supports. (2)

62. Provide access to high quality early childhood education for all children. (4)

63. The pre-school and pre-kindergarten programs should be expanded in community schools in low income neighbourhoods and be provided at no direct cost to low income parents. (6)

64. More control for Aboriginal people over their own employment and academic programs. (6)

65. Interventions for improving safety and security at the community level often involve engagement of local leaders in dispute resolution, investing in lighting and neighbourhood watch initiatives, educational and recreational activities (including job training opportunities), and licit and illicit drug-use prevention and harm reduction, but there are local contexts where other approaches are needed. (14)

66. Increasing access to education, improving educational outcomes, and enhancing literacy skills. (9)

67. Ensure high quality maternity services, parenting programs, childcare and early years education to meet need across the social gradient. (10)

68. Support families to achieve progressive improvements in early child development, including:
    - Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy.
    - Providing paid parental leave in the first year of life with a minimum income for healthy living.
    - Providing routine support to families through parenting programs, children's centres and key workers, delivered to meet social need via outreach to families.
    - Developing programs for the transition to school.

    (10)

69. Provide good quality early years education and childcare proportionately across the

gradient. This provision should be:

- Combined with outreach to increase the take-up by children from disadvantaged families
- Provided on the basis of evaluated models and to meet quality standards.

(10)

70. National targets for child development across the social gradient. It is proposed that national targets should cover:

- Readiness for school (to capture early years development)
- Young people not in education, employment or training (to capture skill development during the school years and the control that school leavers have over their lives).

(10)

71. Child Development

- Ensuring that families have sufficient income to provide their children with the means for healthy development.
- Providing high-quality preschool education.
- Developing a high-quality, national day-care program
- Implementing policies that increase the prevalence of breast-feeding.
- Providing social and emotional support to expectant parents and parents with young children via social and health services.

(11)

72. A commonly mentioned ingredient for tackling poverty and associated low socioeconomic status is through investment in education, more particularly that of children. Investment in education was also seen as a critical ingredient in strengthening Indigenous communities. (12)

73. Provide quality compulsory primary and secondary education for all boys and girls, regardless of ability to pay. Identify and address the barriers to girls and boys enrolling and staying in school and abolish user fees for primary school. (1)

74. Invest in formal and vocational education and training, guarantee pay-equity by law, ensure equal opportunity for employment at all levels, and set up family-friendly policies that ensure that women and men can take on care responsibilities in an equal manner. (1)

75. Incorporate the social determinants of health into medical and health training and make it standard and compulsory, and improve social determinants of health literacy more widely. Train policy-makers and planners in the use of health equity impact assessment. (1)

76. Educational institutions and relevant ministries act to increase understanding of the social determinants of health among non-medical professionals and the general public. (1)

77. Tuition fees for university and college education must be better controlled by Canadian governments so that fees do not exclude children of low-income families from higher education. (2)

78. Initiatives to address social, education, health, and housing needs, including the training of 10,000 health professionals over a 10-year period, the establishment of an Aboriginal peoples' university, and recognition of Aboriginal nations' authority over child welfare. (2)

79. Improve school health programs that include education on drugs, alcohol and tobacco and sex and relationship education. (2)

80. Develop sports facilities to develop physical literacy and maintain active lifestyles. (2)

81. Encourage greater use of school facilities to deliver services for the local community. (2)

82. As well as their vital role in raising educational attainment and the delivery of personal, social and health education (PSHE), schools will be involved in supporting the health inequalities agenda through:
    - National School Fruit Scheme
    - Extended Schools

    (2)
83. Provision of sporting activity, including New Opportunities for PE and Sport in Schools. (2)

84. National Healthy Schools Programme. (2)

85. Participation in local teenage pregnancy strategies. (2)

86. The Food in Schools programme. (2)

87. Mentoring programmes by local business. (2)

88. Individuals also have to be responsible for their own health and that of their children by making appropriate and informed lifestyle choices on smoking, diet and exercise, all of which can widen health inequalities. It is essential that such choices should be informed by clear and accurate advice. Schools have a vital part to play while charities and health care professionals, including community pharmacists and dentists, can advise how to quit smoking, offer exercise on prescription, identify patients at risk of heart disease and provide services for substance miss-users. (2)

89. schools can participate in the Food in Schools programme, improving the diet and nutrition of children. (2)

90. specialist health care staff can work from outreach centres including schools and neighbourhood nurseries. (2)

91. Provide strategies that will incorporate the factors that are linked to success in school. These factors fit into six categories: Leadership, school climate, staff, funding and resources, community, and programs. (15)

92. Reduce financial barriers that prevent qualified students from attending college. (4)

93. Ban sale of soft drinks and junk foods in schools. (4)

94. Modify school lunch programs to improve nutrition. (4)

95. Provide health and social services to schools in low income neighbourhoods in order to prevent school drop-out, encourage academic achievement, increase graduation rates and improve health. (6)

96. Child care should be provided to all low income parents at no direct cost in community schools in low income neighborhoods. (6)

97. The pre-school and pre-kindergarten programs should be expanded in community schools in low income neighbourhoods and be provided at no direct cost to low income parents. (6)

98. Cap the student portion of university tuition fees while increasing the provincial portion in funding. The student portion for low income students should be waived altogether. (6)

99. Comprehensive Healthy Schools Programs (delivered with a focus on equity) offer another opportunity to reduce health inequalities over the long-term. An evaluation of health-promoting schools found that this approach to health promotion can lead to gains in students' knowledge, attitudes, self-esteem and health behaviours, particularly in elementary schools (Hamilton & Saunders, 1997). However, there is no evidence yet that these approaches differentially improve health among disadvantaged children or are particularly effective in low-income areas (Acheson, 1998). For Healthy Schools Programs to effectively decrease inequalities in health there must be attention paid to the particular needs of children experiencing disadvantage. (7)

100. Develop linkages with local community stakeholders, including community programs, organizations, agencies, faith communities, early settlement services, and educational or school programs to share information with currently underserved groups about navigating and accessing health system programs and services. (8)

101. Land-use planning should address the links between "planning/design for health" and design for sustainability, safety and walkability. The application of theories of "new urbanism" and smart growth to planning are not only good for the environment, they are also good for health. Planning schools need to train planners explicitly to consider the health and equity impacts of their design and learn to plan/design for health. The same applies to the training of engineers, architects and other professionals involved in urban planning and design. (14)

102. BC Loan Reduction Program - Reinvesting in the BC Loan Reduction Program to encourage more low-income students to attend university. (9)

103. Make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. (15)

104. Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people. (10)

105. Prioritize reducing social inequalities in life skills, by:

- Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education
- Consistently implementing 'full service' extended school approaches
- Developing the school-based workforce to build their skills in working across school-home boundaries and addressing social and emotional development, physical and mental health and well-being.

(10)

106. Education

- Further developing the concept of "health-promoting schools", including improved nutrition programs at schools.
- Providing additional resources for schools serving children from less-well-off groups.
- Ensuring safe cycling and walking routes to schools.

(11)

107. Support local enterprise, including social enterprises and business development, and encourage community entrepreneurship to improve local job opportunities and skill development. (2)

108. The NHS also has a role alongside other public services in contributing to the local regeneration agenda by being a good 'corporate citizen'. Within the NHS, employment and

procurement policies, the capital build, and training and skills programmes provide opportunities to link health with regeneration by supporting local economies and make the best use of the extra investment in the NHS. (2)

109. The NHSU, the new corporate university for the NHS needs to develop the skills of NHS staff to tackle health inequalities through practical learning opportunities. (2)

110. Invest in adult education opportunities, skills upgrading, work and work clothing, child care, and stable, affordable housing. (3)

111. Learning institutions like SIAST should allocate 10% of their existing skills training vacancies to adults who have been on social assistance for more than one year to take the program at no cost. (6)

112. The skills training sessions should be adapted to include academic support and if required support from health services (i.e., mental health). (6)

113. Re-allocate funding from job search initiatives with limited success to skills enhancement programs. (6)

114. Return to work programs should include a comprehensive combination of adapted skills training, job search, job placement, on the job experience and life skills training in order to increase chances of transitional return to work. Health services should augment the return to work process when required. (6)

115. Increasing high-quality training and education opportunities for people most at risk-in particular, long-term unemployed people. (7)

116. Adult Literacy, Education & Training - Increasing resources for adult literacy, basic education and skills training. (9)

117. Reduce the social gradient 1 in skills and qualifications. (10)

118. Prioritize reducing social inequalities in life skills, by:

- Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education
- Consistently implementing 'full service' extended school approaches
- Developing the school-based workforce to build their skills in working across school-home boundaries and addressing social and emotional development, physical and mental health and well-being.

(10)

119. Increase access and use of quality lifelong learning opportunities across the social gradient, by:

- Providing easily accessible support and advice for 16-25 year olds on life skills, training and employment opportunities
- Providing work-based learning, including apprenticeships, for young people and those changing jobs/careers
- Increasing availability of non-vocational lifelong learning across the life course. (10)

APPENDIX G: REFERENCES

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APPENDIX H: Area for Action (Environment)

Health Equity Recommendation Synthesis

Environment: The physical environment consists of two main components the natural environment (air, water and soil) and the built environment (housing, indoor air quality, community design, transportation and food systems).

Adapted from: Tri-Project Glossary Working Group. Towards an Understanding of Health Equity: Glossary

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
6. Environment	133	83

6.1. Physical and Social Infrastructure Development, Maintenance, and Improvement

6.1.1. Planning

- Healthy cities, physical/social
- Rural/urban/isolated/informal
- Zoning/land use, design, improvement
- **Considerations for planning:** migration trends; building for social interaction; for neighbourhood livability; eco-friendly (e.g., energy efficiency, minimize resource use); health focused; for safety; proactive; 'smart growth' & 'new urbanism'; inclusionary/avoiding segregation; mixed land use and proximities (e.g., home to work); anticipate economic, demographic and technological change; coordinate infrastructure and services; lighting; outdoor landscaping and parks; aesthetics; financing

6.1.2. Services

- Water management (e.g., monitoring standards training and certification, potable, quality, fluoridation)
- Sewage management (e.g., drains for waste water),
- Waste management
- Clean pleasant surroundings (e.g., street cleaning)
- Control vector-borne diseases

6.1.3. Built Environment

- Transportation (aesthetics, safety/injury, traffic patterns, paved, multiple forms, options for commute), alternatives to automobile, active, pedestrian (sidewalks, crosswalks), connectivity of streets to enable walking between locations, cycle, public transportation
- Housing, housing the poor, home ownership and rental options including location options, approval process speed for affordable housing
- Slum/informal settlement (upgrading, recognizing legal status, prevent formation)
- Forest areas
- Retail , buildings
- Green spaces, leisure/recreational facilities, park, playground, children's centres
- Water and waste systems
- Health and social services
- Alcohol and tobacco: retail outlets (hours of operation, location, concentration), advertising, ban smoking in public areas, second hand smoke

6.2. Degradation

- Climate, air, soil, water
- Prevention, restoration, mitigation, adaptation
- Pollution and quality (e.g., noise, lead, commercial activity related [petroleum and extractive industries])
- Environment (ecology, climate change, risk)
- Compensation to Aboriginal people

Original Source Document Recommendation Extractions
Environment

1. Place health and health equity at the heart of urban governance and planning. (1)

2. Manage urban development to ensure greater availability of affordable housing; invest in urban slum upgrading including, as a priority, provision of water and sanitation, electricity, and paved streets for all households regardless of ability to pay. (1)

3. Local government and civil society, plan and design urban areas to promote physical activity through direct investment in active transport; encourage healthy eating through retail planning to manage the availability of and access to food; and reduce violence and crime through good environmental design and regulatory controls, including control of the number of alcohol outlets. (1)

4. Local government and civil society, backed by national government, establish local participatory governance mechanisms that enable communities and local government to partner in building healthier and safer cities. (1)

5. National and local government, in collaboration with civil society, manage urban development to ensure greater availability of affordable quality housing. (1)

6. Promote health equity between rural and urban areas through sustained investment in rural development, addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their homes. (1)

7. Counter the inequitable consequences of urban growth through action that addresses rural land tenure and rights and ensures rural livelihoods that support healthy living, adequate investment in rural infrastructure, and policies that support rural-to-urban migrants. (1)

8. Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity. Consider health equity impact of agriculture, transport, fuel, buildings, industry, and waste strategies concerned with adaptation to and mitigation of climate change. (1)

9. Reinforce the primary role of the state in the provision of basic services essential to health (such as water/sanitation) and the regulation of goods and services with a major impact on health (such as tobacco, alcohol, and food). (1)

10. National governments, in collaboration with relevant multilateral agencies, strengthen public sector leadership in the provision of essential health-related goods/services and the control of health-damaging commodities. (1)

11. The federal government must increase funding for social housing programs targeted for low-income Canadians. Housing policies should support mixed housing as an antidote for urban segregation. (2)

12. Comprehensive prevention strategies should address the social and built environments of the priority settings of everyday living:
    - Neighbourhoods
    - Homes
    - daycares and schools
    - workplaces

- public places (restaurants, entertainment venues, grocery stores, retail stores, recreation facilities, spiritual settings)
- transportation settings (cars, buses, bicycle access)
- special community circumstances (urban built environment, rural areas, isolated communities)

(3)

13. Improving environmental health, including housing conditions and reducing the risk of accidents. (2)

14. Formally recognize the links between the quality of local environments and people's physical and emotional well-being. (2)

15. Improve access to and quality of primary care services in currently underserved areas, for example by making greater use of community settings and services including community pharmacies. (2)

16. Raise housing quality standards and improve local environments and quality of life. (2)

17. Develop a sustainable policy towards the local environment, covering waste management, air pollution, waste quality and street cleaning. (2)

18. Take forward the strategy to improve access to key services (Making the Connections: Final Report on Transport and Social Exclusion). (2)

19. Create better and safer local environments, particularly in disadvantaged areas, so that people are more able to engage in social and physical activities in the public spaces close to where they live and work, in pleasant clean surroundings, without fear of crime. (2)

20. Develop consistent transport and land use planning policies that improve people's ability to access work and key services, and encourage greater exercise. (2)

21. Local authorities can ensure that staff regularly visiting the over 60s know what energy efficiency measures are available in their area. (2)

22. PCTs can work with local people and agencies to set up home safety, energy efficiency and repairs scheme for vulnerable families and older people. (2)

23. Health professionals can make referrals to energy efficiency programmes to address fuel poverty. (2)

24. Neighbourhood wardens can mobilise communities to create clean and safe environments for local people. (2)

25. Local authority transport planners will conduct accessibility planning in partnership with PCTs and other local bodies to improve access to jobs and services for disadvantaged groups and areas in Local Transport Plan areas. (2)

26. Encourage the use of planning conditions and other mechanisms to work with major employers to ensure that the employment opportunities afforded by growth delivers benefits to deprived communities. (2)

27. Local authorities can encourage exercise among young children by increasing the use of abandoned or low-grade green spaces and promoting sports centres and leisure facilities. (2)

28. Local authorities can work in partnership with local communities to improve green spaces so that they can be used for exercise and provide children's play areas. (2)

29. PCTs with poor rates of dental health can consider fluoridating their water supply as part of their overall health strategy and invite the SHA to carry out the necessary consultation. (2)

30. Collaborate with Aboriginal groups to review external causes of death data (e.g., motor vehicle accidental deaths and other injury deaths) and develop local strategies to reduce these causes of death in each community. (4)

31. Develop ways to monitor indoor air quality and study the health effects resulting from second-hand smoke, inadequate heating, and moisture control. (4)

32. Continue to provide training and certification for water system operators and make this mandatory, with subsidies to enable participation. Undertake monitoring to make sure water systems are adequately maintained. (4)

33. Work with First Nations, on a priority basis, to make continued improvements to drinking water systems on-reserve. (4)

34. Encourage public reporting on the impact of human activities on fish stocks, forest areas, mineral supplies, and other natural resources. (4)

35. Improve housing and the physical environment for the Aboriginal population. (4)

36. Tighten zoning to restrict noise and pollution. (5)

37. Increase traffic safety. (5)

38. Ban smoking in public areas, subsidize treatment programs for smoking cessation and drug and alcohol abuse. (5)

39. Control advertising of tobacco and alcohol products. (5)

40. Limit the concentration and operating hours of stores selling alcohol. (5)

41. Increase access to recreational facilities through construction support and policies to open up schools and other institutions evenings or weekends. (5)

42. The City of Saskatoon should continue to examine the benefits of development of a Land Trust, designating surplus city land to affordable housing projects, inclusionary zoning, improving the speed of approval process for affordable housing and a five year tax abatement for affordable housing projects/units. (6)

43. Large-scale initiatives that aim to improve the physical environment of disadvantaged neighborhoods have shown some health improvements among residents. Projects in Norway and England that improved traffic patterns and lighting, outdoor landscaping and parks, and added recreational facilities have resulted in changes to social environment and mental health status among residents (Dalgard & Tambs, 1997 Halpern, 1995). Given the strong association between housing and health, improving housing quality to tackle cold and dampness, particularly for the elderly, has also led to improved health status and is expected to reduce health inequalities (UK Department of Health, Health Inequalities Unit, 2005). (7)

44. Building up the infrastructure in neighbourhoods-through proactive urban design, for instance-to make it easier for social interaction to take place. (7)

45. To reduce the additional negative health impact of alcohol misuse typically experienced among lower socio-economic groups, support systems can be developed in work settings and in the community, both for prevention of alcohol misuse among children and youth and for adults. (7)

46. Working with municipalities to develop or renovate recreational facilities (including playgrounds), especially in disadvantaged neighbourhoods. (7)

47. The provision of safe, sufficient, accessible and affordable drinking-water, proper sanitation, solid waste removal, drains for waste water and control of vector-borne diseases, especially in informal settlements, is essential to reducing health inequity. (8)

48. Adequate, healthy and affordable housing should include the use of safe and sustainable building materials, sound construction practices and appropriate energy conservation considerations. In addition, the poor should not be relegated to building houses in swamps, flood-prone areas, on unstable hillsides, next to toxic industries or other hazardous locations. (8)

49. Facilitating the provision of new affordable housing is an important complement to upgrading low-income informal settlements. Urban policy should aim to prevent the formation of informal settlements through new housing while upgrading existing informal settlements and recognizing their legal status. Upgrading programmes should be coordinated and comprehensive in order that health risks are minimized. (8)

50. Environmentally-friendly public transport and walking and cycling facilities are key elements in providing transport for the poor and reducing the adverse health impacts of a "car society", including reduction of road traffic injuries and urban air pollution. (8)

51. Informal settlement improvement projects that only address local environmental health problems in a partial manner, such as providing water supply and improving road surfaces, are not sufficient to reduce health inequalities in a sustainable manner. The best way forward is comprehensive physical infrastructure improvement (including better drains, household toilets, sewage disposal, vector control, solid waste collection, electricity supply and primary health care services), coupled with empowerment of the community to identify key problems, design appropriate solutions, implement them and maintain the built infrastructure. (8)

52. Recognizing the particular impact of global climate change on the urban poor, coordinated national and international policies to minimize the severity of climate change need to be developed and implemented as a matter of urgency, consistent with the UN Framework Convention on Climate Change (FCCC) and related protocols. Every city should consider developing a "municipal adaptation plan" for climate change. (8)

