Discovery Phase Findings Report

Getting to the Heart of Health Equity at Peel

Strategic Policy and Performance Division

Health Equity, Partnerships and Innovation Team

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Region of Peel
working with you

Front Cover:

“We are in the same storm, **but we are not all in the same boat.”**

At the height of the pandemic in the summer of 2021, a member of Peel’s Community Equity and Engagement Advisory Table shared his concerns about the inequitable impacts the pandemic was having on his community and marginalized and racialized populations across Peel. In very few words, the concept of health inequity was simply and poignantly explained through this one sentence.

Table of Contents

1. Introduction – The Covid Experience
   - [1A] The Covid Experience
   - [1B] Governance Structure, Discovery Phase
   - [1C] What is Health Equity?
   - [1D] Mindset Switch
   - [1E] Differing Starting Points

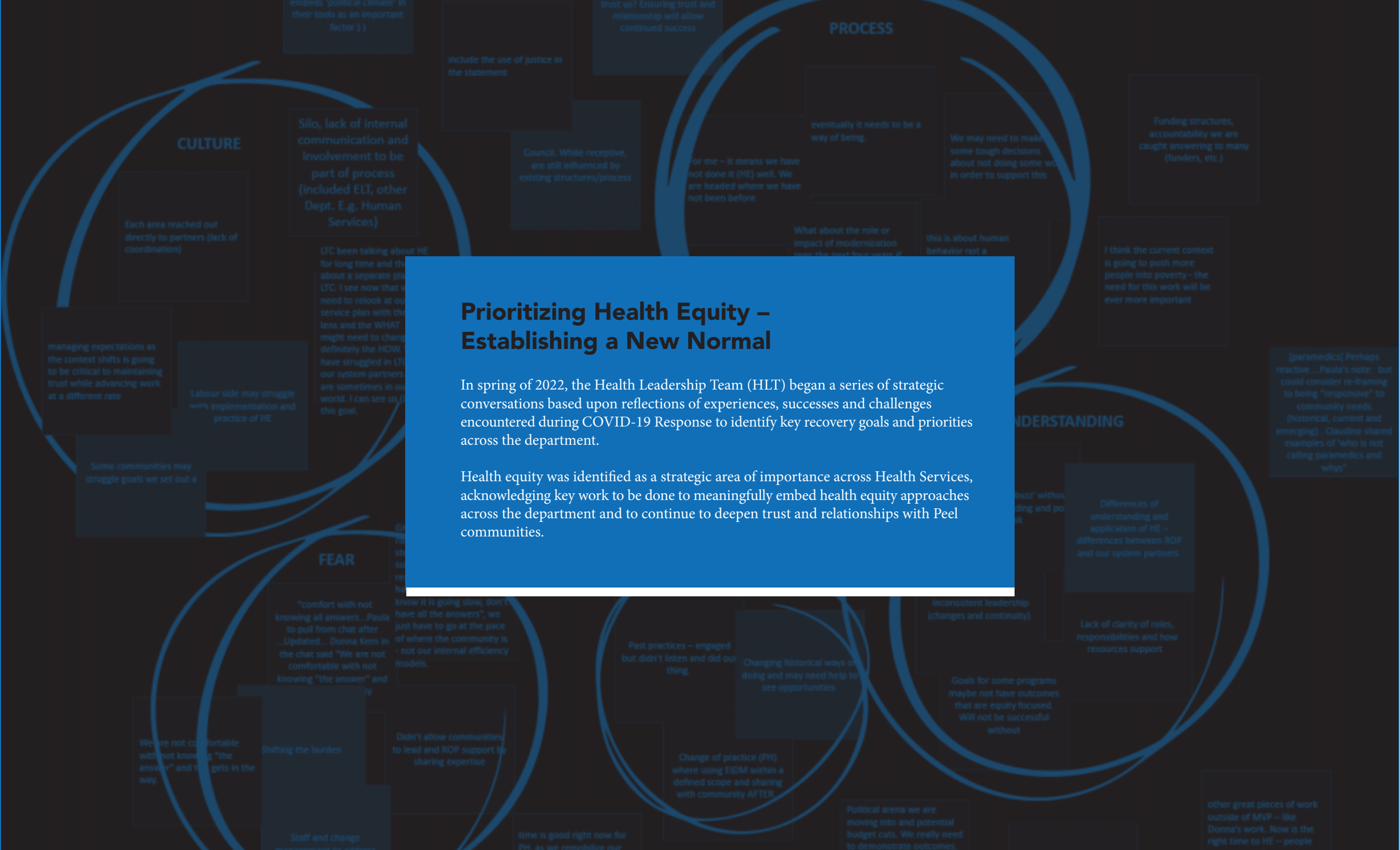
2. Framing the Challenge
   - [2A] Initial Goal Statement and Reframing: Health Leadership Team
   - [2B] Facilitated Discussions: Health Leadership Team
   - [2C] Pre-Mortem Exercise: Health Leadership Team

3. Approach: A Human-Centred Challenge
   - [3A] Guiding Principles
   - [3B] Methodology and Process, Discovery Phase
   - [3C] Discovery Phase Workstreams

4. Key Themes and Findings of Discovery Research
   - [4A] Internal and External Interview Findings
   - [4B] Systems Mapping Findings
   - [4C] Lens and Framework Reviews

5. Insights and Recommendations for Design Phase
   - [5A] Bringing it All Together – Key Insights
   - [5B] Areas of Focus for Health Equity Strategy Design

6. Appendices
   - [1] Journey to Health Equity: Milestones in Public Health
   - [2] Data Collection Tool: Sample
   - [3] Reference Materials, Health Equity Lenses and Frameworks
   - [4] Glossary of Terms


PROCESS
CULTURE
FEAR
UNDERSTANDING
Prioritizing Health Equity – Establishing a New Normal
In spring of 2022, the Health Leadership Team (HLT) began a series of strategic conversations based upon reflections of experiences, successes and challenges encountered during COVID-19 Response to identify key recovery goals and priorities across the department.
Health equity was identified as a strategic area of importance across Health Services, acknowledging key work to be done to meaningfully embed health equity approaches across the department and to continue to deepen trust and relationships with Peel communities.

1 Introduction: The Covid Experience

Transformation of health services and systems was drastically accelerated by the COVID-19 pandemic, creating the single most opportunistic time for new ways of working and serving populations across all sectors.

[1A] The Covid Experience

What was once considered improbable or even impossible, was, by April 2020, fully a reality. Most of us have never seen rapid societal shifts of this nature within our lifetime. Online schooling, remote work first, and accessing medical professionals on the phone or via video messaging became part of daily life. These experiences, implemented out of necessity, changed the way we live and work.

At Peel, the Mass Vaccination Program, and every area of the COVID-19 Response, were thrust into new ways of working. In short order, completely new business models were required and developed, including rapidly onboarding an influx of new and redeployed staff and continually adapting to new circumstances to respond to the evolving emergency at hand.

Early assumptions on how to best protect the health of the communities we serve were challenged, including the adage of "if we build it, they will come." We learned in real time that not everyone would, including those most at-risk facing systemic barriers and inequities. Entirely new ways of understanding, reaching, supporting, and empowering priority populations was needed.

Over time, and with perseverance, new opportunities and partnerships were established, new voices were brought to the table, lived experiences began to inform actions and cross-disciplinary teams worked in real time immersed in available quantitative and qualitative data to make sense of emerging trends, signals, and behaviours.

This unprecedented experience gave hundreds of staff permission to work differently to achieve a shared purpose, including challenging orthodoxies and breaking rules where necessary.

Working in untried ways offered leadership, staff, and community partners the space and permission to be bold, follow instincts and adapt new approaches; and, together, we found better ways to understand our communities, remove barriers and reduce inequities. The experience proved unequivocally that there is no going back, only forward, and only "with" our communities.

Across Canada, health institutions recognize that a well-prepared system requires flexible and resilient strategies to respond to the needs of future public health emergencies. At the heart of this work sits health equity. It is imperative we collectively acknowledge the transformational work this will require. If we apply what was viscerally learned and experienced through the COVID-19 Response, the work ahead will not only be about restarting what was paused, but will intentionally focus on how systems, structures and services are reoriented and redesigned to work for everyone, ensuring no one is left out or behind again.

[1B] Governance Structure, Discovery Phase

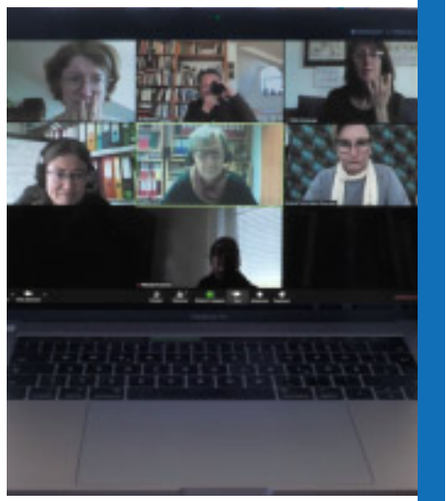
Collectively, HLT committed to the development of a shared goal and approach to amplify impact and embed health equity practices across Health Services.

Guiding Question:
In reflecting on lessons learned through COVID-19 Response, how might we better understand what "embedding health equity" across Health Services could mean moving forward?

To support this work, a multi-disciplinary team was established to lead foundational discovery research and sensemaking on health equity with strategic direction and guidance provided by HLT in the role of Steering Committee, supported by expertise from Health Services Divisional Leadership Teams.

Phase 1 Core Team functions included facilitating strategic conversations with senior leadership, defining a process and methodology to support the collection and synthesis of key information and materials, and sharing learnings and insights regularly with HLT to deepen understanding of key opportunities and challenges.

(See methodology section for full overview of approach).



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Peter Dundas, Chief and Director, PRPS
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Scott Fry, *Systems Planning and Partnerships (as of Jan. 2023)*

PHMT | PLT | LTC/SSD DLT

Figure 1: Governance structure for Phase 1

[1C] What is Health Equity?

Health equity exists when all people can reach their full health potential and are not disadvantaged from attaining it because of their socioeconomic status, race, ethnicity, religion, gender, age, social class, sexual orientation or other socially determined circumstances. *(Adapted from Dahlgren and Whitehead, 2006)*

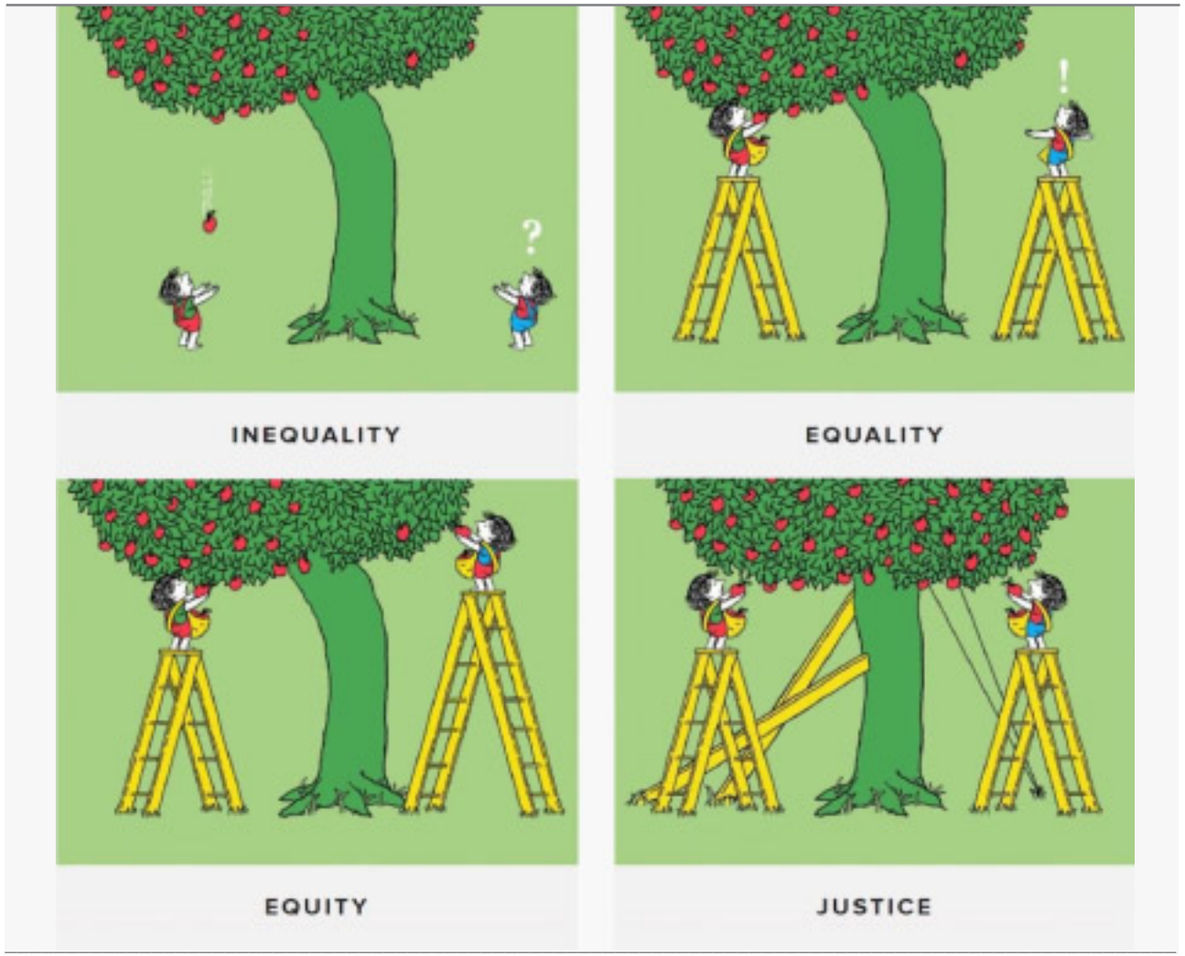


Figure 2: This visual helps to differentiate the concepts of inequality, equality, equity, and justice. Notice how the ladder which was provided to solve the problem does not address the imbalance. A key question to ask ourselves - why is the tree slanted this way in the first place? To affect change, new learning and growth is needed, but considerable "unlearning" is also imperative, acknowledging that the systems we are part of today were constructed unjustly and serve to maintain inequities and create disparities. This journey requires us to undo, unlearn and relearn.

[D] Mindset Switch

In exploring the realm of health equity, it is essential to state this is not an uncomplicated or simple challenge. Health equity is inherently complex, dynamic and requires appreciation of intersecting systems and structures, both past and present, that contribute understanding to the topic. With any complex challenge, there is no "right" answer; complex problems can never be solved, only made better or worse.

Many perspectives are needed to comprehensively unpack this challenge; however, as a starting point, it should be acknowledged that organizations change only if people change. Acknowledging how our mindsets either serve to maintain a status quo or intentionally disrupt it influences how successful we can be.

Global and local events over the past three years have issued a clear call to action for individuals, groups, and organizations. Shifting mindsets is the first step. The important work ahead will include amplifying anti-oppressive practices, meaningfully tackling the complex work of intersectionality; and focusing on how teams work together and with communities for greater impact.

