Community Health Assessment Through an Income-related Health Equity Lens: A Retrospective Case Study of Three Regional Health Authorities in Manitoba

By

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Abstract

Community Health Assessment (CHA) is a legislated process in Manitoba, Canada, which provides an overview of health in each Regional Health Authority (RHA). This process is important for operational and strategic planning, and provides an opportunity to explore health inequities. The CHA process in Manitoba has not been reviewed from an income-related health equity (IRHE) lens to date. The purpose of this dissertation was to learn how Manitoba's RHAs incorporated an IRHE lens in their CHA process and to identify the facilitating and impeding factors for incorporating such a lens. This retrospective research project used case study methodology. Three cases were selected due to their geographic and demographic diversity. Data collection involved document reviews and individual interviews with CHA staff and board members/senior management using a semi-structured interview guide. Interviews were audio-recorded and transcribed verbatim. Categorical aggregation was used to establish themes from the data guided by the IRHE Framework for CHA (adapted from the National Collaborating Centre for Determinants of Health, 2011). The results of this research show that the RHAs did not apply an explicit IRHE lens to the third cycle CHA process, although it was recognized by almost all participants as important work. Several important similarities arose across the RHAs, further validating the findings of this study. Barriers to IRHE-focused CHA work included factors such as other competing priorities, lack of a provincial IRHE-focused framework, confusion over true CHA partnerships, capacity issues, lack of action due to the CHA process largely owned by health departments including Manitoba Health and the RHAs, and a lack of awareness of the social determinants of health (SDOH). Some of the facilitating factors included provincial structures such as the CHA Network (CHAN) and the CHA guidelines and a general consensus that CHA is a valued and respected process. Several recommendations are made,

including suggestions for an improved CHA process focused on IRHE or health equity in general. Future research in health studies and/or evaluations should consider using a health equity lens.

Keywords: community health assessment, health equity, income, case study

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Everyone has the right to be counted

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List of Acronyms

ARHA	Assiniboine Regional Health Authority
BRHA	Brandon Regional Health Authority
CHA	Community Health Assessment
CHAN	Community Health Assessment Network
IRHE	Income-related Health Equity
LICO	Low Income Cut Offs
LIM	Low Income Measure
MCHP	Manitoba Centre for Health Policy
NCCDH	National Collaborating Centre for Determinants of Health
PHAC	Public Health Agency of Canada
PHPEG	Population Health Promotion Expert Group
PRHA	Parkland Regional Health Authority
RHAs	Regional Health Authorities
SDOH	Social Determinants of Health

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Chapter I: Introduction

Social determinants of health (SDOH), such as income, education and social status, have long been associated with overall health (Marmot, 2004). There is evidence that differences in health associated with the SDOH exist on a global level (Evans, Whitehead, Diderichsen, Bhuiya, & Wirth, 2001; Graham, Fitzmaurice, Bell, & Cairns, 2004; WHO, 2008), on a national level in Canada (Brownell et al., 2010; CIHI, 2016; Fang, Kmetic, Millar, & Drasic, 2009; Jackson & Huston, 2016; Muirhead & Lawrence, 2011; PHAC, 2008; PHAC, 2016; Smylie, Fell, & Ohlsson, 2010), and on a provincial level in Manitoba (Kettner, 2011; Routledge, 2015). Systematic differences in health associated with social disadvantage (e.g., low income) are known as health inequities (Braveman, 2006).

Although Canadians, on average, enjoy good health, there is evidence of significant health inequities (CIHI, 2016; PHAC, 2008; PHAC, 2016). Individuals from advantaged neighbourhoods are more likely to live longer than those from average or disadvantaged neighbourhoods (Wilkins, Berthelot, & Ng, 2002). Fang et al. (2009) found the highest prevalence of chronic disease risk among lower-income groups in several provinces.

In Manitoba, there is evidence of health inequities between high-income groups and those from low-income backgrounds, including Indigenous[1] peoples. Reports from the Manitoba Centre for Health Policy (MCHP) have documented that Indigenous peoples have lower life expectancies and higher mortality rates than others living in the province (Martens et al., 2002),

[1] The National Métis Council, the Assembly of First Nations, and the Inuit Tapariit Kanatami have rejected the word "Aboriginal," arguing it is a governmental artifact (J. Lavoie, personal communication, June 7, 2017). Although the term Aboriginal was used by some of the research participants (and in some of the historical documents) in this research, the term Indigenous will be used as it is currently endorsed by Canadian Indigenous organizations. The term Aboriginal will only be used if it is involved in directly quoting/summarizing literature.

and people living in low-income areas have higher mortality rates and are more likely to suffer from physical and mental health issues (Fransoo et al., 2009; Fransoo et al., 2013). In addition, Métis peoples have higher mortality rates compared to other Manitobans (Martens et al., 2010a).

Researchers in Manitoba have also identified differences in health service usage. For example, those from lower socioeconomic groups are less likely to benefit from prenatal care compared to those from more socially advantaged groups in the city of Winnipeg (Heaman, Green, Newburn-Cook, Elliott, & Helewa, 2007). This finding is consistent with research suggesting that health promotion activities often do not consider the socioeconomic living conditions of potential participants, leading to low uptake of services (see Rice, 2011 for a review). On the other hand, research exploring general health service usage often reports people from lower-income groups using health services at a higher rate compared to higher-income groups (Fransoo et al., 2013).

There is evidence of growing social inequalities in Manitoba (Brownell et al., 2003; Fransoo et al., 2013; Martens et al., 2010b) and poverty rates that are significantly higher than the Canadian average (PHAC, 2008). The first report from the Chief Provincial Public Health Officer on the health status of Manitobans identified several health inequities in Manitoba (Kettner, 2011). For example, infant mortality and childhood injury rates follow a gradient based on neighbourhood income in both urban and rural Manitoba. The 2015 update of this report includes specific statistics highlighting income-related health inequities and a short section on health equity. This focused section discusses the definition of health equity, consequences of health inequity, and provides links on taking action on the SDOH. This report also highlights income and social status as the "single most important determinant of health" (Routledge, 2015,

p.10). Several researchers have observed health effects of income, even after adjusting for other factors (for a review, see Braveman & Gottlieb, 2014).

The ability to address inequities requires routine monitoring that is focused on health inequities and the SDOH (WHO, 2008). Community health assessments (CHA) are one of the more formalized processes for examining the health of the population and have the potential to be used to identify and address existing health inequities (Manitoba Health and Healthy Living, 2009) given the information is used in regional strategic planning. In Manitoba, CHA reports, which are mandated by legislation and completed by the Regional Health Authorities (RHAs), involve a systematic approach to the collection, analysis, and interpretation of information about the health of populations in consultation with the communities (Manitoba Health and Healthy Living, 2009). In practice, it is common for health assessments to focus on aggregate statistics on health status instead of providing a more detailed analysis of health distribution by SDOH using a population health conceptual framework. Attention to the SDOH and health inequities is often missing or ignored in the public policy process (Exworthy, 2008; Raphael, Bryant, & Curry-Stevens, 2004), or is misused in health assessments (Austin, Tudiver, Chultern, & Kantiebo, 2007). Valid and reliable qualitative information is necessary to fully understand the SDOH and to address growing inequities through community empowerment (WHO, 2008).

The RHAs in Manitoba were mandated to conduct their first comprehensive CHAs in 1996, which were completed in 1997/1998 and evaluated in 1998 (Community Health Assessment Unit, 1998). The second comprehensive CHAs were completed between 2000 and 2004 and an evaluation was completed in 2006 (Shooshtari & Sparling, 2006). Both evaluations explored the activities of CHA through a process evaluation lens. Although CHA reports in Manitoba provide important information for regional health planning purposes, a comprehensive

income-related health equity (IRHE) focused review of the process has never been undertaken. In the present study, applying an IRHE lens to CHA sought to explore how IRHE was considered within key processes such as data, community consultation and partnerships. No studies have explored regional health assessments in Manitoba through a health-equity lens, or more specifically, an income-related health equity lens.

Several factors can be thought to facilitate action and other factors appear to act as barriers for considering IRHE in processes, such as the comprehensive CHAs. According to the environmental scan by the NCCDH (2011), there are individual, organizational, and system-level factors that could lead to an integration of health equity into practice. For example, leadership was one of the organizational-level factors identified in the scan as influencing health equity. Several other researchers have examined broad-level individual, organizational, and system-level factors (Beckfield & Krieger, 2009; Coelho & Shankland, 2011; Kouri, 2008; Raphael & Brassolotto, 2015), but these factors have not been explored in depth. A research agenda that prioritizes health services and health system factors and barriers associated with health equity practice is required to decrease health inequities (Ostlin et al., 2011). Braveman, Egerter, and Williams (2011) call for more research exploring the barriers and facilitators concerning the "political will to translate knowledge into effective action" (p. 393). Further detail about facilitators and barriers for CHA are described in Chapter II. This dissertation builds on the existing literature and serves as a retrospective case study to explore CHA through an IRHE lens, and sought to identify barriers and facilitators to applying such a lens.

Research Objectives and Questions

Given the clear relationship between low income and health outcomes (Fransoo et al., 2009; Fransoo et al., 2013; MacKinnon, 2010; Martens et al., 2010b), and because low income is

correlated highly with concepts such as education and employment (Mikkonen & Raphael, 2010), this study focused on income as the main driver of health inequities by exploring the third CHA process through an IRHE lens. The third CHAs were conducted between 2004 and 2010 and were the first assessments where many of the health indicators were reported by income quintiles. Additional information about the CHA process can be found in Chapter II.

An IRHE lens in this research context means examining and exploring key parts of the CHA (e.g., indicators, partnerships, community consultation) to identify if IRHE was considered as part of the assessment process. This lens is similar to health equity lenses identified in the pre-existing literature (Hebert-Beirne, Felner, Castaneda, & Cohen, 2017; O'Neill et al., 2014; Wong et al., 2011). In applying a similar lens to the CHA, the purpose of the present retrospective case study was two-fold: (1) to explore how RHAs incorporated an IRHE lens in their third comprehensive CHA; and (2) to identify the facilitators and barriers to incorporating an IRHE into the third CHA processes within Manitoba's health regions. The specific research questions associated with the objectives were as follows:

1a. How did regional-level CHA processes involve an income equity lens in reporting on the selected number of health indicators?

1b. How did regional-level CHA processes involve low-income populations in the community engagement process?

2a. How did regional-level CHA processes involve partners who work with low-income populations?

2b. What are the individual, organizational, and system-level factors (e.g., knowledge, leadership, political priorities) that support or create barriers for an IRHE lens in the regional CHA?

Chapter II: Literature Review and Conceptual Frameworks

This chapter provides an overview of the relevant literature relating to the topics of SDOH, health equity and health inequality, and CHA. The chapter includes an overview of the frameworks used to measure health inequities, measurement challenges, and Canadian initiatives in the area of health inequities and indicators. The general literature on CHA is summarized along with a discussion of the CHA in the Manitoba context and from an evaluation perspective. Finally, barriers and facilitators identified in the literature relating to health equity-based practice, such as engaging in a CHA that is IRHE-focused, are explored.

Social Determinants of Health

The SDOH are the "economic and social conditions, or living conditions, that shape our health" (Raphael, 2010, p.7). The association between these factors and overall health can be traced back to the documentation of health inequities by social class in major reports such as *The Black Report* (Black, Morris, Smith, & Townsend, 1992). Since this foundational report, an overwhelming amount of evidence has accumulated that supports the importance of social and economic conditions to overall health (Braveman & Gottlieb, 2014; Siegrist & Marmot, 2006; WHO, 2008). Several lists and models have been developed to identify and organize the SDOH factors (e.g., CCSDH, 2015; Diderichson, Evans, & Whitehead, 2001; Evans & Stoddart, 1990; Lucyk & McLaren, 2017; Mikkonen & Raphael, 2010; Ministry of Health, 2002). One of the more commonly used lists can be found in Raphael (2009) where 14 SDOH are mentioned, including gender, income, social exclusion, and unemployment. Although lists are helpful, conceptual models and frameworks of the SDOH provide more information about how different factors work together to lead to different outcomes. Solar and Irwin's (2010) model is

particularly relevant as it also includes upstream factors such as social and public policies in addition to intermediary determinants.

The WHO Commission on the SDOH conceptual framework (Solar & Irwin, 2010; depicted in Figure 1) builds on previous models and provides more detail on important structural components, such as socioeconomic and political context, the health system, social policies, and values. Overall, the framework shows how the socioeconomic and political context influences socioeconomic position, which can then lead to social stratification on a number of factors such as income, occupation, education, ethnicity, gender, and social class. Interest in the structural determinants of health inequities is becoming more common as researchers are recognizing the critical role of these factors (Beckfield & Krieger, 2009; Raphael, 2015). These structural factors (policies, values, and culture) have also been linked to equity-focused health services and programs (Gardner, 2008; Kouri, 2008). The SDOH *paradigm* places socioenvironmental factors (such as income) as critical in contributing to health and, consequently, any effort to reduce inequities in health should focus on addressing these root causes. In fact, income is the strongest indicator of health (Raphael, 2016; Routledge, 2015).

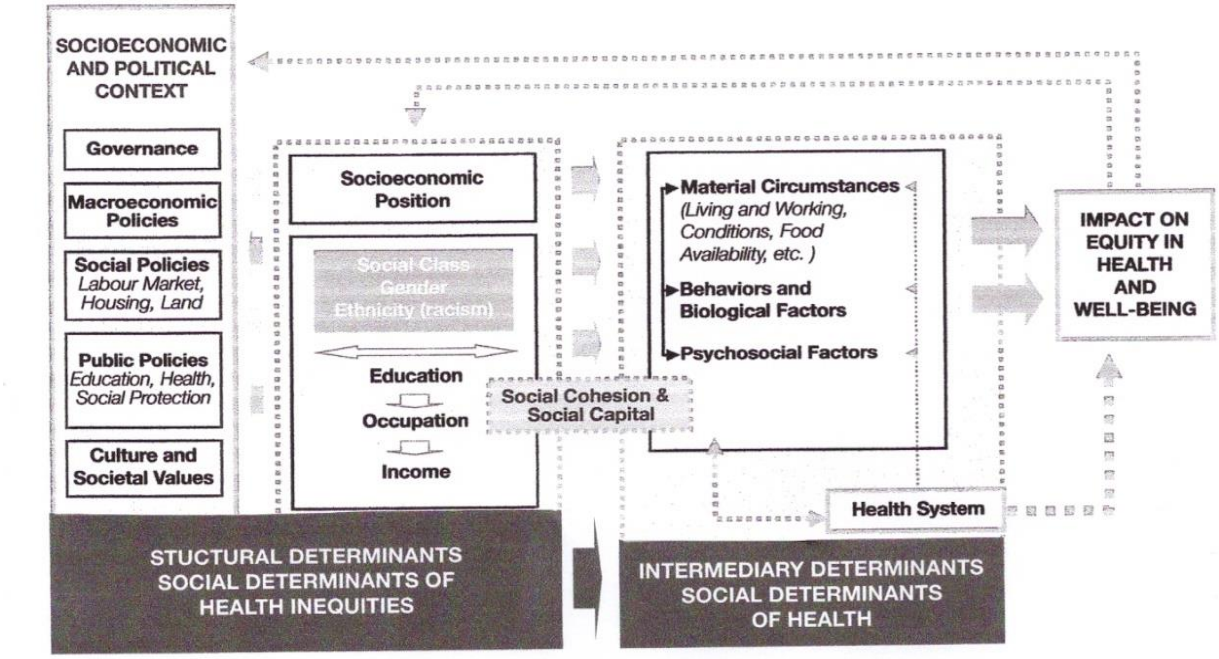

Figure 1. Commission of the Social Determinants of Health (SDOH) Conceptual Framework. Reprinted from Solar and Irwin (2010).