53. Urban planning that encourages multiple forms of transportation. (8)

54. Measures to ensure the provision of safe and healthy working environments, particularly in relation to cottage-based industries, need to be an integral component of initiatives to reduce health inequity. The exposure of the local population, often the poorest, to pollutants emitted from workplaces is another concern for health equity. Urban planning needs to consider how the environment, poverty, health and time to care for children are affected by travel distances and travel modes for commuting to work. In addition, insufficient income from work to cover the cost of living is a key social determinant. (8)

55. Interventions for improving safety and security at the community level often involve engagement of local leaders in dispute resolution, investing in lighting and neighbourhood

watch initiatives, educational and recreational activities (including job training opportunities), and licit and illicit drug-use prevention and harm reduction, but there are local contexts where other approaches are needed. (8)

56. Poor housing conditions, cramped living space and the lack of privacy in small dwelling places in informal settlements may contribute to the perpetuation of sexual, physical and psychological violence at home. In some instances, however, housing proximity favours prevention by allowing neighbourhood organizations to react protectively when it occurs. (8)

57. The Healthy Cities movement has created a vehicle for health equity interventions. (8)

58. Fostering opportunities for information and experience exchange and networking between cities and communities is a powerful strategy to promote mutual learning and implementation of best practices. Urban populations include highly mobile and diverse groups and evidence indicates that the Healthy City, Healthy Municipality or Healthy Settings approaches provide effective frameworks for integrative health promotion. They also constitute a platform for generating healthy urban policies. (8)

59. Proactive urban planning supported by sufficient investment can achieve healthy urbanization. (8)

60. Future urban development needs to consider means to reduce unsustainable energy and resource use and supply of renewable energy. The indirect effects on global public health in the long run can no longer be ignored. Current and emerging eco-friendly approaches to town planning, housing design and workplace developments need to be systematically applied in order to minimize health inequalities in the future. (8)

61. Health-focused urban development planning is also essential in high-income countries. (8)

62. Urban planning and land-use policy should be forward-looking, anticipating economic, demographic and technological changes and providing a mechanism for coordination of services and infrastructure development. Particular attention should be paid to accounting for migration trends and periurban areas. In this context, national and sub-national governments should collectively address the push-pull factors behind rural-urban migration. (8)

63. Land-use planning should address the links between "planning/design for health" and design for sustainability, safety and walkability. The application of theories of "new urbanism" and smart growth to planning are not only good for the environment, they are also good for health. Planning schools need to train planners explicitly to consider the health and equity impacts of their design and learn to plan/design for health. The same applies to the training of engineers, architects and other professionals involved in urban planning and design. (8)

64. Urban planning should support home ownership on the one hand and rental accommodation on the other. In relation to home ownership, urban planning should provide for choice of location, enable the coordination of services and infrastructure development and be underpinned by appropriate public finance frameworks that include, among other things, micro-financing for housing. (8)

65. Building on and supporting community grassroots efforts to develop healthy urban environments and infrastructure. (8)

66. Ensuring access to safe, affordable housing and enhancing the health and liveability of neighbourhoods. (9)

67. Healthy Built Environments - Exploring policy options focused on making changes to the built

environment such as:
- Increasing the usage of mixed land-use patterns
- Increasing the connectivity of urban streets to enable easier (shortest distance) walking between locations
- Increasing the supply of recreation facilities and parks
- Enhancing streetscape design to improve aesthetics and safety for pedestrians and cyclists (e.g., adequate lighting, pedestrian crossings, sidewalks, bike paths)
- Improving physical access to healthy foods and discouraging junk foods through zoning and neighbourhood design where needed to support grocery stores, farmers' markets and restaurants

(10)

68. Implement equity-based social protection systems and maintain and develop effective publicly provided and publicly financed health systems that address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities. (11)

69. Regulate and protect populations from health hazards emanating from commercial activities, such as those created by the tobacco, alcohol, breast-milk substitutes, high fat and sugar processed food, and the petroleum and extractive industries. (11)

70. Make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. (12)

71. Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities. (12)

72. Support families to achieve progressive improvements in early child development, including:
    - Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
    - Providing paid parental leave in the first year of life with a minimum income for healthy living
    - Providing routine support to families through parenting programs, children's centres and key workers, delivered to meet social need via outreach to families
    - Developing programs for the transition to school.

    (13)
73. Prioritize policies and interventions that reduce both health inequalities and mitigate climate change, by:
    - Improving active travel across the social gradient
    - Improving the availability of good quality open and green spaces across the social gradient
    - Improving the food environment in local areas across the social gradient
    - Improving energy efficiency of housing across the social gradient.

    (13)
74. Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality. (13)

75. Increase access to government-funded early childhood centers (CPE) in low-income neighborhoods. (14)

76. Housing and safety:

- Developing a national housing strategy and allocating an additional 1% of federal spending for affordable housing.
- Creating housing policies that provide adequate affordable housing of reasonable standard.
- Providing reasonable follow-up support for those leaving institutional care.
- Developing policies to reduce the fear of crime and violence and creating safe environments for people to live in.

(15)

77. Healthy Cities Movement --The Healthy Cities movement is one of the most developed programs for addressing and supporting social determinants at the municipal level. The policies and principles reflecting this type of approach include:
    - Political decision- making for health in the areas of housing, environment, education, social services and other city programs.
    - Inter-sectoral action through organizational mechanisms by which city departments and community members come together to contribute to health
    - Community participation through projects that promote active roles for community members, in which they have direct influence on project decisions, activities of city departments and local life.
    - Community Action- Other effective approaches that promote community action in support of the social determinants of health include the following:
    - Implementation of projects that allow community members to identify their own health needs.
    - Providing opportunities for public dialogue on the social determinants of health, as a basis for concerted community action.

    (15)
78. Develop a strategy to support healthy community planning across the IH region
    - Municipalities play an important role in community planning and, consequently, in the health of the community. IH needs to work with municipalities and other stakeholders to support effective health-impact assessment and planning protocols that consider the social determinants of health, along with traditional built-environment issues such as sewage and air quality. (15)

79. Colonization and decolonization:
    Means of countering the colonization process include self-determination for Indigenous peoples; practical recognition of human rights; the restoration of rights to land; rehabilitation of degraded environments; facilitating the restoration of cultural heritage, including language; dealing with racism, and Indigenous control of research on Indigenous people. A fundamental call here is for 'decolonization through self-determination and group empowerment for Aboriginal peoples' (Canadian Overview paper, p.8) (16)

80. Land – More safeguards, and rehabilitation of degraded land and other compensatory measures, are necessary. Indigenous people should be able to say no to intrusion on their land. (16)

81. Ecological sustainability. (16)

82. Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity. Consider health equity impact of agriculture, transport, fuel, buildings, industry, and waste strategies concerned with adaptation to and mitigation of climate change. (1)

83. Develop a sustainable policy towards the local environment, covering waste management, air pollution, waste quality and street cleaning. (2)

84. Encourage research and public discussion about environmental risks and the options for managing them, using both traditional and scientific knowledge. (4)

85. Tighten zoning to restrict noise and pollution. (4)

86. Enforce lead abatement ordinances. (5)

87. Air pollution control - indoor and out - benefits the poor. Affordable, dependable and clean household energy alternatives are critical to achieving significant improvements in health and well-being. (8)

88. Measures to ensure the provision of safe and healthy working environments, particularly in relation to cottage-based industries, need to be an integral component of initiatives to reduce health inequity. The exposure of the local population, often the poorest, to pollutants emitted from workplaces is another concern for health equity. Urban planning needs to consider how the environment, poverty, health and time to care for children are affected by travel distances and travel modes for commuting to work. In addition, insufficient income from work to cover the cost of living is a key social determinant. (8)

89. Advocate across the UN system for recognition of the social determination of health including for example in climate change mitigation, trade regulation, migration laws, industrial policy, etc. (11)

90. Develop common policies 1 to reduce the scale and impact of climate change and health inequalities. (13)

91. Prioritize policies and interventions that reduce both health inequalities and mitigate climate change, by:
    - Improving active travel across the social gradient
    - Improving the availability of good quality open and green spaces across the social gradient
    - Improving the food environment in local areas across the social gradient
    - Improving energy efficiency of housing across the social gradient.

(13)

92. Develop a strategy to support healthy community planning across the IH region
    - Municipalities play an important role in community planning and, consequently, in the health of the community. IH needs to work with municipalities and other stakeholders to support effective health-impact assessment and planning protocols that consider the social determinants of health, along with traditional built-environment issues such as sewage and air quality. (15)

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APPENDIX I: Area for Action (Community)

Health Equity Recommendation Synthesis

Community: Community arises from the nature and quality of relationships between people with commonalities such as place, culture, experience, interests, beliefs, values and/or norms. Some aspects of community include sharing, commitment, availability, friendliness, cohesion, safety, connection and participation. People can belong to many communities. Within communities there may be great diversity.

Adapted from: (Tri-Project Glossary Working Group, 2011)

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
7. Community	100	156

7.1. Healthy Communities

7.1.1. Planning

7.1.2. Built environment

- Public spaces that engage people and participation, neighbourhood / local
- Regeneration initiatives
- Recreation / arts and sport facilities, health and fitness, correctional facilities

7.1.3. Social environment

- Social and health services, integrated neighbourhood teams, mental wellness, spiritual wellness, local services and delivery, supporting families, peer support

7.1.4. Priority groups for social inclusion

- Aboriginal (restore Aboriginal culture, language, support networks, decolonization, justice, control, reunite with land)
- Disabled persons and their caregivers (disability supports)
- Mentally ill (stigma)
- Elderly
- Corrections population (transition planning, bridging to release, correctional facility participation in accreditation)
- Immigrants

7.1.5. Rural to urban migration supports (Aboriginal), rural displacement

7.1.6. Community capacity / capital, empowerment / control / self-determination, local norms

7.1.7. Inclusion / cohesion, exclusion / isolation, social development, interaction, networks, dispute resolution, anti-discrimination, resolving intercultural differences, culture

7.2. Safety and Security

- Violence and crime
- Integrated prevention planning
- Prevention / treatment / harm reduction / enforcement
- Recidivism
- Domestic violence (proactive community organization response, support for male perpetrators)
- Neighbourhood watch
- Escort vulnerable people
- Recreation services available evenings and weekends
- Tobacco smuggling

Original Source Document Recommendation Extractions
Community

1. Set up an interagency mechanism to ensure policy coherence for early child development. (1)

2. Promote health equity between rural and urban areas through sustained investment in rural development, addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their homes. (1)

3. Counter the inequitable consequences of urban growth through action that addresses rural land tenure and rights and ensures rural livelihoods that support healthy living, adequate investment in rural infrastructure, and policies that support rural-to-urban migrants. (1)

4. Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity. Consider health equity impact of agriculture, transport, fuel, buildings, industry, and waste strategies concerned with adaptation to and mitigation of climate change. (1)

5. Equity-focused health impact assessment. (2)

6. Contribution to evidence base. (3)

7. Authorities must strongly enforce anti-discrimination laws. (3)

8. The federal government commit to a framework that will assist individuals to meet the costs of disability-related supports; support family/informal caregivers; and enable community capacity to provide supports and inclusion. (3)

9. The federal government make a 'down payment' on a transfer to enhance the supply of disability supports, and commit to a national program of disability supports. (3)

10. Explore a further role for the federal government in addressing poverty, by meeting individual costs of disability through an expenditure program, perhaps modeled after the National Child Benefit. (3)

11. Integrate the Caregiver Agenda into a Framework for Investment in Disability Supports. (3)

12. Comprehensive prevention strategies should address the social and built environments of the priority settings of everyday living:
    - Neighbourhoods
    - Homes
    - Daycares and schools
    - Workplaces
    - Public places (restaurants, entertainment venues, grocery stores, retail stores, recreation facilities, spiritual settings)
    - Transportation settings (cars, buses, bicycle access)
    - Special community circumstances (urban built environment, rural areas, isolated communities) (4)

13. Increase take-up and duration breastfeeding for new mothers, especially those in low income groups through training health professionals and encouraging peer support programs. (3)

14. Develop sports facilities to develop physical literacy and maintain active lifestyles. (3)

15. Improve the quality of life of older people by adequately coordinating and staffing services that enable older people to maintain their health and retain their independence. (3)

16. Improve access to mental health services by reducing the associated stigma, so encouraging people to seek help. Provide triage for people in the community who may need urgent specialist help. (3)

17. Raise housing quality standards and improve local environments and quality of life. (3)

18. Develop a sustainable policy towards the local environment, covering waste management, air pollution, waste quality and street cleaning. (3)

19. Take forward the strategy to improve access to key services (Making the Connections: Final Report on Transport and Social Exclusion). (3)

20. Create better and safer local environments, particularly in disadvantaged areas, so that people are more able to engage in social and physical activities in the public spaces close to where they live and work, in pleasant clean surroundings, without fear of crime. (3)

21. Promoting healthier communities and narrowing health inequalities is one of seven Shared Priorities agreed between central and local government. (3)

22. SHA chief executives managing PCT performance on health inequalities in line with local delivery plans using an appropriate basket of local indicators. (3)

23. The business community will have a major role to play in regeneration and health initiatives from occupational health measures to local employment and procurement and beyond into supporting increased diversity in local recruitment and wider involvement in community development and regeneration - for example, by investing in health and fitness centres accessible to those most in need. Jobcentre Plus can help with recruitment and retention issues but also plays a wider role developing job opportunities for people within local communities, as well as playing its part in LSPs. (3)

24. Local people as well as community and voluntary organizations are an invaluable source of knowledge about the appropriateness and effectiveness of local services. Tapping this knowledge will be crucial to strategic planning and the development of a coherent and effective local response to health inequalities. (3)

25. Action on health inequalities is a key strand in the Government's programme of social justice. The statutory sector can provide support to disadvantaged communities and give communities a voice. This will help ensure an approach that reflects community engagement, relevance to local need and action on health inequalities. (3)

26. There is an opportunity for building practical links between the communities and local services by drawing in lay health workers and providing them with training to provide basic health advice and family support. (3)

27. Local authorities can encourage exercise among young children by increasing the use of abandoned or low-grade green spaces and promoting sports centres and leisure facilities, communities and neighbourhood wardens can introduce walking buses for school children, and provide escorts for elderly people afraid of walking alone. (3)

28. Get local people involved in identifying local needs, influencing decision making and

evaluating their local services. (3)

29. Provision of health and social care services by the community and voluntary sector within the principles of social enterprise. (3)

30. PCTs and local authorities can sign up to and implement a common local Compact. (3)

31. Set up integrated neighbourhood teams including health staff, police and education in disadvantaged areas. (3)

32. Local authorities can integrate health care issues into wider regeneration initiatives, such as Supporting People strategies and LSP community plans. (3)

33. PCTs can work closely with local authorities on the delivery of Sure Start local programmes and other local strategies in their areas. (3)

34. Enabling and supporting communities to manage situations locally. (5)

35. Pay more attention to the non-medical, cultural, and spiritual determinants of health. (6)

36. Encourage participatory research to gain a more clear understanding as to why some Aboriginal communities are "healthier" than others. (6)

37. Identify and collect indicators that are meaningful and useful to Aboriginal communities. Perceived progress in a return to traditional ways, personal commitment to healing, housing quality, and employment opportunities are some examples from the BC Regional Longitudinal Health Survey that could be used as a starting point. (6)

38. Support efforts by Aboriginal people to achieve self-determination and a collective sense of control over their futures, in both on- and off-reserve communities. (6)

39. Aboriginal Health Initiatives Program - Each regional health authority has a community-based funding program that supports and encourages Aboriginal communities to identify health promotion projects that are culturally meaningful. (6)

40. Aboriginal communities and organizations can:
    - Work together to overcome disadvantages of small community size, for example, they can form institutional cooperatives to achieve economies of scale.
    - Continue to honour and support principles in the First Nations Health Plan.
    - Set clear, measurable goals for employment, income, and education levels of Aboriginal people equal to those within the general population, along with methods for public reporting of results.
    - Support efforts by Aboriginal people to achieve self-determination and a collective sense of control over their futures, in both on- and off-reserve communities.
    - Invest in adult education opportunities, skills upgrading, work and work clothing, child care, and stable, affordable housing.
    - Ensure that effective, culturally appropriate programs are in place to support those who have suffered abuse.
    - Encourage participatory research to gain a more clear understanding of the relationship between socioeconomic conditions and the health of Aboriginal communities. (6)

41. Work with Aboriginal communities to develop culturally appropriate reproductive care programs, including better prenatal access, outreach, and nutrition programs for mothers and infants. (6)

42. Support Aboriginal communities in motivating community members to reduce tobacco misuse. (6)

43. Implement community programs (such as the Four Pillars Approach in Vancouver) to prevent, treat, and reduce harms from substance abuse, with a focus on culturally based services specific to the Aboriginal population. (6)

44. Work on Aboriginal control, planning, governance, and delivery of services (especially primary care services) and enhance these services in ways that meet the needs of Aboriginal people, in order to reduce the gap in medically treatable and other diseases. (6)

45. Create a provincial Aboriginal mental health and wellness plan. One pillar of the plan would focus on vulnerable communities and youth suicide prevention. (6)

46. Encourage research and public discussion about environmental risks and the options for managing them, using both traditional and scientific knowledge. (6)

47. Encourage public reporting on the impact of human activities on fish stocks, forest areas, mineral supplies, and other natural resources. (6)

48. Conduct surveillance of contaminants in food safety. (6)

49. Support capacity building initiatives to address knowledge gaps in home maintenance and financial management. (6)

50. Ensure easy access to housing resources and information through expanded broadband connectivity. (6)

51. Commit to making self-determination for the Aboriginal population in the province a reality. (6)

52. Create a provincial Aboriginal Mental Health and Wellness Plan. (6)

53. More control for Aboriginal people over their own employment and academic programs. (7)

54. Aboriginal people in Saskatchewan should be afforded more control over health, social, education and justice policies and funding that disproportionately affect Aboriginal people. (7)

55. Social and Community Inclusion Strategies. (2)

56. Providing to disadvantaged groups and communities additional health and social services that offer emotional support to parents of young children and young mothers (Acheson, 1998). (2)

57. Strengthening or developing systems that foster social interactions among population groups, to build inclusiveness and produce less divided society, one which with reduced social inequities and more equitable access to resources needed for good health (Dahlgren &Whitehead, 2006). (2)

58. Improving access to health and social services and acting directly on the social, economic and environmental contexts that determine both health status and health inequalities. (2)

59. Large-scale initiatives that aim to improve the physical environment of disadvantaged

neighborhoods have shown some health improvements among residents. Projects in Norway and England that improved traffic patterns and lighting, outdoor landscaping and parks, and added recreational facilities have resulted in changes to social environment and mental health status among residents (Dalgard & Tambs, 1997; Halpern, 1995). Given the strong association between housing and health, improving housing quality to tackle cold and dampness, particularly for the elderly, has also led to improved health status and is expected to reduce health inequalities (UK Department of Health, Health Inequalities Unit, 2005). (2)

60. Working with municipalities to develop or renovate recreational facilities (including playgrounds), especially in disadvantaged neighbourhoods. (2)

61. Increased autonomy or control over government, culture and various facets of Aboriginal society. (2)

62. Build and reinforce social cohesion and collective efficacy (e.g., team weight-loss programs). (2)

63. Change local norms and policies by: assuring high visibility of alternate behaviours and engaging formal and informal leaders to model health behaviours. (2)

64. Implement primary prevention initiatives to address vulnerabilities that can lead to criminal activity. A population-based prevention focus integrated with a Primary Care Health Services model would enable people to access health and social services early and thereby reduce the risk of requiring correctional services as a result of unaddressed addictions/mental illness issues. (8)