You may have seen drawings like the one in figure 3 below, ones that yield two different images depending on how you view them. When viewed from one perspective the image clearly shows the ears of a rabbit, viewed from another, it shows the bill of a duck. These are known as Gestalt images and the transition from seeing one picture to seeing the other is known as a Gestalt switch. It requires training the eye to notice the lines in the image differently to see the two different pictures it yields.

Seeing oppressive practices requires precisely this sort of mindset switch. In a settler colonial state like Canada, systemic racism is deeply rooted in every system of this country. This means the systems put in place were designed to benefit white colonists. This power dynamic continues to be upheld and reinforced in our society.

The good news is that the brain CAN switch from seeing the world one way to a completely different way. It may not be recognizable at first but when the brain does connect the dots, it can never go back to seeing the world in just one way. We then have renewed our mind.

Figure 3: Example illustration of a Gestalt switch

Take a moment to review this image. *What do you see?*

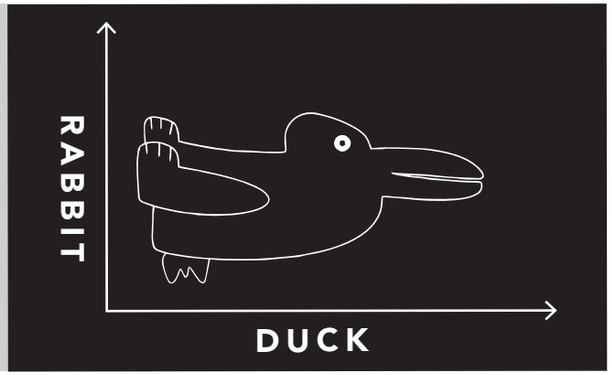


Figure 4: Cynefin Framework is a conceptual framework used to support understanding of different types of challenges from simple to complex.

TYPICAL CHARACTERISTICS OF COMPLEX PROBLEMS

• No agreement on the scope of the problem • Lots of uncertainty, disagreement around the data • No clear solution • Many perspectives and ways to look at the problem, issue, or opportunity • Political leaders are very anxious • Competing futures • Values and ethical consideration important • No clear path forward

[E] Differing Starting Points

It is important to acknowledge significant pre-pandemic work completed and progressing across Health Services that continues to strongly influence the path forward. Public Health is directed by the Ontario Public Health Standards where health equity guidelines inform requirements for planning, implementation, and evaluation. We also acknowledge the extensive work done in Public Health to fulfill the Ontario Public Health Standards and accompanying health equity guideline. Public Health has identified health equity as a strategic priority from 2019-2029 with work dating back to 2008. The timeline of Peel Public Health's journey to embed health equity in its programs and services is outlined in Appendix 1. Likewise, Paramedics, Long Term Care, and Seniors Services have also made advancements towards integrating health equity practices.

The existing legislation and regulation, as well as patient care standards for Paramedics do not include language specific to health equity due to their focused scope and purpose. However, the Ministry of Health's 2017 Framework for Planning, Implementation and Evaluation of Community Paramedicine includes language related to some of the determinants that would act as barriers to home care (i.e. lack of access to primary care, unsafe living conditions, etc.). In 2020, the Region of Peel submitted a response to the Ministry of Health's consultation on Emergency Health Services modernization. In this submission, Peel Regional Paramedic Services specified that improving support for social determinants of health and reducing service gaps and inequities is a priority for both the Region and the Ministry. Opportunities for action to address health equity and issues of action were also presented in the submission.

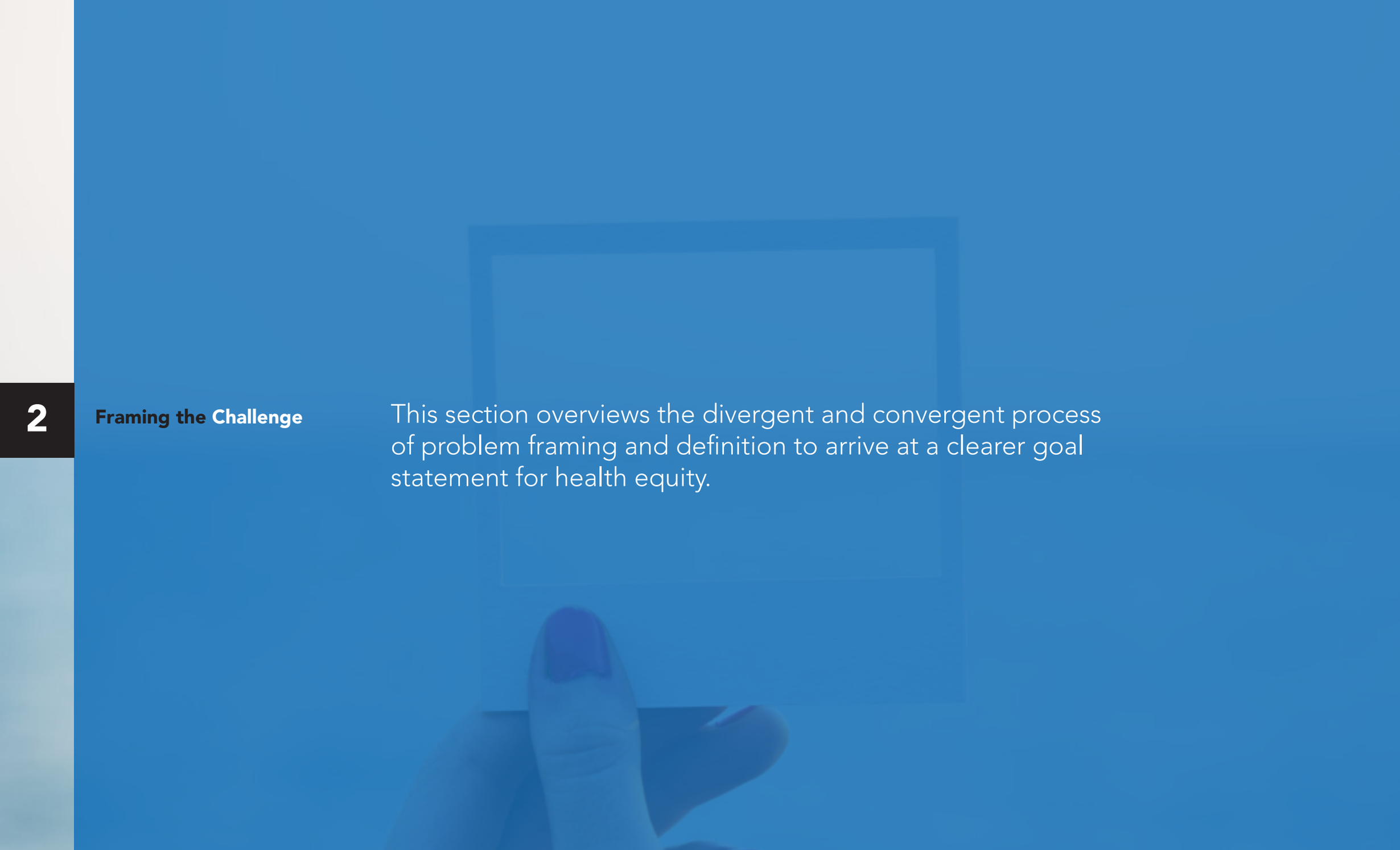
The Long Term Care Act outlines requirements that all Long Term Care Homes must meet to ensure that residents can live safely and with dignity (link: https://www.ontario.ca/laws/statute/21f39). While there are not dedicated guidelines specific to health equity, there are certain regulations related to religious and spiritual practices, plan of care development, and palliative care that guide homes to plan with the diversity of residents in mind. The Health Standards Organization (HSO), a nonprofit recognized by the Standards Council of Canada, has revised the HSO 21001:2020 Long-Term Care Services Standard and developed the new CAN/HSO 21001:2023 (E) Long-Term Care Services standard (link: https://health-standards.org/standard/long-term-care-services-can-hso21001-2023-e/). In this standard, there is a dedicated annex that integrates the principles of equity, diversity, and inclusion.

In 2019, the Region of Peel's Long Term Care and Senior Services Divisions developed a cultural competency and diversity plan for the Long Term Care Homes and Adult Day Service Centres (link: https://www.peelregion.ca/ltc/resources/pdfs/diversityandaccessibility.pdf). This plan outlines a commitment to integrating cultural diversity into service delivery culture and guides Long Term Care and Adult Day Services staff on the best ways to engage persons served in a consistent and respectful manner to build meaningful and positive relationships.

Appreciating that each division across Health Services is at a different stage of this journey and require diverse supports and approaches is acknowledged. Developing an integrated and comprehensive approach to health equity across Health Services is an opportunity to learn from the expertise and knowledge within each division and deepen our impact, empowering those who wish to run ahead to do so while continuously feeding learnings back into the collective.

2 Framing the Challenge

This section overviews the divergent and convergent process of problem framing and definition to arrive at a clearer goal statement for health equity.



[2A] Initial Goal Statement and Re-framing: Health Leadership Team

The below statement is the first iteration of a shared goal across Health Services describing what prioritizing health equity across Health Services may include:

> The Health Leadership Team will prioritize a health equity **framework** in service plans and develop a **common integrated** structure and process to support health equity that includes developing and maintaining a **co-ordinated approach** to system partnerships to improve overall health and well-being and **bringing voice** to lived experience.

Through further conversation, a refined goal and reframed statement emerged to push further and move beyond the consistent application of tools and frameworks and to take more deliberate action to frame this work within a broader focus of justice.

Strategic conversations on what it means to step into this space and what it will require of leaders to commit to this goal together was undertaken, leading to a reframed goal as seen below:

> HLT will **prioritize health equity,** placing it at the core of service plans and design an **integrated structure and process** that includes developing and maintaining a **networked** approach to **system partnerships with our community,** bringing voice to lived experience, both existing and historical, and **proactively identifying emerging needs** to reduce inequities, improve overall health and wellbeing, and influence a more just system for individuals, groups and communities wherever possible.

Figure 5: Reframing Checklist

Reframing Checklist

Frame the problem
What's the problem? Who's involved?

↓

Look outside the frame
What are we missing?

Rethink the goal
Is there a better goal to pursue?

Examine bright spots
Are there positive exceptions?

Look in the mirror
What is my role in creating the problem?

Take their perspective
What problem are they trying to solve?

↓

Move Forward
How do we keep momentum?

[B] Facilitated Discussions: Health Leadership Team

Several discussion sessions with HLT led to greater clarity and personal commitment to a shared goal. Discussion focused on the following questions, resulting in a streamlined goal that was simply stated and accessible to all.

What will it mean for us individually as leaders?

What are the implications of committing to this work?

How will we need to work differently?

Why does this have to be an integrated goal and not an individual deliverable for each Director?

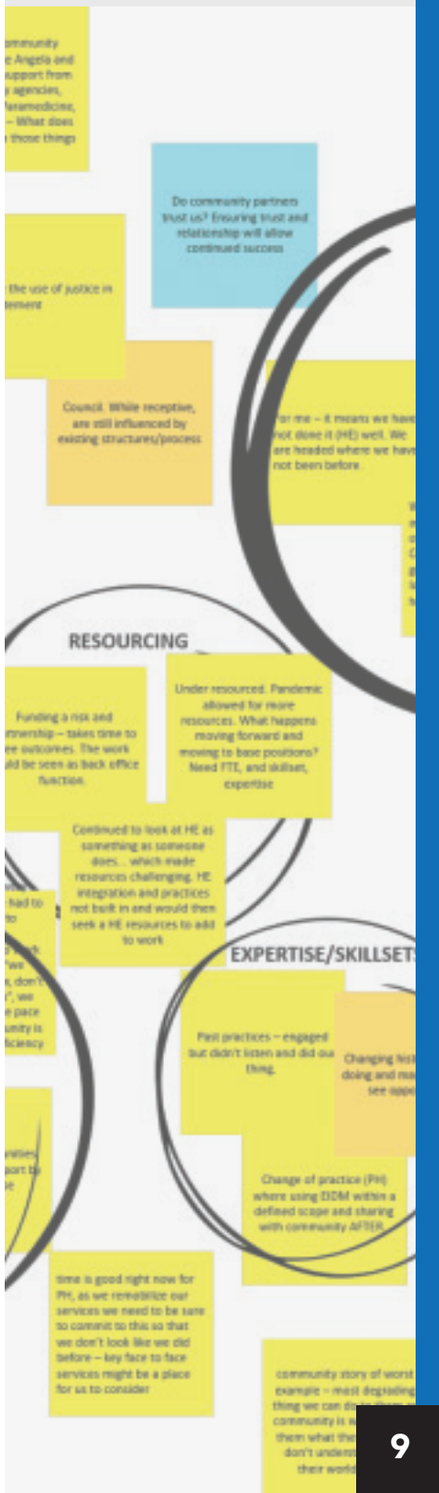
Can we live up to the expectations of making health equity a shared goal?

Why have we not been working this way all along?

Refined Goal Statement:
Health services, **experiences** and **systems** are **equitable, just** and work for everyone; **no one is left out or behind.**

The reframed challenge focused on:

- *Going beyond tools/frameworks*
- *Committing to deeply understanding historical, current, and emerging disparities*
- *Influencing change across Health Services, not only within individual initiatives or divisions*
- *Understanding health equity from the point of view of individuals, not institutions*
- *Recognizing an evolving role to go beyond equity alone and move towards correcting what's broken – towards justice.*
- *Ensuring approaches undertaken are not only a reflection of theoretical perspectives – it should not "sit on a shelf" but instead have an action orientation*

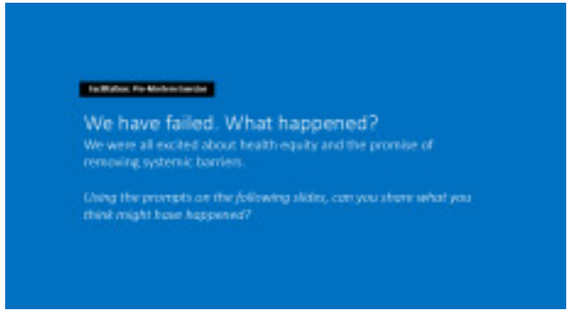


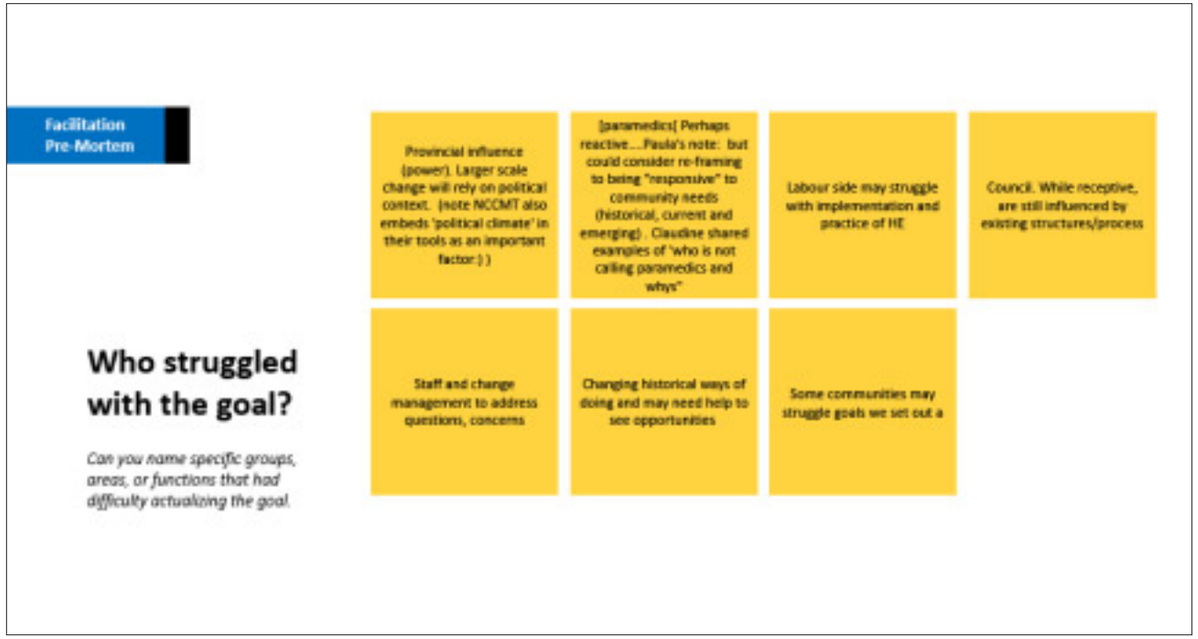
[C] Pre-Mortem Exercise: HLT

A pre-mortem is a way to open space at the inception of a challenge to directly address its risks. Unlike a more formal risk analysis, the pre-mortem asks team members to directly tap into their experience and intuition at the beginning, rather than at the end as is customary in a post-mortem.