The concept of intersectionality is an important adjunct to this discussion because SDOH and their pathways to health inequities are complex (Braveman & Gottlieb, 2014). According to Bowleg (2012), intersectionality is a "theoretical framework that posits that multiple social categories intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level" (p. 1267). For example, the experience of someone from a lower income area may differ significantly from the experience of someone with lower income and other layers of social disadvantage. Intersectionality will be discussed further in the last chapter of this thesis.

Health Inequity

For years, authors have debated how best to define *health inequity* (Braveman & Gruskin, 2003; Braveman, 2006; Whitehead, 1991). The debate has been stimulated by the increasing need to develop a definition that is conducive to measurement, while ensuring that these

differences are highlighted as unjust (Braveman, 2014). One of the first working definitions of health inequity described as the concept as "differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust" (Whitehead, 1991, p.220). This definition was welcomed due to its clarity and accessibility, but was also criticized for its vagueness and lack of guidance on measurement (Braveman, 2006). In an attempt to improve the definition of health inequity, Braveman and Gruskin (2003) suggested that "equity in health is the absence of systematic disparities in health (or in the major SDOH) between groups with different levels of underlying social advantage/disadvantage" (p.254).

Braveman (2006) defined health inequities as "potentially avoidable differences in health (or in health risks that policy can influence) between groups of people who are more and less advantaged socially; these differences place socially disadvantaged groups at further disadvantage on health" (p.180). This definition removed some of the subjectivity from labelling a difference in health as *unfair* by focusing on the potential to avoid differences in health or health risks. Another advantage of this definition is that it better reflects the issues of the social gradient in health. Some authors use the term *health inequality* (i.e., differences in health) synonymously with health inequities, which is problematic because there are significant differences in values and implications associated with these terms (NCCDH, 2013b). Inequality refers to conditions being unequal in terms of numbers, but this may be considered fair. One would not be surprised to see differences in health conditions when comparing younger and older population groups. Inequity is more about unfairness. For example, the finding that life expectancy can differ quite significantly between groups within Manitoba (Fransoo et al., 2013) can be considered inequitable. Thus, in the context of this dissertation, Braveman's (2006) definition of the term health inequity will be used.

Frameworks for Measuring Health Inequities

Although there has been much interest in health equity and measuring health equity, a lack of action on measurement remains (Costa-Font & Hernandez-Quevedo, 2012; WHO, 2008. The work of Braveman (2003; 2006), Asada (2005; 2007), and Asada, Hurley, Norheim, and Johri (2014) provide contributions to the area of measurement of health equity (this work is summarized below). In addition, the WHO (2008) developed a comprehensive national health equity surveillance system that provides guidance on indicators of health inequities. Canada has made some progress in applying this framework in the development of a national set of health inequity indicators (Population Health Promotion Expert Group & Healthy Living Issue Group, 2009).

The strength of Braveman's work is that her most recent definition is one that guides measurement (Braveman, 2006). She suggests that the first thing that should be done in this process is choosing the health indicator of concern and categorizing people by social strata. Rates of health in each social group should then be calculated and displayed graphically. The last steps include the development of rate ratios and rate differences and a plan to examine these over time. Several experts recommend that rate ratios and rate differences be used with caution as results may vary depending on which method is used (Anand, Diderichsen, Evans, Shkolnikov, & Wirth, 2001; Moser, Frost, & Leon, 2007). Lorenz curves and Gini coefficients have proven useful in addressing some of these gaps in addition to providing a visual picture of health inequities, which can be more easily understood. A lorenz curve is the "graphical representation of inequality" and the gini coefficient is the mathematical measurement of health inequities in the curve (Martens et al., 2010b, p. xix). Asada (2007) summarized the top five health inequality measures. These measures include range measures such as the absolute difference and disparity

rate ratio, the concentration index and the generalized concentration index, the slope index of inequality and the relative index of inequality, the gini coefficient, and the WHO Health Inequality Index. An index was also used by Hebert-Beirne et al. (2017) as it "provides a more complex, multidimensional measure of community socioeconomic conditions than provided by individual measures such as income or employment alone" (p. 372).

The main contribution of Asada's (2007) work is that it provides a theoretical and analytical framework for measuring health inequities that reflects moral concerns. These questions are not always addressed by organizations that are measuring health inequities because prompt attention to political issues may be given priority over complex discussions of morality and philosophy. Asada et al. (2014) proposed a three-stage approach to measuring health inequities: (1) measuring univariate health inequality; (2) measuring univariate health inequity; and (3) measuring bivariate health inequities. The authors acknowledge the continuing challenge in this field, particularly the ongoing debate on defining the term "unfair" and the difficulty of managing ethics, methods, and policy. Their approach is flexible in that it allows for a variety of definitions of health inequity and includes information on univariate health inequality, univariate health inequity, and bivariate health inequities. Asada et al. also recommended policy-relevant groupings for analysis involving two variables, also known as bivariate analysis.

Another framework, known as the National Health Equity Surveillance System, was put forth by the Commission on the Social Determinants of Health (see Figure 2; WHO, 2008). This framework can be viewed as an extension of Braveman's model in a practical sense, and suggests that measures of morbidity and mortality should be stratified by sex, at least two social markers (e.g., income/wealth, ethnicity, race) and at least one regional marker. Summary measures of absolute health inequities (e.g., risk differences, actual rate trends, and population

attributable risk) and relative health inequities (e.g., rate ratios) between social groups are also recommended. Finally, the framework encourages the use of good quality data regarding Indigenous peoples, whenever available.

HEALTH INEQUITIES

Include information on:

health outcomes stratified by:
- sex
- at least two socioeconomic stratifiers (education, income/wealth, occupational class);
- ethnic group/race/indigeneity;
- other contextually relevant social stratifiers;
- place of residence (rural/urban and province or other relevant geographical unit);

the distribution of the population across the sub-groups;

a summary measure of relative health inequity: measures include the rate ratio, the relative index of inequality, the relative version of the population attributable risk, and the concentration index;

a summary measure of absolute health inequity: measures include the rate difference, the slope index of inequality, and the population attributable risk.

HEALTH OUTCOMES

mortality (all cause, cause specific, age specific);

ECD;

mental health;

morbidity and disability;

self-assessed physical and mental health;

cause-specific outcomes.

DETERMINANTS, WHERE APPLICABLE INCLUDING STRATIFIED DATA

Daily living conditions

health behaviours:
- smoking;
- alcohol;
- physical activity;
- diet and nutrition;

physical and social environment:
- water and sanitation;
- housing conditions;
- infrastructure, transport, and urban design;
- air quality;
- social capital;

working conditions:
- material working hazards;
- stress;

health care:
- coverage;
- health-care system infrastructure;

social protection:
- coverage;
- generosity.

Structural drivers of health inequity:

gender:
- norms and values;
- economic participation;
- sexual and reproductive health;

social inequities:
- social exclusion;
- income and wealth distribution;
- education;

sociopolitical context:
- civil rights;
- employment conditions;
- governance and public spending priorities;
- macroeconomic conditions.

CONSEQUENCES OF ILL-HEALTH

economic consequences;

social consequences.

Figure 2. WHO's Comprehensive National Health Equity Surveillance Framework. Reprinted from WHO (2008).

Other researchers have explored health equity, measurement, and research. Tugwell et al. (2006a) assessed the capacity and commitment for equity-focused research in low and middle income countries. The authors found only a small number of countries engaged in equity-focused research, and concluded that all countries should work to invest in a minimum level of capacity to improve health and address health inequities. Tugwell et al. (2006b) also explored evidence-based tools to reduce health inequities, such as the *Ottawa Equity Gauge*. The gauge includes 4 pillars: assessment and monitoring (of qualitative and quantitative data), advocacy, community empowerment, and intervention. Similar to the surveillance system by WHO (2008), O'Neill et al. (2014) recommended a framework called PROGRESS; this acronym stands for Place of residence, Race/ethnicity/culture/language, Occupation, Gender/sex, Religion, Education, Socioeconomic status and Social capital. PROGRESS may help researchers identify health inequities, although context plays a role in determining which stratifying factors are most important.

Statistics alone, although helpful, do not explain the lived experiences of people. Qualitative data can be quite powerful in understanding the SDOH and their distributions (Marmot & Friel, 2008; WHO, 2008). Inviting people to share their experiences can be empowering, especially to less-advantaged groups, and ultimately leads towards a reduction in health inequities (WHO, 2008). The collection and analysis of qualitative data "strengthens the CHA in that it allows for a broader examination of the socioecological context of the population and provides insight that individual-level data and/or public health surveillance system data cannot" (Hebert-Beirne et al., 2017, p. 378).

Health inequity measurement challenges. Some challenges exist for the application of these frameworks regarding data availability and quality. For example, although many variables

used as social markers to measure health inequities are relatively easy to define and measure (e.g., sex), some variables (e.g., race/ethnicity) can be challenging to define through an equity lens. Other variables, such as social capital, social cohesion and wealth, present unique challenges as they are often difficult to measure, so they are less frequently used in the literature (Adams & White, 2003; Braveman et al., 2011; Wirth et al., 2006). Some of these variables do not follow an obvious social hierarchy (e.g., occupation) and extra time and attention is necessary to address health inequality considerations. While some researchers agree that small area data has potential in investigating health inequalities (e.g., Wolfson & Rowe, 2001), small numbers can lead to flawed results and interpretations. The potential consequences and challenges of examining small area data, especially survey data, for the identification of health inequities, must be considered. Statistical strategies can be employed to address some of these issues. For example, MCHP uses statistical testing to estimate rates and 95% confidence intervals when exploring differences in rates of diseases, or other health outcomes for different populations or regions based on small area data (Fransoo et al., 2009). But even such methods cannot overcome absolute gaps in available data, such as when suppression is used to protect confidentiality, leaving no useful data for describing discrete regions.

Measures of poverty are also challenging to implement. Canada does not have a government-endorsed poverty line. Low income is commonly defined by the Low Income Cut Off (LICO), which distinguishes those families who spend a higher proportion of their annual household income on the basic necessities (i.e., food, clothing, and shelter) compared to an average family (Statistics Canada, 1999). The Low Income Measure (LIM) refers to families that have an after-tax income lower than 50% of the median income for all families. The LIM is often used when making international comparisons of poverty. The Market Basket Measure is also

used to measure poverty, but it is different from the LICO as it is an absolute measure of poverty; it includes after-tax income, and it adjusts for the cost of living. Many researchers have spent significant time debating these various measures of poverty, where others have taken the stance that poverty should be discussed as broader than a statistic (Levitas, 2003). For the purposes of this thesis, "low income" will be consistent with the CHA-endorsed definition, which used the LICO.

Researchers need to be clear and focused on their indicators and measures of social markers as they can have a significant effect on health inequities (Siegrist & Marmot, 2006). For example, employment tends to be a better predictor of health inequities for men, and social standing tends to be a better predictor of inequities for women (Siegrist & Marmot, 2006; Williams, 2008). A review of the literature on socially disadvantaged populations showed a strong and consistent relationship between the position on the social hierarchy and health (Lemaire, 2010b), but also demonstrated a significant lack of clarity on what researchers meant by "social position/socio-economic status" and a lack of congruency with their definitions and the companion measurements. Of the 61 articles reviewed, only five provided a definition of the term 'socially disadvantaged' and there was a large variability on how socioeconomic status was measured. Some researchers have found that using self-reported health to measure the health concentration index, a measure to health inequity assumed to be driven by socioeconomic status, may lead to an over-statement of health inequities (e.g., Nesson & Robinson, 2017). For example, individuals tended to assess their health more positively as their income level increased. The health concentration index is "the most common metric used to measure income-related inequality in health" (Nesson & Robinson, 2017, p. 4). For these reasons, researchers are

calling for an "interdisciplinary consensus on the measurement of health" (Costa-Font & Hernandex-Quevedo, 2012, p. 203).

Canadian Initiatives Related to Measuring Health Inequity

Taking action to measure inequities is part of a comprehensive strategy to address them. Without valid and reliable information on health inequities in the population, it is challenging to monitor and track changes over time. Many countries, including Canada, do not have a formal national health equity surveillance system that is actively in operation. Of particular significance was the development of the *Health Disparities Task Group of the Advisory Committee on Population Health and Health Security* (HDTG-ACPHHS) in 2004. This committee held a forum on the need for indicators of health inequalities and produced a report with various recommendations. One of these recommendations was for health disparities to be described in terms of gender, geography, Indigenous Peoples, and socioeconomic status (Health Disparities Task Group, 2005). In addition, some progress in the development of health inequity indicators has been made in several provinces and in other national contexts during the past decade (CIHI, 2008; CIHI, 2010; Martens et al., 2010b; Provincial Health Services Authority, 2016; PHAC, 2008).

In response to the recommendations, the Public Health Network Council asked one of their task groups, the Population Health Promotion Expert Group (PHPEG), to develop a list of pan-Canadian indicators of health inequalities. The Public Health Network Council is comprised of Federal/Provincial/Territorial government representatives responsible for public health and governing the Public Health Network. In the summer of 2009, a report highlighting potential indicators for health inequalities was released (PHEPG & Healthy Living Issue Group, 2009). The indicators outlined in the report were based on the comprehensive national health equity

surveillance framework suggested by the Commission on the Social Determinants of Health (WHO, 2008). In early 2010, the report was approved by the Public Health Network Council with the expectation that sub-groups of this process would work with stakeholders to implement some of the report's recommendations. The *Health Inequalities Data Tool*, a web-based, interactive resource containing disaggregated data at multiple jurisdictional levels for more than 70 indicators of inequalities in health status and health determinants, was released in the spring of 2017. This data tool is a joint initiative of PHAC, the Pan-Canadian Public Health Network, Statistics Canada and the Canadian Institute of Health Information (K. Serwonka, personal communication, June 16, 2017), and provides an array of indicators and stratifying variables that are consistent with recommendations from the literature in regards to identifying health inequities (see *Frameworks for Measuring Health Inequities* from earlier in Chapter II). Unfortunately, the tool would have more impact if it included terminology such as *health inequities* compared to *health inequalities*. However, the website (where the tool can be accessed) makes the qualification that many health differences are "…attributable to the unequal distribution of the social and economic factors that influence health and exposure of societal conditions and environments largely beyond the control of the individuals concerned" (Pan-Canadian Health Inequalities Data Tool, 2017). A national-level narrative report on key health inequalities in Canada (based on a shortlist of 20 indicators drawn from the *Health Inequalities Data Tool*) is due for publication in 2018 (M. Betancourt, personal communication, August 29, 2017).

Taking steps to ensure health equity is measured at local, provincial, and national levels is clearly important. According to Nolen et al. (2005), countries that want to address these issues must be able to provide valid data on health inequities and be prepared to establish clear criteria

for when a difference in health becomes a health inequity. Taking action on health inequities requires effort and actions that takes into account other factors (i.e., meaningful involvement of the community) outside of measurement and monitoring.

Community Health Assessment (CHA)

CHA is generally defined as a dynamic process of data collection and analysis used to identify assets and needs to improve the health of the community through some form of action (Friedman & Parrish, 2009; Irani, Bohn, Halasan, Landen, & McCusker, 2006; Manitoba Health and Healthy Living, 2009; PHAC, 2008; Sharma, 2003; Spice & Snyder, 2009). A common theme in the literature is that the involvement of the community, including partnerships, is key to the process of health assessment (Baisch, 2009; Hancock, Labonte, & Edwards, 1999; Sharma, 2003; WHO, 2008).

The level and degree of community involvement varies depending on several factors, such as institutional perspectives, the characteristics of the community itself (Gardner, 2006), resources, and staff capacity. The process of motivating communities to become involved in community health might represent a more important outcome than the overall process of health assessment (Curtis, 2002). The community voice provides context to health data, which makes it an important component of identifying and understanding health inequities (Sen, 2001). Socially disadvantaged populations are less likely than more advantaged groups to express their concerns over health issues, which may perpetuate growing health inequities (Clark et al., 2003; Duffy, 2008; WHO, 2008).