65. Participation in health services accreditation processes by correctional facilities would help identify the organizational practices that could strengthen service delivery and transition planning to improve continuity of care. (8)

66. Information exchange processes should be developed to enable corrections and the health authorities to share relevant information. (8)

67. Clarifying and consistently applying information sharing policies and procedures. (8)

68. Implementing standardized information sharing procedures and processes wherever possible. Improve transition planning to enable corrections populations to bridge the gaps when individuals move within and/or between systems. (8)

69. Formalizing agreements between corrections and the relevant provider(s). (8)

70. Implementing a quality monitoring process implemented. (8)

71. Implementing a participatory approach to transition planning that engages individuals who are in, or have been through the corrections system. (8)

72. Empowered urban communities can be active stakeholders in improving health and promoting social cohesion. Investments in community empowerment and opportunities for participation must be provided by governments and other key stakeholders. This can be a catalyst for releasing the community's capacity for development in health. Poverty can limit community participation and therefore reduce social cohesion. This is particularly pertinent for those groups already marginalized because of discrimination in the job market, for example. Therefore, addressing the social determinants of inequity within poor communities is fundamental to building social capital. (9)

73. Create healthy housing and neighbourhoods. (9)

74. The provision of safe, sufficient, accessible and affordable drinking-water, proper sanitation, solid waste removal, drains for waste water and control of vector-borne diseases, especially in informal settlements, is essential to reducing health inequity. (9)

75. Air pollution control - indoor and out - benefits the poor. Affordable, dependable and clean household energy alternatives are critical to achieving significant improvements in health and well-being. (9)

76. Adequate, healthy and affordable housing should include the use of safe and sustainable building materials, sound construction practices and appropriate energy conservation considerations. In addition, the poor should not be relegated to building houses in swamps, flood-prone areas, on unstable hillsides, next to toxic industries or other hazardous locations. (9)

77. Facilitating the provision of new affordable housing is an important complement to upgrading low-income informal settlements. Urban policy should aim to prevent the formation of informal settlements through new housing while upgrading existing informal settlements and recognizing their legal status. Upgrading programmes should be coordinated and comprehensive in order that health risks are minimized. (9)

78. Partnerships at the neighbourhood level and between community groups and municipal organizations are crucial to creating sustainable housing solutions for the urban poor. Nongovernmental organizations, neighbourhood groups and the provision of "sweat equity" by home owners should be supported as important factors in enabling families to improve their housing and living conditions. (9)

79. Environmentally-friendly public transport and walking and cycling facilities are key elements in providing transport for the poor and reducing the adverse health impacts of a "car society", including reduction of road traffic injuries and urban air pollution. (9)

80. Informal settlement improvement projects that only address local environmental health problems in a partial manner, such as providing water supply and improving road surfaces, are not sufficient to reduce health inequalities in a sustainable manner. The best way forward is comprehensive physical infrastructure improvement (including better drains, household toilets, sewage disposal, vector control, solid waste collection, electricity supply and primary health care services), coupled with empowerment of the community to identify key problems, design appropriate solutions, implement them and maintain the built infrastructure. (9)

81. Recognizing the particular impact of global climate change on the urban poor, coordinated national and international policies to minimize the severity of climate change need to be developed and implemented as a matter of urgency, consistent with the UN Framework Convention on Climate Change (FCCC) and related protocols. Every city should consider developing a "municipal adaptation plan" for climate change. (9)

82. The viability of local food vendors and food markets should be enhanced. (9)

83. Urban planning that encourages multiple forms of transportation. (9)

84. Food safety protocols that are appropriate for local conditions. (9)

85. Support for cooperative ventures among small traders. (9)

86. Governments and nongovernmental organizations should create opportunities for recreation,

physical activity and participation in the arts and other cultural activities to enhance livelihood, social cohesion, health and well-being. (9)

87. Measures to ensure the provision of safe and healthy working environments, particularly in relation to cottage-based industries, need to be an integral component of initiatives to reduce health inequity. The exposure of the local population, often the poorest, to pollutants emitted from workplaces is another concern for health equity. Urban planning needs to consider how the environment, poverty, health and time to care for children are affected by travel distances and travel modes for commuting to work. In addition, insufficient income from work to cover the cost of living is a key social determinant. (9)

88. Prevent urban violence and substance abuse. (9)

89. Governments have a fundamental obligation to ensure safety and security from crime and violence at the societal, community, family/relationship and individual levels. This obligation involves the role of government as a service provider, a regulator, a partner with civil society, and as a facilitator or financial resource for community-based crime prevention and dispute resolution services. (9)

90. Interventions for improving safety and security at the community level often involve engagement of local leaders in dispute resolution, investing in lighting and neighbourhood watch initiatives, educational and recreational activities (including job training opportunities), and licit and illicit drug-use prevention and harm reduction, but there are local contexts where other approaches are needed. (9)

91. Poor housing conditions, cramped living space and the lack of privacy in small dwelling places in informal settlements may contribute to the perpetuation of sexual, physical and psychological violence at home. In some instances, however, housing proximity favours prevention by allowing neighbourhood organizations to react protectively when it occurs. (9)

92. Preventing and managing disputes that may arise when culturally diverse populations are expected to live together within confined urban areas - the product of migration by different ethnic, religious and language groups from their homogeneous homelands - requires context-specific programmes and policies that promote social cohesion in order to minimize the potential physical and mental health consequences of such interactions. (9)

93. In urban communities where highly prevalent diseases have diminished human capital, health promotion and disease control and prevention are the entry points for community mobilization and are a prerequisite for social development. (9)

94. Primary health care systems must be comprehensive, continuous, family- and community-centred, health-promoting, innovative, and focused on providing equitable access to health services for the most vulnerable populations. Efforts to support the work of the Member States in mainstreaming urban health in health systems development should be pursued. Examples of this are:
    - the development and global application of an urban health equity assessment and response tool (Urban HEART, WHO Centre for Health Development, Kobe) that will enable ministries of health to track areas of rapid urbanization and monitor health inequity and appropriateness of responses/interventions in urban settings;
    - a global report on urban health;
    - a joint UN-HABITAT/WHO global meeting on healthy urbanization that could coincide with the regular meeting of the World Urban Forum of UN-HABITAT. (9)

95. The Healthy Cities movement has created a vehicle for health equity interventions. (9)

96. Fostering opportunities for information and experience exchange and networking between cities and communities is a powerful strategy to promote mutual learning and implementation of best practices. Urban populations include highly mobile and diverse groups and evidence indicates that the Healthy City, Healthy Municipality or Healthy Settings approaches provide effective frameworks for integrative health promotion. They also constitute a platform for generating healthy urban policies. (9)

97. Proactive urban planning supported by sufficient investment can achieve healthy urbanization. (9)

98. Future urban development needs to consider means to reduce unsustainable energy and resource use and supply of renewable energy. The indirect effects on global public health in the long run can no longer be ignored. Current and emerging eco-friendly approaches to town planning, housing design and workplace developments need to be systematically applied in order to minimize health inequalities in the future. (9)

99. Health-focused urban development planning is also essential in high-income countries. (9)

100. Urban planning and land-use policy should be forward-looking, anticipating economic, demographic and technological changes and providing a mechanism for coordination of services and infrastructure development. Particular attention should be paid to accounting for migration trends and peri-urban areas. In this context, national and sub-national governments should collectively address the push-pull factors behind rural-urban migration. (9)

101. Land-use planning should address the links between "planning/design for health" and design for sustainability, safety and walkability. The application of theories of "new urbanism" and smart growth to planning are not only good for the environment, they are also good for health. Planning schools need to train planners explicitly to consider the health and equity impacts of their design and learn to plan/design for health. The same applies to the training of engineers, architects and other professionals involved in urban planning and design. (9)

102. Urban planning should support home ownership on the one hand and rental accommodation on the other. In relation to home ownership, urban planning should provide for choice of location, enable the coordination of services and infrastructure development and be underpinned by appropriate public finance frameworks that include, among other things, micro-financing for housing. (9)

103. An integrated approach with community participation for lasting solutions. (9)

104. Promoting equity in urban settings requires an integrated, multi-level approach to problem-solving that involves a variety of stakeholders. There are no single model, quick-fix, one-dimensional solutions. An effective strategy for achieving equity in urban settings requires sensitivity to and respect for local context, an inclusive approach and an explicitly pro-poor orientation. These are key elements of good governance, without which health equity cannot be achieved. (9)

105. Healthy public policy to bring different sectors together for urban health equity. (9)

106. Healthy public policy and urban governance, or the systems, institutions and processes that promote a higher level and fairer distribution of health in urban settings, are key and critical pathways for reducing health inequity in cities. Key features of healthy urban governance include:
    - Putting health and human development at the centre of government policies and actions;
    - Building on and supporting community grassroots efforts to develop healthy urban environments and infrastructure;

- Developing mechanisms for bringing together private, public and civil society sectors, and defining roles and mechanisms for international and national actors to support local governance capacity;
- Higher levels of government providing local governments with both the mandate and the means to improve health;
- Participatory budgeting and other civic engagement processes as important means to engage the local community. (9)

107. Community-based participatory surveillance of urban health determinants should be a component of health and social outcome surveillance initiatives, including the monitoring of intra-urban differentials, to produce comparative analyses. In monitoring progress, community involvement promotes empowerment, engenders the sustainability of interventions and ensures ownership. (9)

108. Appropriate feedback mechanisms for communities to report their satisfaction with the actions and activities of bilateral and multilateral development donors - whose large budgets can significantly impact on development outcomes but potentially undermine existing projects - also promote community empowerment and ownership by ensuring each community's priorities and unique needs are considered. (9)

109. Civil society organizations are an essential means of mobilizing existing knowledge and capacity in poor communities. Significant investment should be made in "micro-governance" interventions to support robust institutions of local governance for people in urban settings, especially the poor. (9)

110. Addressing issues of availability and accessibility determined by the food system by engaging stakeholders (particularly local governments) to pursue strategies and community-based food security initiatives that focus on capacity building and community development. (10)

111. These programs and services should be flexible, and meet the developmental, language, literacy and cultural needs of all children. They should also provide additional opportunities for the early identification of developmental delays, disabilities and other risk factors and appropriate referrals, encourage parent participation, enhance parents' understanding of child development through information, support and role modeling, build supportive social networks amongst children and families, and support and enhance the economic security of women and families. (10)

112. Ensuring access to safe, affordable housing and enhancing the health and liveability of neighbourhoods. (10)

113. Healthy Built Environments - Exploring policy options focused on making changes to the built environment such as:
    - Increasing the usage of mixed land-use patterns
    - Increasing the connectivity of urban streets to enable easier (shortest distance) walking between locations
    - Improving public transit as an effective alternative to the automobile
    - Increasing the supply of recreation facilities and parks
    - Enhancing streetscape design to improve aesthetics and safety for pedestrians and cyclists (e.g., adequate lighting, pedestrian crossings, sidewalks, bike paths)
    - Improving physical access to healthy foods and discouraging junk foods through zoning and neighbourhood design where needed to support grocery stores, farmers' markets and restaurants (10)

114. Health in All Policies, together with intersectoral cooperation and action, is one promising

approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies. As collective goals, good health and well-being for all should be given high priority at local, national, regional and international levels. (11)

115. Improve community capital and reduce social isolation across the social gradient. (12)

116. Support locally developed and evidence based community regeneration programs that:
- Remove barriers to community participation and action
- Reduce social isolation. (12)

117. Develop services and programs to better integrate immigrants. (13)

118. "…We must also strengthen the other mechanisms of family support." (14)

119. Work and working conditions
- Enforcing legislation that protects the rights of minority groups, particularly concerning employment rights and anti-discrimination.
- Assuring access to educational, training and employment opportunities, especially for those such as the long-term unemployed.
- Supporting improved management practices that lead to increased levels of control, variety and appropriate use of skills into the workforce.
- Assessing the impact of employment policies on health and inequalities in Health.
- Ensuring accessible and safe cycling and walking routes to workplaces
- Enacting smoke-free workplace legislation. (15)

120. Healthy Cities Movement --The Healthy Cities movement is one of the most developed programs for addressing and supporting social determinants at the municipal level. The policies and principles reflecting this type of approach include:
- Political decision- making for health in the areas of housing, environment, education, social services and other city programs.
- Inter-sectoral action through organizational mechanisms by which city departments and community members come together to contribute to health
- Community participation through projects that promote active roles for community members, in which they have direct influence on project decisions, activities of city departments and local life.
  Community Action- Other effective approaches that promote community action in support of the social determinants of health include the following:
- Implementation of projects that allow community members to identify their own health needs.
- Providing opportunities for public dialogue on the social determinants of health, as a basis for concerted community action. (15)

121. Develop a strategy to support healthy community planning across the IH region- Local health information can be a powerful tool for improving the health of a community. IH has access to a great deal of this information and has the technical capacity to collaborate with others and support increased access for community stakeholders by:
- Providing tools like data maps (GIS)
- Training users on how to manage and apply available information
- Developing and refining data
- Identifying and filling unmet data needs (15)

122. Develop a strategy to support healthy community planning across the IH region
- Municipalities play an important role in community planning and, consequently, in the health

of the community. IH needs to work with municipalities and other stakeholders to support effective health-impact assessment and planning protocols that consider the social determinants of health, along with traditional built-environment issues such as sewage and air quality. (15)

123. Colonization and decolonization:
Means of countering the colonization process include **self determination** for Indigenous peoples; practical recognition of human rights; the restoration of rights to land; rehabilitation of degraded environments; facilitating the restoration of cultural heritage, including language; dealing with racism, and Indigenous control of research on Indigenous people. A fundamental call here is for 'decolonization through self-determination and group empowerment for Aboriginal peoples' (Canadian Overview paper, p.8) (16)

124. Self determination
- Indigenous people have the right of self determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.
- The health value of reconnecting Indigenous people who have been distanced from their cultural heritage and associated support networks is drawn out. 'Cultural competence' is seen as an important health determinant.
- Apart from reuniting people with their land, there is a clear need for more effective support for Indigenous people who have migrated to urban locations. (16)

125. Family, community and health
Community-based and community controlled services were considered fundamental to improving Indigenous health. Similarly, building Indigenous leadership at the community level was seen as key in tackling health and related problems, such as domestic violence. (16)

126. The need to rebuild or replace weakened community networks and support was also seen as very important. (16)

127. Local government and civil society, plan and design urban areas to promote physical activity through direct investment in active transport; encourage healthy eating through retail planning to manage the availability of and access to food; and reduce violence and crime through good environmental design and regulatory controls, including control of the number of alcohol outlets. (1)

128. The Manitoba government should oversee the coordination and development of a set of integrated prevention strategies that address priorities for health outcomes, health-related behaviours and activities, determinants of health and settings of everyday living. (4)

129. Comprehensive prevention strategies should address the following priority health related behaviours:
- appropriate care and support for children and others who are in need at any stage of the life course
- healthy relationships at home, school, work and in all community settings (self-respectful, mutually respectful, caring, and supportive; free from abuse, violence, intolerance, exploitation, sexism, and racism)
- healthy sexuality (mutually respectful and consenting, using appropriate disease prevention and contraception)
- healthy hygiene practices (hand washing, cough etiquette, food handling)
- protection and sustainability of the natural environment (protection of our water, soil, air, ecology; sustainable management of non-renewable resources and greenhouse gases)

- safety and injury prevention (seatbelt use, other motor-vehicle safety, bicycle helmet use, falls prevention, workplace safety, safety in other settings)
- mental, emotional and spiritual well-being (lifelong learning, work-life balance, personal stress management), balancing active living (adequate and regular physical activity), sedentary activities (television, video games, computers), and adequate relaxation and sleep
- healthy diet (recommended levels of adequate nutrients, fibre, vitamins, calories, saturated fats, refined carbohydrates, alcohol, and salt); oral and dental hygiene
- avoidance of harmful substances (tobacco, illicit drugs) and addictions (including alcohol, prescription drugs); safe levels of exposure to harmful environmental risks (radon, asbestos, ultraviolet radiation)
- appropriate use of preventive health services (vaccinations, screening); harm reduction programs (safe use of injection drugs, sexually transmitted disease prevention); healthcare (primary care, prenatal care); and other services (addictions treatment, dental care, dieticians, personal and family counselling, other allied health services) (4)

130. Comprehensive prevention strategies should address priority issues of all health determinants:

- income and social status: poverty, income disparity, food insecurity
- education: literacy and health literacy, numeracy, school completion
- employment and working conditions: underemployment, regional unemployment, meaningful employment, working conditions, work safety, workplace stress
- environment:
    a. natural environment: sustainable development, including climate change, ecological change,
    protection of air, water, soil
    b. built environment: adequate housing without overcrowding, access to safe running water and sanitation, indoor air quality free from excess humidity and mould, fire safety; community and neighbourhood design with local access to active transportation, adequate green space and locally affordable nutritious food; especially for disadvantaged
    c. social environment, gender and culture: promotion of respect, fairness, caring, tolerance; deterrence of bullying, racism, sexism, exploitation, intolerance of people's sexual orientation or beliefs, and abuse of children, intimate partners and vulnerable persons
- healthy child development: early child development, positive parenting, preventing child neglect and abuse
- social support networks: supportive environments and social connectedness for all, with outreach for elderly, lonely, vulnerable, and disadvantaged people
- personal health practices, coping skills, and priority health-related behaviours, activities
- biology and genetic endowment: genetic counseling and screening (when indicated and appropriate), surveillance for perinatal health and congenital abnormalities
- health services: primary prevention (ex: tobacco cessation) and secondary prevention (ex: breast screening) (4)

131. The Manitoba government should create a multi-departmental oversight body supported by a multi-stakeholder network that provides advice and participates in the development and implementation of prevention strategies. (4)

132. Assess health needs and provide comprehensive health promotion to young people 15-17 who spend time in prison. (3)

133. Create better and safer local environments, particularly in disadvantaged areas, so that people are more able to engage in social and physical activities in the public spaces close to

where they live and work, in pleasant clean surroundings, without fear of crime. (3)

134. Neighbourhood wardens can mobilise communities to create clean and safe environments for local people. (3)

135. Communities and neighbourhood wardens can introduce walking buses for school children, and provide escorts for elderly people afraid of walking alone. (3)

136. Trading standards officers and police can tackle tobacco sales to minors and smuggling. (3)

137. Reduce violence and crime. (17)

138. Aboriginal people in Saskatchewan should be afforded more control over health, social, education and justice policies and funding that disproportionately affect Aboriginal people. (7)

139. Government ministries, health authorities, and provincial and federal corrections should work in partnership to improve continuity of care. Improved partnerships can ensure better access to health and social support services and reduce the risk of recidivism. (8)

140. Prevent urban violence and substance abuse. (9)

141. Governments have a fundamental obligation to ensure safety and security from crime and violence at the societal, community, family/relationship and individual levels. This obligation involves the role of government as a service provider, a regulator, a partner with civil society, and as a facilitator or financial resource for community-based crime prevention and dispute resolution services. (9)

142. Interventions for improving safety and security at the community level often involve engagement of local leaders in dispute resolution, investing in lighting and neighbourhood watch initiatives, educational and recreational activities (including job training opportunities), and licit and illicit drug-use prevention and harm reduction, but there are local contexts where other approaches are needed.(9)

143. Poor housing conditions, cramped living space and the lack of privacy in small dwelling places in informal settlements may contribute to the perpetuation of sexual, physical and psychological violence at home. In some instances, however, housing proximity favours prevention by allowing neighbourhood organizations to react protectively when it occurs. (9)

144. Enhance democratic and transparent decision-making and accountability at all levels of governance, including through enhancing access to information, access to justice and popular participation. (18)

145. Housing and safety

- Developing a national housing strategy and allocating an additional 1% of federal spending for affordable housing.
- Creating housing policies that provide adequate affordable housing of reasonable standard.
- Providing reasonable follow-up support for those leaving institutional care.
- Developing policies to reduce the fear of crime and violence and creating safe environments for people to live in. (15)

146. Programs directed specifically at males, who do less well in respect of various health outcomes and who perpetrate violence at the domestic level, was stressed by a number of delegates. (16)

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APPENDIX J: Area for Action (Housing)

Health Equity Recommendation Synthesis

Housing: Housing is any permanent or temporary building or other structure in which people live. Housing structures will have varying qualities; may be self-contained or shared; may be permanent or transient; and may or may not be owned, rented, or occupied without legal rights.