The pre-mortem exercise asked HLT to imagine two years in the future and acknowledge that health equity goals and outcomes have failed to be achieved. Discussion focused on surfacing the reasons why failure may have happened – noting contributing issues ranging from lack of resources, commitment, political tensions and entrenched organizational silos and views.

The pre-mortem proactively identified these and other potential barriers and vulnerabilities and created space to speak openly about what may need to proactively change to avoid failure moving forward.





Screenshots of the artifacts generated during the facilitated (virtual) pre-mortem exercise with HLT.

3 Approach: A Human-Centred Challenge

[A] Guiding Principles

Guiding principles emerged following several collaborative sessions with HLT to unpack and refine the challenge and continued to be iterated upon following several learning forums, including, *Systemic Discrimination: Collective Action Now*, hosted by the Regional Diversity Roundtable. This session underscored how organizations that are not nudged along this path will not evolve and that we can't get to new knowledge and understanding using the same approaches that reinforced present states. We need to continually iterate and experiment to grow and expand by adding new ideas or ways of looking at complex topics through many lenses. The session also offered that if we're not going to strive for people to show up as their full selves than we are doing something wrong.

Design Principles for Approach to Health Equity

Created with Health Leadership Team

Go Wide and Big
Focus on the whole, not just the parts. Think across all programs and recognize that complexity requires constant iteration and action.

Strive for Collective Impact
Look for the value of joined-up efforts, collaboratives, and networks. See beyond efficiencies and removing duplication alone.

Be Human (Centred)
Start with empathy and focus on the lived experience, human needs, perceptions, histories, and realities.

Be Patient
Acknowledge that everyone's starting point is different, and that's ok (it's a journey) – we need to have patience.

Let Go
Invite others into the tent and get comfortable with relinquishing control.

Release Fear
We will get it wrong, but we will learn, grow together and continuously do better through persistence.

Practice Reflexivity
Consider how our understanding of the world, our personal and organizational biases, privilege, and power may impact the decisions we make.

[B] Methodology and Process, Discovery Phase

Human-Centered Design is a flexible yet disciplined approach to innovation that prioritizes people's needs and concrete experiences in the design of complex systems.

Recognizing a wealth of available research, evidence and literature on this topic exists and is critical to access and leverage, defining a path forward requires an action-oriented, contextually-driven approach to support understanding health equity in local terms, including lived experiences, and defining an iterative path forward to support identification of key areas of focus that are most relevant to individuals, groups and our own organization and governance structures. Avoiding inflexible, cookie-cutter approaches that sometimes lack the nuances of people's needs, beliefs, fears, experiences, and behaviours is essential.

Human-Centred Design as framed within this challenge is not a replacement to scientific methods and models but a supportive compliment that allows us to understand this challenge in new terms. The approach is underpinned by multidisciplinary collaboration, centering on people in their contexts, creativity, and iteration.

The Health Equity Core Team has and will continue to leverage existing evidence found within peer-reviewed and grey literature sources. For example, the six National Collaborating Centre's for Public Health, funded through the Public Health Agency of Canada, work together to promote the use of scientific research and other knowledge to strengthen Public Health practices, programs, and policies in Canada. The National Collaborating Centre for Determinants of Health has several health equity resources that have been leveraged to support this work. In addition, The National Collaborating Centre for Methods and

Tools, Model for Evidence Informed Decision Making (EIDM) in Public Health recognizes that evidence stems from a variety of sources including:

- Community health issues and local context
- Existing public health resources
- Community and political climate
- The best available research findings

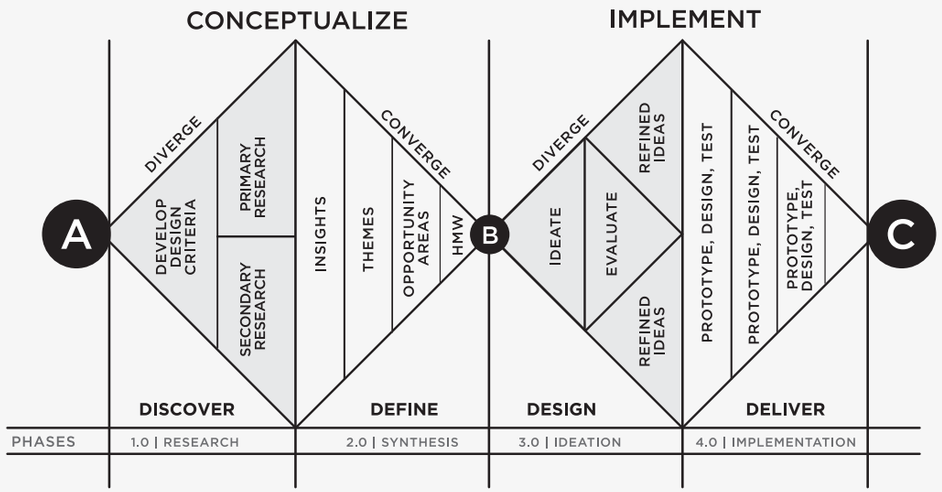


Figure 6: Double Diamond Design Model, British Design Council, 2003.

Figure 6 is a visualization of the Human-Centred Design Process, often referred to as the Double Diamond, which starts with an extended phase of immersion in the problem/challenge area with a goal of understanding the challenge space and the needs of those in the space, reducing assumptions or preconceptions.

The diamond structure emphasizes the divergent and convergent stages of the design process, referring to different modes of thinking; a process of exploring an issue more widely or deeply (divergent thinking) and then taking focused action (convergent thinking).

The process starts by questioning the problem, expanding the scope of the problem, and diverging to examine all the fundamental issues that underlie it. This is referred to as the Discovery Phase – Phase 1.

The second diamond combines divergent and convergent thinking to determine systemic solutions, strategies, policies, or other forms of response required – This is the Design Phase – Phase 2.

Human-Centred Design emphasizes the need to recognize a diversity of perspectives in understanding complex issues. In the domain of health equity, acknowledging the human factor is key and requires techniques rooted in many disciplines, particularly social sciences. A commitment to fostering stakeholder, partner, and resident/community participation through all phases of complex change — from discovery to design to implementation is especially distinctive.

[C] Discovery Phase Workstreams

Four workstreams were developed to guide the work of the Discovery Phase – Internal and External Interviews, Stakeholder and Systems Mapping, Research and Scanning (frameworks, lenses), Socializing Concepts and Building Capacity.

>> Internal and External Interviews:

Objective: To better understand internal and external partner perceptions and experiences to help inform how we shape and embed health equity principles in our work and how best to work with our communities for impact.

A total of 45 semi-structured, one-hour interviews were conducted with both internal and external participants.

Internal participants were identified by HLT and included leaders from across Health and Human Services working within areas of the social determinants of health, as well as the Diversity, Equity and Inclusion Office, Corporate Services.

The Core Team supported identification of external interview participants based on knowledge of key organizations working closely with priority populations in Peel as well as others.

Snowball techniques were leveraged by the team in which research participants were asked to assist in identifying other potential research participants.

All interviews were voluntary.

Customized interview probes and guides were developed for interview participants and shared in advance upon request.

Written transcripts were recorded, and informed verbal consent was described and provided at the outset of each interview.

Participants were informed that their comments would not be directly attributed to them and efforts in support of deductive disclosure were taken, avoiding the reporting of identifiable traits of the individual or group unless permission was provided upon request of the Core Team.

Participant consent was also granted to allow the interviewer to share important details of the interview with other members of the Health Equity Core Team to support the discovery research and synthesis process.

Recorded transcripts were summarized within interview workbook templates accessible by the Core Team and leveraged within synthesis sessions.

Eight Core Team synthesis sessions were conducted to support affinity clustering and theming of interview findings.

>> Systems Mapping:

Objective: To understand the current system landscape to improve system co-ordination, support program planning and identify gaps.

To inform current state understanding and establish initial baselines, a primary goal of the system mapping workstream was to leverage mapping tools and techniques to better understand community engagement practices and participation within the area of health equity.

It is important to note that the technique of visual mapping was leveraged in this workstream as a tool to support greater sensemaking and assist in understanding the complex network of existing relationships, and interconnections between participants, organizations, and issues. Development of a static map or artifact was not a singular goal of this workstream, but instead a byproduct to assist in better understanding the nature of community engagement and forms of community participation and knowledge currently leveraged and exchanged across Peel tables and forums.

Questions guiding the mapping included:

Who are we working with in the community space?

Who is at the table now (who isn't and why not?)

In what ways are we working with communities to identify, understand and intervene on barriers and inequities faced by priority populations?

Process:
Information and inputs were collected through small team workshops and supported by a data collection tool that asked all participants common questions to assist in the identification of tables, forums, membership, goals, and connections between tables to adjacent issues or groups. An example of the data collection tool is included in Appendix 2.

The map was developed through an iterative process and supported by Kumu, a tool that assists designers in organizing complex data, systems, and relationships in a visual illustration.

Acknowledging key contexts and points of view needed: It is important to note that the rendering of the systems map is at present representative of an organizational point of view. The map is an evolving product of internal team knowledge exchange and sensemaking among those staff who were consulted. This phase represents a 1.0 foundational version of the map, more work is needed to fully depict and reflect the perspectives and judgments of community partners to reflect a multi-dimensional understanding of networks and relationships.

>> Research and Scanning (Frameworks and Lenses)

Objective: To understand existing equity frameworks, lenses and practices in use in other organizations and evaluate their effectiveness in enabling outcomes.

At the outset of the Discovery Phase, adoption of a research lens was discussed. With full appreciation for the value of leveraging a specific lens to inform the Discovery Phase, it was collectively decided that adoption of a lens and/or framework at the outset would be prematurely convergent.

Instead, the team elected to identify an independent workstream to broaden understanding and support evaluation of several health equity lenses and frameworks, their respective components, similarities, and differences and how achievement of health outcomes is influenced through their use.

Figure 7: Several lenses are explored later in this report. An Anti-Oppression Lens is seen here which illustrates the importance of seeking to understand the multiple forms of oppression that are at play at a global, community and organizational level – including practices of our own within our organization.

A search strategy was developed for this review and shared with the Peel Public Health librarian (Appendix 3). The Core Team identified key questions that would support the objective of this stream of work. The literature review phase focused on answering the questions:

What are the main components (or elements) of a Health Equity framework?

How do health equity frameworks address intersectionality?

How do health equity frameworks address social determinants of health?

The findings from the search using OVID (MEDLINE, MEDLINE In-Process, Cochrane Database of Systematic Reviews, HealthStar, Global Health) and Academic Search Primer resulted in 340 articles. In addition to this peer reviewed research, the librarian's search also found 40 articles from grey literature. In total, the team reviewed 380 articles as part of the literature review of which there were a few duplicates.

Using the inclusion and exclusion criteria identified in the search strategy, the team conducted a relevance review (screening title and abstract only). This narrowed down the list of relevant articles to 15 which included a mix from published and grey literature. The team then conducted a full-text review of these articles using the criteria. This resulted in eight final frameworks being selected, and data extraction templates were completed for each to identify the components.

In addition to the articles identified through the database search, the team also reviewed additional frameworks that were shared by external partners in the first phase of the stakeholder interviews. In total, 11 frameworks were shared through this process and after reviewing these against the inclusion and exclusion criteria, three were selected.

The eight frameworks that meet the inclusion and exclusion criteria (five published, three grey literature sources) will be further examined in the Design Phase and key components will be identified and synthesized using the fundamentals of power and privilege, described below.

>> Socializing Concepts and Building Capacity

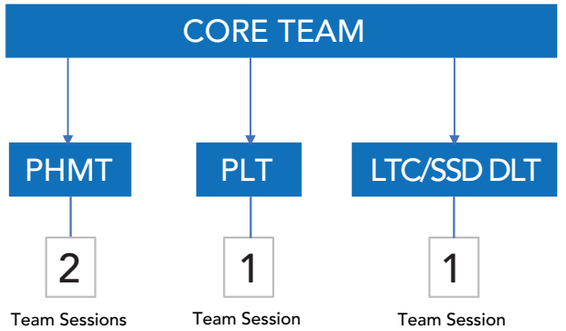
Objective: To amplify awareness of the need to prioritize health equity and highlight ways of working together to increase impact.

This workstream focused on the value of creating space for discussion, debate and socialization of health equity concepts, practices, and requirements. Recognizing that individuals and teams are currently at varied levels of awareness, health equity knowledge transfer and capacity building are key. Dialogue is a significant aspect of this journey and can sometimes be overlooked and under resourced. Developing safer spaces and supporting individuals on this journey is important.

The Core Team intentionally engaged with several teams across Health Services, small groups, and individuals to socialize the work in progress, focus on the why driving needed change, and helped inform staff of the journey ahead, building interest and expectations for the important role everyone will play in this work long-term.

These sessions were an important feedback loop and additional source of information to support understanding of current state levels of awareness, barriers, and opportunities across divisions.

While socialization of Discovery Findings is key, the next phase, Design, will ensure requisite variety of participants across divisions and teams to bring practical implications and contexts to the work of strategy design and implementation.



Meetings

- Human Services, Public Health, DEI and Health Services
- DEI and Health Equity Leaders (Juliet Jackson and Liz Estey)

Figure 8: Shows how the Core Team supported socialization and capacity building throughout the Discovery Phase.

4 Key Themes and Findings of Discovery Research

This section summarizes key themes and findings that emerged across workstreams.

