

# The Health Equity Resource Toolkit of Global 1HN

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This Policy Brief introduces the **Health Equity Resource Tool Kit for the Governance of Infectious Diseases**, developed by Global 1HN. The purpose of the Toolkit is to inform health practitioners, researchers, and decision-makers about the unique perspectives and challenges that must be considered when working with equity-seeking groups (see Box.1 for a definition). It also provides an inventory of resources for the modelling, implementation, and integration of policies and programs to address health inequities in the governance of infectious diseases. The SARS-CoV-2 pandemic unveiled how existing inequalities in the distribution of social determinants of health (SDH) can drive pandemic outcomes. Populations with pre-existing vulnerabilities and compromised access to SDHs, such as Indigenous Peoples, racialized groups, LGBTQ2S+, and immigrant communities have higher rates of morbidity and

mortality associated with SARS-CoV-2 (1). Such inequities in outcomes reach far beyond the direct health consequences of the pandemic, and include the longer-term indirect consequences via SDH pathways, such as growing income inequality or lack of access to education (2).

The Toolkit emphasizes three ways in which equity considerations should guide policy response to infectious disease outbreaks:

1. Prioritize equity-seeking groups and ensure the integration of health equity into policies and programs.
2. Promote equity-centered approaches to data collection, contact tracing, vaccination, and non-pharmaceutical interventions.
3. Collect better surveillance data on SDH to identify and monitor health inequalities.

## Box.1 Health Equity Terms

**Equity-seeking groups** are groups of people that face significant collective challenges in participating in society, recognize common barriers to equal access, opportunities, and resources due to disadvantage and discrimination, and seek social justice and reparation.

**Health inequities** are defined as the presence of unfair and avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Since health inequities are driven by the inequitable distribution of social determinants of health (e.g., income and education), they can be reduced by the right mix of government policies.

**Health inequalities** are differences in health, or differences in important influences on health, that are systematically associated with being socially disadvantaged (e.g., being poor, a member of a disadvantaged racial/ethnic group, or female), and that put already disadvantaged groups at further disadvantage.

**Social determinants of health** are non-medical factors that influence health outcomes. They describe the circumstances in which people are born, grow, work, live, and age, and the broader set of systems and policies shaping the conditions of daily life. These systems include economic policies, development agendas, social norms, social policies, and political systems (3).

# INTEGRATING EQUITY CONSIDERATIONS INTO POLICY

When responding to an infectious disease pandemic, governments and health leaders are making difficult policy decisions in rapid succession based on emerging data. It is important that those decisions take into consideration the ways in which they may unfairly or unintentionally impact groups with heightened vulnerabilities, and how action or inaction might worsen living conditions that were already unjust. Common pandemic preparedness strategies to reduce transmission may be nominally fair and neutral but might create new or additional inequalities when applied in contexts

with underlying inequities in the social determinants of health (4). Policies or strategies that support a health equity framework consider the provision of appropriate funding for equity efforts and targeted investments to address the disproportionate impacts of pandemics on equity-seeking groups. Therefore, equity-centered programs and practices for data collection, contact tracing, vaccination, and non-pharmaceutical measures should consider unintended negative consequences on equity seeking populations and include mitigation strategies to address those impacts.

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## EQUITY IN DATA COLLECTION

Data, especially sociodemographic data that includes race, ethnicity, age, and gender, are critical for pandemic preparedness and planning. Such data are important to understand pre-existing inequities experienced by equity-seeking groups, and to plan and implement health-equitable pandemic response. Current limitations experience during the COVID-19 pandemic include inadequate collection of race-based (or subsect) data, and missing integration of existing data sources (5). **Access to socio-demographically disaggregated data will help facilitate evidence-based policy decisions and interventions, while ensuring that public resources are allocated in most the strategic and effective way possible.** Further, such data will contribute to identifying gaps and barriers to existing programs, while also leading to the development of more culturally sensitive services in an effort to increase accessibility amongst equity-seeking groups.

## EQUITY IN CONTACT TRACING

Contact tracing has played a pivotal role in controlling COVID-19 spread. It has helped individuals who have been in contact with a case of COVID-19 understand their risk and limit further spread of the virus. Given the magnitude of COVID-19 cases, the attempt to stop the chain of transmission was critical and more urgent in vulnerable settings. For example, immigrant and refugee communities face structural inequities caused by the intersection of multiple SDH, such as poverty, food and housing insecurity, and lack of access to high quality education, health care, and childcare (6). In the context of contact tracing, several factors impact immigrant and refugee communities' ability to be traced,