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
8. Housing	80	49

8.1. Housing Characteristics

8.1.1. Problems to address

- Humid / damp; mould; cold; cramped / privacy; poor or no insulation; indoor air quality; home maintenance

8.1.2. Planning

- Density of development
- Supply of affordable housing and choice of affordable housing options (including new)
- Emergency shelters (e.g., homeless)
- Temporary housing; multi-occupant; social housing (consider stigma)
- Eco-friendly neighbourhood and housing design; clean energy alternatives; energy conservation and efficiency; sustainable
- On-reserve
- Local needs
- Supported (e.g., cooperatives or independent apartments with off-site staff or case management; group homes often with on-site staff)

8.2. Housing Governance

8.2.1. Finance

- Micro-financing for housing
- Restore federal housing to funding to levels <1986
- Add 1% of federal spending for affordable housing
- Five year tax abatement for affordable housing projects
- Increase monthly shelter allowance to current rates including utility costs
- Set aside 10% of undeveloped land for affordable housing
- Land trust of surplus land for affordable housing
- National housing standards
- Mechanisms to set rates

8.2.2. Policy considerations

- Housing stability
- Rent to own
- Purchase and renovate abandoned or neglected multi-family buildings
- Convert low income rentals to home ownership opportunities
- Address affordable housing wait lists; mixed housing; transitional
- **Youth homelessness prevention:** Convert and target housing units to supportive housing for at risk and homeless youth
- Set decent housing standards targets
- Transfer title to non-profit housing agencies with goal of transferring title to home owners
- Sweat equity to improve housing; housing repair scheme; housing safety scheme
- Address wait period for "Rental Assistance" (BC)
- Transition period out of "Welcome House" (BC)

- Keep shelter allowances current with inflation
- Construction standards

8.2.3. Safety standards

- Fire safety
- Minimized health risks
- Implement housing health and safety ratings

Original Source Document Recommendation Extractions

Housing

1. Providing affordable housing and childcare would reduce other family expenses and leave more money for acquiring an adequate diet. (1)

2. Housing policy needs to be more explicitly linked to comprehensive income (including a jobs strategy), public health, and health services policy. (1)

3. Housing policy must make affordable and quality housing available for all Canadians. Provinces should provide their matching share for housing provision as defined in the Affordable Housing Framework Agreement of 2001. (1)

4. Comprehensive prevention strategies should address the social and built environments of the priority settings of everyday living:
   • neighbourhoods
   • homes
   • daycares and schools
   • workplaces
   • public places (restaurants, entertainment venues, grocery stores, retail stores, recreation facilities, spiritual settings)
   • transportation settings (cars, buses, bicycle access)
   • special community circumstances (urban built environment, rural areas, isolated communities) (2)

5. Improving environmental health, including housing conditions and reducing the risk of accidents. (3)

6. Improving housing conditions, especially for children in disadvantaged areas. (3)

7. Eliminate the homelessness of families with children. (3)

8. Raise housing quality standards and improve local environments and quality of life. (3)

9. Ensure that all social housing meets the decent housing standard by 2010. (3)

10. Ensure that between 2003-04 and 2005-06 80,000 vulnerable households in the private sector will have been helped to make their homes decent. (3)

11. Introduce a housing health and safety rating system to enable local authorities to take action against bad housing conditions on the grounds of health and safety, focusing particularly on multiple occupation housing. (3)

12. Tackle some of the causes of ill health associated with living in poorly insulated homes and reduce excess winter deaths. (3)

13. Work collaboratively to improve housing conditions and economic and educational opportunities for Aboriginal people. (4)

14. Invest in adult education opportunities, skills upgrading, work and work clothing, child care, and stable, affordable housing. (4)

15. Focus on underlying factors that lead to illness, such as poverty, family distress, child abuse,

inadequate housing, and untreated mental illness. (4)

16. Engage with Aboriginal organizations to actively improve on-reserve housing. (4)

17. Work with First Nations to ensure that housing conditions on-reserve are regularly monitored and tracked so that deficiencies may be addressed. (4)

18. Develop ways to monitor indoor air quality and study the health effects resulting from second-hand smoke, inadequate heating, and moisture control. (4)

19. Support Aboriginal communities to identify and address local housing needs; e.g., by supporting loan funds operated by First Nations organizations or by offering courses on technical or administrative subjects. (4)

20. Support capacity building initiatives to address knowledge gaps in home maintenance and financial management. (4)

21. Improve housing and the physical environment for the Aboriginal population. (4)

22. Provide affordable housing. (5)

23. Reduce the number of people on the waiting list for affordable housing from 2,150 to zero in four years (2011). (6)

24. The provincial government should consider adopting this policy for at least four years to address chronic housing shortages. (6)

25. Evidence Based Policy Option #29 - Develop a Long-term, Consolidated, Comprehensive, Interagency Social Housing System for Hard to House Individuals Develop a long term, consolidated, comprehensive, interagency social housing system in Saskatoon and Saskatchewan for hard to house individuals; including those living with mental health problems and addictions. (6)

26. Develop a communication strategy to overcome the stigma of affordable housing in order to gain community acceptance. (6)

27. Large-scale initiatives that aim to improve the physical environment of disadvantaged neighborhoods have shown some health improvements among residents. Projects in Norway and England that improved traffic patterns and lighting, outdoor landscaping and parks, and added recreational facilities have resulted in changes to social environment and mental health status among residents (Dalgard & Tambs,1997; Halpern,1995). Given the strong association between housing and health, improving housing quality to tackle cold and dampness, particularly for the elderly, has also led to improved health status and is expected to reduce health inequalities (UK Department of Health, Health Inequalities Unit, 2005). (7)

28. Create healthy housing and neighbourhoods. (8)

29. Air pollution control - indoor and out - benefits the poor. Affordable, dependable and clean household energy alternatives are critical to achieving significant improvements in health and well-being. (8)

30. Adequate, healthy and affordable housing should include the use of safe and sustainable building materials, sound construction practices and appropriate energy conservation considerations. In addition, the poor should not be relegated to building houses in swamps, flood-prone areas, on unstable hillsides, next to toxic industries or other hazardous locations.

(8)

31. Poor housing conditions, cramped living space and the lack of privacy in small dwelling places in informal settlements may contribute to the perpetuation of sexual, physical and psychological violence at home. In some instances, however, housing proximity favours prevention by allowing neighbourhood organizations to react protectively when it occurs. (8)

32. Future urban development needs to consider means to reduce unsustainable energy and resource use and supply of renewable energy. The indirect effects on global public health in the long run can no longer be ignored. Current and emerging eco-friendly approaches to town planning; housing design and workplace developments need to be systematically applied in order to minimize health inequalities in the future. (8)

33. Ensuring access to safe, affordable housing and enhancing the health and liveability of neighbourhoods. (9)

34. Affordable Housing - Ensuring there is an adequate supply of appropriate, safe and affordable housing for low-income families and individuals. (9)

35. Housing First - Developing policies to provide a range of housing and related supports for the homeless, and particularly for those with mental illness and/or addictions. A full continuum of housing options should be provided and matched to individuals' needs, including emergency and temporary accommodation (e.g., shelters), transition housing, and supportive (e.g., group homes often with on-site staff) and supported housing (e.g., co-operatives or independent apartments with off-site staff or case management support). (9)

36. Healthy Built Environments - Exploring policy options focused on making changes to the built environment such as:
    - Prioritize policies and interventions that reduce both health inequalities and mitigate climate change, by:
    - Improving active travel across the social gradient
    - Improving the availability of good quality open and green spaces across the social gradient
    - Improving the food environment in local areas across the social gradient
    - Improving energy efficiency of housing across the social gradient. (9)

37. Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality. (10)

38. Increase funding for social and community housing and ensure that the mechanisms used to set housing rental rates are rigorous and effective. (11)

39. Ensure adequate and accessible housing. (11)

40. Housing and safety:
    - Developing a national housing strategy and allocating an additional 1% of federal spending for affordable housing.
    - Creating housing policies that provide adequate affordable housing of reasonable standard.
    - Providing reasonable follow-up support for those leaving institutional care.
    - Developing policies to reduce the fear of crime and violence and creating safe environments for people to live in. (12)

41. Healthy Cities Movement --The Healthy Cities movement is one of the most developed

programs for addressing and supporting social determinants at the municipal level. The policies and principles reflecting this type of approach include:

- Political decision- making for health in the areas of housing, environment, education, social services and other city programs.
- Inter-sectoral action through organizational mechanisms by which city departments and community members come together to contribute to health.
- Community participation through projects that promote active roles for community members, in which they have direct influence on project decisions, activities of city departments and local life. (12)

42. Community Action- Other effective approaches that promote community action in support of the social determinants of health include the following:
    - Implementation of projects that allow community members to identify their own health needs.
    - Providing opportunities for public dialogue on the social determinants of health, as a basis for concerted community action. (12)

43. Indigenous people should have the right to be different and, if they wish, exempt themselves from the 'mainstream'. (13)

44. The federal government must increase funding for social housing programs targeted for low-income Canadians. Housing policies should support mixed housing as an antidote for urban segregation. (1)

45. Public support and advocacy is needed to create the political will to establish housing initiatives. An initiative called the 1% Solution proposes that Canadian governments can solve the housing crisis by increasing their budgetary allocation for housing by 1% of overall spending (http://tdrc.net/1-solution.html). (1)

46. PCTs can work with local people and agencies to set up home safety, energy efficiency and repairs scheme for vulnerable families and older people. (3)

47. Regional policies, including regional economic and housing strategies can also be assessed for their impact on health and health inequalities. (3)

48. Ensure easy access to housing resources and information through expanded broadband connectivity. (4)

49. The City of Saskatoon should continue to examine the benefits of development of a Land Trust, designating surplus city land to affordable housing projects, inclusionary zoning, improving the speed of approval process for affordable housing and a five year tax abatement for affordable housing projects/units. (6)

50. Any developer that purchases land from the City of Saskatoon should set aside 10% of the new housing projects/units. (6)

51. The provincial government should consider purchasing 20 abandoned or neglected multifamily and apartment buildings in the heart of Saskatoon's six low income neighbourhoods, renovate them and transfer the title to not-for-profit housing authorities with the eventual goal of transferring title to home ownership. (6)

52. The provincial government should consider investing in a Saskatoon-based home ownership pilot program to convert 31 multi-units provincially owned affordable rental units to home ownership. A long-term rent-to-own program should be considered to increase the number of households in stable, safe, affordable housing. (6)

53. Develop and implement a permanent and comprehensive youth homelessness prevention strategy to eradicate youth homelessness in Saskatoon. (6)

54. In addition to the need for overall service coordination, the province of Saskatchewan should consider converting and targeting 125 affordable housing units to supportive housing for at risk consider converting and targeting 125 affordable housing units to supportive housing for at risk and homeless youth. (6)

55. The Saskatchewan government should consider increasing monthly shelter allowances for all households receiving income assistance to match the 2008 average monthly rental rate and also include the total monthly cost for utilities. (6)

56. In addition, shelter allowance rates should be reviewed bi-annually and compared to current average monthly rates and brought up to market standards when necessary. (6)

57. The federal government needs to restore funding for social housing to the levels established prior to 1986. (6)

58. Eliminate wait period for BC Rental Assistance. (14)

59. Increase the transition time period out of Welcome House. (14)

60. Facilitating the provision of new affordable housing is an important complement to upgrading low-income informal settlements. Urban policy should aim to prevent the formation of informal settlements through new housing while upgrading existing informal settlements and recognizing their legal status. Upgrading programmes should be coordinated and comprehensive in order that health risks are minimized. (8)

61. Partnerships at the neighbourhood level and between community groups and municipal organizations are crucial to creating sustainable housing solutions for the urban poor. Nongovernmental organizations, neighbourhood groups and the provision of "sweat equity" by home owners should be supported as important factors in enabling families to improve their housing and living conditions. (8)

62. Urban planning should support home ownership on the one hand and rental accommodation on the other. In relation to home ownership, urban planning should provide for choice of location, enable the coordination of services and infrastructure development and be underpinned by appropriate public finance frameworks that include, among other things, micro-financing for housing. (8)

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APPENDIX K: Area for Action (Transportation)

Health Equity Recommendation Synthesis

Transportation: Transportation is the movement of people or goods. Transportation may be accomplished through human power, motor vehicles or other methods. Transportation-related risks such as injury, noise and pollution may be mitigated. Concerns include affordability and accessibility.

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
9. Transportation	10	13

- Planning for social inclusion (transportation planning to access key services using affordable public transportation
- Land use planning that promotes mixed use neighbourhoods without reliance on vehicles
- Local participation in planning)
- Policy (e.g., number of strollers allowed on buses)
- Strategy
- Walking and cycling facilities
- Investment
- Mitigate climate change effects of transportation and adapt to climate change in ways that promote equity
- Disability gas tax rebate

Original Source Document Recommendation Extractions

Transportation

1. Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity. Consider health equity impact of agriculture, transport, fuel, buildings, industry, and waste strategies concerned with adaptation to and mitigation of climate change. (1)

2. The federal government commit to a 'disability dimension' in new initiatives, including Caregivers, Childcare, Cities and Communities, and the Gas Tax Rebate to enhance accessible transportation and other services. (2)

3. Comprehensive prevention strategies should address the social and built environments of the priority settings of everyday living:
   • neighbourhoods
   • homes
   • daycares and schools
   • workplaces
   • public places (restaurants, entertainment venues, grocery stores, retail stores, recreation facilities, spiritual settings)
   • transportation settings (cars, buses, bicycle access)
   • special community circumstances (urban built environment, rural areas, isolated communities) (3)

4. Improve access to local services by improving transport and the location of service. (2)

5. Take forward the strategy to improve access to key services (Making the Connections: Final Report on Transport and Social Exclusion). (2)

6. Develop consistent transport and land use planning policies that improve people's ability to access work and key services, and encourage greater exercise. (2)

7. Local authority transport planners will conduct accessibility planning in partnership with PCTs and other local bodies to improve access to jobs and services for disadvantaged groups and areas in Local Transport Plan areas. (2)

8. Provide bus pass. (4)

9. Revise policy around the number of strollers permitted on the bus.(4)

10. Environmentally-friendly public transport and walking and cycling facilities are key elements in providing transport for the poor and reducing the adverse health impacts of a "car society", including reduction of road traffic injuries and urban air pollution. (5)

11. Improving public transit as an effective alternative to the automobile. (6)

12. Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality. (7)

13. Invest in public transport and make it more affordable. (8)

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APPENDIX L: Area for Action (Food)

Food and Food Security: Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. (Office of Nutrition Policy and Promotion, 2006)

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
10. Food	51	36

Health Equity Recommendation Synthesis

10. Food	51	36

10.1. Food Production and Distribution

- Agriculture sector, food system, food distribution
- Local control: governance of the local activities of multinational supermarkets and food suppliers, food distribution hubs, food markets, vendors, support for cooperative ventures among small traders
- Economic, environmental, development and food crises

10.2. Food Security and Safety

- **Affordability:** hunger; determine income assistance based on actual cost of food; child food security; routine availability of food in all schools (e.g., 'Food in Schools'); stronger local economies and greater control over the price of food
- **Food self-sufficiency and sustainability:** urban agriculture program; optimal conditions for food security in rich and poor countries; food security initiatives; access to food
- Food deserts
- **Food safety:** protocols appropriate for local conditions

10.3. Food Quality and Fortification

- Nutritional quality of processed food; ban all trans fats; ban sale of soft drinks and junk food in schools
- Promote fortification (e.g., folic acid); reduce salt content requirements; stronger labeling requirements on all packaged foods; regulation of breast-milk substitutes; regulation of high fat and sugar processed foods
- Food contaminants
- **Incentives:** modify lunch programs to improve nutrition; green markets and grocery stores that sell fresh produce; subsidize nutritional foods; zoning and neighbourhood design to discourage junk food and support grocery stores, farmers markets and restaurants; availability of fruits and vegetables in schools (e.g., 'National Fruit Scheme', '5 a DAY')
- **Disincentives:** increase taxes on junk food; restrict advertisement of junk food

Original Source Document Recommendation Extractions
Food

1. Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity. Consider health equity impact of agriculture, transport, fuel, buildings, industry, and waste strategies concerned with adaptation to and mitigation of climate change. (1)

2. The health and agriculture sectors should jointly promote national food systems based on the principles of: 1) self-sufficiency in dietary diversity (where environmental conditions permit); and 2) the provision of livelihoods through the production and distribution of food, providing the optimal conditions for food security in rich and poor countries alike. Self-reliant food systems contribute to stronger local economies and to greater control over the price of foods. (2)

3. Food security, good nutrition and health of urban people would be enhanced through environmentally-friendly "urban agriculture" programmes and locally controlled distribution hubs that foster food system self-sufficiency and sustainability; these also contribute both to the availability of higher quality food (particularly fruits and vegetables) and local economic vibrancy. (2)

4. The viability of local food vendors and food markets should be enhanced through:
   - Control and better governance of the local activities of multinational supermarkets and food suppliers;
   - Support for cooperative ventures among small traders. (2)

5. Addressing issues of availability and accessibility determined by the food system by engaging stakeholders (particularly local governments) to pursue strategies and community-based food security initiatives that focus on capacity building and community development. (3)

6. Behind the immediate determinants of health (education, housing, decent jobs, food security, social protection and universal health care) lie the deeper structural determinants including unequal power relations and unequal access to resources and decision making. Widening inequalities and institutionalized discrimination across axes of class, race, gender, ethnicity, caste, indignity, age and ability contribute to the impossibility of good health. Action on these structural determinants of health is essential to overcome the economic, environmental, development and food crises. (4)

7. Governments must reduce food insecurity by increasing minimum wages and social assistance rates to the level where an adequate diet is affordable. (5)

8. Providing affordable housing and childcare would reduce other family expenses and leave more money for acquiring an adequate diet. (5)

9. Facilitating mothers' employment through job supports, making available affordable childcare, and providing employment training would serve to reduce food insecurity among the most vulnerable Canadian families. (5)

10. Better monitoring systems must be designed and implemented to produce up-to-date accounts of food insecurity in Canada. (5)

11. The Food in Schools programme. (6)

12. Schools can participate in the Food in Schools programme, improving the diet and nutrition of children. (5)

13. Local planners can map food deserts so local 5 A DAY programmes can improve food access. (5)

14. Work with Aboriginal communities to develop culturally appropriate reproductive care programs, including better prenatal access, outreach, and nutrition programs for mothers and infants. (7)

15. Tackle the larger issues that affect children's health and development: Poverty, food security, and social conditions. (7)