[A] Internal and External Interviews

[B] Systems Mapping

[C] Research and Scanning (Lenses and Frameworks)

Overall Findings

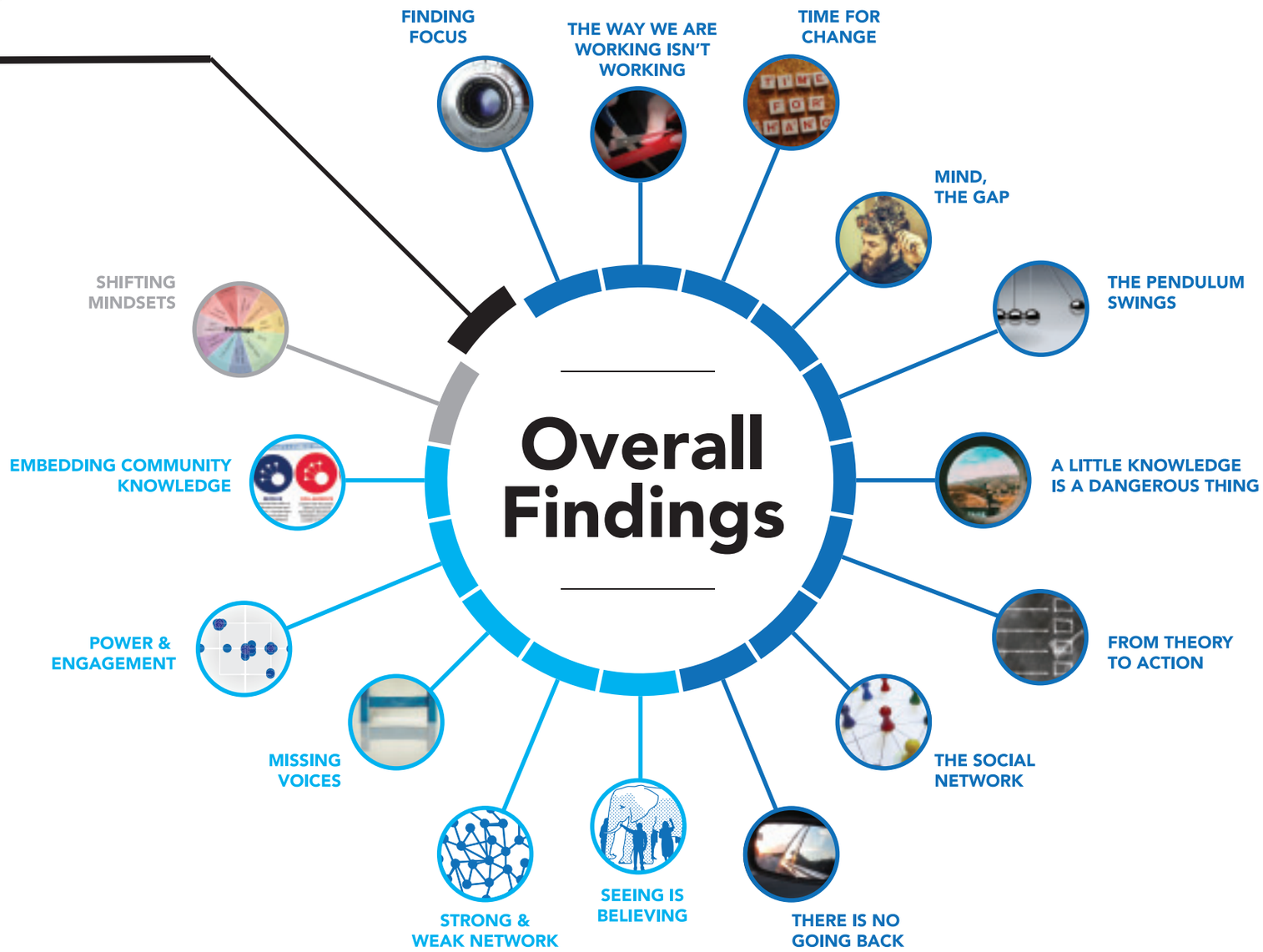
Across the 3 work streams:

15 findings emerged across 3 workstreams, coded by colour in this graphic. Significant interconnections exist across findings and workstreams.

Internal and External Interviews

Systems Mapping

Research and Scanning
(Lenses and Frameworks)



There is No Going Back

Many partners shared positive experiences working with Peel throughout COVID-19 Response. Trust was earned through difficult and courageous conversations and by stepping outside of existing structures, policies, and ways of working to get it right.

Participants shared that confidence in our organization and leadership was earned and appreciated; however, partners question if things will change and are curious if our commitment will recede as the emergency does as well. Many have cautioned us that we cannot go back to how things were pre-pandemic and that we need to build on the positive relationships forged during COVID-19 Response.

Internal participants noted that Peel excels in an emergency state and that departmental silos do not get in the way. Things get done and bureaucracy falls away. They remark that seeing what is possible when we work together is inspiring, and staff wish to see greater collaboration and co-design as part of new operating structures stemming from lessons learned. Concerns remain that progress will be lost in pursuit of "getting back to normal".

PARTICIPANT PERSPECTIVES

"Get to know your communities as if you're building relationships with them – know what they like, what is important to them, what is offensive to them, who they are, what they celebrate and why, and be mindful of when and how you show up"

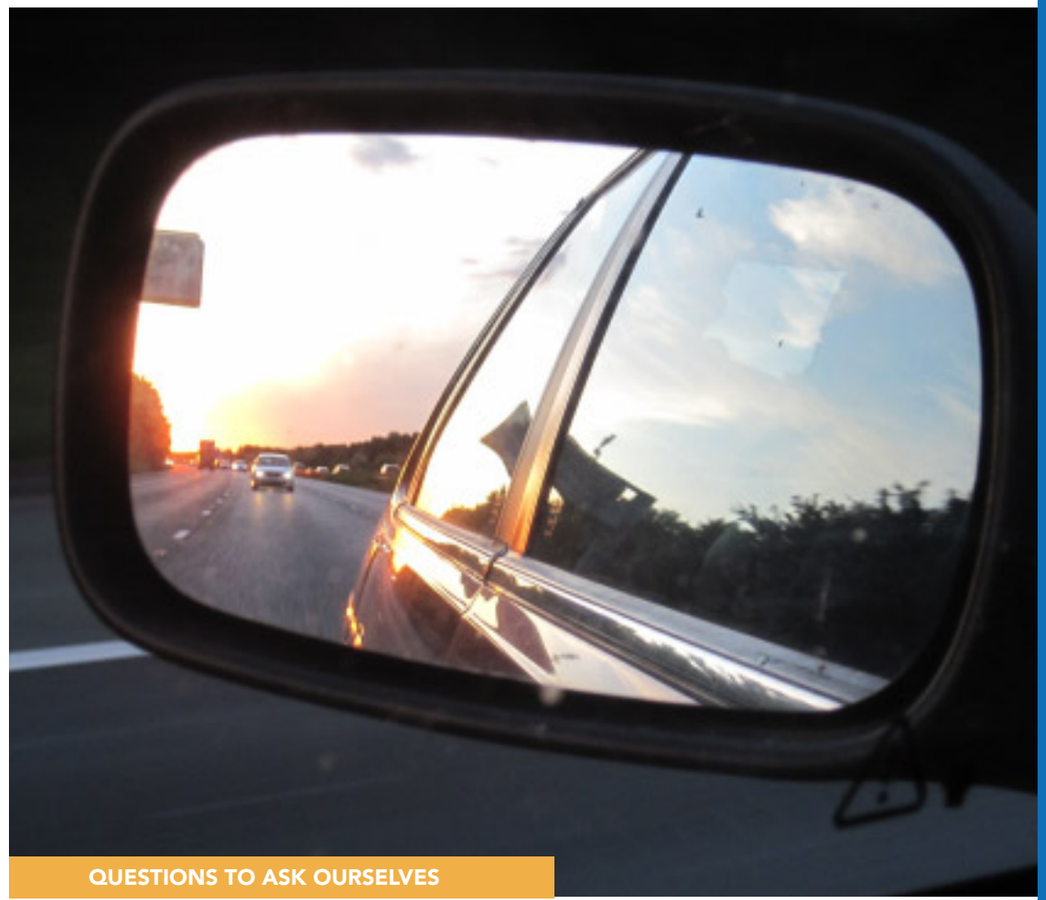
"Seeing someone put my communities' needs in front of their job felt good"

"Covid was simpler — We all, partners included, had a common enemy. Easier"

"Finding ways to manage our networks and the intelligence/data coming out of those relationships is important"

"We can quickly help community better together – we can't lose the successes we saw in the Pandemic"

"Room for growth but we are on a good path and hope this continues"



QUESTIONS TO ASK OURSELVES

How might we intentionally put in place practises that prevent natural tendencies to "get back to normal"?

How do we balance our need for structure with the flexibility required to collaborate effectively?

QUESTIONS TO ASK OURSELVES

Have we considered the role power plays at the tables where we sit with partners?

How can we be responsive to the needs of our communities, respecting the urgency of their needs while working within our mandates?

PARTICIPANT PERSPECTIVES

"Need to ensure those coming to the work and the team have that willingness to learn"

"Make the space and time to actually listen and act on feedback"

" Take the time to come out and engage with community leaders and agencies helps; come with an open mind"

"Continue to engage the community and have an open mind – not always easy to get to community members but continue working with agencies"

"The Region of Peel has a role in building community capacity because local, smaller community agencies need this support to do the work"

The Social Network

Participants noted the need for Peel to critically think about and discuss what authentic, trust-based relationships look like to us in the future. There is a desire to continue to go further and work with each other beyond the pandemic; however, participants noted that Peel needs to be aware that many groups are at the table out of responsibility to their communities and not necessarily by choice.

Acknowledging our inherent power and influence within the sphere of our social networks and relationships is asked of us by some participants along with a need to move beyond consultation towards action.

Our ability to increasingly expand and sustain high-functioning relationships with community groups on matters of equity will require new approaches, including relinquishing power and leadership at times, focusing on reciprocity, showing up for our partners in ways that matter to them and committing time and resources to do the work required to gain access and build trust with harder to reach groups and networks whose voices are not currently included or as strong as others already at the table.

The Pendulum Swings

Participants noted the challenge created by intentional shifts in philosophy and practice over time – referencing the swinging pendulum from a community-based orientation (while not consistently outcome-focused or impact generating), to a more epidemiological framework for population health and universal approaches. Participants expressed concern that the pendulum has swung too far in this direction, noting a perceived lack of a focus on issues of equity and social change in the population health perspective and a reliance on formal and academic sources of knowledge and evidence.

Participants commented that more balance is needed to include complimentary forms of social research to understand lived experience, social context, and community-based insights.

PARTICIPANT PERSPECTIVES

"This is a big shift. You must remember, if we choose to continue to focus on high needs — we just have to acknowledge that this is a shift from population health — we need to bring everyone along"

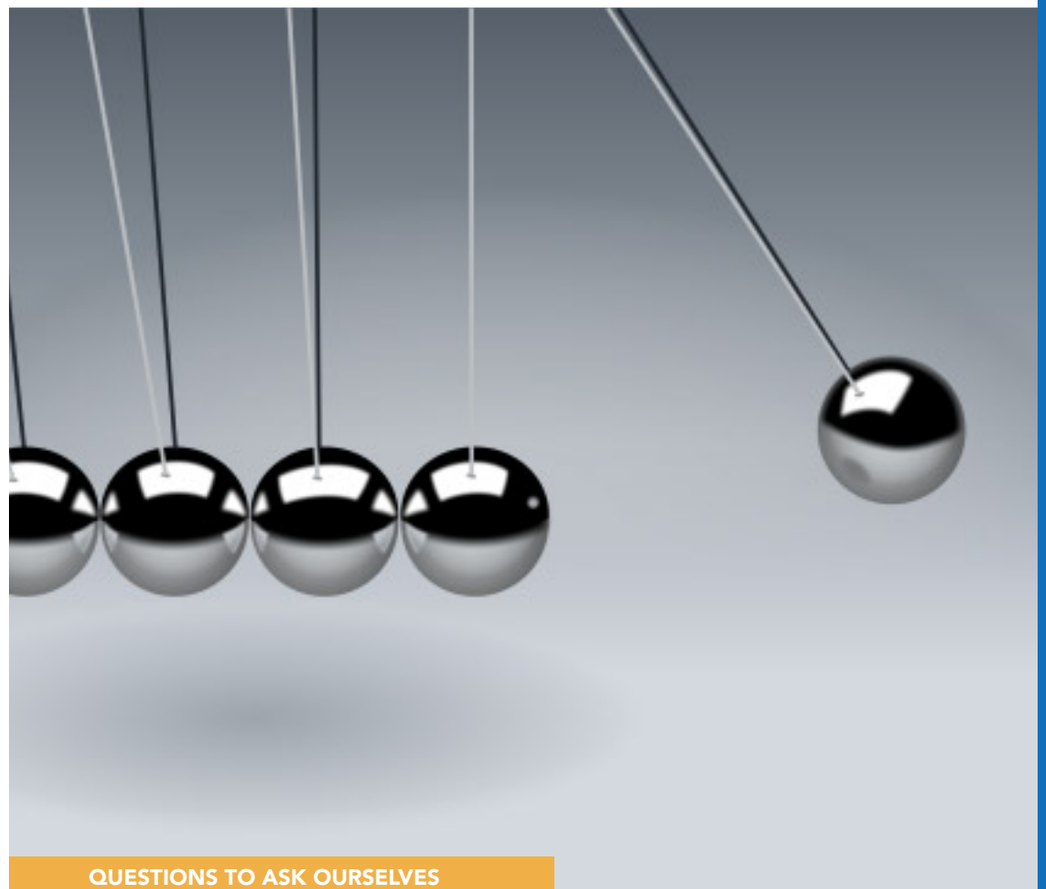
"Difficult to understand why Health Services' /PPH is epidemiology/data/evidence-driven (instead of people, community-driven)"

"Public Health had limited connections to community"

"The pendulum always swings – history does repeat itself and you learn from it"

"Community based vs POP Health. No one way is better than the other – it is issues-based"

"We have often approached Public Health from the standpoint of we know what the community needs from the data -but not from the community side"



QUESTIONS TO ASK OURSELVES

How well do we take both universal and targeted approaches to our programs and services?

QUESTIONS TO ASK OURSELVES

What can and can't data tell us?

What role can the community have in our collection, analysis and use of data?

PARTICIPANT PERSPECTIVES

"An intersectional approach to HE is key, especially as it relates to Mental Health and Addiction and data collection; race is an important factor but need to go deeper"

"Don't underutilize or ignore the diversity of wisdom and lived experience in community, like seniors/elders, different ways of knowing and doing, community-based research – it can be our strength in evolving and adapting"

"HE data cannot just be limited to race-based data; need to include data around other determinants of health so that we prioritize those that need to be prioritized – For example - vaccine roll-out prioritization missed out on identifying those that use substances as a priority population even though they were at disproportionate risk for poor COVID outcomes"

A Little Knowledge is a Dangerous Thing

Throughout the pandemic, multiple forms of data, information and knowledge was required to achieve outcomes with acknowledged limitations of available data sources. Limited progress on the collection of race-based and disaggregated data has been noted by community partners as a systemic barrier that requires bolder action and clearer accountabilities.