Community participation in the health sector has been growing, and while there was a paucity of published theoretical frameworks guiding this practice (Maloff, Bilan, & Thurston,

2000), some researchers have done significant work in this area (Abelson et al., 2016). However, as identified by the NCCDH (2013a), "…the actual practice (of community engagement) remains unclear and even intimidating to many public health practitioners" (p. 3). Traditional engagement techniques (e.g., community forums, town halls) do not work with hard-to-reach populations (Fagan, 2008; Gardner, 2006; Niederdeppe, Kuang, Crock, & Skelton, 2008) as they often have limited access to technology, transportation, and stable housing. Future research is necessary to develop models and methods for engaging socially disadvantaged populations in activities such as health assessment (Gardner, 2006). One of the recommendations from the third evaluation of the Manitoba CHA process was to prepare a standardized tool for assessing CHA community engagement activities in future CHA cycles (Community Health Assessment Evaluation Working Group, 2013).

Involving and engaging community members in discussing health issues, in addition to asking for their input in health decisions, can theoretically have positive impacts, such as social inclusion and empowerment (Baillie et al., 2004; Hancock et al., 1999; Rifkin, 2003; WHO, 2008). However, the reality is that most community involvement initiatives do not result in such a shift in power (Arnstein, 1969; Rifkin, 2003). Pennel, McLeroy, Burdine, Matarrita-Cascante, and Wang (2017) found that very few hospitals engaged a broad array of community stakeholders and community members and that involvement lacked meaningful participation in the health assessment process.

Partnerships are another important component of the assessment process. Partnerships can be considered joint working arrangements where partners are otherwise independent bodies cooperating to achieve a common goal (Audit Commission, 1998). Similar to the gap in knowledge and theoretical frameworks with community involvement in the health sector,

evidence for what makes an intersectoral partnership effective seems to be sparse (McMurray, 2007; Ndumbe-Eyoh & Moffatt, 2013). Recent research indicates that new studies should be focused on established best practices for intersectoral approaches to addressing health inequities (Collins & Hayes, 2013). Some general models that identify key success factors for effective partnerships have been proposed (Brinkerhoff, 2002; Dowling, Powell, & Glendinning, 2004; Halliday, Asthana, & Richardson, 2004; Quantz & Thurston, 2006). Some examples of process indicators include trust, recognized need and purpose of partnership, accountability, communication, structural supports, and leadership. Outcome indicators of effective partnerships include value-added features due to the partnership (e.g., increased capacity, linkages with other programs, changes to service delivery, multiplier effects), partnership identity, and satisfaction.

More recent research on CHA has explored the utility of academic partnerships within the process (Caron & Tutko 2013; Chudgar et al. 2014; Hebert-Beirne et al., 2017). For example, Hebert-Beirne et al. (2017) found that engaging qualitative researchers in their assessment process enriched their CHA and provided training for public health practitioners. Another example of CHA being supported by academic collaboration was *The Need to Know Team* based out of Winnipeg, Manitoba. *The Need To Know Team* is comprised of researchers from MCHP and representatives from the RHAs and Manitoba Health. This team was focused on fostering relationships, creating relevant knowledge and research and working to inform policy and decision-making. Although the resources available to support this team have significantly decreased since 2011, an earlier evaluation found that the networking and workshops provided team members with the opportunity to build on research skills that were helpful for CHA processes (Bowen, 2004). The evaluation provided evidence that the overlap of team members on both *The Need to Know Team* and Community Health Assessment Network (CHAN;

described below) was helpful. For example, this collaborative network created synergy between the CHA teams in the RHAs and *The Need to Know Team* as they both developed and used the RHA Atlas reports. The RHA Atlas reports provide information and indicators which inform the CHA process.

Community health assessment and evaluation. CHA is widely recognized as an essential part of the public and population health portfolios at several levels of government, yet is rarely evaluated (L. Carley, personal communication, November 16, 2010; C. Sanford, personal communication, November 16, 2010; D. Seskar-Hencic, personal communication, November 12, 2010). The lack of evaluation is not specific to regions in Canada, but is also lacking in the US (Friedman & Parrish, 2009; Myers & Stoto, 2006; Spice & Snyder, 2009). In their review, Myers and Stoto noted that they "found no rigorous, systematic reviews of community health assessments, nor any comprehensive summaries of community health assessment strengths, weaknesses, and outcomes" (2002, p.43). Over a decade later, researchers are still reporting that there remains only a small number of published evaluations examining outcomes and impact of the CHA process (Gutilla, Hewitt, & Cooper, 2017). In addition to a lack of evaluations of CHA, research has shown a minimal focus on health equity considerations in CHA approaches (see Lemaire, 2010a).

Community health assessment and health equity. A comprehensive literature review showed that the purpose of CHA varies widely (Lemaire, 2010a) and the majority of the articles reviewed were categorized as *needs assessments*. The analysis revealed that only two articles (13.3% of all articles), with one from Canada (Hancock et al., 1999) and the other from the United States (Jack & Holt, 2008), made significant references to health inequities within the CHA process. Only a handful of articles focused on socio-environmental indicators of health – a

cause for concern in light of the evidence that social factors are of key importance in health outcomes (WHO, 2008; Vissandjee, Des Meules, Cao, Abdool, & Kazanjian, 2004). Of those who identified more socio-environmental indicators, some creative and innovative techniques were discussed. For example, Galea, Ahern, and Karpati (2005) derived a socioeconomic vulnerability variable based on several indicators that allowed them to identify health inequities. Asada, Yoshida, and Whipp (2011) proposed a summary measure (Extended Gastwirth Index) that included multiple, policy-relevant health inequalities. The inclusion of geographic information systems (GIS) and maps (Basara & Yuan, 2008; Marko, Whitehead, Clarke, Ugolini, & Muhammad, 2011; Martens et al., 2010b) was also considered a promising method for highlighting inequities in a visual format. Martens et al. (2010b) explored health inequities over time using gini coefficients and lorenz curves. In addition, only 3 of the 15 reviewed articles involved socially disadvantaged populations in the use of the findings. The traditional needs assessment approach to CHA may have its limitations in identifying and taking action on health inequities.

More recent research exploring CHA shows a movement towards action-oriented models, such as data synthesis and community health improvement planning (Bender, 2017; Erwin et al., 2013; Wetta, Pezzino, LaClair, Orr & Brown, 2014). Community health improvement planning "describes how the health department and the community it serves will work together and improve the health of the population of the jurisdiction that the health department serves" (Bender, 2017, p. S6). Only one publication was found in the literature where an explicit health equity lens to the CHA process was applied (Hebert-Beirne et al., 2017). The authors of this article used a health equity lens to their CHA in order to better understand how residents in the US perceive health inequity in their neighborhoods. Community areas were chosen based on the

Economic Hardship Index – an index based on census-level data that incorporates several socioeconomic variables such as crowded housing, income level, and high school graduation. Qualitative data was collected using focus groups and oral histories. Oral histories are "appropriate for providing a complex and contextual narrative view detailing the opinions of individuals from a set community or group" (Hebert-Beirne et al., 2017, p. 373). Academic-led qualitative inquiry strengthened their CHA process and allowed for a "…personalization of experience of health inequities that may be missed in traditional health assessment methodologies" (Hebert-Beirne et al., 2017, p. 378). Although this research provided important information about how community members from lower socioeconomic areas perceive health inequities, it is limited by its small sample size and lack of generalizability.

CHA in the Manitoba context. Comprehensive CHA are *needs-assessment* oriented approaches to exploring the health of the population. The CHA process in Manitoba came about with the legislation creating the original RHAs. The RHA Act (1996) states that, in carrying out its responsibilities, each RHA shall: "promote and protect the health of the population of the health region and develop and implement measures for the prevention of disease and injury; assess health needs in the health region on an ongoing basis; and develop objectives and priorities for the provision of health services which meet the health needs in the health region and which are consistent with provincial objectives and priorities".

CHA is an on-going process leading to the production of a comprehensive report which supports and informs the five-year strategic planning requirement in all health authorities (see Figure 3). The CHA process consists of three components: technical (the use of analytical tools and technologies to generate evidence); social (it involves members of the community and health care providers in decision-making); and ethical [it explores issues of "the worth of health and

life, societal fairness and resource priorities" (Manitoba Health and Healthy Living, 2009, p. 6)]. Therefore, the process in Manitoba not only explores the health of the community in general, but a specific focus on the involvement of the community, in addition to notions of health and fairness.

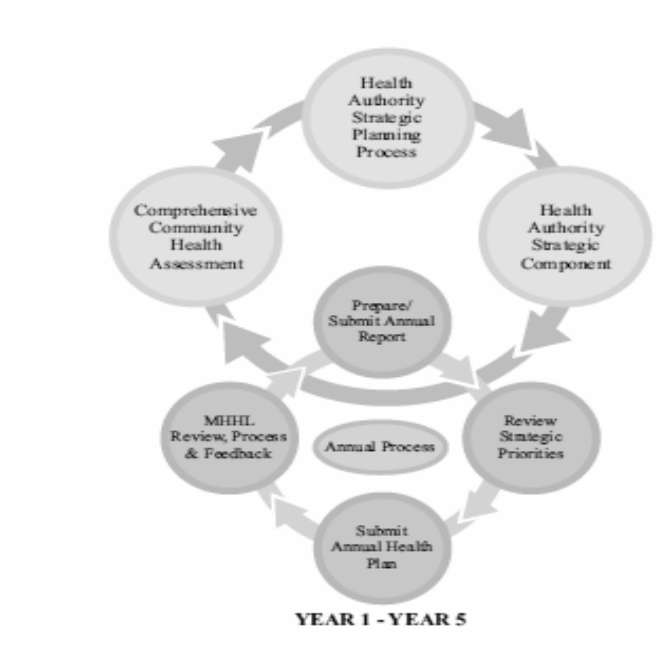

Figure 3. CHA and the Health Planning Cycle in Manitoba. Reprinted from Manitoba Health and Healthy Living (2009).

A CHA Unit was created at Manitoba Health shortly after the creation of regionalization to support health authorities in undertaking this work. The first CHAs were completed shortly after regionalization in 1997/98, and were unique to the new regions. Currently, the CHA process is coordinated provincially by the CHAN. This network is a province-wide collaborative group comprised of RHAs (including CancerCare Manitoba), MCHP, and Manitoba Health, and was created to support more collaborative planning for the second CHA cycle (2004), and CancerCare Manitoba (CCMB) was included in CHA for the first time. Manitoba Health, through its Health Systems Development Branch, oversees the health assessment process and

provides support to regional-level staff (i.e., engagement and involvement). Manitoba is unique in that it is the only province in Canada to have a provincially coordinated and consistent CHA process (Health System Development Branch, 2012). Several CHAN working groups are responsible for selecting a core set of indictors for the purpose of comprehensive CHA; methods for community engagement/involvement; and evaluation. CHA results can help to identify health inequities in the regions (e.g., higher rates of teenage suicide rates in Northern regions in Manitoba), which can then set the stage for strategic planning that includes addressing the SDOH (e.g., education, preparing more culturally-appropriate and accessible mental health services). Exploring how identified health inequities were addressed in regional health plans was outside the scope of this thesis.

To date, there have been four cycles of the CHA process completed in Manitoba (see Table 1). For the third cycle, further refinements to processes and indicators continued under a coordinated provincial approach. The third cycle was the first to report health indicators by income quintile, wherever possible. As will be described in Chapter V, results of this study showed that there was limited attention to IRHE-focused indicators and processes in the third CHA cycle. The fourth CHA cycle and companion reports were completed in 2015. As was highlighted in Oickle (2015, June 29), the RHAs in Manitoba have made some progress in taking account of equity considerations in their CHA reports. For example, Prairie Mountain Health RHA (2015) used measures such as the disparity rate ratio and the disparity rate difference to quantify existing health inequities. The systematic use of these measures and a number of other recommendations are made in Chapter VI.

Table 1

Community Health Assessment (CHA) Cycles and Related Details

Cycle Number	Start Date	End Date	Key Details	Evaluation
1	1996	1997/1998	Regionalization in 1996. Legislated requirement of CHA. CHAN developed after the 1997/1998 reports to further support this work.	Process evaluation in 1998 (Community Health Assessment Unit, 1998).
2	2000	2004	Five year cycle established due to recommendations of 1998 evaluation.	Process evaluation in 2004 (Shooshtari & Sparling, 2006).
3	2004	2010	Delayed reports due to pandemic planning. First cycle where many of the health indicators were reported by income quintiles.	Outcome evaluation in 2009 including development of logic model (Community Health Assessment Evaluation Working Group, 2013). PhD student starting thesis with IRHE focus.
4	2011	2015	RHAs amalgamated in 2012 (from 11 to 5). Planning cut short by one year due to delay of previous cycle.	No evaluation although recognition from NCCDH of attention to health inequities (Oickle, 2015).

Three evaluations of the CHA process in Manitoba have been completed (Community Health Assessment Evaluation Working Group, 2013; Community Health Assessment Unit, 1998; Shooshtari & Sparling, 2006). Two evaluations focused on the process of health assessment. These evaluations focused on the activities and actual operations of CHA to draw conclusions about strengths and areas for improvement. The results of these evaluation reports

confirmed the resource-intensive nature of CHA work and the need for ongoing support and funding for such activities. Several suggestions were provided for improvement, such as support for CHA staff through capacity building, support for the community engagement process, broader consultation with external partners (e.g., Addictions Foundation of Manitoba, Aboriginal Health Leaders, Family Services), consultation with partners at an early stage of planning, and enhancement of knowledge exchange tools. The most recent evaluation, which was focused on outcomes, was completed with support from the PhD student authoring this dissertation. Health equity was not a focus in the three evaluations of the CHA in Manitoba, although the most recent evaluation recommended a health equity lens to the next evaluation. Although the CHA guidelines directed CHA representatives to use a population health framework, where income and social status were documented as the most important determinants of health, they were not specifically asked to apply an IRHE lens to the CHA process.

Community engagement. A comprehensive review of the community engagement methods used in the 2004 CHA in Manitoba was completed by the Health System Development Branch. Based on this review, the most popular methods for involving the community tended to be telephone surveys, focus groups, and key informant interviews. Community meetings comprised of representatives of all population groups, including members of socially disadvantaged groups, were rare. Staff reported that in-depth meetings were challenging for a variety of reasons, including the amount of time necessary for planning, resources, and the low attendance rates for some sessions due to travel costs or poor weather (an important challenge for rural regions). Another challenge noted from the community meetings was the potential for the forum to be "an opportunity for airing personal complaints and heightening expectations that cannot be met" (p.14). Another limitation in the 2004 public participation portion of the health

assessment process was the fact that the community/district health advisory councils were consulted in only three RHAs. One health authority reported that their health council was suspended as it was struggling to identify how it fit within the process. The regions also identified a lack of capacity for the design, implementation, and analysis of community meetings as a significant challenge. To further support this review, the second cycle process evaluation found that more support was needed for community engagement in the Manitoba CHA (Shooshtari & Sparling, 2006).

Community involvement at the RHA level. As per Manitoba's RHA Act (1996), health authorities were required to create a district/community health advisory council system, which is a formal mechanism for community input and involvement in health-related discussions, and to support the decision-making of the board of directors. These councils were directly responsible to the RHA boards. In some cases, the Minister of Health approved that an RHA be exempt from this requirement if they could provide evidence of another mechanism for community input (e.g., public surveys, public forums, public meetings).