16. Conduct surveillance of contaminants in food safety. (7)

17. The health and agriculture sectors should jointly promote national food systems based on the principles of: 1) self-sufficiency in dietary diversity (where environmental conditions permit); and 2) the provision of livelihoods through the production and distribution of food, providing the optimal conditions for food security in rich and poor countries alike. Self-reliant food systems contribute to stronger local economies and to greater control over the price of foods. (2)

18. Food security, good nutrition and health of urban people would be enhanced through environmentally-friendly "urban agriculture" programmes and locally controlled distribution hubs that foster food system self-sufficiency and sustainability; these also contribute both to the availability of higher quality food (particularly fruits and vegetables) and local economic vibrancy. (2)

19. Food safety protocols that are appropriate for local conditions. (2)

20. Food Security - Developing a healthy eating and food security strategy. (3)

21. Ensuring income assistance rates are determined with consideration for the actual cost of food. (3)

22. Addressing issues of availability and accessibility determined by the food system by engaging stakeholders (particularly local governments) to pursue strategies and community-based food security initiatives that focus on capacity building and community development. (3)

23. Make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. (8)

24. "…Food security meaning the certitude of being able to eat a healthy diet, at a reasonable cost, day after day without relying on charity." (9)

25. Local government and civil society, plan and design urban areas to promote physical activity through direct investment in active transport; encourage healthy eating through retail planning to manage the availability of and access to food; and reduce violence and crime through good environmental design and regulatory controls, including control of the number of alcohol outlets. (1)

26. Governments must assure that healthy foods are affordable (e.g., milk, fruits, and foods high in fiber). (5)

27. Providing affordable housing and childcare would reduce other family expenses and leave more money for acquiring an adequate diet. (5)

28. Comprehensive prevention strategies should address the following priority health related behaviours:
    - appropriate care and support for children and others who are in need at any stage of the life course
    - healthy relationships at home, school, work and in all community settings (self-respectful, mutually respectful, caring, and supportive; free from abuse, violence, intolerance, exploitation, sexism, and racism)
    - healthy sexuality (mutually respectful and consenting, using appropriate disease prevention and contraception)
    - healthy hygiene practices (hand washing, cough etiquette, food handling)
    - protection and sustainability of the natural environment (protection of our water, soil, air, ecology; sustainable management of non-renewable resources and greenhouse gases)
    - safety and injury prevention (seatbelt use, other motor-vehicle safety, bicycle helmet use, falls prevention, workplace safety, safety in other settings)
    - mental, emotional and spiritual well-being (lifelong learning, work-life balance, personal stress management), balancing active living (adequate and regular physical activity), sedentary activities (television, video games, computers), and adequate relaxation and sleep
    - healthy diet (recommended levels of adequate nutrients, fiber, vitamins, calories, saturated fats,
      refined carbohydrates, alcohol, and salt); oral and dental hygiene
    - avoidance of harmful substances (tobacco, illicit drugs) and addictions (including alcohol, prescription drugs); safe levels of exposure to harmful environmental risks (radon, asbestos, ultraviolet radiation)
    - appropriate use of preventive health services (vaccinations, screening); harm reduction programs (safe use of injection drugs, sexually transmitted disease prevention); healthcare (primary care, prenatal care); and other services (addictions treatment, dental care, dieticians, personal and family counseling, other allied health services). (10)

29. Ensure that women and young children from low income families have access to healthy diet and provide increased support for breastfeeding mothers. (5)

30. Improve nutrition of families and children and other groups in disadvantaged areas by increasing access to and consumption of fruits and vegetables and by increasing uptake and duration of breastfeeding. (5)

31. National School Fruit Scheme. (5)

32. Schools can participate in the Food in Schools programme, improving the diet and nutrition of children. (5)

33. Local planners can map food desserts so local 5 A DAY programmes can improve food access. (5)

34. Conduct surveillance of contaminants in food safety. (7)

35. Increase excise taxes on cigarettes, alcohol and junk food and use proceeds to support

public health programs. (6)

36. Ban sale of soft drinks and junk foods in schools. (6)

37. Modify school lunch programs to improve nutrition. (6)

38. Provide incentives (e.g., tax breaks or low cost business loans) for green markets and grocery stores that sell fresh produce. (6)

39. Carrying out health equity impact assessments on local and provincial agricultural policies to monitor whether they are helping or hindering access to healthy diets for low- income groups (Dahlgren & Whitehead, 2006). (11)

40. Working with the food industry to improve the nutritional quality of processed food. (11)

41. Raising financial and other supports given to low-income families with children, to make it more possible for them to choose a healthier diet (Acheson, 1998). (11)

42. Use the motivating force of friendly competition (e.g., 100 Mile Clubs). (11)

43. Promote and facilitate good nutrition and physical activity. (2)

44. Food security, good nutrition and health of urban people would be enhanced through environmentally-friendly "urban agriculture" programmes and locally controlled distribution hubs that foster food system self-sufficiency and sustainability; these also contribute both to the availability of higher quality food (particularly fruits and vegetables) and local economic vibrancy. (2)

45. Ensuring adequate incomes and access to affordable, nutritious food. (3)

46. Supporting stronger labeling requirements on all packaged foods, banning trans-fats, reducing salt content requirements, restricting advertisements and sales of junk foods, implementing subsidy programs for nutritional foods, and promoting nutrient fortification (e.g., folic acid). (3)

47. Improving physical access to healthy foods and discouraging junk foods through zoning and neighbourhood design where needed to support grocery stores, farmers' markets and restaurants. (3)

48. Regulate and protect populations from health hazards emanating from commercial activities, such as those created by the tobacco, alcohol, breast-milk substitutes, high fat and sugar processed food, and the petroleum and extractive industries. (4)

49. Make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. (8)

50. Prioritize policies and interventions that reduce both health inequalities and mitigate climate change, by:
    - Improving active travel across the social gradient
    - Improving the availability of good quality open and green spaces across the social gradient
    - Improving the food environment in local areas across the social gradient

- Improving energy efficiency of housing across the social gradient. (12)

APPENDIX L: REFERENCES

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APPENDIX M: Area for Action (Behaviour)

Behaviour: Behaviour is any personal action that influences health. Behaviour includes but is not limited to substance use, sexual risk-taking and physical activity. Behaviour also includes personal actions associated with other factors that influence health (i.e., food, transportation, housing, environment, community, childhood, education, work, income, economy, health services).

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
11. Behaviour	73	56

Health Equity Recommendation Synthesis

11.1. Healthy Living

- Diet
- Hygiene, oral, dental
- Rest, stress management, work-life balance
- Injury prevention (intentional and unintentional)
- Sexual expression
- Relationships
- Providing care for others
- Use of primary care, hypertension, preventive health service use, use of allied health services
- Environmental stewardship
- Safe exposure to harmful environmental risks
- Lifelong learning, develop skill

11.2. Active Living

- **Active transportation:** adverse effects of "car society"; cycling and walking; walking buses
- **Physical activity promotion**: cycle training; exercise; play; "Sport in School"

11.3. Substance Use

- Prevention, harm reduction, treatment and enforcement
- Redirect taxes and increase price of alcohol, cigarettes and junk food to public health programs
- Health hazards from commercial activities – alcohol and tobacco
- Tobacco cessation and reduction, tobacco sales to minors, tobacco smuggling, tobacco control programs, education,
- **Alcohol misuse and reduction:** alcohol consumption among high-risk groups; negative health impact of alcohol misuse; social exclusion that triggers problem drinking
- Avoidance of harmful substances and addictions
- Coordinated response to health and social problems faced by injection drug users

Original Source Document Recommendation Extractions
Behaviour

1. Achieving health equity requires safe, secure, and fairly paid work, year-round work opportunities, and healthy work-life balance for all. (1)

2. Protect all workers. International agencies should support countries to implement core labour standards for formal and informal workers; to develop policies to ensure a balanced work-home life; and to reduce the negative effects of insecurity among workers in precarious work arrangements (informal, temporary and part-time work). (1)

3. Reinforce the primary role of the state in the provision of basic services essential to health (such as water/sanitation) and the regulation of goods and services with a major impact on health (such as tobacco, alcohol, and food). (1)

4. National governments, in collaboration with relevant multilateral agencies, strengthen public sector leadership in the provision of essential health-related goods/services and the control of health-damaging commodities. (1)

5. Social marketing. (2)

6. Government policies must support Canadians' working life so that demands upon workers and their rewards are balanced. (3)

7. The Manitoba government should oversee the coordination and development of a set of integrated prevention strategies that address priorities for health outcomes, health-related behaviours and activities, determinants of health and settings of everyday living. (3)

8. Comprehensive prevention strategies should address the following priority health related behaviours:
    - appropriate care and support for children and others who are in need at any stage of the life course
    - healthy relationships at home, school, work and in all community settings (self-respectful, mutually respectful, caring, and supportive; free from abuse, violence, intolerance, exploitation, sexism, and racism)
    - healthy sexuality (mutually respectful and consenting, using appropriate disease prevention and contraception)
    - healthy hygiene practices (hand washing, cough etiquette, food handling)
    - protection and sustainability of the natural environment (protection of our water, soil, air, ecology; sustainable management of non-renewable resources and greenhouse gases)
    - safety and injury prevention (seatbelt use, other motor-vehicle safety, bicycle helmet use, falls prevention, workplace safety, safety in other settings)
    - mental, emotional and spiritual well-being (lifelong learning, work-life balance, personal stress management), balancing active living (adequate and regular physical activity), sedentary activities (television, video games, computers), and adequate relaxation and sleep
    - healthy diet (recommended levels of adequate nutrients, fibre, vitamins, calories, saturated fats, refined carbohydrates, alcohol, and salt); oral and dental hygiene
    - avoidance of harmful substances (tobacco, illicit drugs) and addictions (including alcohol, prescription drugs); safe levels of exposure to harmful environmental risks (radon, asbestos, ultraviolet radiation)

- appropriate use of preventive health services (vaccinations, screening); harm reduction programs (safe use of injection drugs, sexually transmitted disease prevention); healthcare (primary care, prenatal care); and other services (addictions treatment, dental care, dieticians, personal and family counselling, other allied health services) (4)

9. To achieve consistent progress towards the recommended goals and to enhance comprehensive prevention strategies, it is recommended that the Manitoba government, including all departments, relevant crown corporations and funded agencies use the following approaches:
    - In collaboration with Manitoba Health and Manitoba Healthy Living, Youth and Seniors, adopt methods to assess the impact of all major decisions, policies, legislation and other actions on the health of Manitobans and the inequalities of health among Manitobans.
    - Develop and implement ways to increase the engagement of all organizations and citizens in the shared opportunities and responsibilities to prevent disease and injury.
    - Strengthen and support the vital role of families and communities in promoting the health of children and others throughout all stages of the life course.
    - Achieve a more equitable distribution of the determinants of health and improve the settings of everyday living to promote healthier behaviours.
    - Strengthen the capacity and coordination of preventive services and programs delivered by public health, primary care and others with more outreach and follow-up for those with the highest need and least ability to access care. (4)

10. Preventing and managing other risk factors such as poor diet and obesity, physical inactivity and high blood pressure. (3)

11. The HDA needs to act as the national authority and information resource for "what works" to reduce inequality, producing guidance about effective action and helping practitioners get evidence into practice. (3)

12. The NHS Modernisation Agency needs to use its expertise to support the implementation of best practice and effective action locally. (3)

13. The NHSU, the new corporate university for the NHS needs to develop the skills of NHS staff to tackle health inequalities through practical learning opportunities. (3)

14. Change local norms and policies by: assuring high visibility of alternate behaviours and engaging formal and informal leaders to model health behaviours. (5)

15. Implement equity-based social protection systems and maintain and develop effective publicly provided and publicly financed health systems that address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities. (6)

16. Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities. (7)

17. Local government and civil society, plan and design urban areas to promote physical activity through direct investment in active transport; encourage healthy eating through retail planning to manage the availability of and access to food; and reduce violence and crime through good environmental design and regulatory controls, including control of the number of alcohol outlets. (1)

18. Comprehensive prevention strategies should address the following priority health related behaviours:
    - appropriate care and support for children and others who are in need at any stage of the life course
    - healthy relationships at home, school, work and in all community settings (self-respectful, mutually respectful, caring, and supportive; free from abuse, violence, intolerance, exploitation, sexism, and racism)
    - healthy sexuality (mutually respectful and consenting, using appropriate disease prevention and contraception)
    - healthy hygiene practices (hand washing, cough etiquette, food handling)
    - protection and sustainability of the natural environment (protection of our water, soil, air, ecology; sustainable management of non-renewable resources and greenhouse gases)
    - safety and injury prevention (seatbelt use, other motor-vehicle safety, bicycle helmet use, falls prevention, workplace safety, safety in other settings)
    - mental, emotional and spiritual well-being (lifelong learning, work-life balance, personal stress management), balancing active living (adequate and regular physical activity), sedentary activities (television, video games, computers), and adequate relaxation and sleep
    - healthy diet (recommended levels of adequate nutrients, fiber, vitamins, calories, saturated fats, refined carbohydrates, alcohol, and salt); oral and dental hygiene
    - avoidance of harmful substances (tobacco, illicit drugs) and addictions (including alcohol, prescription drugs); safe levels of exposure to harmful environmental risks (radon, asbestos, ultraviolet radiation)
    - appropriate use of preventive health services (vaccinations, screening); harm reduction programs (safe use of injection drugs, sexually transmitted disease prevention); healthcare (primary care, prenatal care); and other services (addictions treatment, dental care, dieticians, personal and family counselling, other allied health services) (4)

19. Preventing and managing other risk factors such as poor diet and obesity, physical inactivity and high blood pressure. (3)

20. Develop sports facilities to develop physical literacy and maintain active lifestyles. (3)

21. Raise levels of physical activity, particularly among disadvantaged groups, including action to increase cycling and walking. (3)

22. Create better and safer local environments, particularly in disadvantaged areas, so that people are more able to engage in social and physical activities in the public spaces close to where they live and work, in pleasant clean surroundings, without fear of crime. (3)

23. Improve employment prospects in the worst areas by tackling employment rates and addressing the issue of inactivity and incapacity. (3)

24. Develop consistent transport and land use planning policies that improve people's ability to access work and key services, and encourage greater exercise. (3)

25. Provision of sporting activity, including New Opportunities for PE and Sport in Schools. (3)

26. The Sport and Physical Activity Board led by DH/DCMS has a specific remit to strengthen the evidence base around physical activity interventions which are effective. (3)

27. Local authorities can encourage exercise among young children by increasing the use of abandoned or low-grade green spaces and promoting sports centres and leisure facilities. (3)

28. Local authorities can promote and fund pedestrian safety and cycle training for children. (3)

29. Communities and neighbourhood wardens can introduce walking buses for school children, and provide escorts for elderly people afraid of walking alone. (3)

30. Local authorities can work in partnership with local communities to improve green spaces so that they can be used for exercise and provide children's play areas. (3)

31. Primary health care professionals and local authorities can collaborate to promote exercise on referral schemes for individuals whose health is being seriously put at risk by physical inactivity. (3)

32. Each regional health authority has an Aboriginal health plan that specifies actions on issues unique or specific to each region, targets the specific areas for health authority actions, and is aligned with relevant bilateral and tripartite plans. In addition to region-specific strategies, the health plan includes the following three components that will improve the health of Aboriginal people. (8)

33. Environmentally-friendly public transport and walking and cycling facilities are key elements in providing transport for the poor and reducing the adverse health impacts of a "car society", including reduction of road traffic injuries and urban air pollution. (9)

34. Promote and facilitate good nutrition and physical activity. (9)

35. Governments and nongovernmental organizations should create opportunities for recreation, physical activity and participation in the arts and other cultural activities to enhance livelihood, social cohesion, health and well-being. (9)

36. Prioritize policies and interventions that reduce both health inequalities and mitigate climate change, by:
    - Improving active travel across the social gradient
    - Improving the availability of good quality open and green spaces across the social gradient
    - Improving the food environment in local areas across the social gradient
    - Improving energy efficiency of housing across the social gradient. (10)
37. Encourage active transportation and ensure users' safety. (11)

38. Work and working conditions:
- Enforcing legislation that protects the rights of minority groups, particularly concerning employment rights and anti-discrimination.
- Assuring access to educational, training and employment opportunities, especially for those such as the long-term unemployed.
- Supporting improved management practices that lead to increased levels of control, variety and appropriate use of skills into the workforce.
- Assessing the impact of employment policies on health and inequalities in Health.
- Ensuring accessible and safe cycling and walking routes to workplaces
- Enacting smoke-free workplace legislation. (12)

39. Reinforce the primary role of the state in the provision of basic services essential to health (such as water/sanitation) and the regulation of goods and services with a major impact on health (such as tobacco, alcohol, and food). (1)

40. National governments, in collaboration with relevant multilateral agencies, strengthen

public sector leadership in the provision of essential health-related goods/services and the control of health-damaging commodities. (1)

41. Comprehensive prevention strategies should address the following priority health related behaviours:
    - appropriate care and support for children and others who are in need at any stage of the life course
    - healthy relationships at home, school, work and in all community settings (self-respectful, mutually respectful, caring, and supportive; free from abuse, violence, intolerance, exploitation, sexism, and racism)
    - healthy sexuality (mutually respectful and consenting, using appropriate disease prevention and contraception)
    - healthy hygiene practices (hand washing, cough etiquette, food handling)
    - protection and sustainability of the natural environment (protection of our water, soil, air, ecology; sustainable management of non-renewable resources and greenhouse gases)
    - safety and injury prevention (seatbelt use, other motor-vehicle safety, bicycle helmet use, falls prevention, workplace safety, safety in other settings)
    - mental, emotional and spiritual well-being (lifelong learning, work-life balance, personal stress management), balancing active living (adequate and regular physical activity), sedentary activities (television, video games, computers), and adequate relaxation and sleep
    - healthy diet (recommended levels of adequate nutrients, fiber, vitamins, calories, saturated fats, refined carbohydrates, alcohol, and salt); oral and dental hygiene
    - avoidance of harmful substances (tobacco, illicit drugs) and addictions (including alcohol, prescription drugs); safe levels of exposure to harmful environmental risks (radon, asbestos, ultraviolet radiation)
    - appropriate use of preventive health services (vaccinations, screening); harm reduction programs (safe use of injection drugs, sexually transmitted disease prevention); healthcare (primary care, prenatal care); and other services (addictions treatment, dental care, dieticians, personal and family counselling, other allied health services). (4)

42. Reducing smoking in manual social groups through smoking cessation services and other tobacco control programmes. (3)

43. Reducing smoking and improving nutrition in pregnancy and early years, including increasing the number of mothers who breastfeed. (3)

44. PCTs and local authorities can work together to reduce smoking, providing tobacco education programmes and smoking cessation clinics. (3)

45. PCTs can work with communities and charities to introduce more comprehensive smoking prevention and cessation strategies targeted at low-income groups, black and minority ethnic groups, young people, pregnant smokers and prisoners. (3)

46. Trading standards officers and police can tackle tobacco sales to minors and smuggling. (3)

47. Fiscal policies (e.g. increase price of tobacco and alcohol products). (13)

48. Support Aboriginal communities in motivating community members to reduce tobacco misuse. (8)

49. Develop culturally sensitive and supportive programs to address the root cause of alcohol and substance use and to help achieve better health outcomes for mothers and their infants. (8)

50. Implement community programs (such as the Four Pillars Approach in Vancouver) to prevent, treat, and reduce harms from substance abuse, with a focus on culturally based services specific to the Aboriginal population. (8)