Participants note that meaningful socio-demographic data is required to provide measurable evidence to address inequities, racism, and discriminatory practices and to dismantle oppressive structures of white supremacy. Disaggregating this data is also imperative to allow for patterns between, and among groups to be revealed to support more targeted and effective strategies.

Sharing accountabilities with our community partners in the way data is collected, analyzed, and shared is a key area for growth and a significant indicator of trust for many of our partners. They have been clear in their expectations and critique of current approaches.

Participants stated that bolder actions are required on behalf of Peel to address this issue. Since the time of these interviews, work in Public Health has been spearheaded to do so. Peel Public Health is the lead health unit on a Public Health Ontario sponsored Locally Driven Collaborative Project in collaboration with Ottawa Public Health and St. Michael's Hospital (Unity Health) to better understand enablers and barriers to public health unit (PHU) collection of socio-demographic data (SDD). The project will formally collect, collate, and synthesize feed-back from PHUs regarding practices that enhanced SDD completeness during COVID-19 case management and vaccination to develop a set of recommendations to support ongoing SDD collection and reporting.

The inability to consistently conduct and obtain qualitative, lived experience insights is also noted by participants as a current barrier. Throughout the COVID-19 Response, qualitative methods directly informed effective actions to support implementation of vaccines across priority populations, working in close proximity to community partners. Skillsets in how to conduct, collect, synthesize, and translate qualitative insights into action is limited, as is broad acceptance of these techniques as forms of evidence across areas of Health Services.

Mind, The Gap

Interview participants shared key opportunity spaces for Peel to think differently about the role we play within a broken health and social system to help fill systemic gaps that compound inequities and vulnerabilities within our communities. Partners and colleagues in Health and Human Services shared ways that mindset shifts and new ways of working with our communities can influence positive change through a focus on collective impact.

Participants offered several examples of ways that Peel can offer "backbone support" to community partners by using key levers and advantages to address gaps in the system. Participants described how perpetual funding delays from the Ministry leads to gaps in services at the local level and harm residents' health and wellbeing (i.e., The Ministry's consistent lag in providing funding letters or confirming funding continuation to Lead Agencies as part of the High Priority Communities Strategy).

Amplifying advocacy efforts and thinking differently about how Peel frames its advocacy portfolio is another example offered by participants as a way for Peel to evolve its role for greater support and impact. Partners noted that Peel's voice carries influence and using this voice to amplify and support issues of importance to smaller agencies would support shared outcomes, as well as rethinking our conventional supports when community capacity gaps are observed.

PARTICIPANT PERSPECTIVES

"A shift in mindset to think about what it means to empower community is needed"

"Developing a clearer understanding of how advocacy can be utilized as our greatest tool for supporting community"

"We can each back the other up; collectively stick our necks out together"

"Partner to make it work, not to delegate work or to 'fix' inefficiencies caused by the system"

QUESTIONS TO ASK OURSELVES

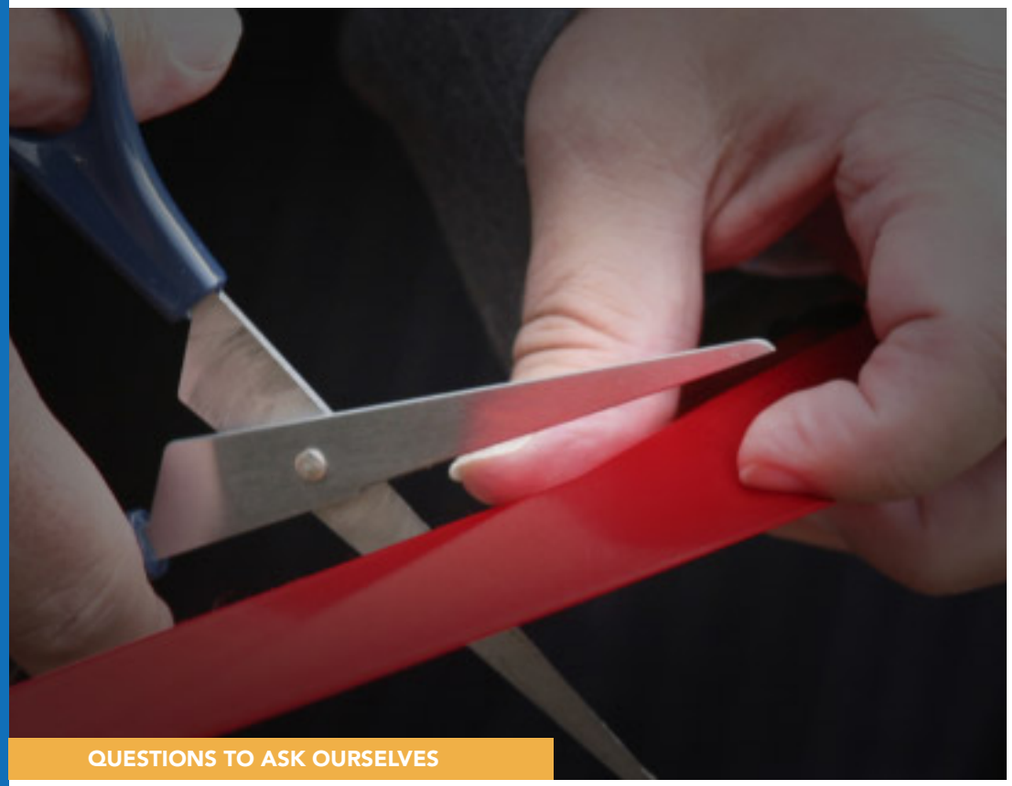
What is our role in advocacy?

How can we amplify the voices of our partners and the communities we serve?

What's stopping us from re-thinking how we might better support partners by evolving our role as needed?

What is our role in supporting community capacity building to address health inequities?

"BC puts the spotlight on cutting red tape" by BC Gov Photos, is licensed under (CC BY-NC-ND 2.0)



QUESTIONS TO ASK OURSELVES

How can we leverage work across Health Services in an integrated and co-ordinated way?

What are the opportunities to have a united voice with our system partners?

Are collective impact models possible here?

What does taking greater action and accountability look like for Health Services?

PARTICIPANT PERSPECTIVES

"Coming together of like-minded partners to challenge systems is key – creates a collective that can stand up against barriers that prevent health equity"

"How do we systematically work with Human Services? How do we collaborate better? I would like to see more thinking about strengthening our strategic partnerships with Human Services?"

"Funders, institutions, the Region - there are no repercussions for not meeting needs, or for creating or upholding barriers"

The Way We Are Working, Isn't Working

Participants expressed frustration with several barriers to equity-based work and achievement of outcomes, noting the need to transform internal processes and ways of working.

These include a recognition of the determinants of health and their complexity; however, planning and actions typically take place within corporate teams and initiatives working in narrow efforts with few opportunities for connections and processes to meaningfully work on shared community issues between Health and Human Services (Apart from present examples of CRT, CSWB).

Participants note support for the direction of this work and the need to prioritize health equity while citing that there remain commonly shared staff sentiments and actions that challenge the value of this work, noting that it often does not align with statistically significant numbers of residents and does not always "justify the cost of the effort". These attitudes reinforce current-state discriminatory structures and practices within the system and within this organization.

Across Health Services, each division has a different starting point for this journey, appreciation of these differences as well as the needs for different levels of resources and supports will be important.

Partners note a lack of co-ordination among "big players" (OH, ROP, OHTs) in Peel around health equity initiatives, creating double the work for agencies.

Partners also offered that Peel needs to do more to be accountable to and address community inequities, taking action to disrupt systems that oppress, taking more risks and investing in failing forward, appreciating the value of learning that comes from trial and error.

Finding Focus

Participants note that the challenge of improving health equity is complex, resource intensive and must occur over longer-than-average time spans for outcomes to be achieved.

Participants noted that due to this complexity, it is critical to ensure planning and prioritization practices include an equity lens and that initiatives and efforts are designed around impact that is aligned to internal and external partner planning and funding cycles. Driving this degree of co-operation and finding focus to drive efforts is essential.

PARTICIPANT PERSPECTIVES

"Fear, of what happens next. How do we keep the momentum going around HE? ...How can we evolve to support community? Team is made up of volunteers (zero funding). The need is there in many ways"

"The Region is responsive to feedback and open to working together. This was a great partnership and the outcomes were great"

"It can feel more like competition than collaboration at times; even though we are all solving the same problems, but separately"

"Emergencies allow us to focus on the need at hand, to be more blunt and to get it done. It allows us to step outside of the processes and structures"

QUESTIONS TO ASK OURSELVES

What tools can we use to prioritize our efforts and assess impact?

What would this look like from the point of view of our partners? How difficult or straightforward might this be?

What might measurement approaches look like for health equity and complexity to demonstrate progress being made over a protracted period?

QUESTIONS TO ASK OURSELVES

How can we support staff to be introspective about concepts related to health equity?

What skillsets are important to move from theory to action?

How can we balance our teams to have a diversity of skillsets?

How do we see our role in empowering community capacity to support health inequities?

What is needed beyond tools and modules to close the theory to action gap?

PARTICIPANT PERSPECTIVES

"Finding ways to manage our networks and the intelligence/data coming out of those relationships is important"

"It's a definite shift. Level of shift will depend on the program area. First steps – getting people to know that we truly mean business. People will not buy in until they see it in action"

"If we don't actually mean it, you can't just say it unless you really want to do it – otherwise health equity is just lipstick on a pig"

From Theory to Action

Throughout COVID-19 Response, many teams worked in new ways to achieve results. In several ways, experiences working with community partners moved beyond forms of consultation, requiring more specialized skillsets. Currently, awareness of health equity and principles of equity-based work vary across Health Services with some teams expressing strong understanding and others requiring more information and knowledge. In all cases, participants noted that while theoretical understanding may be strong in areas, practical experience, skills and supports to bridge theory to action are needed.

External participants noted a desire for Peel to also consider ways to build capacity with community agencies. Many agencies are resource and time strapped and offered ways that Peel could also help support their staff learning and capacity building by including/inviting their participation in Peel's employee capacity building efforts such as lunch and learns, sharing of resources and materials, etc.

It was also noted that while professional capacity and ability are a focus, personal awareness, growth, and transformation is also part of this journey. As such, personal commitment is also required of employees and must be supported.

Participants expressed that to build true capacity organizationally, Peel must reach beyond training modules and check lists where some see that efforts have been focused historically.

Time for Change

Across Health Services, participants noted that different lines of business carry multiple operational priorities demanding significant time and resources to maintain, namely Long Term Care, Adult Day and Seniors Program and Paramedic Services. Participants offered that by nature of their work and demands on their service, little time is available to consider how their businesses could strategically embed an equity perspective.

There is potential across all service areas for growth and innovation to design services and experiences that meet the needs of the community, especially those most vulnerable and marginalized by forces outside of their control such as racism, discrimination, and unjust structures.

Each area expressed desire to learn and do more while challenged by time and resources to support improvement and impact. Some staff are working "side of desk" on inclusion and equity and require more contextually relevant supports that can fuel and support improvement in their service areas.

Time is also relevant in terms of how we as an organization view and evaluate health equity related programs and initiatives. At the same time, evolving our mechanisms for measuring progress and impact need reconsidering — moving beyond a focus on low-hanging fruit and towards joined-up efforts that lead to collective action and impact.

PARTICIPANT PERSPECTIVES

"The progression is now to build a baseline level of competency about how to bring evidence into our work while including the lived experience and community engagement components."

"The HOW is going to be challenging. There are different groups moving at different speeds – I don't think the answer is to hold anyone back but to support across the board where people are - There is a significant workforce development side to this as well as a community component."

"How do we know we have influenced a more just system?"

"Everyone is on a continuum — being kind to each other when we slip or have ownership issues. This is a big shift from population health and we need to take the time to bring everybody along with us"

QUESTIONS TO ASK OURSELVES

What supports are needed to assist divisions and teams in applying health equity practices where time and resources are limited?

How might organizational learning support the transfer of knowledge from areas of Health Services where health equity approaches are commonly employed to those with less direct experience?

How does transformation happen when time and resources are limited? What specifically is needed?

[B] Systems Mapping Findings

Internal partners from across Health, Human and Corporate Services provided information related to community engagement tables, meetings, councils, and forums related to matters of equity or the needs of priority populations. Information collected on these tables included the purpose and objective of the engagement/table, leadership direction, membership, and description of the nature of the engagements, ranging from sharing information, pursuing consultation or deliberation and/or participation and co-design.

Information was plotted within a visual tool to support clustering and sensemaking of individual data points. Below is a holistic image of the map and a detailed view included as an example. Please note limitations on access to the tool prevent sharing the link within this report.

The following pages describe themes that emerged.