In 2008, the Ministers of Health and Healthy Living commissioned an independent review of the RHAs in Manitoba (Manitoba Regional Health Authority External Review Committee, 2008) and their CHA and community involvement processes. In some regions, the advisory councils worked well, but major challenges were evident in other regions. For example, some advisory council members indicated that they were unable to make meaningful input to the RHAs, especially when resolving problems. In addition, recruitment of community members was expressed as a challenge, as many of the RHAs expect members to be part of the Council for at least two years with some of the responsibilities being difficult to maintain because of travel and costs. In addition, the RHAs were not held accountable for methods or effectiveness of the

advisory council process. Therefore, any issues that have been experienced in the past were not subject to a formal improvement processes.

The recommendations from the review suggested that the RHAs should be held "accountable for and report on the development of effective methods of obtaining community input through the district health advisory councils, community health advisory councils or other community engagement mechanisms chosen by the region" (Manitoba Regional Health Authority External Review Committee, 2008, p.51) and that RHAs should:

> implement methods to engage and empower their communities and districts based on the following principles: (i) identifying issues of common concern to strive for a common goal, (ii) identify relevant organizations and community leaders to work in a collaborative fashion, (iii) provide community members with information and knowledge so that informed evidence-based decisions are made, and (iv) have a democratic process" (p. 52).

Proposed amendments to the RHA Act in May 2011 continued to emphasize community and patient involvement through the development of a declaration of patient values and a concern resolution process (Government of Manitoba, 2011). Although the 2008 review and 2011 amendments suggested that RHAs needed to improve their processes for involving the community, there were no specific references to addressing the needs of the most socially disadvantaged populations, nor were there any references to health equity.

In Spring 2012, further legislative amendments were introduced in Manitoba, including the reduction of the number of RHAs from 11 to 5, to improve accountability and community involvement (Government of Manitoba, 2012). The RHA merger became effective on May 30, 2012. The amendments included the development of Local Health Involvement Groups, and

increased consultation with patients and families on the CHA and health needs of the communities. Again, no discussion of the most socially disadvantaged populations was included in these amendments and changes.

Intersectoral partnerships. The CHA guidelines encourage the development of partnerships within the CHA process to enhance information gathering and to obtain feedback (Manitoba Health and Healthy Living, 2009). Intersectoral partnerships are thought to be critical to the success of CHA, as the goal of such a process requires the knowledge and cooperation of a variety of different groups, including the community (Manitoba Health and Health Living, 2009). Shooshtari and Sparling (2006) recommended broader consultation with external partners and at an early stage of the CHA process. The CHA process in Manitoba has seen limited review and evaluation of partnerships, especially from a health equity lens.

Barriers and Facilitators of Health Equity-focused Practice

In the last several years, there has been growing momentum among researchers and government representatives who are working to mobilize resources to take action on the SDOH and to improve health inequities. Of particular significance was the Rio Political Declaration on SDOH in October of 2011 where the heads of government and other government representatives worldwide joined together to announce their commitment to addressing health inequities (WHO, 2011). Since that time, more attention is being paid to addressing the SDOH (NCCDH, 2014) and it appears that the general population is starting to better understand the SDOH and health inequities (Lofters, Slater, Kirst, Shankardass, & Quinonez, 2014). However, as identified by the NCCDH (2014), there is still concern that the momentum created is lacking concrete action to address health inequities.

Although the movement towards addressing health inequities and promoting health equity is still gaining traction, it is unknown why some regions and organizations appear to be leading the way whereas others are not. According to Rachlis (2009), "generally government has a weak capacity for leading and analyzing research" (p. 8), and even though health authorities have been identified as key in addressing health inequities (Gardner, 2008), several factors facilitate action and other factors act as barriers.

In 2010, the NCCDH conducted an environmental scan exploring the key challenges, gaps, and opportunities related to addressing the SDOH and health equity for the public health sector in Canada (NCCDH, 2011). The scan of the literature revealed a number of challenges to health equity practice in public health. The challenges centered around the existing evidence base (e.g., pathways to health inequities, interventions to address SDOH, the need for the literature to be shared, and evaluation of what works), the lack of clarity for the role of public health (e.g., SDOH outside the direct control of public health's mandate/work 'too big' for public health), limitations due to public health practice, community engagement, leadership, communication, capacity issues, and the political environment (e.g., political agenda – lifestyle focused). These key factors have been mentioned often in the literature (Beckfield & Krieger, 2009; Coelho & Shankland, 2011; Kouri, 2008).The NCCDH repeated this scan in 2014 and found themes similar to the first scan, but also found evidence of changes in the field. Many participants reported an increase in attention to health equity, an increase in "voiced commitment to health equity action at all levels of the Canadian public health sector", and a number of examples of health equity action and public health reports that incorporated a health equity lens in their reporting of data (NCCHD, 2014, p. v). The most frequent challenges identified included: inadequate structures and organizational supports for health equity such as dedicated staff position and strategic plans;

variance in the level of leadership support for health equity; lacking skill and competency developments in several areas such as health equity assessment and surveillance; engaging health sector partners to advance health equity; the need to be clear on healthy equity concepts and language; the need to build upon existing health equity networks and align health equity priorities; and the need for the key roles promoted by NCCDH for advancing health equity action.

Kouri (2008) examined facilitators and barriers relating to addressing health inequity across several RHAs in Canada, including the Winnipeg RHA. The author identified four strategies for addressing health inequities: (1) explicit strategies and documents (e.g., an explicit commitment to addressing disparities in a strategic plan); (2) information for planning and raising awareness (e.g., provincial government mandate to conduct health assessments every five years); (3) multi-sectoral and multi-organizational strategies for non-medical determinants (e.g., RHA membership on a local poverty coalition, community development responsibilities in public health departments, involvement in initiatives that address disparities); and (4) health services (e.g., primary health services located in underserved and poor areas of the RHAs). In addition to strategies, the report also discussed facilitators and barriers for addressing health inequities. Themes extracted from the key informant interviews included three key barriers: (1) prioritization of medical solutions and budgets; (2) insufficient capacity of public and population health professionals; and (3) city councils not interested in the common purpose. Facilitators included having a mandate from the provincial government reinforcing the RHA role regarding population health and disparities, provincial resources and other support, authority to reallocate resources, ability to work with staff to re-orient services, and the public health independence in role of informing and communicating with the public about health inequities.

In 2008, the Canadian Institute for Health Information's Canadian Population Health Initiative (CPHI) published a report on the health inequities of 15 different urban centres. Engagement with the non-health sector was seen as key to combating health disparities. The report suggested that when community members are involved in solutions, they are more invested in the process and the outcomes (CIHI, 2008).

Beckfield and Krieger (2009) conducted a systematic search of several databases exploring the link between political environment (i.e., systems, priorities) and the magnitude of health inequities. The authors concluded that political systems that incorporate and involve socially disadvantaged groups were more likely to reduce health inequities compared to other political factors and systems.

Coelho and Shankland (2011) summarize the ongoing challenges in Brazil for health equity. Over the past 20 years, Brazil has seen government arrangement and structural changes that have impacted health inequities. The introduction of the *Citizen's Constitution*, which declared health to be a universal right, was initially linked to a reduction in health inequities.

McIntyre, Shyleyko, Nicholson, Beanlands, and McLaren (2013) examined the perceptions of the SDOH with two groups, one more and one less affiliated with Canadian public health. Both groups discussed the SDOH "without acknowledging structural inequity in power and resources when discussing actions that might be used to improve health" (p. 7). The participants more affiliated with public health tended to struggle with moving beyond individual level cases and solutions regarding addressing health inequities. Public health representatives also felt overwhelmed within their professional role and addressing the SDOH. The authors recommended that the way forward may be in providing concrete population health intervention

strategies that are evidence-based in addressing health inequities versus attempts to further educate key stakeholders.

Raphael and Brassolotto (2015) interviewed Medical Officers of Health and lead staff from several public health units in Ontario to examine factors relating to SDOH-related activities. They found that "action on the SDOH is a result of a complex interplay of micro-, meso- and macro-level factors that requires recognition of the contested nature of public health, the presence of Ministry of Health mandates, local jurisdictional characteristics, and politics" (p. 1). More specifically, personal background and attitudes of key staff can influence SDOH-related activities. The authors called for provincial mandates related to action on the SDOH and accountability structures to ensure implementation, and recommend further research to explore the impact micro, meso, and macro-level factors on health.

McPherson, Ndumbe-Eyoh, Betker, Oickle, and Peroff-Johnston (2016) conducted a qualitative study of the Ontario public health system in which they created two SDOH nurse positions in each of the province's health regions. The purpose of these positions was to examine organization and leadership strategies that would increase health equity within the health care system. Barriers included the overly medical orientation and prioritization, budget and resource issues, insufficient capacity, and attitudes and values.

Therefore, although several researchers have identified barriers and facilitators to addressing health inequities, no research has explored these factors in the context of the CHA process. In addition, only a few published studies have focused on individual-level factors in the context of addressing health inequities although more recent research suggests these are likely part of the complexity interplay of various factors (Raphael and Brassolotto, 2015).

Conceptual Frameworks

Human rights-based approach. The Canadian Human Rights Act (CHRA) was passed in 1977, and is based on the principles of equal opportunity to all individuals who may be discriminated upon due to their sexual orientation, gender, religion, and several other factors. The CHRA is in effect for all federally-regulated activities. In Manitoba, the Manitoba Human Rights Commission is responsible for provincial human rights provisions. Protected characteristics from which a human rights complaint can be filed include (but are not limited to) age, religion, source of income, and political beliefs. In June 2012, the list of protected categories was expanded to include social disadvantage (i.e., homelessness or inadequate housing, low levels of education, chronic low income, and chronic unemployment or underemployment) and gender identity (The Human Rights Code, 1987). A human rights-based approach to health equity places health as a right. This is relevant due to the indivisibility of civil/political rights and socioeconomic rights, active agency by those vulnerable to human rights violations, and the powerful role of human rights in establishing accountability (London, 2008).

The concept of community health is grounded in ideologies of social justice and empowerment (Baisch, 2009; Sadan & Churchman, 1997). In addition, CHA in Manitoba has been introduced not just as a technical and social process, but as an ethical process (Manitoba Health & Health Living, 2009). As is evidenced by the principles of the World Health Organization's recent international report (WHO, 2008), action on the SDOH is a matter of social justice. Therefore, the connection between community health and social justice is well established.

Although social justice is a primary driver for many researchers and policy makers who are working to address the SDOH, it has been criticized for being too broadly focused

(Chapman, 2010; Rasanathan, Norenhag, & Valentine, 2010; Venkatapuram, Bell, & Marmot, 2010), compared to a rights-based approach, which has shown promise in research concerning health inequities. For example, rights-based approaches provide a concrete legal foundation for addressing health inequities, support the facilitation of participation in policy making and governance, and support the measurement of health as backed by a *right to be counted* (Rasanathan et al., 2010, p. 54). In addition, the connection to human rights is often missing from discussions and research relating to the SDOH and action towards addressing health inequities. This disconnect is not surprising given the rich and distinct history and traditions of the human rights perspective and the public health discipline (Rasanathan et al., 2010). In addition, the concept of human rights can evoke fear in people, and this leads some to feel that a focus on human rights may have unintended consequences for health equity. Nevertheless, the value of incorporating a human rights-based approach to health equity cannot be overlooked.

A human rights-based approach supports the rights of the socially disadvantaged by ensuring they are counted by being included in the selection, measurement, and monitoring of indicators. This approach supports the inclusion of disadvantaged groups in health-related discussions around health, decision-making, policy, and governance. The specific areas that are supported by a human rights-based approach have also been supported in national and international reports on health equity (PHAC, 2008; WHO, 2008). Most importantly, a human rights-based approach emphasizes the importance of accountability within the context of health equity, and can be inspirational for those working in government (Hynes, 2012).

A human rights-based approach has been chosen for this study because it relates to values and beliefs (individual, organizational, and systemic) that can ultimately impact health equity practices, and as such, will generate new knowledge for both health equity and human rights.

Income-related health equity-based framework for CHA. As mentioned earlier, an environmental scan (NCCDH, 2011) of the Canadian public health sector revealed a number of challenges and opportunities for health equity practice in health organizations, which could be grouped into three levels: individual, organizational, and systemic. The NCCDH scan focused on public health and placed the individual, organizational, and system-level factors within the organizational structure of health. For example:

> The knowledge, skills and attitudes of those staff are important enablers of action, but the decision-making authority regarding organizational priorities and practice rests ultimately with the management layers of organizations (p. 35).

The present study has adapted NCCDH's contribution on a broader sense by exploring individual-level factors of participants/health employees such as values and knowledge. Exploring individual-level factors in this context is also consistent with the literature (Raphael and Brassolotto, 2015). Figure 4 shows the IRHE framework developed for this study. This framework guided the research and coding of data.

The present research attempts to look both within and beyond the organizational-level (RHA), as decision-making also falls within the realm of the provincial government and, in some cases, at the individual-level. Themes for the data analysis were guided by the framework on a system-level (e.g., political agenda/priorities, political environment), an organizational-level (e.g., partnerships, leadership, values, capacity of CHA department), and individual-level (e.g., knowledge and values) factors. As the data was analyzed, the factors in the framework changed. For example, *SDOH orientation* (defined in Chapter V) replaced *values*. Explicit strategies and knowledge were also helpful in gaining a better understanding of each case, but did not seem to be related to barriers or facilitators of an IRHE-focused CHA process. Explicit strategies were

also related to provincial priorities and structures. Some factors (e.g., political environment) were removed as there was no data to describe them. In addition, new factors emerged from the interviews and document reviews, such as *access to health services* orientation from the individual-level perspective.

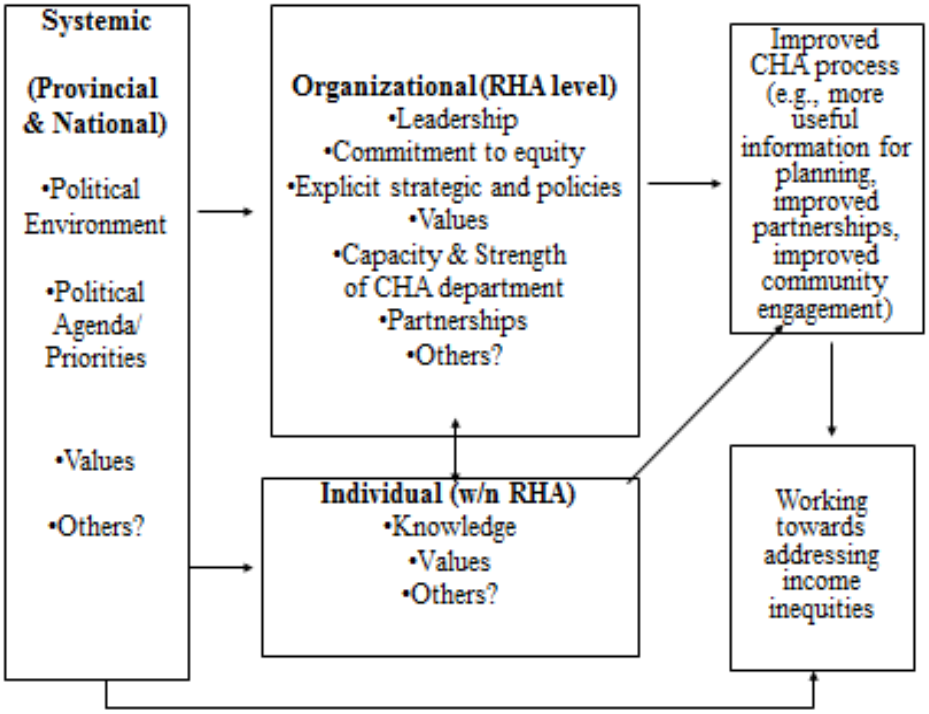

Figure 4. Income-Related Health Equity-based Framework for CHA. Framework created for the purposes of this study and inclusive of findings in NCCDH (2011), Kouri (2008), and Raphael & Brassolotto (2015).