51. In consultation with Aboriginal communities, develop and deliver education programs to heighten awareness of arthritis, osteoporosis, exercise, weight control, and injury prevention. Expand prevention and treatment for alcohol and substance misuse. (8)

52. Continue to develop a coordinated response to the health and social problems faced by injection drug users. (8)

53. Develop ways to monitor indoor air quality and study the health effects resulting from second-hand smoke, inadequate heating, and moisture control. (8)

54. Increase excise taxes on cigarettes, alcohol and junk food and use proceeds to support public health programs. (15)

55. Intensive tobacco reduction programs targeted and tailored to disadvantaged groups and communities are essential to reducing health inequalities. (5)

56. Reducing alcohol consumption among high-risk groups. (5)

57. Tackling upstream causes of alcohol misuse in society- for example, the unemployment and social exclusion that triggers problem drinking. (5)

58. To reduce the additional negative health impact of alcohol misuse typically experienced among lower socio-economic groups, support systems can be developed in work settings and in the community, both for prevention of alcohol misuse among children and youth and for adults. (5)

59. Prevent urban violence and substance abuse. (9)

60. Interventions for improving safety and security at the community level often involve engagement of local leaders in dispute resolution, investing in lighting and neighbourhood watch initiatives, educational and recreational activities (including job training opportunities), and licit and illicit drug-use prevention and harm reduction, but there are local contexts where other approaches are needed. (9)

61. Regulate and protect populations from health hazards emanating from commercial activities, such as those created by the tobacco, alcohol, breast-milk substitutes, high fat and sugar processed food, and the petroleum and extractive industries. (6)

62. Implement fully the Framework Convention on Tobacco Control (FCTC) and develop other global treaties that promote good health and address the social determinants of health, such as in the areas of access to essential medicines and regulation of the baby food, alcohol and food industry. (6)

63. Accelerate the implementation by the State Parties of the WHO Framework Convention on Tobacco Control (FCTC), recognizing the full range of measures including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the FCTC as we recognize that substantially reducing tobacco

consumption is an important contribution to addressing social determinants of health and vice versa. (7)

64. Implement an evidence-based program of ill health preventive interventions that are effective across the social gradient by:
    a. Increasing and improving the scale and quality of medical drug treatment programs
    b. Focusing public health interventions such as smoking cessation programs and alcohol reduction on reducing the social gradient
    c. Improving programs to address the causes of obesity across the social gradient. (10)

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APPENDIX N: Area for Action (Health Services)

Health Equity Recommendation Synthesis

Health Services: The health services or health system includes all actions whose primary purpose is to promote, restore, or maintain health. (World Health Organization, 2000)

Themes and Sub-Themes	Number of Associated Codes	Number of Associated Recommendations
12. Health Services	317	233

12.1. Finance Strategies

- **Fund**: health promotion, illness prevention, based on need, refugee care, interpretation for medical care, patient transportation
- Avoid per capita funding
- **Redirect funding**: taxes from alcohol, cigarettes and junk food to public health programs
- **Funding health care options:** special 'health' tax on financial speculation, medicare, community initiatives, subsidize high risk individuals, preventing impoverishment when seeking medical treatment
- **Health resources distributed proportionate to need (geographically):** human resources, areas with high health needs have adequate capacity for delivering quality care, avoid gaps and duplication of services

12.2. Comprehensive Programs and Services

- Community information and referral systems
- Shared electronic health records
- **Population focused:** community-based primary care; access 24/7 to follow-up care; home care; dental; support to help young people with mental health needs; integrated mental health and addictions services (e.g., smoking cessation); medical drug treatment; arthritis care; sexual and reproductive; counseling (e.g., coping skills interventions, trauma, social and emotional support); pharmacare; disability services
- **Comprehensive holistic care:** programs of outreach (range of outreach services); holistic approach to health (includes spiritual, physical, mental, emotional, cultural economic, social and environmental); self-management services; patient navigation; integration of alternate therapies; shared guideline for practice; continuum of care (e.g., prevention; health protection; health promotion [e.g., referral schemes for exercise]; curative; rehabilitative)
- Health services are delivered in locations where people congregate (e.g., community centres, outreach organizations, community and social organizations); school nurses; correctional system's health
- Community development; engagement in development, implementation and evaluation of services
- **Culturally and linguistically appropriate**: standards for culturally competent policies, programs and services; culturally proficient systems; cultural competency training; culture integrated into health services; specialty clinics that offer multi-disciplinary services including mental health programs, trauma counselling and social support services of underserved or inappropriately served groups; Aboriginal patient liaison workers or navigators; cultural brokers, interpretation services, language capacity within services, bridge between western and traditional healing practices
- **Refugee health:** specialty clinics for refugees who require enhanced medical support; comprehensive health services for refugees and refugees resettled as permanent residents (Interim Health Program)

12.3. Public Health Promotion and Prevention

- **Guidelines:** for public health practice; for public on use of public health and primary care system for primary and secondary prevention
- Health literacy so clients can better access, understand, communicate, evaluate and act on

health
- Communicable disease control and prevention; HIV increase uptake of HAART
- **Continuum of Care - Policy and Strategy (including programs of outreach):**
  6. **Social determinants of health:** early detection of the determinants; determinants underlying HIV, mental illness and other diseases; determinants to maintain health; determinants supporting physical and social well-being; teenage pregnancy.
  7. **Primary prevention:** chronic disease (e.g., diabetes); immunization; 'brushing for life'; smoking; increase awareness of arthritis, osteoporosis, exercise, weight control and injury prevention; to address vulnerabilities that can lead to criminal activity.
  8. **Early detection:** screening (e.g., Pap and mammography); mental health triage; suicide; Aboriginal equity; adverse outcomes of pregnancy and infancy; smoking cessation.
  9. **Early intervention:** mental health early intervention for first episode of psychosis; chronic disease self-management.
  10. **Early treatment:** mental health intensive support in first three years after first episode of psychosis; chronic disease management (e.g., diabetes); medically treatable diseases; expert patient program (e.g., self-management for long-term conditions).
- Public health workforce (e.g., inspectors, nurses, medical officers of health (MOH), home visitors, dietitians)
- Enhance public health system capacity

12.4. Health Sector Workforce and Partners

- **Healthcare organizations**: colleges; unions; community organizations; health authorities; departments; nursing homes; partners and external stakeholders
- **Professional competence and capacity**: health professional education; participation in health service design and delivery; about health literacy; to communicate effectively with clients; health literacy is embedded in education of future health professionals
- **System competence and capacity:** to prevent a decline in health due to unemployment; relationships between health and refugee and asylum seeker serving organizations; build Aboriginal leadership at the community level; sufficient skilled staff to tackle health inequities to meet strategic objectives; policies and procedures about sharing personal health information; cultural competency infrastructure; comprehensive primary care and public health services, coordinated with allied health, social and other programs and services including primary care networks
- **Levels of responsibility:** Boards; executive; decision makers; front line staff; clinical workers; community development teams
- **Workforce:** representative workforce (i.e., staffing reflects the diversity of the communities served); recruitment; planning; balance rural urban health-worker density; position description
- **Professional staff**: dentists, clinical epidemiologists; general practitioners; pharmacists; health literacy coordinators; patient navigators; primary care; specialists
- International cooperation

12.5. Addressing Barriers and Opportunities

- **Opportunities:** health services community based and community controlled; national health goals, transferring technology for pharmaceutical production to developing countries; primary care services under Aboriginal control; resources proportionate to size and need of ill population; integrated health and social services; continuity of care; equity as a priority in design and delivery of public health services and programs; staff capacity and skills to improve health equity; democratize health systems; location of health facilities (e.g., pharmacies); regulation of the private medical sector; prescribe and promote exercise; collaborative health networks focused on improving care for specific populations with complex chronic health conditions (e.g., refugees, persons involved in corrections); relationship between corrections and health authorities
- **Barriers:** financial (e.g., medication, transportation to health facilities); service inequities;

jurisdictional; medication affordability; costly and ineffective screening, diagnostics and treatments
- **Problems:** inappropriate medication prescribing

12.6. Knowledge and Planning
- **Knowledge**: provide information to underserved groups for the purpose of promoting full participation the planning cycle
- National indicators (e.g., wellbeing, life expectancy, health expectancy [quality of life])
- National guidelines (e.g., falls, osteoporosis)
- **Planning:** developing urban health systems; annual service plans; public health strategic plan; wait times; prioritization system for surgical intervention for people with arthritis; First Nations Health Plan; working effectively with local business to support local regeneration; location of health facilities; plan for innovation
- **Setting goals, objectives and standards:** performance expectations for Aboriginal health policies; equity-oriented workplace health policies; audit, inspection and accountability

Original Source Document Recommendation Extractions
Health Services

1. New national and global public finance mechanisms be developed, including special health taxes and global tax options. (1)

2. Services should be provided according to need, not ability to pay. This requires a system of health care financing that pools risks across the population, so that those at high risk are subsidized by those at low risk at any given time. (2)

3. The medicare system must be strengthened and governments should resist the increasing involvement of for-profit companies in the organization and delivery of health care. (3)

4. To foster timely and efficient prevention and care and to avoid gaps and duplication of services, continue to develop a comprehensive primary care and public health system that can provide, for all Manitobans, continuing and holistic care, including allied health, social and other programs and services within one coordinated system that includes primary care networks and 24/7 access to on-call emergency intake to facilitate immediate care or follow-up, as appropriate. (4)

5. Reform Patient Transport Services and Hospital Travel Costs scheme to reflect better the needs of patients. Physical access to health care will have a higher priority in decisions about the location of health care facilities. (3)

6. Ensuring that areas with high health needs have adequate capacity for delivering quality care, in particular GPs, health visitors and other community-based health professionals. (3)

7. PCTs can match staffing to levels of health need. (3)

8. Increase excise taxes on cigarettes, alcohol and junk food and use proceeds to support public health programs. (5)

9. The number of health resources in Saskatoon's low income neighbourhoods should, at the very least, be proportionate to the size of the population; let alone to the disproportionate number of health disorders. (6)

10. For health authority public health programming, this suggests that moving away from per-capita funding or similar methodologies to needs-based funding offers an opportunity to dedicate resources in a manner conducive to reducing inequalities in health. It could be possible for resources to remain universally available, but with the greatest allocation to those most in need. (7)

11. Provide training to ESL teachers on educating their students about the Canadian health system. (8)

12. Improve the health system's accessibility and responsiveness by developing, implementing, and evaluating health programs and services in partnership with the communities and community members being served by supporting and building on existing community support programs and advisory committees. (8)

13. Promote communication and coordination between the health system and external stakeholders by examining where opportunities exist to set up processes for information sharing to communicate best practices and research findings more effectively. (8)

14. Strengthen linkages with community-serving organizations and other local stakeholders to share information about the range of services and programs available within the health system and the community. (8)

15. Increase the capacity of the health system to better serve the needs of BC's culturally and linguistically diverse population by:
    - Ensuring that policies, programs, and services are culturally competent.
    - Implement employment equity policies and plans for the recruitment and retention of health system staff that reflect the diversity of the population.
    - Utilize the knowledge and expertise of community members and organizations to help develop the cultural competency training modules and tools for health system employees. (8)

16. Add refugees to chronic disease group so GPs will receive extra remuneration. (8)

17. Create MSP fee code for interpreting services. (8)

18. Extend medical coverage to migrant workers. (8)

19. Provide equitable universal health care coverage including high quality preventive, curative and rehabilitative health services throughout the life cycle, based on comprehensive primary health care. (9)

20. Build, strengthen and maintain health financing and risk pooling systems that prevent people from becoming impoverished when they seek medical treatment. (10)

21. Promote mechanisms for supporting and strengthening community initiatives for health financing and risk pooling systems. (10)

22. Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality. (11)

23. Increase availability of long-term and sustainable funding in ill health prevention across the social gradient. (11)

24. Prioritize investment in ill health prevention and health promotion across government departments to reduce the social gradient. (11)

25. Income, employment, and socio-economic status.
    - Provide a guaranteed minimum income; a living wage as the minimum wage;
    - Improving pay equity
    - Restoring and improving income supports for those unable to gain employment
    - Reducing inequalities in income and wealth within the population through progressive taxation of income and inherited wealth.
    - Preserving and creating jobs
    - Directing attention to the health needs of immigrants and to the unfavourable socio-economic position of many groups, including the particular difficulties many New Canadians face in accessing health and other care services
    - Restoring employment benefits and eligibility to previous levels
    - Requiring that provincial social-assistance programs be accessible and funded at levels to assure health, especially for women of child-bearing age, children and seniors.
    - Assuring that supports are available to citizens through critical life transitions, possibly by increasing the uptake of benefits in entitled groups. (12)

26. Increase investment in sexual and reproductive health services and programmes, building to universal coverage and rights. (1)

27. Public health services should not be driven by profit, and patients should never be exploited for profit. (2)

28. The same high standard of care should be offered to everyone, without discrimination with respect to social, ethnic, gender or age profile. (2)

29. Modify public health interventions to meet the unique needs and capacities of priority populations. (13)

30. Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs. (13)

31. Attention must be directed to the health needs of immigrants and to the unfavourable socio-economic position of many groups, including the particular difficulties many new Canadians face in accessing health and other care services. (3)

32. Governments must implement a pharmacare program and increase public coverage of home care and nursing home costs. (3)

33. Consideration should be given to providing dental care to families living on low incomes. (3)

34. To achieve consistent progress towards the recommended goals and to enhance comprehensive prevention strategies, it is recommended that the Manitoba government, including all departments, relevant crown corporations and funded agencies use the following approaches:

- In collaboration with Manitoba Health and Manitoba Healthy Living, Youth and Seniors, adopt methods to assess the impact of all major decisions, policies, legislation and other actions on the health of Manitobans and the inequalities of health among Manitoban.
- Develop and implement ways to increase the engagement of all organizations and citizens in the shared opportunities and responsibilities to prevent disease and injury.
- Strengthen and support the vital role of families and communities in promoting the health of children and others throughout all stages of the life course.
- Achieve a more equitable distribution of the determinants of health and improve the settings of everyday living to promote healthier behaviours.
- Strengthen the capacity and coordination of preventive services and programs delivered by public health, primary care and others with more outreach and follow-up for those with the highest need and least ability to access care. (4)

35. Increase capacity in Manitoba Health and regional health authorities as well as collaborate with health care professionals, academics and others to select or develop, implement, and monitor prevention guidelines for health practitioners in public health and primary care which will enhance appropriateness, quality, and efficiency and further advance health system innovation, equity and sustainability. (4)

36. Strengthen and improve integration of public health and primary care through better communication and collaboration, using common guidelines and standards for prevention, shared electronic health records and enhanced information systems for surveillance. (4)

37. To complement guidelines for health care practitioners, develop and disseminate guidelines for the public on use of the public health and primary health care system in an appropriate, effective, and efficient manner for primary and secondary prevention. (4)

38. Increase outreach programs in public health and primary care to proactively engage individuals, families and populations at highest risk and greatest need who are least likely to seek care (ex: prenatal care; newborn assessment and follow-up; immunizations; screening; and mental health promotion and care). (4)

39. Improve access to and raised awareness of local drug and alcohol misuse services, particularly in disadvantaged areas. (3)

40. Improve access to mental health services by reducing the associated stigma, so encouraging people to seek help. Provide triage for people in the community who may need urgent specialist help. (3)

41. Ensure specialist mental health services and primary care services, including dentistry, are available to all prisoners and provide better detoxification services. (3)

42. Share and promote good practice in the care and treatment of asylum seekers and refugees so that their health care addresses their particular needs. (3)

43. Improve access to local services by improving transport and the location of service. (3)

44. Improve access to and quality of primary care services in currently underserved areas, for example by making greater use of community settings and services including community pharmacies. (3)

45. Improving access to effective treatment. (3)

46. Tackle the 'inverse care law' by matching need with high quality services and by monitoring and improving the uptake of services in areas with high levels of illness but low referral rates. (3)

47. PCTs can work with partners to promote access to welfare advice and support in health and outreach facilities. (3)

48. Providing responsive services, focusing on the skills of key professionals on reaching groups and individuals that access services late or not at all. (3)

49. Match companies/business leaders with community health-related projects and/or with health care organizations to maximize the potential impact of both sectors on health inequalities. (3)

50. Workforce Development Confederations on behalf of SHAs need to ensure that there are appropriate numbers of appropriately skilled staff to tackle health inequalities to meet strategic objectives. (3)

51. School nurses can work with 'Connexions' personal advisers to ensure that the appropriate support is in place to help a young person with mental health needs. (3)

52. PCT staff can work with transport planners to improve access to health services for those in disadvantaged groups and areas. (3)

53. Primary health care professionals and local authorities can collaborate to promote exercise on referral schemes for individuals whose health is being seriously put at risk by physical inactivity. (3)

54. PCTs with poor rates of dental health can consider fluoridating their water supply as part of

their overall health strategy and invite the SHA to carry out the necessary consultation. (3)

55. Encourage greater Aboriginal participation in health governance and in the design and delivery of culturally appropriate health services. (14)

56. Each regional health authority has an Aboriginal health plan that specifies actions on issues unique or specific to each region, targets the specific areas for health authority actions, and is aligned with relevant bilateral and tripartite plans. In addition to region-specific strategies, the health plan includes the following three components that will improve the health of Aboriginal people. (14)

57. Cultural Competency. (14)

58. Aboriginal Patient Liaisons/Navigators. (14)

59. Work with Aboriginal communities to develop culturally appropriate reproductive care programs, including better prenatal access, outreach, and nutrition programs for mothers and infants. (14)

60. Develop culturally sensitive and supportive programs to address the root cause of alcohol and substance use and to help achieve better health outcomes for mothers and their infants. (14)

61. Implement community programs (such as the Four Pillars Approach in Vancouver) to prevent, treat, and reduce harms from substance abuse, with a focus on culturally based services specific to the Aboriginal population. (14)

62. Expand arthritis services to include all health professionals important in arthritis care (e.g., physiotherapists, occupational therapists) and provide these services to the areas of the province where care is needed. (14)

63. In consultation with Aboriginal communities, develop and deliver education programs to heighten awareness of arthritis, osteoporosis, exercise, weight control, and injury prevention. Expand prevention and treatment for alcohol and substance misuse. (14)

64. Increase awareness and promotion of HIV disease prevention and develop more treatment options and increase uptake of HAART among Aboriginal patients. (14)

65. Encourage Aboriginal involvement in describing and capturing evidence about what works to promote health, treat illness, and care for the vulnerable. Support the use of traditional healing in conjunction with other primary health services. (14)

66. Ban smoking in public areas, subsidize treatment programs for smoking cessation and drug and alcohol abuse. (5)

67. Provide health and social services to schools in low income neighbourhoods in order to prevent school drop-out, encourage academic achievement, increase graduation rates and improve health. (6)

68. Return to work programs should include a comprehensive combination of adapted skills training, job search, job placement, on the job experience and life skills training in order to increase chances of transitional return to work. Health services should augment the return to work process when required. (6)

69. Providing to disadvantaged groups and communities additional health and social services

that offer emotional support to parents of young children and young mothers (Acheson, 1998). (7)

70. Integrate inequalities reduction into health programs and services. (7)

71. Improving access to health and social services and acting directly on the social, economic and environmental contexts that determine both health status and health inequalities. (7)

72. Access is not just about geographical issues. Improving access also needs to take account of factors such as different attitudes and beliefs in different groups, the multiple needs of individuals, accessibility of services-for example, transport issues especially non-car owners etc. (UK Department of Health, Health Inequalities Unit, 2005). (7)