Figure 9: Full view of the systems map

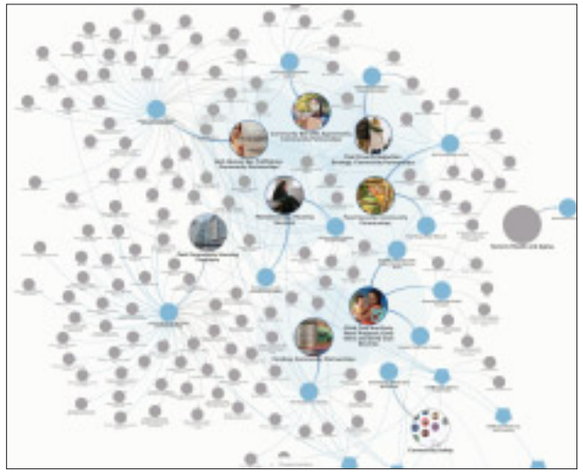


Figure 10: Zoomed in view of the systems map

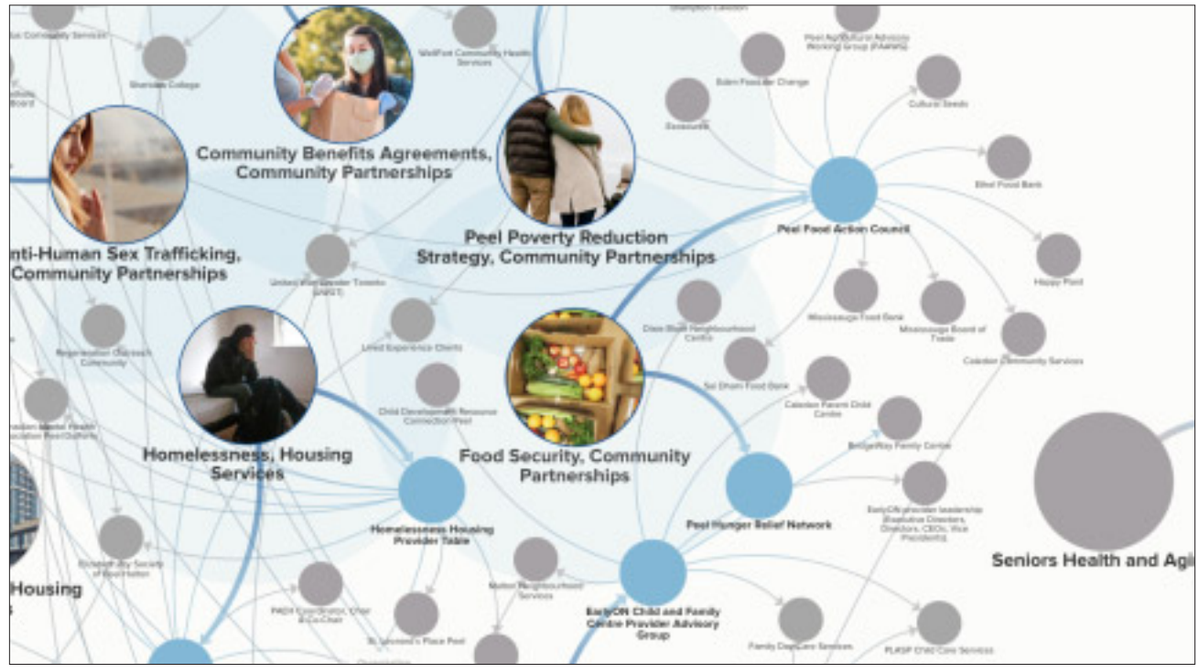
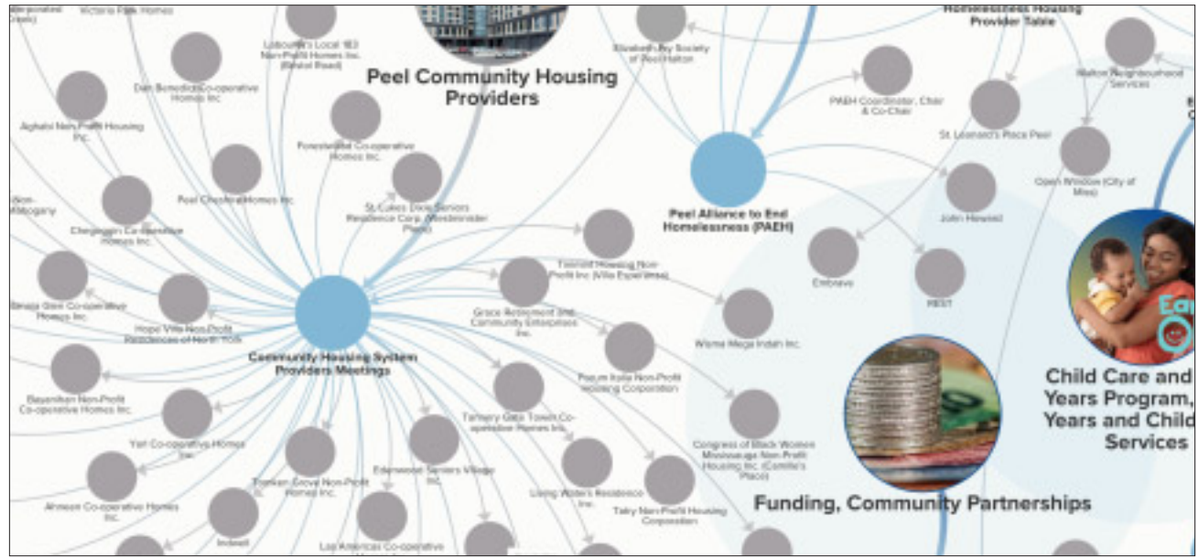


Figure 11: Zoomed in view of the systems map



Seeing is Believing

A key finding of the visual mapping exercise is the value of the visual process in itself. At the outset of the Discovery Phase, the Core Team anticipated the mapping workstream to be a straightforward task. It soon became clear that no one group had a complete or comprehensive understanding of the depth and breadth of engagement activities Regional staff across Health and Human Services participate in.

Supportive foundational work was established through an early list developed by Human Services but over time the list was no longer reflective of current states post pandemic. By plotting each group, initiative and membership, a comprehensive visual slowly emerged (although incomplete) and could be seen. Visualizing the system allowed for greater insight into how involved and extensive our connections to communities are.

The map is dynamic and customizable, allowing any user to discover simple information related to table membership as well as more detailed information, such as how frequently some community voices are represented at multiple tables, and more easily observing the absence of other voices.

The map offers useful information for partners across Health and Human Services (and others) to understand key community partners participating within defined areas and topics and who may be helpful to reach out to for community information.

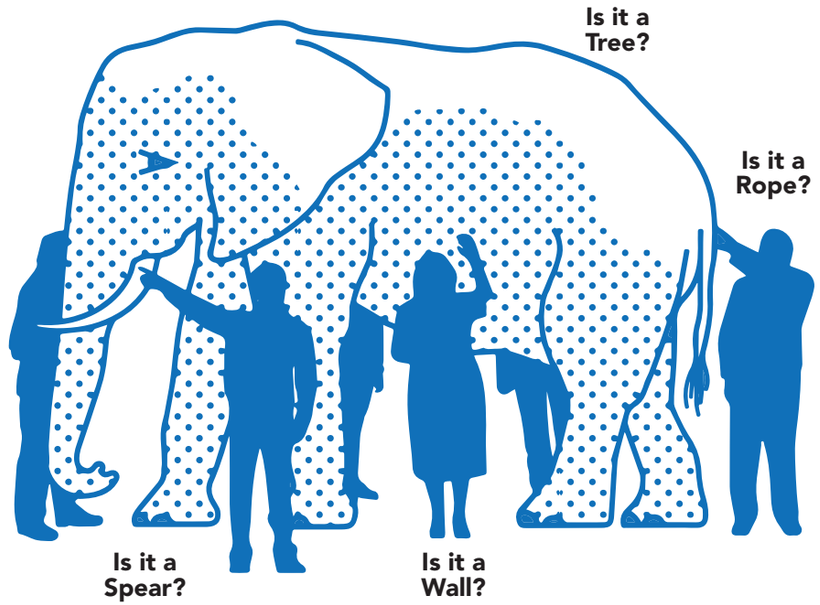
With a degree of integrity established with a 1.0 version of this map, continual renewal is required to keep this a living and relevant tool. Proceeding to build and layer multiple other perspectives and points of view beyond those of Health and Human Services is recommended to support effective strategy design and implementation. Visualizing the system allows for new connections to be made, new partnerships to be developed and allows for dynamic interaction within the map to support understanding how value is both being created and exchanged between groups within the network.

QUESTIONS TO ASK OURSELVES

How useful is data visualization in supporting health equity goals?

What is needed to ensure real-time and relevant information is available?

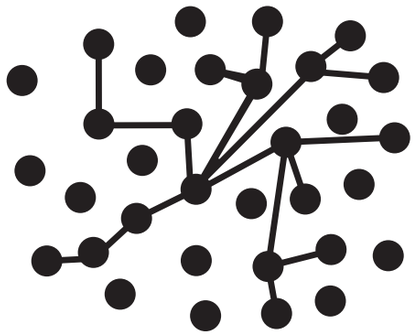
Figure 12: The Parable of the Blind Men



The Value of Visual Thinking

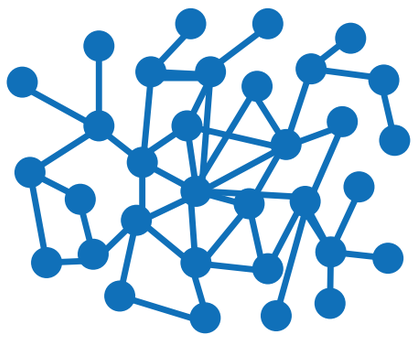
The parable of the blind men and an elephant is a story of a group of blind men who have never come across an elephant before and who learn and imagine what the elephant is like by touching it. Each blind man feels a different part of the elephant's body, but only one part, such as the side or the tusk. They then describe the elephant based on their limited experience and their descriptions of the elephant are different from each other. Similarly, without a visual understanding of the ways in which we show up within Peel communities, no true understanding exists.

Figure 13: Two Types of Networks



Weak Network

Unintegrated individuals, individuals held to the network by only one relationship, network over-reliant on star figures.



Strong Network

All individuals are integrated, many individuals are held to the network by multiple relationships, reliance on star figures is diminished by relationships unrelated to star figures.

Strong Component Parts but Weak Overall Network

Any purposeful system requires an intentional set of reciprocal relationships, feedback loops and a central organizing principle to function well. As community engagement practices evolved independently through standalone tables, the current system is representative of independent parts that over time and through necessity have grown and sprawled. As forms of community engagement were amplified through the pandemic, new stakeholders, system partners and players entered the space.

Independently, value is created and captured within parts of this network, but an intentional underlying architecture designed for optimal value, efficiency, knowledge generation and knowledge sharing is not apparent. Currently, community insights and knowledge generated within one "node" stays within the membership and sphere of that group and value cannot easily be distributed or shared broadly to support continual organizational learning and wisdom. This leads to several community organizations consulting across numerous tables. It should be noted that repetition of agencies across tables is neither positively or negatively determined through this mapping exercise.

Opportunities exist to amplify value through development of a more integrated, dynamic and equitable network consisting of greater requisite variety of community voices and clearer paths for value and knowledge to be democratized and distributed more effectively.

QUESTIONS TO ASK OURSELVES

What elements would need to exist to support a purposive network?

What do we see our role being in the planning and support of integrated networks?

What does it require of us to do more of and to let go of to support a stronger network?

How can we unlock community learnings housed within parts of the system and share insights more broadly across Health Services as a whole?

How valuable is a high-functioning community network to this work?

Modes of Engagement and Power Dynamics

Contributors to the map were asked to consider where their table/group sits across a spectrum of engagement from dialogue-based to action-based orientations; and on a spectrum from informing community members to empowering community members. The information provided was plotted on a 2x2 matrix as seen below in figure 14 to support a gap analysis.

This view helps to evaluate the nature of our engagements by taking a deeper look at how we are working with community, what the nature of interactions looks like and how power is featured.

Analysis of the 2x2 matrix indicates table/group activity across a spectrum of engagement modes with some initiatives stepping into the space of co-design and empowerment.

This perspective is reflective of the views of Regional staff who are working within these initiatives and indicates their personal opinions of where their table sits along the engagement spectrum of informing to co-design. Developing a comparative tool that includes the perspective of community members and partners is recommended to support further understanding, as well as a critical review to support validation.

There is significant activity within the bottom-left quadrant with a focus on more discussion based and transactional exchanges including seeking input, focusing on consultation, providing updates, or leveraging community in support of deliberate decisions.

In most of the cases included within the mapping exercise, the Region of Peel is considered the leader and/or organizer of the table. Power is typically concentrated within the organization and other groups are brought to “our” table. Evolving the map will need to include broader context and inclusion of community-led groups to support greater understanding of how the Region’s role and influence is occurring across the full network.

In reviewing the standard meeting formats across tables, in nearly all instances, the approach to engagement is quite formal in nature. This includes ensuring clarity around all roles, pre-structured meeting agendas, roundtable formats, and regularly recurring meeting rhythms. Several members shared their observations and perceptions of how tables and groups are brought together. Often groups meet because there has been an established expectation to do so at an agreed upon schedule which creates a mindset that meetings must occur and at times agendas are created with the purpose of filling the meeting schedule. There is also a perception that dialogue and discussions happen only (or predominantly) at those scheduled sessions and dates.

Internal staff noted a desire to move towards more informal and open styles for some issues and groups, where appropriate. One participant offered an observation that when the Region of Peel hosts or operates a community forum, there is a tendency to "fill up the full time with agenda items", leaving little time for dialogue. Participants noted how this can stunt productive and deeper dialogues and projects a sense that the organization may be trying to “control” the direction of conversations rather than create space for meetings and sessions to move with more fluidity and emergence around issues that matter to the group.

Participants also indicated that exploring more flexible and informal engagement methods may support agencies to self-elect which meetings they are required to attend and which meetings smaller break off sessions are most suitable.

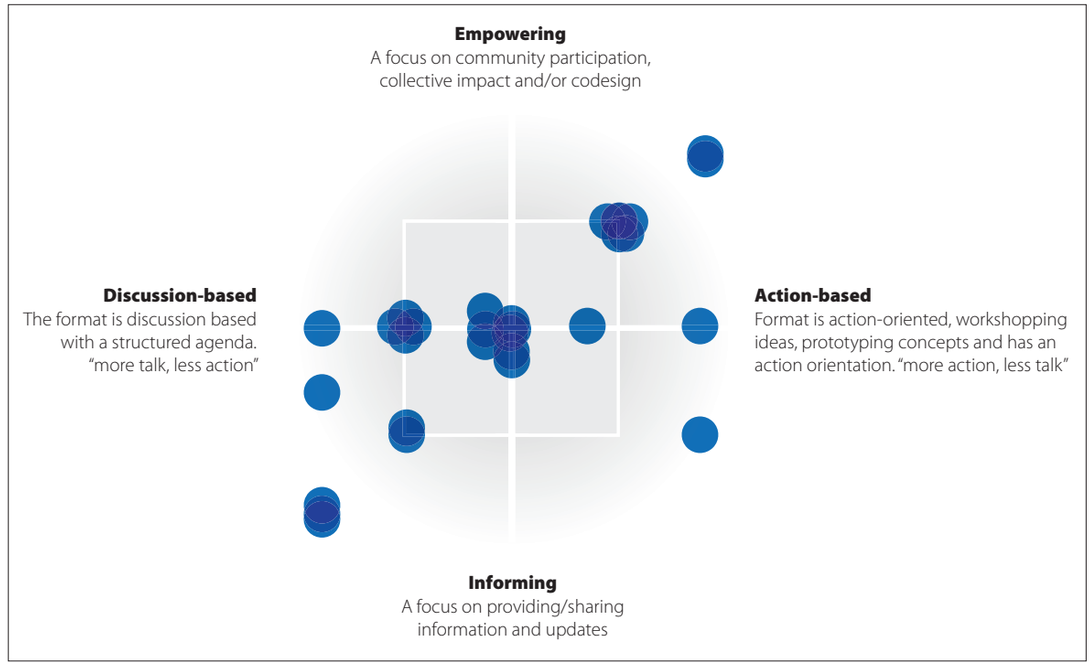


Figure 14: 2x2 Matrix Region of Peel Engagement Styles

QUESTIONS TO ASK OURSELVES

How well do you think we consider the effects of power and privilege in our work with community organizations?

How comfortable are we with less formal and less bureaucratic engagement structures?

QUESTIONS TO ASK OURSELVES

What role do we see community engagement playing within a health equity transformation journey?

Should it be a core part of our business processes? Why or why not?