Chapter III: Methods

Multiple Case Study Design

The complex examination of CHA from an IRHE lens must be studied within its specific social, economic, and political context. Each RHA in Manitoba is distinct and requires an in-depth understanding of its geography, history, demographics, and CHA-related processes. Case study methodology is most suitable for this study's research questions because they are complex and involve *how* or *why* questions (Yin, 2014), require in-depth study within the social environment, and require a variety of data sources to fully understand the topics in question (Yin, 2009). Collective or multiple case study design is preferred when the information gathered from one case may not be sufficient to address the research questions or to show different perspective on the issues (Creswell, 2007; Stake 2006). Multiple cases also provide the opportunity to explore common themes and differences across cases, leading to a more accurate study (Casey & Houghton, 2010). As mentioned in Chapter I, this is the first time the CHA process in Manitoba has been examined using an IRHE lens; as such, this study is primarily exploratory in nature. Case studies that are *exploratory* in nature have legitimate reasons for not having any propositions or hypotheses (Yin, 2014). Instead of propositions, exploratory case studies must state their purpose (as was done in Chapter I) and assign criteria "by which an exploration will be judged successful (or not)" (Yin, 2014, p. 30).

This multiple case study covered the years of the third comprehensive CHA (see Table 1; when the strategic planning of each RHA was completed for this cycle). The timeframe for this CHA process was longer compared to other five-year cycles due to the emergence of H1N1 influenza in Manitoba, and the necessary urgent response which delayed data reports (D. Beattie, personal communication, July 18, 2012).

Selection of Cases

While the province of Manitoba is responsible for the overall performance of the health system, direct service delivery is the responsibility of the RHAs. Three RHAs – Assiniboine (ARHA), Parkland (PRHA), and Brandon (BRHA) – were chosen purposefully to allow for more meaningful cross-case comparisons (see Figure 5). BRHA was chosen as it is an urban center in the province with a higher prevalence of mental health issues. PRHA was chosen due to its remoteness, cultural diversity and low income. The rural region of ARHA was chosen due to its large geographic area. These three regions were amalgamated in 2012 to create the Prairie Mountain Health region, but will be referred to by the RHA names that existed during the study period.

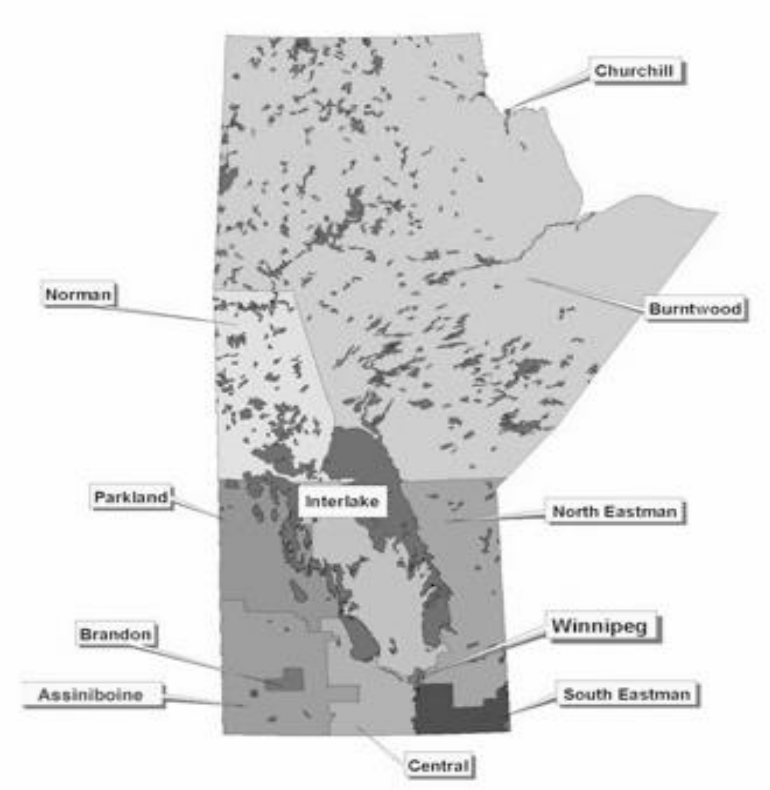

Figure 5. Map of Manitoba with 11 RHAs. Reprinted from Bowman, Grymonpre, and Rippin-Sisler (2012, January).

Table 2 demonstrates the diversity within and between the RHAs from an IRHE lens. The case study descriptions in Chapter IV provide more detail on the demographic and geographic diversity among the cases.

Table 2

Review of Selected Regional Health Authorities (RHAs)

RHA	**Income Indicators within RHA**	**Income Indicators- RHA and MB**	**Other Factors in Case Selection**
Assiniboine	Difference of $5,480 in median household income between the highest and the lowest districts. Median individual incomes for males are $6333 higher compared to females. Low income prevalence varies across districts (e.g., 6% in North 2 vs. 10% in three different districts for economic families and 23% in West 2 vs. 34% in East 1 for unattached individuals).	Difference of $9,704 in median household income between Manitoba and ARHA (ARHA lower than Manitoba)	Widespread and large RHA Culturally diverse Higher number of seniors
Brandon	Median individual incomes for males are $11,029 higher compared to females. Low income prevalence varies across districts (e.g., ~5% in Brandon Rural vs. 19% for Brandon Central for economic families and 13% in Brandon Rural vs. 48% in Brandon Central	Difference of $929 in median household income between Manitoba and BRHA (BRHA lower than Manitoba).	Urban case High prevalence of mental health Growing new immigrant population

	for unattached individuals).		
Parkland	Difference of $6,682 in median household income between the highest and the lowest districts. Median individual incomes for males are $3,870 higher compared to females (~$559 for the Indigenous peoples). Low income prevalence varies across districts (e.g., 10% in Central District vs. 16% for East District for economic families and 32% in East District vs. 39% in both North and West Districts for unattached individuals).	Difference of $14,561 in median household income between Manitoba and Parkland RHA (lowest of all RHAs). Difference of $20,077 in median household income between MB and Parkland's Indigenous population.	Remote and largely rural RHA Several Indigenous communities Median household income lowest of all RHAs

Note. Data for Assiniboine from Assiniboine Regional Health Authority (2010b), for Brandon from Brandon Regional Health Authority (2009b), and for Parkland from Parkland Regional Health Authority (2010b).

Data Collection Sources and Procedures

Multiple methods of data collection were involved in this multiple case study to increase the credibility and validity of the research (Stake, 1995; Yin, 1994). This study required data from documents, interviews, and field notes. Methodological triangulation was achieved when several data sources converged on similar findings.

Documentation. Documents are used in case studies to corroborate and augment evidence from other sources (Yin, 2009). Documentation has several strengths, such as stability, unobtrusiveness, broad coverage and precision of information. Various documents were

reviewed in this study, including CHA reports, RHA annual reports, RHA strategic plans, and meeting minutes (see Table 3). Reviewing documents early in the project and throughout ensured effective and efficient interviews, and provided an opportunity to clarify any issues or inconsistencies in the documents. The majority of the documents required for this study were publicly available, but some (e.g., meeting minutes) required permission to access. All documents spanning the third cycle of the CHA were included. Executive meeting minutes were not available for any regions. Documents were searched for the following terms: *community health assessment, CHA, community needs assessment, indicators, poverty, disadvantage, advantage, social determinants of health, SDOH, low income, inequity, partners, national, provincial, Manitoba Health, priorities, priority, community, strategy, strategies, deliverables, leadership, policy, engagement,* and *advisory council.* Key sections were highlighted and documented to prepare for analysis.

Table 3

Documentation Review

Document Type	Purpose of Document Review
CHA documents • ARHA 2004 (summary) and 2010 • PRHA 2004 and 2009 • BRHA 2004 and 2009 • CHA Evaluation 1998, 2006 and 2013	CHA reports are completed every five years and provide information on the CHA process and indicators. Previous evaluations of the CHA process were also used to inform the literature review of this thesis.
CHA-related meeting minutes (e.g., partnership meetings, various working groups meetings)	CHA-related minutes were reviewed for any discussion on IRHE or key search terms. Minutes were reviewed to locate more information on the CHA process.

- PRHA

RHA annual reports • ARHA (4 reports - 3 were unavailable) • PRHA (7 reports) • BRHA (7 reports)	RHA annual reports from 2004 to 2010 were reviewed. The annual reports provide key information on the strategic priorities of the region and evidence on how/if the CHA reports and processes were used in the regions. The reports were also reviewed by the key search terms.
RHA strategic plans, visions, and missions • PRHA 2006-2011 • BRHA 2005-2011	RHA strategic plans, if available, were reviewed for any evidence of IRHE or by the key search terms. The strategic plans were used in the development of the case description.
RHA Accreditation reports • ARHA 2005 and 2009 • BRHA 2006 and 2009	Every three years the RHAs engage in the accreditation process, which evaluates the quality of RHA services against nationally accepted standards. The accreditation reports were used to identify topics related to IRHE and to search the reports by key terms. The accreditation reports provided an objective perspective on the region.
Board meetings minutes • ARHA 50 documents (missing 2009) • PRHA 69 documents • BRHA 64 documents	Board meeting minutes were reviewed from Sept 2004-Dec 2010 to identify how often the CHA process was discussed and why. Meeting minutes were also explored by key search terms.

Interviews. Before formal interviewing began, the questions and the interviewing process were pilot-tested with CHA volunteers and employees from non-participating RHAs. Three pilot tests per interview guide by each of the key informant groups were completed. There were three key informant groups including CHA representatives, senior management/board members, and partners who work with low income groups. These individuals were selected by one key person in each region who provided a list of stakeholders most involved in the third

CHA cycle. The interviews were conducted face-to-face using a semi-structured interview guide (Appendices A-C). The guide was informed by the literature and the Health Equity Audit Tool (Department of Health, 2004). Table 4 provides an overview of the interview questions and how they were mapped and coded to the conceptual framework. Revisions to the questions and the interview process were made as necessary based on feedback from the pilot. A formal ethics review was completed in the fall of 2012.

Table 4

Interview Questions

Question	Link to Conceptual Framework (Figure 4)
1. Target: CHA representatives	
1. Please tell me about your role in _____ (insert RHA here) (probe: what do you do, how are you involved in CHA, how long have you been involved in CHA, etc.).	(Introductions)
2. Please tell me what you know about health inequities in your RHAs during the third CHA (note: please remind the respondent to focus all answers thinking back to the timeframe during the third CHA only). Were there wide differences in health across the RHAs? [note: provide the Braveman (2006) definition]	Individual: Knowledge
3. Was there good quality data providing an overview of local health inequities (i.e., low income) in this RHA? In the districts? If no, please explain (probe: an example of low income inequity "people from poorer areas in the RHA were more likely to have chronic disease compared to those from richer neighbourhoods").	Organizational: Capacity and Strength of CHA Department (data) Individual: Knowledge
4. How important is income equity to you as it applies to the work of CHA? What do you think of the statement, "everyone has the right to health".	Individual: Values

5. How important is income equity to the Department you work in? Do you feel there is a commitment to equity? Please explain.	Organizational: Values, Commitment to Equity
6. Thinking back to the third CHA, who were the leaders when it comes to equity in your Department? Why would you consider these individuals to be leaders (note: please just refer to the role of the person and not their actual name)	Organizational: Leadership
7. How well do you think the community health assessment guidelines address health inequities and the potential for taking action to address them?	Organizational: Explicit strategies and policies
8. What is the purpose of having CHA partners? What is the purpose of having CHA partners who work with low-income groups? (probe: Neighbourhood Renewal Corp, Samaritan House Ministries, Mood Disorders Association of Manitoba, Regional staff in Home Care, First Nation Health Centre, Addictions Foundation of Manitoba, Women's Institute, partnerships with New Immigrant groups). In your opinion, is this purpose agreed upon by the partners?	Organizational: Partnerships
9. Which groups (note: those representing low-income groups) were you able to partner with during the third CHA? Which groups were you not able to partner with? Please explain.	Organizational: Partnerships
10. Tell me about how you go about forming the partnerships, or what barriers you came across while attempting to form partnerships?	Organizational: Partnerships Organizational: Capacity and Strength of CHA Department
11. Would you be willing to share a list (and if you have contact information – provided there is permission to share) of all partners from the third CHA process? (if yes: please identify which partners work with low-income groups).	Organizational: Partnerships
12. Overall, were you satisfied with these partnerships? Was there value added?	Organizational: Partnerships
13. During the community engagement sessions were there any specific considerations made to ensure that low-income populations were included?	Organizational: Capacity and Strength of CHA Department (community engagement)

	Organizational: Commitment to Equity, Explicit strategies and policies
14. To what extent did the members of the community/district health advisory council (or alternative) in your region consists of representatives from low-income populations?	Organizational: Commitment to Equity, Explicit strategies and policies
15. In your experience what are some things that (insert RHA here) did during the third CHA to address income inequities? What are some challenges to addressing income inequities? (probe: explicit strategies/policies, leadership, policies, capacity, systemic factors)	Organizational: all sub-factors
16. Is there anything else you would like to share with me or anything that I should know specific to this topic?	(Closing of interview)

2. Target: Senior Management (i.e., CEOs, VPS, Senior positions in Planning & Development, Health information) and Board

1. Please tell me about your role in _____ (specify) (probe: what do you do, were you involved in the third CHA, etc.).	(Introductions)
2. How important is income equity to you as it applies to the work of CHA? In your opinion, what would the RHA think of the statement, "everyone has the right to health". [note: provide the Braveman (2006) definition of health equity and apply low-income]	Systemic: Values
3. In your opinion, how important was health equity among the various priorities for your region during the third CHA? How important was income equity among the various priorities for your region?	Systemic: Political agenda/priorities
4. How well do the current community health assessment guidelines address health inequities and the potential for taking action to address them? Are there any other strategies or policies that address income inequities in your region?	Organizational: Explicit strategies and policies
5. Thinking back to the third CHA, what would you say was the RHA's role in working towards addressing income inequities? The province? Local partners (who would these partners be)? Anyone else (probe: other health department, departments	Organizational: Leadership, Partnerships

outside of health)? Who should be the leader in this regard?	
6. In your experience what are some things that (specify RHA here) did during the third CHA to address income inequities? What are some challenges to addressing income inequities? (probe: explicit strategies/policies, leadership, policies, capacity, systemic factors)	All factors
7. Is there anything else you would like to share with me or anything that I should know specific to this topic?	(Closing of interview)

3. Target: CHA Partners working with Low Income Populations

1. Please tell me about your role at _____ (specify organization). (probe: what do you do, how are you involved in CHA, etc.).	(Introductions)
2. Please tell me about your partnership with (insert RHA here). How long have you worked with (insert RHA here)? Thinking back to the third CHA, what was the purpose of your partnership with CHA staff? Would you say there was a need for your partnership? Explain.	Organizational: Partnerships
3. During the third CHA how satisfied were you with the partnership between your organization and (insert RHA here)? Explain (probe: strengths and challenges).	Organizational: Partnerships
4. Did you feel there were other groups who work with low-income populations who were not involved (and should have been) in the CHA process? Which groups?	Organizational: Partnerships
5. During the third CHA process, the RHA held community consultation sessions in your region to discuss the CHA process and results. Did you attend these sessions? If so, how satisfied do you think someone from a low-income would have been after attending the sessions? What are your thoughts on how low-income individuals were involved in this process? If you did not attend these sessions do you have any suggestions on how to involve individuals from low-income backgrounds?	Organizational: Capacity and Strength of CHA Department (community engagement)
6. Is there anything else you would like to share with me or anything that I should know specific to this topic?	(Closing Interview)

Teleconferences were held with key staff in each of the RHAs to discuss interview procedures (e.g., letters of consent, scheduling) and to ensure that everyone was comfortable with the study. Key CHA contacts in each of the regions were asked to provide a list of potential interviewees. The criteria for eligibility included significant involvement in the third CHA cycle. Figure 6 provides an overview of the research timeline.