73. Inequalities in life expectancy can be reduced through improving access to high-quality primary care in disadvantaged geographic areas, particularly among those over the age of 50. (7)

74. Improving the competence and capacity of the health sector to prevent a decline in health due to unemployment; for example, through outreach mental health services (Dahlgren & Whitehead, 2006; Acheson, 1998). (7)

75. Working with companies and organizations to enhance the possibilities for employees to influence how the work is to be performed, especially in high-stress workplaces. A review of international case studies on improving psychosocial health in the workplace found that it was possible to make improvements by tailoring changes to specific workplaces. For example, changes made in the workplace included increased variety and understanding of the different tasks in a production process, workforce participation in identification of problems and their solutions, and altered shift patterns to make them less tiring and disruptive to workers' personal lives (Karasek, 1992). (7)

76. Initiating and/or maintaining community development initiatives that enable people to work collectively on their identified priorities for health. (7)

77. Partnership - Working together with Māori communities to develop strategies for Māori health gain and appropriate health and disability services. (7)

78. Participation - Involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services. (7)

79. Protection - Working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices. (7)

80. Supporting opportunities to increase the capacity of underserved or inappropriately served groups to better access, understand, communicate, evaluate, and act on health information and services. (8)

81. Build on and increase the capacity of language and interpreting services within the health system to provide interpreting services for a wide range of health services, including primary health care and counseling services. (8)

82. Support the introduction of health literacy coordinators who could work in collaboration with community-serving organizations/programs and health authorities to provide improved health literacy support to health system users. For example, a health literacy coordinator could help improve health literacy among recent newcomers to BC by working in collaboration with settlement agencies, immigrant serving agencies, and health authorities. (8)

83. Increase equitable access to prevention and curative services for underserved populations by:
    - Enhancing the availability of community-based primary health care services.
    - Building on existing specialized, population-focused primary health care services.
    - Increase the accessibility of primary health care services, health promotion, and primary prevention programs, and self-management services by offering and delivering services in locations where populations congregate (such as community centres, outreach organizations, and community and social organizations).
    - Support and expand specialty clinics that offer multi-disciplinary services, including mental health programs, trauma counseling, and social support services, to better meet the complex health needs of currently underserved or inappropriately served groups. (8)

84. Develop intersectoral collaborative and knowledge exchange mechanisms to inform existing programs and the development of new health promotion, primary prevention, and self-management support programs that are culturally competent by:
    - Promoting communication and coordination between the health system and stakeholders, including community members, for dialogue and joint problem solving. (8)

85. Improve continuity of care by developing mechanisms for secure patient care information sharing between health authorities and other health care providers such as primary care physicians or the correctional system's health facilities. (8)

86. Link to existing health and community information and referral services that could be communicated widely. (8)

87. Increase the capacity of the health system to better serve the needs of BC's culturally and linguistically diverse population by:
    - Ensuring that policies, programs, and services are culturally competent.
    - Providing skill-based cultural competency training opportunities for health system providers to improve communication with users and to respond to their diverse needs.
    - Develop a centralized infrastructure to oversee cultural competence within the health system, including the development and implementation of provincial standards for culturally competent policies, programs, and services, and the measurement of the impact and outcomes of such standards.
    - Implement employment equity policies and plans for the recruitment and retention of health system staff that reflect the diversity of the population.
    - Learn from and build on existing cultural competency training models to create a multicultural competency training program available to all health system staff to enhance the delivery of high quality programs and services.
    - Utilize the knowledge and expertise of community members and organizations to help develop the cultural competency training modules and tools for health system employees.
    - Implement multi-pronged educational strategies to ensure that all health system staff receive ongoing education and training in cultural competency and about the importance and appropriate use of interpreting services. (8)

88. Engage with community members and community organizations to help assess and enhance the system's capacity to deliver health services and programs, including prevention efforts and interventions to enhance coping skills, in a culturally competent manner. (8)

89. Utilize existing websites created for primary care teams and health care providers to provide information on best practices in providing care for diverse populations. Include tools, resources, and a directory of relevant community organizations. (8)

90. Explore the introduction of cultural health broker and patient navigator programs, building on existing models. Patient navigators and cultural health brokers can help individuals navigate the health system, help improve health literacy, enhance the capacity of health care providers and organizations to deliver more culturally competent care, and work in liaison with the health system and other sectors. (8)

91. Implement primary prevention initiatives to address vulnerabilities that can lead to criminal activity. A population-based prevention focus integrated with a Primary Care Health Services model would enable people to access health and social services early and thereby reduce the risk of requiring correctional services as a result of unaddressed addictions/mental illness issues. (8)

92. Health services should integrate a culturally-responsive and person-centred approach. (8)

93. A person-centred approach could help communities recognize the need for integrated services to prevent care fragmentation. e.g. integration of mental health and addictions services due to the frequency of these co-morbidities. (8)

94. Increase capacity within the interpreting community to provide services to GPs. (8)

95. Provide the opportunity for foreign trained health care professionals to act cultural health brokers. (8)

96. Increase support for cultural health brokers. (8)

97. Hire foreign trained health care professionals as cultural health brokers. (8)

98. Medical outreach services. (8)

99. Mental health services. (8)

100. Cultural health brokers and existing community programs, (8)

101. Promote awareness of interpreting services for health care providers. (8)

102. Examine waiting period policies in BC, as they appear to contradict the Accessibility Principle of the Canada Health Act. (8)

103. Providing education to health care providers, including how to work with cultural brokers and interpreters, as well as on the use of alternate therapies. (8)

104. Utilizing the knowledge and expertise of immigrant serving agencies to help train health care providers and/or improve health programs and services. (8)

105. Create a website that provides information to primary care teams. (8)

106. Ensure the availability of specialty clinics for refugees who require enhanced medical support. (8)

107. Increase availability of trauma counselling. (8)

108. Train teachers and counsellors to identify mental health concerns in refugee children. (8)

109. The Interim Federal Health (IFH) program should fund counselling and interpretation for counselling for refugees. (8)

110. Simplify the IFH processes and improve timeliness of the payment system. (8)

111. Implement a cultural health broker program. (8)

112. Implement a cultural health broker program, building on existing models. (8)

113. Provide accompaniment (e.g. cultural health broker). (8)

114. In urban communities where highly prevalent diseases have diminished human capital, health promotion and disease control and prevention are the entry points for community mobilization and are a prerequisite for social development. (15)

115. Radical reform of the structures of globalization is necessary if national governments are to act to ensure universal quality health care and action on the social determinants of health. (9)

116. Give special attention to gender-related aspects as well as early child development in public policies and social and health services. (10)

117. Integrate equity, as a priority within health systems, as well as in the design and delivery of health services and public health programs. (10)

118. Foster North-South and South-South cooperation in showcasing initiatives, building capacity and facilitating the transfer of technology on mutually agreed terms for integrated action on health inequities, in line with national priorities and needs, including on health services and pharmaceutical production, as appropriate. (10)

119. Implement an evidence-based program of ill health preventive interventions that are effective across the social gradient by:
- Increasing and improving the scale and quality of medical drug treatment programs.
- Focusing public health interventions such as smoking cessation programs and alcohol reduction on reducing the social gradient.
- Improving programs to address the causes of obesity across the social gradient. (11)

120. "…Improving health and well-being by strengthening first-line services, making community care more available, and stepping up measures to promote health and prevent disease." (16)

121. Child Development
- Ensuring that families have sufficient income to provide their children with the means for healthy development.
- Providing high-quality preschool education.
- Developing a high-quality, national day-care program
- Implementing policies that increase the prevalence of breast-feeding.
- Providing social and emotional support to expectant parents and parents with young children via social and health services. (12)

122. Closer dialogue and interface between western and traditional health practices. (17)

123. The need to take account of 'Indigenous people's holistic approaches to, and understandings of. 'Health and well-being'. (17)

124. In elaborating on the more holistic approach, reference was made in various places to a spectrum of factors integral to Indigenous health, including those termed 'spiritual, physical,

mental, emotional and cultural, economic, social (and) environmental'. (17)

125. Programs directed specifically at males, who do less well in respect of various health outcomes and who perpetrate violence at the domestic level, was stressed by a number of delegates. (17)

126. Challenge inequity through health systems (Final Report Knowledge Network on Health Systems June, 2007). (18)

127. Build health-care systems based on principles of equity, disease prevention, and health promotion. (1)

128. The health sector expands its policy and programmes in health promotion, disease prevention, and health care to include a social determinants of health approach, with leadership from the minister of health. (1)

129. Improve competencies/organizational standards.(4)

130. Intersectoral action. (12)

131. Housing policy needs to be more explicitly linked to comprehensive income (including a jobs strategy), public health, and health services policy. (3)

132. Canadian decision-makers must reevaluate whether minimizing government intervention is an ethical and sustainable approach to maintaining health, promoting social well-being, and increasing economic productivity. (3)

133. Comprehensive prevention strategies should be enhanced or developed to address the following priority health outcomes:
- unintentional injuries (transportation-related, falls)
- intentional injuries (self-injury, aggression, violence)
- chronic conditions and diseases (heart disease, stroke, cancers, lung disease, kidney disease, diabetes, liver conditions, musculoskeletal conditions, obesity)
- mental illness and addictions (depression, anxiety disorders, learning disorders, behaviour disorders, substance abuse)
- infectious diseases: communicable diseases (influenza, tuberculosis and other causes of pneumonia, causes of invasive infections, HIV/AIDS and other sexually transmitted and blood-borne infections, antimicrobial-resistant organisms) and environmentally-mediated infections (food-borne and animal-borne infections) (4)

134. Comprehensive prevention strategies should address the social and built environments of the priority settings of everyday living
- Neighbourhoods
- Homes
- daycares and schools
- workplaces
- public places (restaurants, entertainment venues, grocery stores, retail stores, recreation facilities, spiritual settings)
- transportation settings (cars, buses, bicycle access)
- special community circumstances (urban built environment, rural areas, isolated communities) (4)

135. To ensure that strategies are developed on the best available evidence, the Manitoba government, in collaboration with academic and other organizations, should support an

enhanced network of analysts and experts (including research and clinical epidemiologists, health economists, information technologists, subject experts, and public health strategists) and augment the surveillance capacity and availability of information needed to facilitate their work. (4)

136. Manitoba Health and Manitoba Healthy Living, Youth and Seniors should work with appropriate partners and stakeholders to make available to all Manitobans a set of clear, consistent and appropriate health guidelines which can be used to guide healthy living and other health-related behaviours and activities. (4)

137. Enhance support for regional health authorities, health care professionals, and other health organizations and partners to develop and implement strategies to enhance prevention throughout the health system. (4)

138. Strengthen the capacity in Manitoba Health to provide provincial leadership for standards and guidelines for public health practice by public health officials, including the establishment of a leadership function for public health nurses to complement the existing leadership roles for medical officers of health and public health inspectors. (4)

139. Resolve jurisdiction issues for public health inspectors in Winnipeg and other places, and strengthen the regional public health teams of medical officers of health, public health nurses, public health inspectors, and other practitioners. (4)

140. In collaboration with First Nations and the federal government, resolve the jurisdiction issues for public health, health care and other services for First Nations' communities, as part of the development of a coordinated, comprehensive, and integrated province-wide public health and primary care system. (4)

141. Reducing smoking in manual social groups through smoking cessation services and other tobacco control programmes. (3)

142. Brushing for Life scheme to reduce inequalities in dental health of young children in sure start areas without water fluoridation. (3)

143. Assess health needs and provide comprehensive health promotion to young people 15-17 who spend time in prison. (3)

144. Formally recognize the links between the quality of local environments and people's physical and emotional well-being. (3)

145. Improve the quality of life of older people by adequately coordinating and staffing services that enable older people to maintain their health and retain their independence. (3)

146. Preventing illness and providing effective treatment and care. (3)

147. Reducing risk through effective prevention. (3)

148. Develop more smoking prevention and cessation services for low income groups and pregnant women. (3)

149. Early detection, intervention and treatment. (3)

150. Expand early intervention services so that every young person with a first episode of psychosis be treated promptly and receive the intensive support they need during the first three years of their illness with the aim to keep them in or helping them to return to education

or employment. (3)

151. Create better and safer local environments, particularly in disadvantaged areas, so that people are more able to engage in social and physical activities in the public spaces close to where they live and work, in pleasant clean surroundings, without fear of crime. (3)

152. As the headquarters of the NHS locally, SHAs need to ensure that tackling health inequalities is a NHS priority and it is addressed strategically. They should highlight action on inequalities in the way the NHS delivers its services, as well as the wider NHS contribution to the regeneration of deprived communities. Health inequalities should be central to their planning and performance management, and they should support NHS organizations in meeting the targets and in contributing to effective partnerships. They should also build the capacity and skills of staff and others throughout SHA public health networks to promote better understanding of inequalities issues and what can be done to address them. (3)

153. RDs PH providing professional leadership, supporting SHAs and PCTs to identify priorities and deliver change PHOs producing regional intelligence to support focusing of priorities and resources, and monitoring local progress. (3)

154. Participation in local teenage pregnancy strategies. (3)

155. Individuals also have to be responsible for their own health and that of their children by making appropriate and informed lifestyle choices on smoking, diet and exercise, all of which can widen health inequalities. It is essential that such choices should be informed by clear and accurate advice. Schools have a vital part to play while charities and health care professionals, including community pharmacists and dentists, can advise how to quit smoking, offer exercise on prescription, identify patients at risk of heart disease and provide services for substance misusers. (3)

156. Specialist health care staff can work from outreach centres including schools and neighbourhood nurseries. (3)

157. PCTs can work with communities and charities to introduce more comprehensive smoking prevention and cessation strategies targeted at low-income groups, black and minority ethnic groups, young people, pregnant smokers and prisoners. (3)

158. PCTs can support the expert patients programme which provides self management training for people with long-term conditions. (3)

159. Continue to improve immunization coverage. (14)

160. Work on Aboriginal control, planning, governance, and delivery of services (especially primary care services) and enhance these services in ways that meet the needs of Aboriginal people, in order to reduce the gap in medically treatable and other diseases. (14)

161. Work with communities to develop prevention programs for diabetes in order to improve treatment outcomes. (14)

162. Focus on underlying factors that lead to illness, such as poverty, family distress, child abuse, inadequate housing, and untreated mental illness. (14)

163. Increase awareness and promotion of HIV disease prevention and develop more treatment options and increase uptake of HAART among Aboriginal patients. (14)

164. Create a provincial Aboriginal mental health and wellness plan. One pillar of the plan

would focus on vulnerable communities and youth suicide prevention. (14)

165. Work towards increasing the participation of Aboriginal women in prevention and screening programs, such as Pap tests and screening mammography. (14)

166. Make a comprehensive effort to respond to mental health problems and trauma in Aboriginal communities. (14)

167. Work with Aboriginal communities to increase the uptake of breast cancer screening and Pap tests by Aboriginal women. (14)

168. Make issues underlying HIV/AIDS a priority. (14)

169. The role of the health sector, including public health programmes, in reducing health inequities. (14)

170. Having effective, accessible chronic disease management programs, especially among low-income groups (UK Department of Health, Health Inequalities Unit, 2005). (7)

171. Improve health literacy by:
- Supporting opportunities to increase the capacity of underserved or inappropriately served groups to better access, understand, communicate, evaluate, and act on health information and services.
- Support the development, implementation, measurement, and evaluation of a Health Literacy Strategy for BC.
- Implement multi-pronged educational strategies that will enhance the capacity of health care professionals to clearly communicate with their clients and to support improved access to information and services for health system users.
- Develop partnerships with universities and colleges to ensure health literacy is embedded within the education of future health care professionals.
- Support the introduction of health literacy coordinators who could work in collaboration with community-serving organizations/programs and health authorities to provide improved health literacy support to health system users. For example, a health literacy coordinator could help improve health literacy among recent newcomers to BC by working in collaboration with settlement agencies, immigrant serving agencies, and health authorities. (8)

172. Provide improved information support to health system users by utilizing community-based media sources as well as other information sharing methods and tailored information tools such as webinars, interactive plays, art, and interactive educational focus group or learning sessions as avenues to communicate health promotion and chronic disease prevention and self-management information. Involve local communities and stakeholders in the development of appropriate messaging. (8)

173. Develop linkages with English as a Second Language (ESL) classes to support the introduction of health literacy curricula. (8)

174. Introduce health promotion and education materials in a variety of formats, such as pictorial flashcards and role playing, tailored to a different learning abilities and strengths. (8)

175. Increase equitable access to prevention and curative services for underserved populations by:
- Increase the accessibility of primary health care services, health promotion, and primary prevention programs, and self-management services by offering and delivering services in locations where populations congregate (such as community centres, outreach

organizations, and community and social organizations). (8)

176. Educational programming for service providers and decision makers involved with under-serviced populations about successful prevention initiatives and alternatives to entering corrections. (8)

177. Health promotion. (8)

178. Improve health literacy. (8)

179. For an equitable health system, communicable disease control should be considered a priority. (15)

180. Reducing financial and other barriers to preventive and curative health care services. (19)

181. Support community engagement in monitoring and planning; democratize public health systems. (9)

182. Build, strengthen and maintain public health capacity including reform of health professional education to incorporate a strong emphasis on the social determinants of health and health care of the majority. (9)

183. Regulate the private medical sector to mitigate the negative impact of business interests on health and enhance the capacity of the public health system. (9)

184. Build, strengthen and maintain public health capacity, including capacity for intersectoral action, on social determinants of health. (10)

185. Support families to achieve progressive improvements in early child development, including:
- Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy.
- Providing paid parental leave in the first year of life with a minimum income for healthy living.
- Providing routine support to families through parenting programs, children's centres and key workers, delivered to meet social need via outreach to families.
- Developing programs for the transition to school. (11)

186. Prioritize prevention 1 and early detection of those conditions most strongly related to health inequalities. (11)

187. Focus core efforts of public health departments on interventions related to the social determinants of health proportionately across the gradient. (11)

188. Maintain and develop the public health care system. (20)

189. The Medical officer of Health report regularly to the Board of Health on key health inequality indicators for the City of Toronto. (21)

190. The Medical Officer of Health consult with community partners and the Board of Health to incorporate appropriate strategies to reduce health inequalities in the next Toronto Public Health Strategic Plan (2010-2014 and annual service plans, including measures to monitor progress on reducing health inequalities. (21)

191. The Medical Officer of health review Toronto Public Health data collection practices and collaborate with partners to strengthen the monitoring of the impact of social determinants on health, including racialization, immigration and settlement status, education and income. (21)

192. Build quality health-care services with universal coverage, focusing on Primary Health Care. (1)

193. Strengthen public sector leadership in equitable healthcare systems financing, ensuring universal access to care regardless of ability to pay. (1)

194. Build and strengthen the health workforce, and expand capabilities to act on the social determinants of health. (1)

195. Invest in national health workforces, balancing rural and urban health-worker density. (1)

196. Act to redress the health brain drain, focusing on investment in increased health human resources and training and bilateral agreements to regulate gains and losses. (1)

197. Provide training on the social determinants of health to policy actors, stakeholders, and practitioners and invest in raising public awareness. (1)

198. Incorporate the social determinants of health into medical and health training and make it standard and compulsory, and improve social determinants of health literacy more widely. Train policy-makers and planners in the use of health equity impact assessment. (1)

199. Making our health organizations reflective of our communities, (health sector responsibility). (22)

200. Operations and Human Resources (health sector responsibility). (22)

201. District health authorities and health policymakers must direct attention to existing inequities in access to health care and identify and remove barriers to health care. (3)