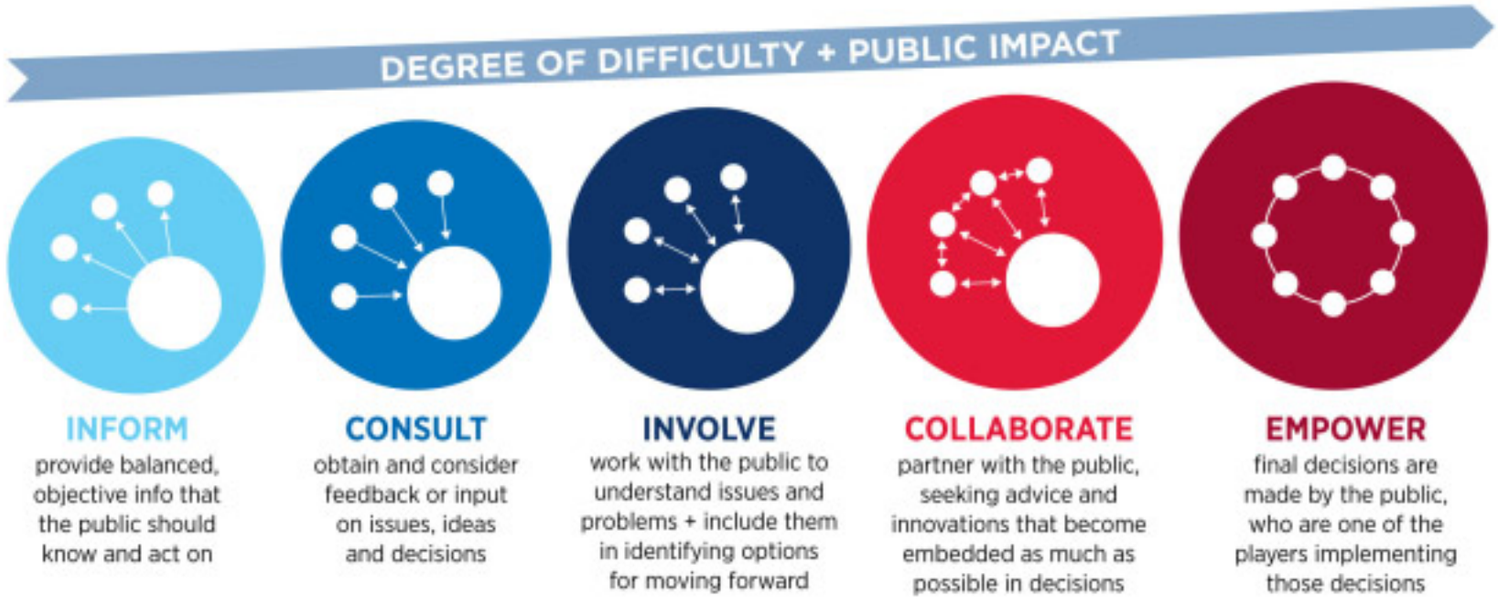
Where do we see our work across a continuum of engagement from informing to empowering?

Building Capacity and Embedding Community Insights and Knowledge

The practice of community engagement across all levels of public service is an evolving field dotted with a mixed bag of practitioners and outcomes. Done well, community engagement is a bona fide research method and a source of shared knowledge and value creation. Done poorly, engagement is seen as an end in and of itself; a one-way communication tool to produce buy-in for an already determined policy or intervention.

How we work with and engage with communities is shifting. New and inspiring relationships have recently developed through COVID-19 Response and Recovery work. Applying health equity approaches would not have been possible without understanding the lived experiences of priority populations, identifying contextual barriers or reaching groups where trust did not exist. While there is greater awareness and desire to engage with community, there is a need to anchor participatory research methods and engagement tools in a discipline-based approach to support strategic intelligence goals and embed practice within program planning and service design to build capacity across Health Services.

Figure 15: Spectrum of Public Participation



This continuum provides a framework for how community partnerships can grow over time across degrees of complexity and public impact. Continuing to build capacity, develop trusting partnerships, take risks, share power, and embrace new ways of working through complex challenges with communities can expand our toolbox, support the development of successful and replicable approaches and enhance organizational knowledge of unmet needs and barriers, especially those of priority populations.

Adapted from International Association for Public Participation (IAP2) Spectrum of Public Participation

Missing Voices and Meaningful Interactions

Several community agencies and partners participate across multiple tables, notably, Peel's six High Priority Communities Strategy Lead Agencies, along with others. Within 1:1 interviews, participants noted the desire for increased representation and greater variety of voices around Peel tables, including those of smaller agencies, organizations and groups that represent all voices and perspectives of Peel residents. Searching out marginalized and lesser heard voices is key in expanding our knowledge, understanding, and support of health practices. Further relationship building and deeper analysis is needed to identify missing voices required.

Participants noted the need to ensure meaningful interactions and clear objectives are identified for community engagement. Partners provided examples of value-add Regional tables, noting that when roles are clear and the purpose mutually supports their needs, the number of tables they are invited to is not an issue.

"Often the voices most needed to be heard

ARE NOT AT THE TABLE"

Sentiment shared by a research participant

QUESTIONS TO ASK OURSELVES

How do we define "meaningful interactions" with communities? How might community members define it? Is there alignment?

Time and effort is required to successfully engage with and build trust among harder to reach groups. Are we willing and equipped to do the work?

Shifting Mindsets

Although the selection of a lens (or lenses) is not a part of this phase of the work, it is critical to understand the fundamentals of power and privilege and their relation to health equity. Grounding health equity in an understanding of power and privilege and how it plays out as part of individual action, ideology, and institutional barriers (Figure 16) is the mindset shift that is required for transformational change.

By situating ourselves, both individually and institutionally, along the power wheel (example provided in Figure 17), our understanding of health equity deepens as does the awareness of the institutional barriers that exist in our pursuit of this goal.

As part of the Design Phase, the principles of power and privilege will be fundamental to the expansion of the frameworks and lens(es) workstream.

QUESTIONS TO ASK OURSELVES

Is power a health and social justice issue?

Can we identify our own layers of privilege?

What actions can we take to intentionally shift power?

Power is a key driver of health inequities. What is our role in changing public narratives related to social determinants?

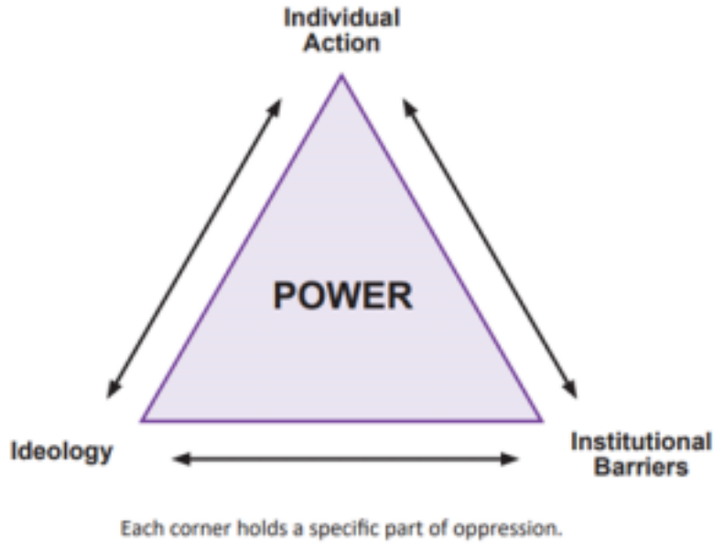
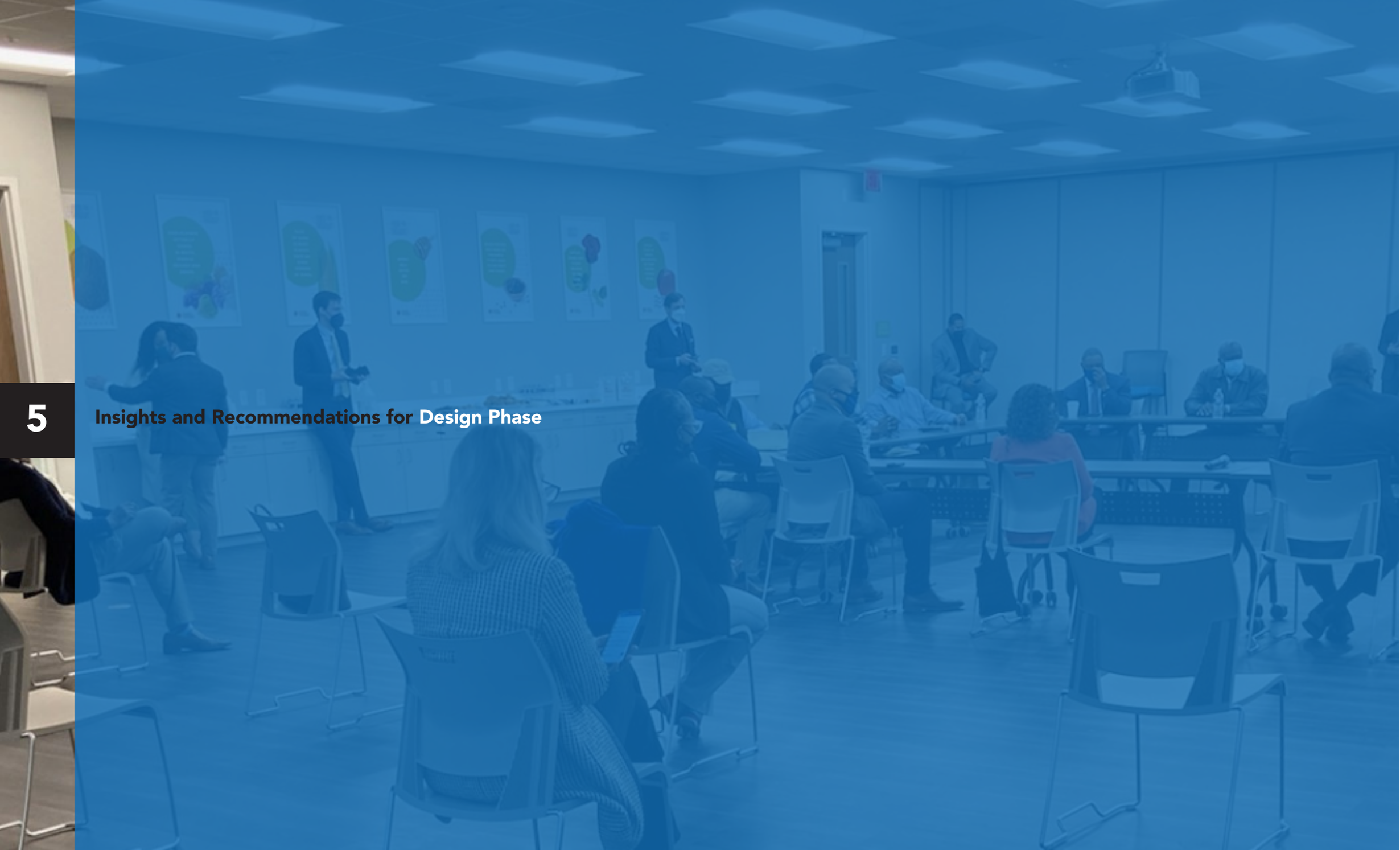


Figure 16: Power Pyramid
The Elementary Teachers' Federation of Ontario (2021). Anti-Oppressive Framework: A Primer. Toronto (March, 2021). Accessed March, 2023 from: https://www.etfo.ca/get-media/67d7eb05-4c08-414a-8979-7d98d94899bc/210504_Anti-OppressiveBooklet.pdf

Figure 17: Wheel of Power
Canadian Council for Refugees. Accessed March, 2023 from: https://ccrweb.ca/en/anti-oppression

Figure 16: Power Pyramid

Figure 17: Wheel of Power



5 Insights and Recommendations for Design Phase

Taken independently, Discovery Findings tell us important and helpful things about the problem space; however, insights tell us what's significant about what was found. The Core Team worked to synthesize the vast collection of facts, literature, previous work undertaken to address health equity across Health Services, and Discovery Themes and Findings to consider the underlying insights or the "so what" that can help us to meaningfully address health equity across Health Services. These insights became foundational concepts that shaped the development of Areas of Focus to provide direction for the Design Phase, where strategies and actions are built.

Three Key Insights

1 Transformational Change and Adaptation Needed

This is transformational change – big ideas and bold actions are needed to see real change.

2 Addressing Constructs of Power

Little will change if we do not recognize the systems of power and privilege that oppress, and the roles Health Services can play in dismantling oppressive practices.

3 Hyper-Local Understanding is Essential

Understanding health inequities requires deeper contextual knowledge and locally based data and information to drive change.

Three Key Insights

1 **Transformational Change and Adaptation Needed**

2 Addressing Constructs of Power

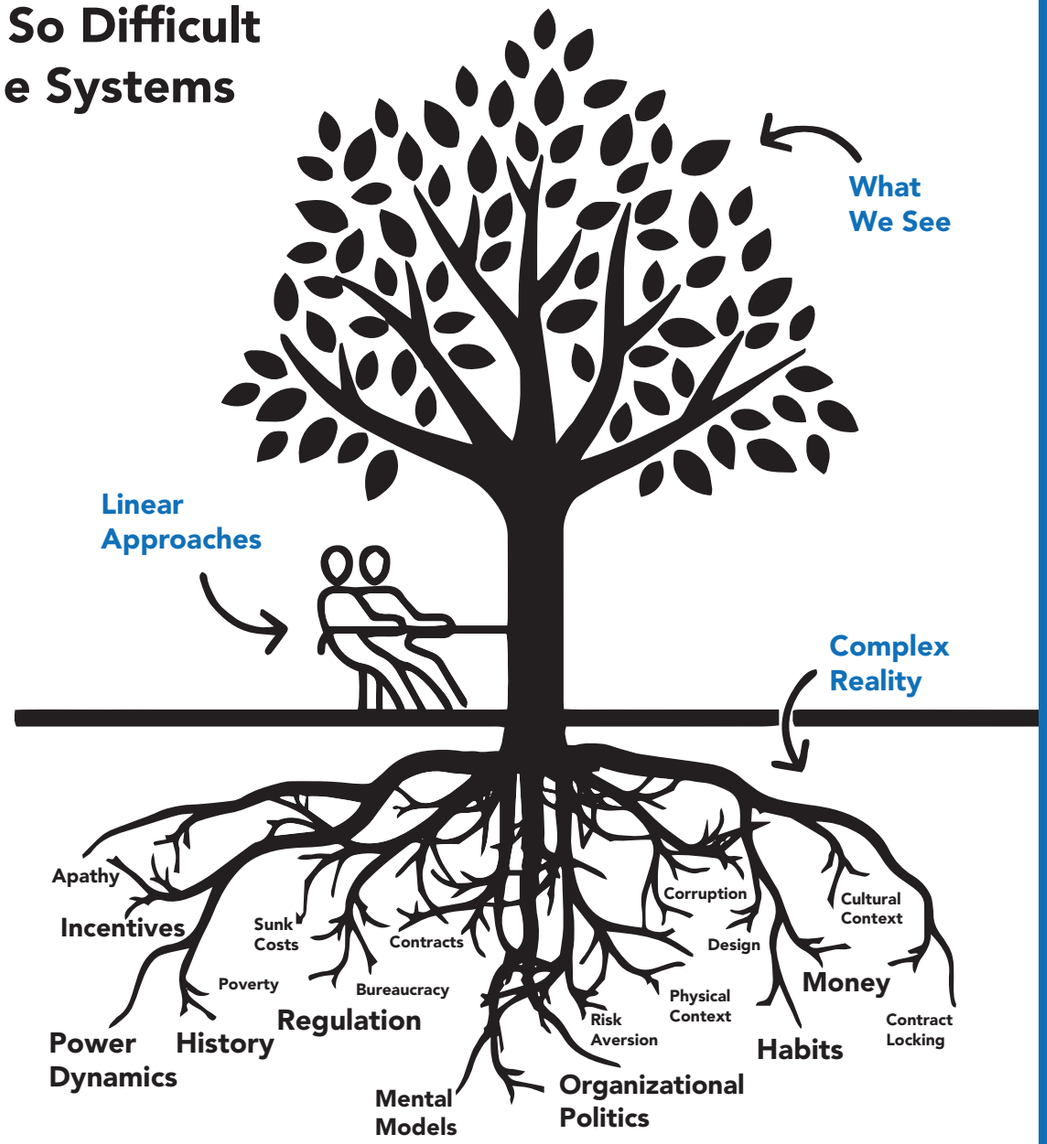
3 Hyper-Local Understanding is Essential

Transformational Change and Adaptation Needed

To achieve health equity, we must change the systems and policies that have resulted in the generational injustices that give rise to health inequities. As the Centre for Disease Control has stated, this is a generational challenge. Transformation will happen over time, but our call to action is to push as hard as we can with the power we are given at this time. Appreciating the complexity of this task includes thoughtful consideration of multiple intersecting factors, many of them unseen as depicted in figure 18. Transformation will require constant adaptation and a departure from linear approaches unsuited for tackling complexity.