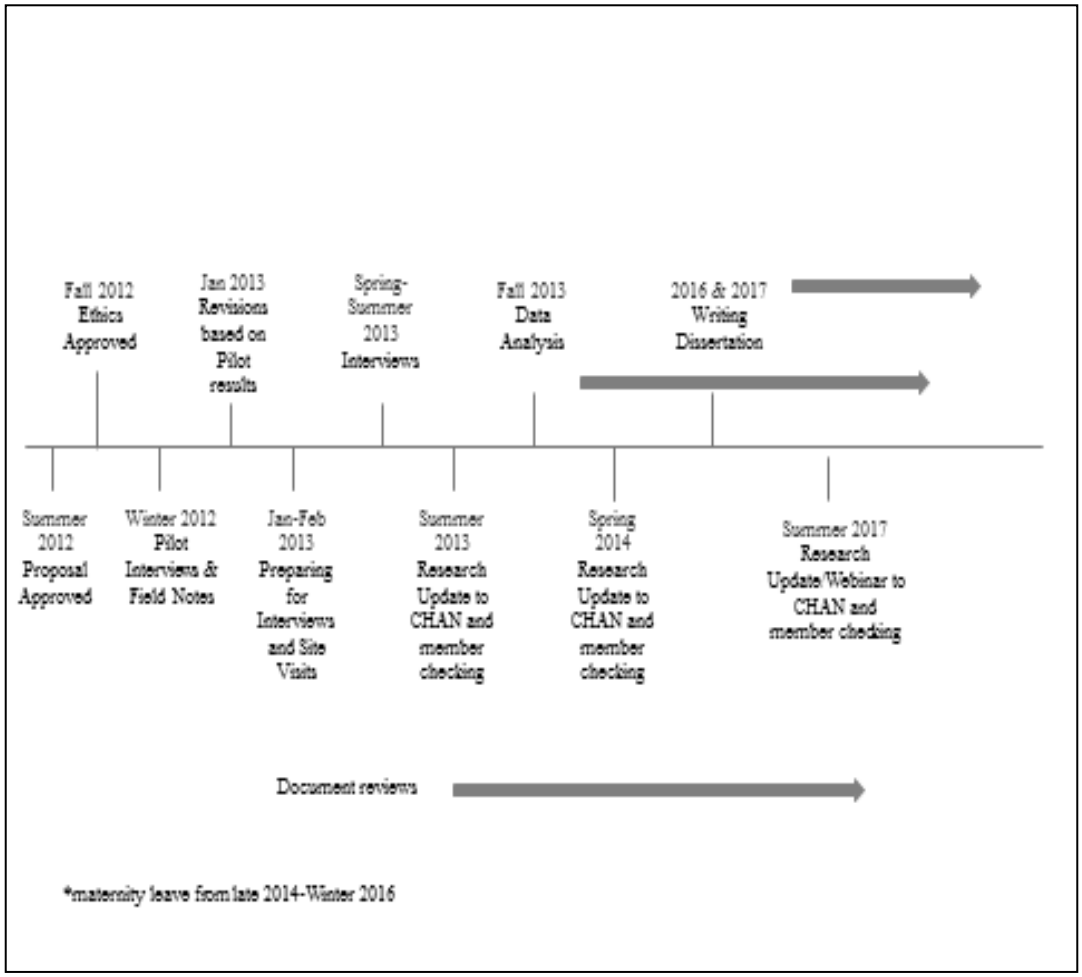

Figure 6. Research Activity Timeline

To more readily access the information required for document reviews and to conduct the interviews face-to-face, the researcher spent approximately three weeks travelling in each of the RHAs with a general office located in the former Brandon RHA downtown location. Interviews did not commence until the participants were provided with an overview of the study and consented to participate (Appendix D). A signed copy of the consent form was also provided to the participant. One interview was completed over the phone due to scheduling conflicts. A recording application was used to record the interview over the phone. Key informant interviews were conducted with CHA representatives, board members, and senior management. CHA representatives were selected as they were responsible for the planning, coordination, and implementation of the CHA in their regions, and were best suited to answer the questions relating to the CHA processes and provide perspectives on income equity and CHA. Board members and senior management were selected as they provide important information relating to the organizational and system-level components of this research project. Finally, CHA partners who work with low-income populations were interviewed to obtain information that addresses the gap in our understanding of partnerships from an income equity lens. Attempts to interview CHA partners who work with low-income populations were not successful for a variety of reasons, including staff in the regions not being able to provide names of partners, partners not replying to interview requests and two partners declining. Overall, response rates were higher for CHA representatives compared to board and senior managers (see Table 5).

Table 5

Study Participants and Response Rates by Regional Health Authority (RHA)

RHA	CHA reps (N = 11)	Board and Senior Management (N = 20)	Community partners (N = 6)	Total (N = 37)
Brandon	4 (complete)	6 (complete) 1 (declined) 2 (could not reach)	n/a No partners identified for this study	10 (completed) 77% response rate
Assiniboine	4 (complete)	3 (complete) 1 (declined) 3 (could not reach)	4 (could not reach) 1 (declined)	7 (completed) 44% response rate
Parkland	3 (complete)	2 (complete) 1 (declined) 1 (could not reach)	1 (declined)	5 (completed) 63% response rate
Total completed	11	11	0	22
Response Rate	100%	55%	0%	60%

Field notes. Several steps were taken to ensure methodological rigour in this research, including the consistent documentation of comprehensive field notes immediately after each interview. Field notes are important in qualitative research as they provide important information critical to comprehensive data analysis. Field notes also provide an opportunity for the researcher to reflect on their thoughts and feelings during the data collection procedure, which can contribute to a more objective perspective when analyzing the data (Wolfinger, 2002). Spradley's (1980) *generalized list of concerns* was used to provide structure and focus to the

field notes. This list contains categories such as the physical environment, the actors involved, and feelings experienced. The field notes will not be summarized in detail because this individualized information could identify some of the participants.

Data Analysis

Data was obtained from the following three sources in this research project: 1) documents that were reviewed; 2) individual interviews; and 3) field notes. Before interviewing staff from the regions, all available documents were read and reviewed. During the data analysis phase, all documents were searched by the 25 key terms (see page 43) and any instances were highlighted. Anything that seemed relevant to IRHE and CHA, outside of the key search term, was also highlighted. This information was summarized and provided case description information and supported some of the key informant interview data.

Key informant interviews were audio-recorded and transcribed verbatim. NVivo (version 10) was used to manage, code, and analyze the transcripts. Categorical aggregation is the "sums or distributions of coded data" (Stake, 1995, p. 169) and was used to establish themes or patterns within the data collected (Creswell, 2007). The IRHE Framework for CHA (see Figure 4) was used to guide the coding of data. Any themes that emerged outside of the model would also be captured in an open coding process. In the end, several factors in the model remained important within the interview and document review data (e.g., political priorities, partnerships). Some factors did not seem to fit in the discussion relating to barriers or facilitators of an IRHE-focused CHA or were best combined with other factors. Overall, within-case theme analysis and cross-case theme analysis (e.g., similarities and differences that might emerge between the three RHAs) contributed to knowledge generation and validity of the findings.

As identified by Houghton, Casey, Shaw, and Murphy (2013), several steps were taken to ensure rigour of the research. Firstly, multiple sources of data contribute to the trustworthiness and credibility of the results. Secondly, if requested, participants were provided with a summary of the findings of their interviews to further increase the credibility of the data. Field notes were taken immediately after each interview and created an important form of reflexivity. At several points throughout the study timeframe, preliminary research updates were provided to CHAN and representatives of Manitoba Health, as a form of member checking on the development of the key themes. Through the ongoing collaborations, documentation reviews, and the information that was produced from the interviews, a comprehensive in-depth understanding of each case was presented. Prolonged engagement with the CHA staff and representatives of Manitoba Health increased the credibility of the research findings. In fact, some practical implications from this dissertation have already been implemented in the regions (please see Chapter VI for more information). Thick case descriptions increased the rigour and transferability of the findings.

Chapter IV: Results

This chapter summarizes the results of three case studies in the following order: Assiniboine RHA, Parkland RHA, and Brandon RHA. Results for each case begins with a description of the RHA, followed by a summary of document review and key informant interview findings. The last section for each case provides a summary of the themes generated based on the findings for that particular case, followed by concluding comments.

Assiniboine Regional Health Authority (ARHA) Case Results

The ARHA region is large and widespread (32,134 square kilometers, including 72 towns and villages), which creates challenges in "ensuring consistency in standards and practice, sufficient time and human resources, effective communication and availability of educational opportunities (for employees)" (ARHA, 2011a, p. 15). ARHA consists of six smaller districts (depicted in Figure 7). As of June 1, 2010, the population of the region was 68,505 (ARHA, 2011a, p. 3). The region had fewer children and a higher number of seniors compared to the provincial averages. For example, 18.2% of the population in the region was under 15 years old and 19.3% were 65 years or older compared to the provincial rates of 19.6% and 13.6%, respectively (ARHA, 2010b). Up until 2009/2010, the region's population was on a steady decline. More recently, however, the population of the ARHA has been increasing due to immigration and a high birth rate. One of the unique characteristics of this region is its *cultural diversity*. The region is home to seven First Nation communities, several communities with significant Métis populations, and several Hutterite colonies. Agriculture is the region's main industry.

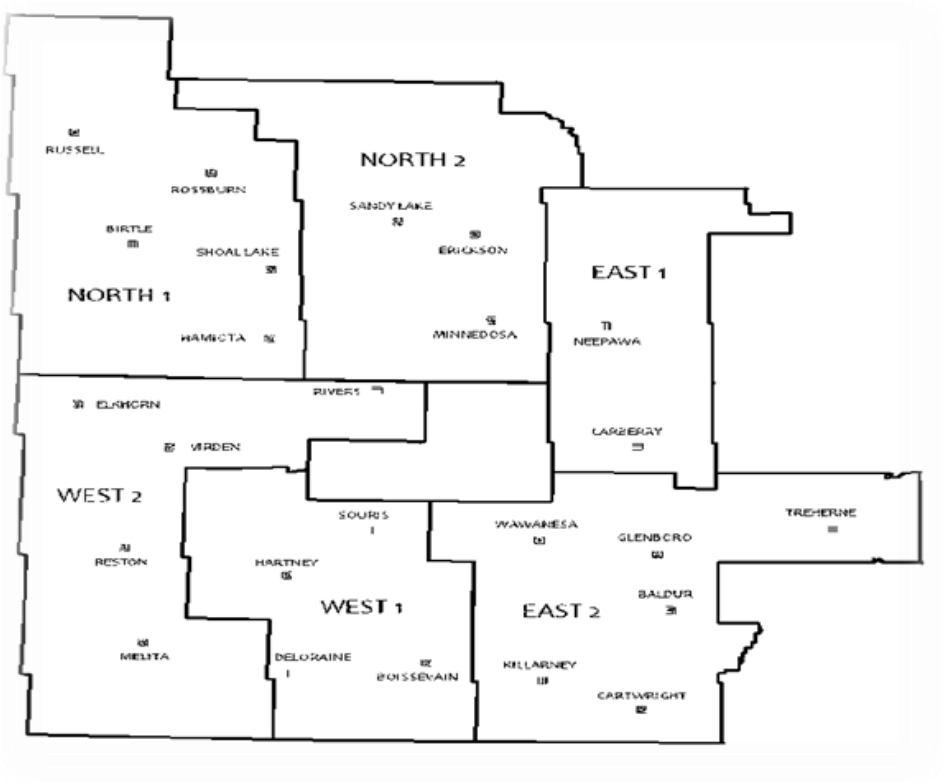

Figure 7. ARHA Districts. Reprinted from Assiniboine Regional Health Authority (2010b).

According to the CHA report, the region has higher rates of stroke mortality and unintentional injury rates among males compared to the men in the rest of the province (Assiniboine Regional Health Authority, 2010b). The residents of this region also continue to have a lower use of specialists. The percentage of people in the region who rated their health as *fair/poor* was lower than the provincial average (9.4% vs. 11.6%).

Although the median household income for the ARHA increased from 2001 to 2006, this region had the second lowest income level for the province at $38,171, which was also lower than the provincial average ($47,875). Median individual incomes for males and females in this region were also lower compared to their provincial counterparts. In 2006, males reported a median income of $23,968 and females reported a median income of $17,635, compared to $29,919 and $20,169 for Manitoba, respectively. The median household income and individual

income levels also vary across the districts of the region. For example, North 1 district had the lowest median household income levels ($34,528) and East 1 district ($40,008) had the highest income levels. The highest median individual income level was found in East 1 district for males ($26,002) and in the West 1 district for females ($18,823). The lowest median individual income level was found in the North 1 district for males ($19,824) and in the West 2 district for females ($16,666).

Prevalence of low income among residents of the region were lower compared to Manitoba as a whole and varied somewhat across the districts. However, the low-income prevalence rate for unattached/single individuals was higher in the East 1 district compared to the other districts and to the region as a whole (i.e., 34% vs. 27%). The ARHA also has lower unemployment rates compared to the rest of the province, with 3.8% for females and 3.7% for males, compared to the Manitoba averages of 10.5% and 5.5% for females and males, respectively.

Findings from document reviews. Key staff in the regions provided a list of documents, if available. Although the ARHA had team meetings during the third CHA cycle, minutes were not recorded as committee members were more focused on planning involving details about report layout and data analysis. Minutes were also not recorded at the community/district health advisory council meetings. ARHA had a health advisory council which consisted of 28 members in 2009/2010 (Beattie, 2011). Executive management meeting minutes were not available. Documents that were reviewed for information relating to the research questions and conceptual framework included the accreditation reports, board meeting minutes, annual reports, CHA reports, and a strategic plan (see Table 3).

Accreditation reports. The 2005 accreditation report identified the data on mental health, collected during the CHA process, as one of the region's strengths. The report suggested that strategies on suicide prevention will become part of the province's deliverables. However, ARHA and the provincial government may have more work to do regarding direction on priorities for service delivery and for the provincial government to "…acknowledge the challenges of sustainability in the current system" (Canadian Council on Health Services Accreditation, 2005, p. 37). The report highlighted the challenges that the region had in obtaining input in focus groups from consumers. Still, several partners (i.e., district advisory councils, school board representatives, Métis association, seniors' society, child services, local press and the municipal government) were interviewed, and the region received favourable responses. These partners were not directly connected to the CHA process, but were identified as partners of the health region. One of the larger challenges identified for ARHA was communication due to the size of the region. In addition, there was a clear need for this RHA to improve on "engaging the aboriginal communities in planning and service delivery for aboriginal specific health care issues" (Canadian Council on Health Services Accreditation, 2005, p. 39).

Overall, the majority of the accreditation report focused on the quality of services and only mentions CHA a few times. While the report provides a good overview of the region, it appears that CHA is not a significant part of the day-to-day operations as evidenced by the statement that "...team and programs are just starting to use information from the needs assessment to determine priorities and programming" (Canadian Council on Health Services Accreditation, 2005, p. 111).

CHA are mentioned more often and appear to be more integrated into the region's operational activities in the 2009 than 2005 reports. For example, CHA is mentioned in the

surveyor's commentary as a strength: "In terms of community, there is a strong community health assessment, and a good community health assessment process overall" (Accreditation Canada, 2009b, p. 4). The region was acknowledged for its dedicated and committed staff and strong leadership at the senior team level, and for the region's community partnerships, although these partnerships were not directly related to CHA. Another theme that emerged was the strong leadership at the senior level, with a great working relationship between the ARHA's Board of Directors and senior management (Accreditation Canada, 2009b).