202. Health authorities must find means of controlling the use of costly but ineffective new treatments (e.g., pharmaceuticals and screening technologies) that are being marketed aggressively by private corporations. (3)

203. Increase take-up and duration breastfeeding for new mothers, especially those in low income groups through training health professionals and encouraging peer support programs. (3)

204. GPs and health professionals can take account of the wider determinants of health in their consultations. (3)

205. Local authorities and PCTs will work together more closely on the delivery of Sure Start local programmes and Children's Centres. (3)

206. PCTs have the lead locally in driving forward health inequalities work with a range of partners. They are responsible for leading and supporting partnerships in this area and influencing partners so that their services support improvements in health and narrowing of health inequalities. (3)

207. The NHS also has a role alongside other public services in contributing to the local regeneration agenda by being a good 'corporate citizen'. Within the NHS, employment and procurement policies, the capital build, and training and skills programmes provide

opportunities to link health with regeneration by supporting local economies and make the best use of the extra investment in the NHS. (3)

208. Both PCTs and NHS Trusts, as major providers of health care, must work together across care pathways to improve access to high quality services for people from disadvantaged communities or where health needs are high, for example to meet the needs of ethnic groups with high prevalence of particular conditions. (3)

209. Supporting health professionals to develop skills needed to involve the community in key decisions about services and to meet their needs. (3)

210. Recruiting staff locally so that services reflect the diversity of communities served, improving cultural sensitivity, and supporting regeneration. (3)

211. Include an annual performance review of local health communities performance on their role and achievement in reducing health inequalities. The review would be conducted with health partners including PCT and local Trusts. (3)

212. PCT chief executives ensuring that the PCT is taking a lead to ensure that the LSP is working effectively and leading work with other partners to develop agreed priorities. (3)

213. PCTs monitoring local progress, including the use of a basket of indicators. (3)

214. SHA chief executives managing PCT performance on health inequalities in line with local delivery plans using an appropriate basket of local indicators. (3)

215. RDsPH providing professional leadership, supporting SHAs and PCTs to identify priorities and deliver change PHOs producing regional intelligence to support focusing of priorities and resources, and monitoring local progress. (3)

216. The new Commission for Healthcare Audit and Inspection (CHAI) will assess the performance of PCT and hospital trusts in tackling health inequalities and providing high quality services. SHAs will performance-manage PCTs to ensure action has been taken in response to CHAI reports. (3)

217. The modernisation of the NHS will lead to new ways of working and create employment opportunities across the country, including in some of the most deprived areas. NHS Trusts and PCTs should work with other agencies to ensure that local unemployed people are equipped for these opportunities. (3)

218. The business sector has a key role to play in tackling health inequalities. There is a growing understanding that good health is good economics, and good economics leads to better health. By focusing on the "wealth creators" (the business sector) as "health creators" and the "health creators" (NHS and other public services) as "wealth creators", the potential to make an impact positively on health and regeneration in our communities is huge. (3)

219. Encourage employers to take responsibility for health in the workplace through better access to information on health matters at work. (3)

220. Support best practice health policies (e.g. mental health) and organisational policies on issues such as recruitment/retention, improving the health of the workforce, and helping to regenerate the community. (3)

221. The HDA needs to act as the national authority and information resource for "what works" to reduce inequality, producing guidance about effective action and helping practitioners get

evidence into practice. (3)

222. The NHS Modernisation Agency needs to use its expertise to support the implementation of best practice and effective action locally. (3)

223. The NHSU, the new corporate university for the NHS needs to develop the skills of NHS staff to tackle health inequalities through practical learning opportunities. (3)

224. In order to ensure that the action being taken is having the desired effect, and to inform future policy, a strong framework to assess how well this is being achieved will be required. In line with the mainstreaming approach of the strategy, health inequalities will become part of mainstream performance management and inspection systems, particularly those used for local government and the NHS. (3)

225. PCTs can encourage low-income mums to initiate and continue breastfeeding by targeting support at low income and black and minority ethnic groups, using link workers and community mothers schemes. (3)

226. PCTs and local authorities can work together to reduce smoking, providing tobacco education programmes and smoking cessation clinics. (3)

227. Health and local authority community development teams working in areas of greatest need can be jointly funded. (3)

228. Set up integrated neighbourhood teams including health staff, police and education in disadvantaged areas. (3)

229. Encourage greater Aboriginal participation in health governance and in the design and delivery of culturally appropriate health services. (14)

230. Each regional health authority has an Aboriginal health plan that specifies actions on issues unique or specific to each region, targets the specific areas for health authority actions, and is aligned with relevant bilateral and tripartite plans. In addition to region-specific strategies, the health plan includes the following three components that will improve the health of Aboriginal people:
- Aboriginal Health Initiatives Program - Each regional health authority has a community-based funding program that supports and encourages Aboriginal communities to identify health promotion projects that are culturally meaningful.
- Work with Aboriginal communities to develop culturally appropriate reproductive care programs, including better prenatal access, outreach, and nutrition programs for mothers and infants. (14)

231. Continue to monitor the birth weights of Status Indian infants, to better understand the factors that affect it. (14)

232. Develop better methods for preventing, diagnosing, and tracking the occurrence of fetal alcohol spectrum disorder. (14)

233. Support Aboriginal communities in motivating community members to reduce tobacco misuse. (14)

234. Continue to promote awareness of how to prevent sudden infant death syndrome. (14)

235. Promote car safety including appropriate child seats. (14)

236. Work with the Aboriginal community to develop performance expectations for Aboriginal health. Include performance measures and targets in health authority service plans. (14)

237. Continue to monitor professional prescribing practices and deal with those professionals who are inappropriately prescribing medication. (14)

238. Continue to work on Aboriginal health plans for health authorities. (14)

239. Make health disparity reduction a health sector priority in the Saskatoon Health Region. (6)

240. Integrate disparity reduction into all health programs and services in the Saskatoon Health Region. (6)

241. The Saskatoon Health Region should offer integrated and comprehensive services in Saskatoon's six low income neighbourhoods including public health, mental health, addictions and primary care services. (6)

242. Make health inequalities reduction a health sector priority. (7)

243. Engage with other sectors in health inequalities reduction. (7)

244. Strengthen knowledge development and exchange activities. (7)

245. Equity focused impact assessments. (7)

246. The Equity Lens for clinical practice. (7)

247. All DHB boards and committees must have Māori membership, and all boards must ensure all their members are skilled and knowledgeable about Māori health issues, and about their local Māori communities. (7)

248. There is a need to develop explicit objectives to reduce health inequalities that are directly linked to policies, actions and financial resources needed for implementation. These plans need to include a realistic assessment of possibilities and constraints (especially for the role of health authorities), given the broad array of environmental influences that generate inequalities in health. (7)

249. Improve health literacy by:
- Increasing the capacity of health care providers to communicate effectively with health system users and to respond to their diverse needs.(8)

250. Develop partnerships with universities and colleges to ensure health literacy is embedded within the education of future health care professionals. (8)

251. Develop linkages with local community stakeholders, including community programs, organizations, agencies, faith communities, early settlement services, and educational or school programs to share information with currently underserved groups about navigating and accessing health system programs and services. (8)

252. Provide improved information support to health system users by utilizing community-based media sources as well as other information sharing methods and tailored information tools such as webinars, interactive plays, art, and interactive educational focus group or learning sessions as avenues to communicate health promotion and chronic disease prevention and self-management information. Involve local communities and stakeholders in

the development of appropriate messaging. (8)

253. Develop linkages with English as a Second Language (ESL) classes to support the introduction of health literacy curricula. (8)

254. Introduce health promotion and education materials in a variety of formats, such as pictorial flashcards and role playing, tailored to a different learning abilities and strengths. (8)

255. Develop a centralized coordinating mechanism within the health authorities to bring together stakeholders, including community members, for dialogue and joint problem solving. (8)

256. Increase the capacity of the health system to better serve the needs of BC's culturally and linguistically diverse population by:
- Ensuring that policies, programs, and services are culturally competent. (8)

257. Develop a centralized infrastructure to oversee cultural competence within the health system, including the development and implementation of provincial standards for culturally competent policies, programs, and services, and the measurement of the impact and outcomes of such standards. (8)

258. Implement employment equity policies and plans for the recruitment and retention of health system staff that reflect the diversity of the population. (8)

259. Utilize the knowledge and expertise of community members and organizations to help develop the cultural competency training modules and tools for health system employees. (8)

260. Implement multi-pronged educational strategies to ensure that all health system staff receive ongoing education and training in cultural competency and about the importance and appropriate use of interpreting services. (8)

261. Monitor and evaluate the implementation of cultural competency training and overall organizational cultural competence to continually modify and improve the training based on identified barriers and successes. Measures could be included within staff/department performance improvement plans and patient-satisfaction assessments. (8)

262. Educational programming for service providers and decision makers involved with under-serviced populations about successful prevention initiatives and alternatives to entering corrections. (8)

263. Information exchange processes should be developed to enable corrections and the health authorities to share relevant information. (8)

264. Clarifying and consistently applying information sharing policies and procedures. (8)

265. Implementing standardized information sharing procedures and processes wherever possible. Improve transition planning to enable corrections populations to bridge the gaps when individuals move within and/or between systems. This includes:
- Formalizing agreements between corrections and the relevant provider(s)
- Implementing a quality monitoring process implemented.
- Implementing a participatory approach to transition planning that engages individuals who are in, or have been through the corrections system.
- Increase capacity within the interpreting community to provide services to GPs.
- Build capacity among settlement workers & immigrant serving agencies.

- Improve information support between health literacy coordinators and settlement agencies. (8)

266. Improve health literacy. (8)

267. Develop partnerships between immigrant serving agencies and the BC Health Literacy Strategy. (8)

268. Build capacity and quality in the health care system. (8)
269. Create a website to help caregivers locate resources. (8)

270. Provide cultural competency training to front line staff health care providers and students. (8)

271. Improve partnerships between health care system and settlement/community-based organizations. (8)

272. Create new government position that could serve as a liaison between organizations. (8)

273. Create a list of community groups arranged geographically and by language. (8)

274. Promote communication and coordination between health services and settlement agencies. (8)

275. Provide free legal representation for refugees. (8)

276. Ensure that laws and regulations under Employment Standards and WorkSafe BC are complied to by employers of migrant workers. (8)

277. Health care system utilization linked to the social determinants of health. (8)

278. Increase the number of housing search workers. (8)

279. Eliminate wait period for BC Rental Assistance. (8)

280. Increase the transition time period out of Welcome House. (8)

281. Enhance level of income assistance. (8)

282. Extend income assistance period for refugees, after they find employment. (8)

283. Abolish travel loan repayment. (8)

284. Provide childcare for two years post-arrival. (8)

285. Develop job coaching, counselling and specialty training services for refugees. (8)

286. Increase diversity of types of English as a second language classes, including programs for illiterate people, different learning abilities, locations, rates of learning, etc. (8)

287. Provide bus pass. (8)

288. Develop and fund mobile health clinic. (8)

289. Primary health care systems must be comprehensive, continuous, family- and community-centred, health-promoting, innovative and focused on providing equitable access to health

services for the most vulnerable populations. Efforts to support the work of the Member States in mainstreaming urban health in health systems development should be pursued. (15)

290. Support community engagement in monitoring and planning; democratize public health systems. (15)

291. Build, strengthen and maintain public health capacity including reform of health professional education to incorporate a strong emphasis on the social determinants of health and health care of the majority. (9)

292. Support the efforts of governments to promote capacity and establish incentives to create a sustainable workforce in health and in other fields, especially in areas of greatest need. (10)

293. The Medical officer of Health report regularly to the Board of Health on key health inequality indicators for the City of Toronto. (21)

294. The Medical Officer of Health consult with community partners and the Board of Health to incorporate appropriate strategies to reduce health inequalities in the next Toronto Public Health Strategic Plan (2010-2014 and annual service plans, including measures to monitor progress on reducing health inequalities. (21)

295. The Toronto board of Health send this report to the Premier of Ontario and strongly urge the government to maintain its stated commitment to poverty reduction in Ontario as a public health measure. (21)

296. "…It is important that clinical workers in the network try harder to reach disadvantaged clienteles…". (21)

297. In elaborating on the more holistic approach, reference was made in various places to a spectrum of factors integral to Indigenous health, including those termed 'spiritual, physical, mental, emotional and cultural, economic, social (and) environmental'.

- Family, community and health – Community-based and community controlled services were considered fundamental to improving Indigenous health. Similarly, building Indigenous leadership at the community level was seen as key in tackling health and related problems, such as domestic violence.
- Obviously, the far from fully realized benefits of international covenants are one expression. Another is in the form of exchange of information and strategic directions. Indigenous peoples should be assisted in developing means for effective international cooperation, advocacy and other action. (17)

298. Challenging inequity through health systems (Final Report Knowledge Network on Health Systems June 2007). (18)

299. District health authorities and health policymakers must direct attention to existing inequities in access to health care and identify and remove barriers to health care. (3)

300. Health authorities must find means of controlling the use of costly but ineffective new treatments (e.g., pharmaceuticals and screening technologies) that are being marketed aggressively by private corporations. (3)

301. Continue to upgrade local primary care facilities, particularly in disadvantaged areas. (3)

302. Reform Patient Transport Services and Hospital Travel Costs scheme to reflect better the needs of patients. Physical access to health care will have a higher priority in decisions about the location of health care facilities. (3)

303. The NHS also has a role alongside other public services in contributing to the local regeneration agenda by being a good 'corporate citizen'. Within the NHS, employment and procurement policies, the capital build, and training and skills programmes provide opportunities to link health with regeneration by supporting local economies and make the best use of the extra investment in the NHS. (3)

304. Supporting health professionals to develop skills needed to involve the community in key decisions about services and to meet their needs. (3)

305. Taking account of health inequalities in the planning and delivery of services, informed by health equity audits and the annual public health report. (3)

306. The business sector has a key role to play in tackling health inequalities. There is a growing understanding that good health is good economics, and good economics leads to better health. By focusing on the "wealth creators" (the business sector) as "health creators" and the "health creators" (NHS and other public services) as "wealth creators", the potential to make an impact positively on health and regeneration in our communities is huge. (3)

307. Support best practice health policies (e.g. mental health) and organisational policies on issues such as recruitment/retention, improving the health of the workforce, and helping to regenerate the community. (3)

308. Performance will need to be tracked both nationally and locally. At national level, a high-level cross-Government set of indicators, to be published annually, will enable DA(SER) and the Prime Minister's Delivery Unit to track progress. (3)

309. The use of a basket of indicators offers an effective means of measuring progress. Other measures of impact can include qualitative feedback on progress that can help to gauge the views of individuals and communities, and evidence of improvements in mainstream services as part of a strategy to tackle inequalities. (3)

310. Projects and programs to promote health equity may result in risks. Appropriate monitoring of potential risks is important to recognize unintended consequences of policy change. Account will need to be taken of:

- the nature of the risk
- the probability of the risk becoming reality
- the potential impact if risk becomes reality, including its effect on inter-dependent programmes elsewhere in the strategy
- contingency plans with measures to tackle problems, and stages at which plans should be implemented.
- The kind of risks that might impede progress include:
- monitoring systems failing to capture the total impact of the strategy
- insufficient progress made in clarifying evidence on "what works"
- conflicting priorities so that Government departments fail to work in a coordinated and synergistic way
- delays and difficulties so that local partners fail to work in a coordinated and synergistic way, reducing the overall impact of the strategy (3)

311. A more integrated set of actions across Canada aimed at revitalizing the national health goals and matching these goals with indicators and targets for health disparities. (23)

312. Develop services to assist Aboriginal people with chronic illnesses and disability-related activity limitations. (14)

313. Continue to monitor professional prescribing practices and deal with those professionals who are inappropriately prescribing medication. (14)

314. Work from the principle that Aboriginal people, like all British Columbians, have the right to receive services that will help them achieve and maintain good health and wellbeing. Jurisdictional issues should not negatively impact the delivery of health services. (14)

315. Broadening Health Policy - Health policy and social policy are interwoven. (5)

316. Fourth, ensuring coordination and coherence of action on social determinants is essential. Fifth, a social determinants approach cannot be a "programme" that is rolled out, but rather requires a holistic approach incorporating all of the five building blocks applied across society. (24)

317. The number of health resources in Saskatoon's low income neighbourhoods should, at the very least, be proportionate to the size of the population; let alone to the disproportionate number of health disorders. (6)

318. The Saskatoon Health Region should offer integrated and comprehensive services in Saskatoon's six low income neighbourhoods including public health, mental health, addictions and primary care services. (6)

319. Aboriginal people in Saskatchewan should be afforded more control over health, social, education and justice policies and funding that disproportionately affect Aboriginal people. (6)

320. Support the implementation of collaborative health networks whose focus is to improve care for specific populations with complex chronic health conditions such as refugees or individuals transitioning into or out of the correctional system. (8)

321. Increase the capacity of the health system to better serve the needs of BC's culturally and linguistically diverse population by:

- Ensuring that policies, programs, and services are culturally competent.
- Implement employment equity policies and plans for the recruitment and retention of health system staff that reflect the diversity of the population.
- Utilize the knowledge and expertise of community members and organizations to help develop the cultural competency training modules and tools for health system employees.

(8)

322. Government ministries, health authorities, and provincial and federal corrections should work in partnership to improve continuity of care. Improved partnerships can ensure better access to health and social support services and reduce the risk of recidivism. (8)

323. Information exchange processes should be developed to enable corrections and the health authorities to share relevant information. This includes:

- Clarifying and consistently applying information sharing policies and procedures. (8)

324. Preventing and managing disputes that may arise when culturally diverse populations are expected to live together within confined urban areas - the product of migration by different ethnic, religious and language groups from their homogeneous homelands - requires context-specific programmes and policies that promote social cohesion in order to minimize the

potential physical and mental health consequences of such interactions. (15)

325. Reducing financial and other barriers to preventive and curative health care services. (19)

326. Incentives or policy levers. (25)

327. Regulate the private medical sector to mitigate the negative impact of business interests on health and enhance the capacity of the public health system. (9)

328. We acknowledge that action on social determinants of health is called for both within countries and at the global level. We underscore that increasing the ability of global actors, through better global governance, promotion of international cooperation and development, participation in policy-making and monitoring progress, is essential to contribute to national and local efforts on social determinants of health. Action on social determinants of health should be adapted to the national and sub-national contexts of individual countries and regions to take into account different social, cultural and economic systems. Evidence from research and experiences in implementing policies on social determinants of health, however, shows common features of successful action. There are five key action areas critical to addressing health inequities:
    a. to adopt better governance for health and development;
    b. promote participation in policy-making and implementation;
    c. to further reorient the health sector towards reducing health inequities;
    d. to strengthen global governance and collaboration; and
    e. to monitor progress and increase accountability. (10)

329. Promote access to affordable, safe, efficacious and quality medicines, including through the full implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property. (10)

330. The Medical Officer of Health consult with community partners and the Board of Health to incorporate appropriate strategies to reduce health inequalities in the next Toronto Public Health Strategic Plan (2010-2014 and annual service plans, including measures to monitor progress on reducing health inequalities. (21)

331. Reform of institutions and services. (17)

332. The need for, and value of, properly funded primary health care services under Indigenous control. (17)

333. Challenge inequity through health (Final Report Knowledge Network on Health Systems June 2007). (18)

APPENDIX N: REFERENCES

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