Figure 18:

Why it is So Difficult to Change Systems



Three Key Insights

1 Transformational Change and Adaptation Needed

2 Addressing Constructs of Power

3 Hyper-Local Understanding is Essential

KEY MESSAGES

- Power, specifically collective power, is at the root of the history of public health.
- Power impacts health equity and individual and collective health at a structural level, which puts it in the purview of public health.
- Power can be harnessed or redistributed through a variety of means, many of them accessible to public health practitioners.

Adapted from National Collaborating Centre for Determinants of Health, Let's Talk Redistributing Power to Advance Health Equity, Part of the Let's Talk Series

Addressing Constructs of Power

Power is a fundamental driver of social inequity. Power imbalances are not accidental or unavoidable. Our society, and our health system and practice has been built upon multiple systems of oppression (white supremacy, colonization, nationalism, capitalism, patriarchy) that historically contributed to these imbalances and actively ensured that wealth, status, land ownership and other resources remain in the hands of the few.

Health equity strategies and actions must acknowledge the multiple forms of unearned power and privilege in place at a societal, institutional, and individual level – we must bring these hidden, visible, and invisible issues to light and actively address them for change to happen. Considering dimensions of power and opportunities to redistribute power to address health inequities is a key insight to carry forward into the Design Phase.

Figure 19 references four different types of power as described in the World Health Organization's conceptual framework for action on the social determinants of health.

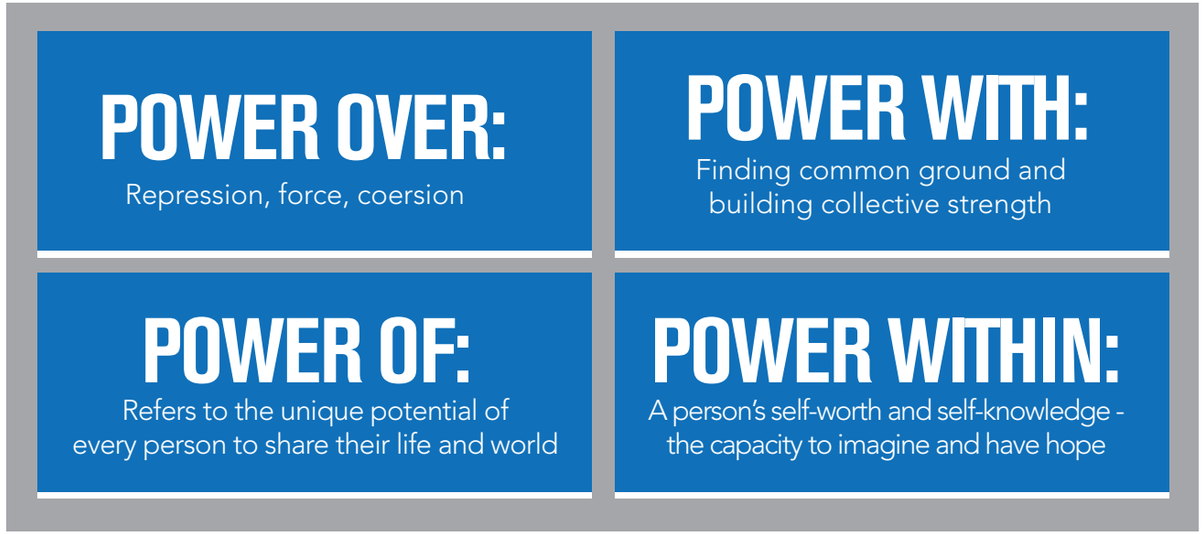


Figure 19: Different Forms of Power

Three Key Insights

1 Transformational Change and Adaptation Needed

2 Addressing Constructs of Power

3 Hyper-Local Understanding is Essential

Hyper-Local Understanding is Essential

Fundamentally, health equity can neither be understood or addressed without locally based, contextual understanding of the inequities and disparities that individuals and populations across Peel experience.

Deepening our understanding of the needs and differences between Peel communities, their direct experiences living with inequities and expanding our appreciation of intersectional identities is required to see whole people, beyond one-dimensional personas or broad groups (South Asians, 2SLGBTQ+ communities, Black, African, and Caribbean communities, among others).

This is a core distance to be travelled, regardless of how we elect to intervene (i.e., upstream policies and advocacy or downstream community-based health programs, health promotion, and services).

A commitment to delivering health services, experiences and systems that are equitable, just and work for everyone; where no one is left out or behind, requires targeted approaches that must start with deep understanding and empathy. Improving cultural and community knowledge and practices and deepening cultural proficiency and respect for community differences is needed to advance health equity practices.

Figure 20: A Model for Evidence-Informed Decision Making in Public Health

Implicit across Health Services is the need to understand local and community context. Amplifying our methods and approaches to better understand the diverse and intersectional identities of our communities is a key opportunity for growth and transformation.

Four Areas of Focus have been identified to drive health equity related improvement and transformation across Health Services. These areas are broad territories within which refined strategies and implementation plans will be designed, integrating multi-disciplinary knowledge, participation, and leadership from across Health Services.

Within each Area of Focus interconnections exist; and strategies may be developed to either close existing gaps in practise (a focus on implementing standards and improving current states) or designed to support long-term change across Health Services (a focus on transformation). Each of the four Areas of Focus offer examples of what strategies may include. These examples are offered to support practical understanding and are not prescriptive. Leadership teams will refine and determine specific strategies within the Design Phase.

[1] Amplifying Health Equity Capacity Through Continual Renewal and Learning

Effective practise of health equity principles requires continuous learning, unlearning, and relearning. Strengthening workforce capacity to support health equity requires acquiring new skills and tools, developing proficiencies in bi-directional learning with communities, and valuing all forms of knowledge and wisdom.

Transformational change will also require nurturing a supportive learning environment within teams and across Health Services to encourage a learning organization that supports deeper understanding and bolder action.

Understanding inequities and experiences across Peel, seeking out creative approaches and methods, and applying learnings with a bias towards action are components of a learning organization designed for constant change, complexity, and uncertainty. Intentionally supporting leaders and staff along this journey and creating safer spaces for change and transformation to occur is also key.

This may include:

Establishing core skillsets, toolsets, and expectations to advance health equity.

Creating accountable and safer environments for learning and practice.

Developing accountability structures and transparencies to uphold integrity of health equity work.

Building training strategies and supports to improve health equity practices in day-to-day work.

Designing a learning system that helps staff continuously learn about health equity concepts and the broader systems they are operating within.

Leveraging learning labs as flexible and experimental spaces where it is safer to learn, pilot new approaches, and focus on iteration and learning by doing.

Developing approaches to democratize knowledge and share learnings across teams, divisions, partnerships, and communities.

Tapping into the wealth of internal knowledge that exists within our diverse workforce across Health Services. There is power in people being their full selves when supported to learn and grow from each other's experiences.

[2] Propelling Locally Driven Data and Community-based Insights to Support Strategies and Actions

Data has significant power in shaping community issues and narratives. Consistent inclusion of communities to understand inequities and barriers and allowing them to shape their own population narratives around such things as gender, race, sexuality, and ability is an important aspect of heath equity. Community knowledge is evidence. The knowledge of people who live with inequities is grounded expertise that shapes how health institutions approach questions of equity. Considering how we balance and leverage both qualitative and scientific methods requires consideration. Democratizing data and opening it up for partners and others to support shared understanding of community inequities (where possible) and embedding equity-based principles across our data strategies is key.

This may include:

Embedding equity principles across the data life cycle (planning, collection, access, analysis, dissemination).

Enhancing practise of qualitative research methods, integrating lived experiences and contextual inquiry methods to generate relevant primary data and information.

Valuing engagement as a core health practise and building high-functioning networks to support the exchange of community-based knowledge.

Continuing to pursue and amplify collaboration across multiple sectors and actors, including community and academic institutions.

Understanding the enablers and barriers to sociodemographic data collection (SDD) (e.g., leveraging findings from Public Health's Locally Driven Collaborative Project regarding practices that enhanced SDD completeness across PHUs case management and vaccination).

Improving the collection and analysis of disaggregated socio-demographic data, such as gender, race, religion/faith, age, income, education, where people live, their healthcare access, the discrimination they may face, etc. (Leveraging Public Health's Data Strategy).

Working to open and democratize available health data to support shared understanding, planning and collective impact approaches across partners and community agencies.

Complimenting current sensemaking approaches of analysis, with synthesis-based approaches such as inference and abduction, to move from data and information towards knowledge and wisdom.

Developing a deep knowledge and understanding of inequities and injustices experienced across Peel communities, including the important nuances of intersectionality.

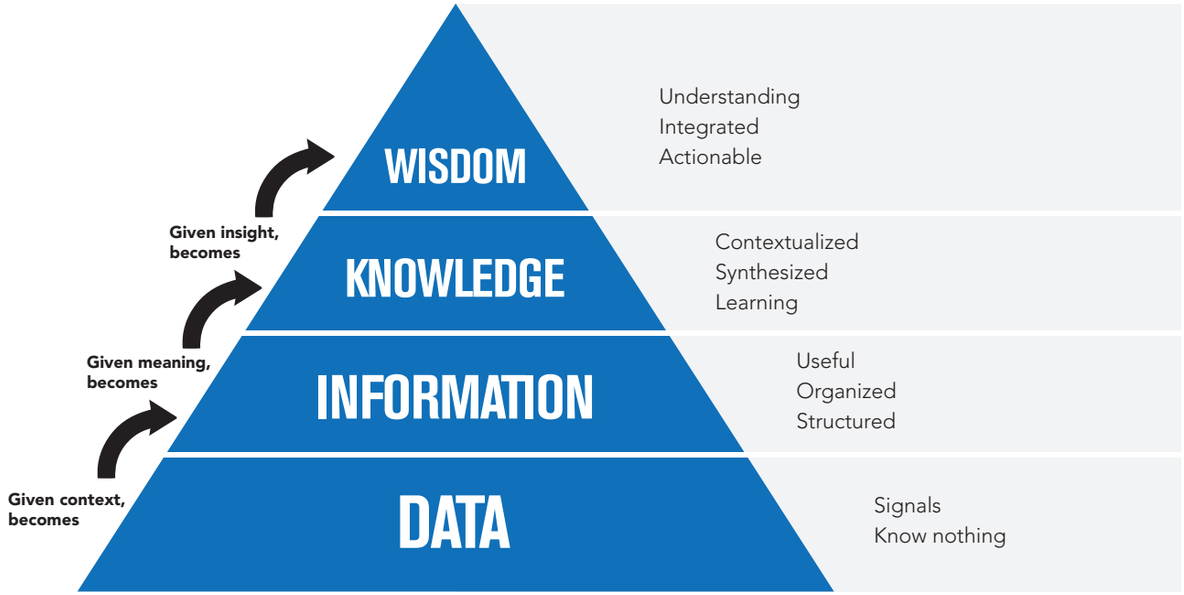


Figure 21: Ackoff's Knowledge Pyramid, Russell Ackoff, 1988

Advancing health equity requires more than good data; climbing the Data, Information, Knowledge, and Wisdom Pyramid requires local and contextual insights that allow for sensemaking, synthesis and the connecting of dots that can lead to meaningful action.

[3] Dismantling Systems of Power and Oppression and Building Systems of Trust and Empowerment

Acknowledging power imbalances alone is not enough but it does start with awareness and deeper understanding. Institutional and structural change and disruption is required to dismantle oppressive practices and redistribute power equitably. To address structural changes, it is important to understand and acknowledge all dimensions of unearned privilege and power, both historical and present.

How do power and privilege exist in our internal systems and how is it reflected within our programs and services? How might we disrupt institutional practices, both conscious and unconscious, and consider ways to redistribute power to address health inequities?

This may include:

Developing approaches to systematically identify oppressive practices.

Designing collaborative structures with communities, opening spaces for deeper discourse, co-design, and empowerment.

Considering how bureaucratic structures may reinforce power imbalances for community members leading to feelings of tokenism.

Considering ways of sharing and distributing power and influence with community (e.g., collective impact.), strengthening partnerships and alliances and pursuing joined up efforts to support social justice issues and reduce health inequities.

Co-designing decision making processes that prioritize multiple perspectives on what matters most, not only organizational interests and perspectives.

Supporting civic agency and capacity building among communities to bring about structural change, mobilize resources and identify common problems.

Investing in leadership approaches that champion equity principles and focus on creating safer spaces.

Supporting community partners and showing up in spaces of discomfort and transition, lending Peel's voice to lesser-heard groups.

Continuing system mapping efforts to support ongoing understanding of community issues, partnerships, and community groups working across determinants of health.

Developing structural supports for community engagement.

[4] Re-orienting Systems Processes to Strengthen Health Equity Approaches and Health Programs and Policies

Evaluating and modifying the systems and processes that govern how we do our work is a key area of focus to support improved equity and justice outcomes for priority communities.

Across Health Services, work is framed and guided by a series of foundational business, program and service planning, and implementation processes. Embedding health equity approaches across Health Services requires building in or enhancing existing systems processes to support improvement and transformation.

This may include:

Reviewing end-to-end planning and service design processes.

Defining appropriate theoretical health equity frameworks and lenses to leverage across a spectrum of complex issues.

Integrating COVID-19 lessons learned into systems processes and practices.

Considering how health equity work is resourced (time and budgetary processes).

Reorienting how health equity work is identified and prioritized (prioritization processes), measured, evaluated, and reported.

Evolving roles and practices to meet community needs (upstream causes, advocacy, policy design, local approaches).

Developing foresight and scenario planning processes to better anticipate how future trends, signals, societal and local values, beliefs, and behaviours may influence health inequities.

Developing long-term sustainability and shared governance for health equity.

Renewing how employees are onboarded and oriented to support critical understanding of Peel communities (orientation processes), focusing on inclusion and cultural centeredness.

Enhancing interdepartmental processes of collaboration across social determinants to achieve greater impact.

Region of Peel

working with you