Board meeting minutes. Nearly 600 pages of board meeting minutes (see Table 3) were reviewed. CHA was only mentioned ten times in this review and in the context of being shared with board members, as part of the health advisory group meetings, or as part of budget items. There was no discussion about IRHE and CHA. The term 'social determinants of health' did not appear in the minutes until the fall of 2010, when the board began to show initiated interest in the SDOH. It was evident from these meeting minutes that the ARHA was comprised of hard working employees who struggled to provide health care services in a large region with constant staffing demands. Leadership was an important area of focus and several senior staff received prestigious awards during the study timeframe. The region prioritized reaching out to the community in the form of regular public meetings, and focused meetings when needed. The Aboriginal Health Strategy was also mentioned several times within the board meeting minutes.

Annual reports. In the 2004/2005 annual report, the 2004 CHA report results were highlighted, and some income information was included. For example, "Agriculture is the main industry in the Assiniboine Region, with difficult economic times affecting everyone in our rural communities" and "Compared to residents of Manitoba, our residents are: More likely to have a lower household income" (Assiniboine Regional Health Authority, 2005, p. 5). One of the

strategic priorities identified for the region was to identify select health needs associated with particular population groups and develop a service delivery strategy. Specific examples of these services included the Aboriginal Specific Health Strategy, the Regional Diabetes Program, and the Regional Breastfeeding Framework, although there was no mention of low income groups. Similar to other reports from the region, evidence was found regarding the importance of community consultation and several community engagement sessions. The Strategic Plan included a "focus on people, communication and relationship and partnerships."

In the 2008/2009 annual report (Assiniboine Regional Health Authority, 2009), the themes were partnerships, achieving results, and community responsiveness (although specific groups in the community were rarely identified). The board of directors appeared to be a strong team of leaders who were very much involved in several key activities at ARHA; these key activities included inviting community stake-holders to meetings, reviewing CHA information, sharing leadership with the Executive Management Committee, being responsive to community need.

Positive and *effective* partnerships were discussed as priorities several times in the report. First Nation populations were identified as priority populations. Seniors were discussed briefly. Epidemiological information was presented on a regional basis only, with statements that the "social and economic status of people in the region is also generally good" (Assiniboine Regional Health Authority, 2009, p. 4). It was difficult to determine from the report if there were certain districts that experienced lower social and economic status.

Approximately 20% of strategic priorities in the ARHA could be considered "equity-focused" in the 2008/2009 fiscal year [e.g., "The ARHA will implement a chronic disease prevention and management strategy targeting priority populations as appropriate" (Assiniboine

Regional Health Authority, 2009, p. 8)]. ARHA's report included a focus on staff and the community (e.g., one of their values is "Focusing on People"), and discussed financial challenges and lack of resources. Due to the size of the region, communication is important and the region has made it a priority through strategic planning.

The 2009/2010 report focused on the strategic plan, accreditation, and the H1N1 pandemic experience. The CHA report was mentioned as being complete and validated in the 2009/2010 fiscal year:

> This included a year-long process of: reviewing health status information, utilization data; ten community engagement and subsequent validation meetings; consultation with population groups, and partner agencies and advisory committees; active in-person staff participation as well as access to a staff on-line survey which culminated in one comprehensive report (Assiniboine Regional Health Authority, 2010a, p. 5)

Partnerships and the importance of working with the First Nation communities were mentioned three times in the report. In addition, the pandemic response team in the region won an award for their work during the H1N1 crisis. The report includes a paragraph stating that the region's social and economic statuses are generally good, although this was reference to education and employment only. The term "vulnerable populations" is mentioned, but a definition was not provided.

Accreditation and annual reports consistently identify the CHA process in the region as one of their strengths. As identified in the annual report, "The Board recognizes the importance of addressing health inequalities when planning and setting priorities for health programs and services" (Assiniboine Regional Health Authority, 2011a, p. 10), although there was no explicit

connection to the CHA process. This finding is consistent with the board meeting minutes where discussion related to SDOH did not occur until 2010.

Community health assessment reports. Two CHA reports (2004 and 2010) were analyzed similar to the other documents and using the key search terms but also from an IRHE lens exploring indicators, efforts to involve low-income populations in the community engagement process, and any efforts to involve partners who worked with low-income populations. The 2004 report could only be located in summary format. As such, there was limited information about the specific indicators used and details on the community engagement strategies. From the summary, there appeared to be a limited focused on indicators by income (Assiniboine Regional Health Authority, 2004). In some sections, Indigenous communities were identified as having lower life expectancies, and higher diabetes rates, although statistics were unavailable. There was no mention of how income or other SDOH could also play a role in health outcomes. The summary includes a section on stress in rural communities due to economic impacts, but only relates this to unhealthy coping strategies, such as drinking and smoking. The summary also mentions a telephone survey and interviews with doctors and community members. Because a detailed report in 2004 was unavailable, further in-depth analysis was not possible.

The 2010 CHA report identified median individual income, median household income, and low-income prevalence by district and region (Assiniboine Regional Health Authority, 2010b). The income levels reported pockets of the region, particularly the North that appeared to be worse-off than other districts. The report then makes an attempt to describe health of the community using a number of key health indicators (e.g., ischemic heart disease, premature mortality, potential years of life lost, depression, acute myocardial infarction, mammography

rates) by district, although the details on income levels were limited and/or hidden within the text and was not visually displayed. The report also contained a comprehensive overview of the SDOH and provided qualitative and quantitative information on each determinant. For example, as for income, they highlighted how community members, partners, and staff were concerned about the economy and poverty. School staff noticed growing disparities between families who are well-off and those who are not, and "there was general agreement that income greatly affects quality of life" (p. 40). In addition, there was clear concern from community members regarding the financial difficulties of seniors and those earning minimum wage.

The 2010 CHA report provided evidence of comprehensive community engagement, including the desire to engage with partners representing socially disadvantaged populations, which included groups that likely experience issues with low income. For example, "Although the intent was to obtain a cross-section of individuals in communities, it was not always possible to recruit people who represented every aspect of a community" and "…vulnerable populations may not always be represented at community meetings and made attempts to obtain their perspectives by other means" (Assiniboine Regional Health Authority, 2010b, p. 2).

2005-2011 strategic plan. Community partnerships are seen as a priority in the ARHA, and are explicitly identified in their six-year strategic plan (e.g., focusing on people, relationships and partnerships). In addition, another strategic priority included: "ARHA will identify select health needs associated with population groups as priority for service delivery strategy development" (Assiniboine Regional Health Authority, 2011b, p. 1). Although a focus on SDOH is not explicit in the strategic plan, it appeared to be subtly implied. This finding was also substantiated by key informants, which will be summarized next.

Findings from the key informant interviews.

CHA representatives. All CHA representatives (*n* = 4) participated from the region. Study participants' roles in the ARHA varied from leading the entire CHA process to participation through report writing or community consultation. All participants were involved in the ARHA for at least two years and were familiar with the data in their regions.

All participants agreed that the topic of health equity was important in general, and in conducting a comprehensive CHA. However, the study participants were aware of the limitations of the data in identifying income-related health inequities in their region and districts. For example, several individuals mentioned not being able to drill down deep enough with the data, especially at the district level for their region, because of issues such as the way people live. For example:

> It likely should be incredibly important, but of the limitations in the data that we receive we aren't able to do terribly much with it…Yeah, it's not so much the data that's the problem, it's the way people live here. They live in groups that aren't separate by income like they would be in Brandon, for example.

Thus, it appeared that there may be particular concern with this region due to its vastness and number of diverse neighborhoods/districts. There was a general sense from the participants that engaging in a CHA process was a significant amount of work for staff.

Participants were asked to comment on the importance of IRHE within their department. While most agreed that the department, including the people they worked with, believed in the concept of IRHE, there were mixed responses about commitment and actions on a day-to-day basis. For example, one individual stated that IRHE was not a lens that was frequently discussed with regards to program planning.

On the other hand, some participants did see some evidence of IRHE-focused leadership within the CHA process in their region. For example, one participant discussed how the board requested that the CHA team be more targeted in the communities they engaged with during the consultation process, which was seen as very proactive and IRHE-focused. The CEO was mentioned by most of the participants as a leader in the area of taking action on the SDOH. In addition to a passion for the CHA process, leaders also exemplified interpersonal skills, such as problem solving, communication, and coordinating information and communities. From an IRHE lens, knowledge about the SDOH and the ability to communicate was also seen as important:

> Yeah, it was looking into data and looking for trends and calendared all the quantitative data. I was in the quantitative and really hearing what people needed and one of the most common things people said was, "We need a medical school in (city). We need more doctors". But (CHA representative) had the neatest little puzzle for the 12 determinants of health and health services is only a very very small piece of the puzzle, and once people really realized that they said, 'Okay, well I guess we have to talk about other things than doctors and nurses.

It was also important for CHA leaders to be supported by senior management and leadership can be both a facilitator and a barrier to taking action on the SDOH. As stated by one individual:

> If you have somebody within the region who has a passion for something and they have the blessing of their supervisors…usually they can run with it and make some big strides. However, if you have somebody in leadership who is opposed to an idea it can really stall things.

Only one or two individuals provided the names of organizations that would be considered true partners with the RHA as it pertains to the CHA process. Efforts to interview individuals from these organizations were not successful. Much of the discussion around partnerships and relationships tended to focus around the general community and the needs assessment process. Participants stated that the purpose of partnerships as it pertains to CHA would not differ for those groups who work with low-income populations. This purpose mostly centered on a fairly simplistic relationship of gathering information and feedback.

Ensuring that partners are also aware of what the RHA is going to do with the data and information in the CHA process was seen as a strength in partnership building. In some areas of the region, it was apparent that CHA staff experienced some discomfort from partners and community members who were skeptical about being part of the surveying and/or data discussions:

> When we were talking community health assessment, one of the key messages we got – I guess, from one of the communities – was again, what are you going to do with that information? Then there was that – like the flags, went up. The flags went up, because of the old saying that we've been surveyed to death, like whatever.

More specifically, some participants expressed the importance of respectful community and partnership consultation processes. One example provided was for individuals to be trained on the Ownership, Control, Access and Possession (OCAP) principles due to the large number of Indigenous peoples in the region. As stated by one individual:

> …But want to work with the communities. Also, leave something behind, like, there's a capacity building piece, like, to share knowledge. Not just our knowledge, but for them to share theirs also, with us. So that's again, I hope that that carries on in this—

Participants were asked to discuss the special considerations that were made in their regions during the community engagement sessions to ensure that low-income populations were included. No individuals were able to identify any significant specific actions that were taken in the community sessions to ensure members from low incomes groups were more easily able to participate. Overall, most participants agreed that the community engagement process of CHA, although a very important part, was time-consuming and resource-intensive and that it would be costly to make special considerations for low income populations. However, one participant gave some examples of attempts that were made to garner community participation overall:

> Yeah, knowing that people didn't have to pay for, like, coffee, beverages would be free; that people really wouldn't be judged when we came, we were here to find out what they said. We wanted people to know that. Sometimes, people would tell me information over the phone, but they would not want to come to the meetings because in a small town everybody knows you and some of them said, "I'm just not comfortable with that".

Finally, most participants knew of the CHA guidelines, but felt unable to discuss the potential of the guidelines to steer the CHA process towards an IRHE lens. In addition, no individuals were able to confidently state that the community/district health advisory councils included representation from low-income populations

Board members and senior management. Nearly one half of eligible study participants (3/7) participated in the interviews. All participants had several years of experience on the board

and/or management level. None had direct involvement in the CHA process, although they did report some oversight functions (e.g. "…making sure that there's opportunity for public engagement in that process…"). All participants recalled receiving the information and indicated using the CHA information either for program planning, policy, and/or for accreditation purposes.

All participants felt that IRHE, as applied to the work of CHA, was very important. Several of the participants talked in great detail about the income-related health inequities that existed in their region, and often were able to relate this back to the CHA report. There was an emphasis on the importance of IRHE within the CHA process, particularly as a way of responding to the needs of the region:

> I think that it's a critical piece in being able to provide an understanding of some of the barriers that, umm, our stakeholders have when it comes to health issues. And being able to provide, ah, some solid evidence that's fact-based, ah, that we can use as a level to try and move us towards getting rid of those inequities.

Often participants would frame the conversation about health equity in regards to access to health services. For example:

> To me health equity means that anybody, regardless of age, gender, income, or any of those differences, has equal access to all the same treatments and care and everything else. There's differences in knowing how to navigate the system and certainly somebody on the inside that's in healthcare knows how to navigate and you will really notice the knowledge differences in the way referrals are done or time in the system, or who to go to, or how to get these medications through Pharmacare, stuff like that.

One individual discussed the importance of partnerships when consulting about the CHA report, or if the region needed data from a specific organization. Data was also mentioned several times from the participants regarding something that needed to be improved upon from an IRHE lens.

> Yeah, it doesn't necessarily provide a really meaningful picture as to where within that region or within that district are the true issues. Like, if there's really a pocket of population that's income or socially disadvantaged, how do we reach out to them? How do we then work with other partners to specifically target those populations? And so, sometimes without having the data drilled down enough, we tend to take more of an over-arching approach versus targeted approach…And I think you know over time, in terms of making sure that we're doing what's most appropriate, we really need to be able to drill down further.

Several comments from participants emphasized the importance of Manitoba Health needing to partner with other sectors in order to work towards addressing the SDOH within the CHA context:

> And then as a region in that context we should be, as a priority of community health assessment, talking to some of those other partners as well around what opportunities exist for us to collaborate and work together to improve the health status of socially disadvantaged populations.

Participants emphasized the importance of the provincial government's leadership as it pertains to an IRHE-focused CHA process. For example:

> Well, I think the provincial government has to ultimately take lead role, because they need to set the framework whereby all of the different sectors are working together.

> Because if you don't have sufficient income, if you don't have appropriate housing...then you likely aren't going to get post-secondary education that might enable you to get a better job. You know, all of those things that I think is, so the government has to set the tone from my perspective, and then as a component of those, you know, determinants, in terms of people who deliver health services is how, how do we ensure that we are providing access in a way that doesn't disadvantage people by virtue of their income?

The CHA guidelines were discussed. One participating stated the following about the lack of explicit language in the guidelines regarding an IRHE-focused CHA processes:

> Again, for us it wasn't something that was specific. However, it was implied. It was something that you know they were very clear that they wanted us to know about - what are the different determinants - how do we use those as something that we can go on to develop community strategies or that kind of thing.

Most of the participants felt that the community engagement process of CHA was the most important part. For example:

> Well it's absolutely, because the thing about it is that the people – when it comes to an income-based perspective, the people that have the smallest voice, are the ones that have the least amount…So their role is crucial for us to be able to gauge the effectiveness of the current program and to look at strategies when it comes to improving, tweaking or making new services for the future.

Summary of themes from document reviews and individual interviews.

System-level themes.

Other priorities. In addition to ensuring the region was fiscally responsible, one of the more significant political priorities for the province during the study timeframe was the H1N1

influenza virus. Two waves of the influenza virus impacted the province. The first wave was in the spring of 2009 and the second wave was in the fall of 2009. The first death in Manitoba linked to the virus was reported on June 16, 2009. Overall, the provincial government invested $83 million to respond to this flu pandemic (Manitoba Health, 2010). The timing of the pandemic was challenging for staff involved in CHA as the waves were linked to critical stages for the process, such as community consultation and report writing. In the ARHA region, staff were significantly impacted by the pandemic. According to the 2009/2010 annual report (Assiniboine Regional Health Authority, 2010b), in April 2009 the ARHA Corporate Incident Command System (ICS) was activated and this led to teams in the region becoming focused on the delivery of the vaccine to the region's population. Public health staff were involved in ensuring that over 3,000 ARHA staff were fitted for masks. Staff were also involved in communications, sourcing, disseminating H1N1 prevention messages to the public, confirming cases, collaborating with the First Nation communities, and immunization program planning and implementation. (H1N1 impacted all regions in the province and will not be elaborated/repeated in each case result section as it was here.)