Resources

**In Pursuit of Health Equity: Defining Stratifiers for Measuring Health Inequality**

**Health Equity Resource Series: Data Collection, Stratification, and Use**

**The role of data collection in the COVID-19 pandemic**



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for example, individual preconceptions and fear of stigmatization and further ostracization, and most notable, health literacy, lack of mobility, language, and communication obstacles (7). This is why it is essential that program organizers **and policymakers consider providing culturally appropriate contact tracing services in a manner that is inclusive of equity-seeking populations and elevated-risk individuals.** To do this communication tools used during contact tracing interventions could be adapted to groups with low literacy (e.g., integrating visuals and pictographs), migrants who do not speak official languages (e.g., use of including

## EQUITY IN IMMUNIZATION

Vaccine distribution has the potential to exacerbate health inequalities. Although this is most pronounced globally as wealthy countries pre-purchased most of the available vaccines and patent-holding pharmaceutical companies refused to share their technology, leading to critical inequities in access for poorer countries, it is also a concern within rich nations. One of the largest challenges in vaccine distribution during pandemics is convincing the public of a vaccine's safety and efficacy profile, due to the possible politicization of public health measures and the rapid spread of disinformation, leading to vaccine hesitancy. Equity challenges also arise when considering vaccine availability and prioritization, as well as operational and administrative concerns.

Evidence from past pandemics show notable gaps in immunization coverage and low vaccine coverage within marginalized communities. These

Resource

**Guidance on the prioritization of key populations for COVID-19 immunization**

**A Guidebook: Community Led Messaging for COVID-19 Contact Tracing**

## EQUITY IN NON-PHARMACEUTICAL INTERVENTIONS

In the absence of vaccines, infection rates can be reduced by various non-pharmaceutical interventions (NPIs). NPIs refer to a wide range of both top-down (i.e., governmental) and bottom up (i.e., self-initiated) measures aimed to interrupt chains of infection. Non-pharmaceutical

translators or contact tracers recruited from their own communities), and people with disabilities (e.g., use of audio messages).

Resources

**COVID-19 Testing and Contact Tracing Health Equity Guidebook**

**A Guidebook: Community Led Messaging for COVID-19 Contact Tracing**

gaps may be a result of healthcare access barriers, individual beliefs that vaccines are not safe, and historic mistrust of the healthcare system stemming from well-documented inequity and exploitation of racialized and ethnic communities. To counteract such tendencies, place-based targeting of hotspots for vaccine roll outs in communities with concentrations of equity-seeking groups should be implemented. In Canada, such a program was implemented in the City of Toronto, and included reaching groups via mobile vaccination programs such as housebound home-care patients, individuals experiencing homelessness, isolated and remote Indigenous communities, and people who can't easily make public health's vaccination clinics (including shift workers) (8). Importantly, although targeting hotspots for immunization pop-ups have proved successful, policies and programs to confront the underlying social inequalities that create conditions of pandemic vulnerability should be developed to better achieve future pandemic vaccine rollouts. In addition, **community-targeted advertising, accurate messaging, and outreach to community leaders and partners particularly for groups marginalized within medical and social structures are critical for vaccine acceptance.**



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interventions can limit the spread of a virus, they also come with individual physical and psychological harms, group and social harms, and opportunity costs and longer-term SDH impacts that may disproportionately affect equity-seeking populations (2).

For those without stable housing, uptake of NPIs such as social or physical distancing, handwashing and maintaining hygiene, wearing personal protective equipment, following appropriate quarantine and isolation regulations, and using less public transportation is difficult or even unfeasible (9). Incorporating equity in non-pharmaceutical interventions guidance is integral for the appropriate planning and response to ID transmission, especially among those experiencing homelessness, unstable housing situations, or lacking access to clean

water. Guidance should support the response to ID pandemics by involving the community, including local and state health departments, service systems, housing authorities, emergency planners, healthcare facilities, and outreach services. **NPIs must be supplemented with SDH policy and program interventions, such as emergency income supports and health benefits, to ensure that NPIs have their intended effect.**

#### Resources

##### **Modeling COVID-19: Nonpharmaceutical Interventions**

##### **The Canadian Policy Response to the COVID-19: What's in it for Health Equity?**

**As we now look forward to the emergency approval of new therapeutic drugs to treat COVID-19, it is more important than ever that we ensure equity-seeking groups are considered when looking at the initial limited distribution of these drugs within community settings. People with low access to family care services will be at a possible disadvantage to receiving timely access to COVID-19 therapeutics. Additionally, communities with limited access to advanced healthcare services or communities with limited ICU capacity should be prioritized for the delivery of therapeutics. This may include remote and isolated Indigenous communities, where early intervention with therapeutics may slow the spread of disease in community and prevent the need for hospitalization in faraway urban centres.**

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#### Resources

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