Accreditation was another political priority for the province, with two surveys during this study's timeframe -- one in 2005 and one in 2008. Annual reports identified provincial health goals, although they were not present in every report, and the framework was not always the same. For example, in 2004/2005 the goals were referred to as "Manitoba Health Performance Deliverables," which included: Aboriginal health strategy; regional injury prevention plan; primary health care; regional disaster management program; accreditation; annual board self-assessment; mental health consumer participation; reduction in sexually transmitted diseases; best practices in immunization; regional diabetes program; and restraint policy in personal care

homes. In 2008/2009 and 2009/2010, the health goals were reduced to the following: optimize the health status of all Manitobans through prevention and health promotion; and improve quality, accessibility and accountability of the health system.

In 2009/2010 the annual report identified that Manitoba Health had approved the health plan submissions. Of the submissions, 52% were senior services-related, 19% were mental health-related, 16% were health promotion-related, and 13% were ambulatory-care-related. Many of these submissions would not be considered advancing the SDOH, but a combination of health services and health promotion. In addition, the board meeting minutes lacked any reference to IRHE or the SDOH.

Lack of provincial leadership. There was also evidence from some of the documents and key informant interviews that provincial priorities were not always clear, and this impacted their work. According to the Canadian Council on Health Services Accreditation Canada (2005), "The RHA needs to continue to work with government to get clear direction on priorities for service delivery" (p. 5). A few of the key informants stated that there is a need for the provincial government to take the lead in establishing a framework for an IRHE-focused CHA process. The CHA guidelines, which were a result of a working group coordinated by the province, were discussed, although most participants were not aware of them in any detail. The guidelines provide some direction to the regions to consider a *population health framework,* although there is no clear statement – from an IRHE lens – on how to integrate this into the process.

Overall, it was clear from the documents and key informant interviews that the region and Manitoba Health had other priorities during the study timeframe, which may have taken away the possibility of an IRHE- informed CHA process. In addition, there appeared to be a lack

of direction and/or leadership from the province regarding advancing the SDOH of the people of the region.

Organizational-level themes.

CHA-related partnerships are unclear. The document reviews for ARHA revealed that significant attention and efforts were made to develop and build partnerships in the region during the study timeframe. However, while the majority of these partnerships were related to health, they were rarely discussed in the context of CHA or IRHE. Key informant interviewees suggested various partners who were known to work with low-income populations and would have been thought to meet the criteria to participate in this research project. Unfortunately, despite several attempts, no partners could be reached. Only one interviewee responded to the initial interview request and stated that they did not really remember anything about CHA and would not identify it as a *partnership*. That said, many documents identified the important of *partnerships with Indigenous peoples* in the community.

Participants described their relationship with the CHA partners as fairly simplistic, with partners providing data for the CHA report or responding to the draft results of the report. Sometimes partners could provide added information that would be considered helpful to the CHA process. In general, the relationship was short-term and focused on the CHA report and associated activities. Partnership development and building, while important, was considered costly and time-consuming. In addition to the lack of resources creating challenges to partnership building, many respondents spoke of the difficulties of developing and maintaining partners in their widespread region.

Leadership isn't consistent/disconnect from CHA. Overall, document reviews consistently found evidence of strong leadership at the senior management and board-level,

although it should be noted that this was not in the CHA context. The board was actively involved in the region during this study timeframe, although there were only a few references to the CHA process (e.g., Board requesting consultations with specific groups that could be considered socially disadvantaged, board members actively attending consultation sessions). In fact, many board members were upfront that their knowledge of the actual CHA process was quite limited, and this was to be expected given their role in the region. Some CHA representatives expressed appreciation for board and senior management support and involvement in the CHA community consultation process. Every participant could easily suggest one person who could be considered a *leader* in the CHA process, especially from an IRHE lens.

Capacity concerns. All participants valued the importance of health equity - personally and professionally - and expressed their belief that the region also valued equity. That said, there were mixed responses about the region's commitment and actions from an IRHE lens on a day-to-day basis. For example, one individual stated that IRHE was not a lens that was frequently discussed regarding program planning. There was also recognition from the participants that, although they tried as much as they could, they were sometimes limited in what they could do in this regard. Although one individual could not agree fully with the statement that the region was committed to IRHE, they felt hopeful that things were changing.

It was clear from the interviews and document review that the CHA process is an enormous amount of work and requires specialized skills. CHA representatives have other job responsibilities in addition to the CHA work, and other regional priorities can also lead to a very full workload. Although the annual reports and accreditation reports commend the CHA process for its strength, not a lot is known about the day-to-day requirements and work tasks associated with a comprehensive CHA process. For example, community consultations and partnership

building for a large and culturally diverse RHA can be very challenging. Applying an IRHE lens to the CHA process would require additional resources and likely the need for a review on current CHA processes.

Although the region was able to receive additional funding in the third cycle for their community consultations, they were not successful in reaching residents from lower incomes and/or socially disadvantaged backgrounds. Other challenges in the CHA department centered on data quality and resources required for CHA-related partnerships.

All interview participants believed in the concept of IRHE, and all agreed that it was important to the work of the CHA process, although there were limitations to what they could do as RHA employees given the resources and tools they had to work with. As mentioned by one individual: "It likely should be incredibly important, but because of the limitations in the data that we receive we aren't able to do terribly much with it."

Community engagement is key. In several documents, the importance of evidence from the CHA process was highlighted. The importance of evidence was also raised by the interview participants. It was commonly agreed upon that both quantitative and qualitative information was important to the CHA process. Several participants felt that community engagement was one of the most important parts of the CHA process.

Individual-level themes.

Access to health services orientation. An orientation towards talking about and framing conversations related to health as *access to health services* was a theme that arose from the interview and document review data on an individual-level. Throughout the interviews, it was very common for participants to respond to IRHE questions from the perspective of *access to health services*.

Some participants were more upfront about talking about health services when asked about SDOH than others who did not appear to have insight into this change in perspective. For example, "Okay. So, from a health perspective what I do…*"* and "The thing about, our primary reason for being, um, as health care organizations in Manitoba is defined in the legislation, it`s for the delivery of health services. So, certainly you shouldn`t have issues around access to health services by virtue of income in any shape or form." All participants felt that health equity was an important topic, however, and some framed their discussion about health in a broader context.

A review of the documents revealed no discussion about IRHE and CHA. However, towards the later years of the study timeframe, there appears to be the beginning of board-initiated interest in the SDOH. For example, "The Board recognizes the importance of addressing health inequalities when planning and setting priorities for health programs and services" (Assiniboine Regional Health Authority, 2011a, p. 10) although there was no explicit connection to the CHA process. This is also consistent with the board meeting minutes, where SDOH just started to be discussed in 2010.

Concluding remarks regarding the ARHA case. The ARHA case is unique due to the following factors: widespread and large geographic area, making communication a constant challenge; rural and agriculture-based region; higher population of residents age 65 years or older; culturally diverse, including several First Nation reserves and Hutterite colonies; has median income levels and low-income prevalence lower than the province; and displays a variation of income levels across the districts, although there are key pockets of the region that are definitely more likely to have lower incomes.

Based on the information gathered from the key informant interviews (both CHA representatives and board members/senior management) and the document reviews, it can be concluded that the region did not apply an explicit IRHE lens to the CHA process. However, several efforts were made in subtle ways that contributed to a CHA process that considered IRHE.

For example, the region attempted to analyze the data from an IRHE lens, although they were limited in being able to drill down into specific areas of the region. Most health indicators were analyzed by district and not by income. Partnerships, especially with Indigenous communities, were seen as a priority in the region, but not necessarily connected to CHA as it was an overall emphasis for the RHA at the time of the study. Partnerships were unclear in the context of CHA. This was further confirmed by a lack of response from any partners to participate in the study. More importantly, most of the partnerships mentioned in the documents and interviews were partners of the RHAs, in general, and not connected specifically for the purposes of the CHA process.

Although community consultation was comprehensive and widespread, it was not successful with people from disadvantaged socioeconomic backgrounds. Participants expressed disappointment that the community consultations were not successful in involving those members of their region who would be considered disadvantaged, but they were clear that they were not given explicit instructions to do so nor did they have the resources.

Parkland Regional Health Authority (PRHA) Case Results

The PRHA region is a large area (~ 34,000 square kilometers) of the province with a population of 40,058 in 2006 (PRHA, 2010b). Since 1996, the population had decreased by more than 3,000 people. The percentage of older adults (aged 65 years and over) is higher in this

region (20%) compared to the province (14%) (PRHA, 2010b). The region is home to several First Nation communities and has the fourth highest percentage of Indigenous peoples in Manitoba. Indigenous peoples are younger compared to non-Indigenous peoples in PRHA (45% under the age of 19 years compared to 28%). PRHA is largely rural, with 35.6% of the people living in Dauphin, Manitoba. The PRHA had the highest dependency ratio compared to all other RHAs in 2006. According to the 2010/2011 annual report, "the major economic industries and employers within the region are agriculture, forestry, construction, manufacturing, retail trade, health and social services, government services, and education" (PRHA, 2011b, p. 11). In 2006, the median household income for PRHA (i.e., $33,314) was the lowest of all RHAs and well below the provincial average of almost $50,000. Median individual incomes for the residents of PRHA were also well below the provincial average, with Indigenous peoples having even lower levels (i.e., $13,396 for males and $13,955 for females). However, in 2006, the proportion of residents below the LICO was similar to the provincial average.

The health of the residents of PRHA is a concern for people in the region, with many believing that the low incomes in the area are impacting the communities (PRHA, 2010b). The region has significantly higher rates of cardiovascular disease and diabetes compared to the province. According to the health assessment, "Parkland has lower rates of depression and substance abuse compared to the Manitoba average and similar rates of anxiety disorders, schizophrenia, personality disorders" (PRHA, 2010b, p. 111). The region has higher levels of *fair/poor* self-rated health compared to the province (14.1% vs. 11.6%).

PRHA had a general health advisory council and a mental health advisory council, with a total of 38 representatives (Beattie, 2011). The councils reported to the board and presented council reports on strategic planning criteria and priorities.

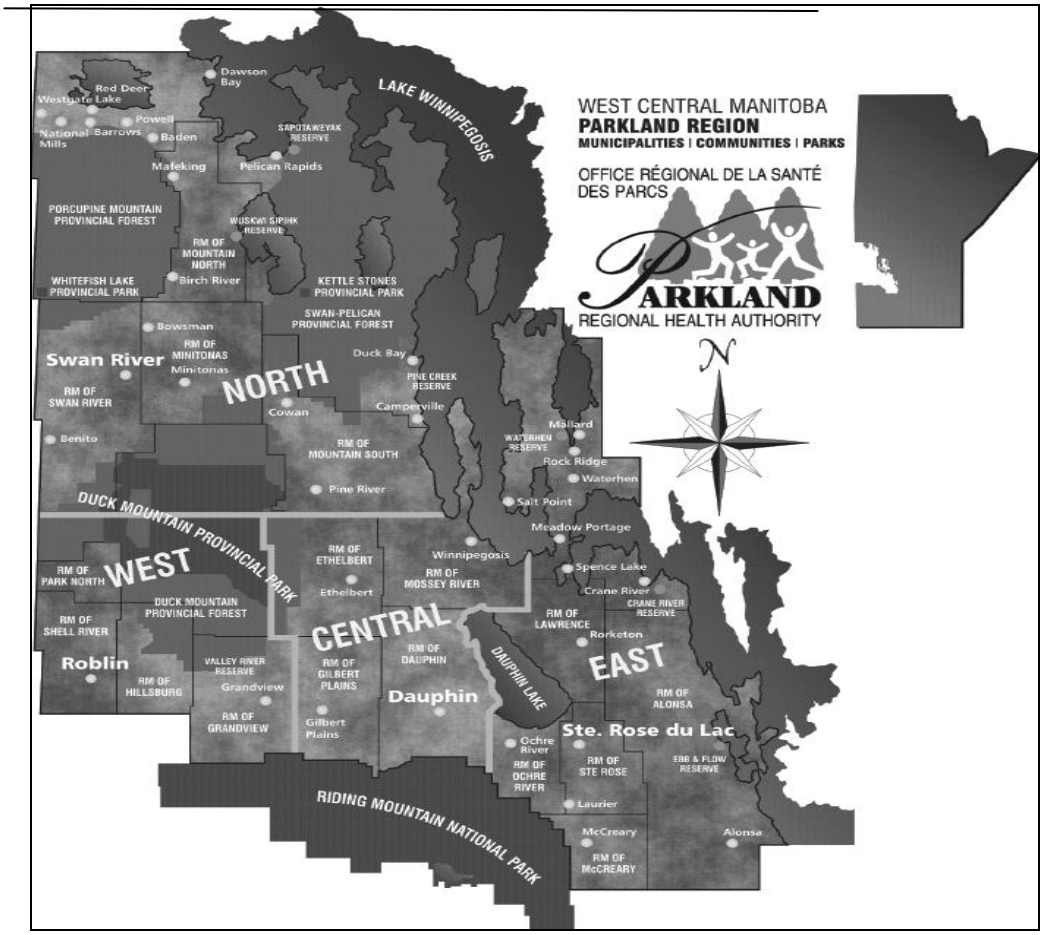

Figure 8. PRHA Districts. Reprinted from Parkland Regional Health Authority (2010b).

Findings from document reviews. The PRHA did not have any accreditation reports available for the third cycle timeframe, nor was it possible to find any online, or through the Government of Manitoba Digital Collection website. Minutes were not available for the community/district health advisory council meetings, nor from the executive management meeting minutes. Documents reviewed included the board meeting minutes (September 2004 – December 2010), annual reports, CHA reports (2004 and 2009), the strategic plan for 2006-2011, and the available meeting minutes from the CHA working group.

Board meeting minutes. Approximately 550 pages of board meeting minutes from fall of 2004 until the end of 2010 were reviewed during the study timeframe. The health assessment process was mentioned on less than 10 occasions, usually when board members were given a presentation of the findings, or if there were consultation sessions in the region at that time. There was a general lack of discussion about the SDOH, although there were two to three references to some of the poverty issues in the region. Other than these findings, there was not much more information related to the CHA, or any of the key terms used to search the documents.

Annual reports. The 2004/2005 annual report highlighted several of the region's accomplishments, including the 2004 CHA, which was mentioned by the CEO in his introductory greetings (Parkland Regional Health Authority, 2005, p. 4). The CHA was a major focus in the fall 2004 Advisory Council Workshop, and a separate communication was developed to further spread the word of the CHA and its findings. The Board Chair mentioned a focus on partnerships and communication for the 2004/2005 year and discussed some of the challenging aspects of the region, including health and health care delivery, financial issues and human resources concerns.

The 2005/2006 report referenced a follow-up workshop in the fall of 2005 regarding the 2004 health assessment. The CHA was also referenced as contributing to the upcoming strategic plan. The majority of the report focused on the challenges and accomplishments of the region that year, which was heavily focused on access to health services and related issues. A section on healthy lifestyles, which is part of the board's mission, was included. Partnerships and the training of staff in community engagement were highlighted in the report. In particular, reference

to a *Community Relations Committee* was noted. This committee is a sub-group of the board, which makes recommendations about communication with stakeholders.

The 2006/2007 report highlighted the new strategic directions for the region. One of the strategic directions, called *Healthy Living*, includes a goal that will "target specific population of communities to reduce inequities in health status" (Parkland Regional Health Authority, 2007, p. 13). Accomplishments related to reducing inequities included staff partnering with key stakeholders to work towards improvements in the broader determinants of health. One of the challenges/future directions of the region was to continue exploring "ways to strengthen partnerships that lead to improvements in the broader determinants of health" (p. 13).

Although inequities were mentioned in the 2006/2007 report, there was no mention explicitly of inequities or the SDOH in the 2007/2008 or the 2008/2009 reports. The reports between 2006 and 2009 were organized by the strategic directions, with discussion on how the PRHA has been working towards improving the health of the region, including Indigenous peoples and seniors. There was some reference to the CHA report, with a presentation given to the Advisory Council on the CHA timeline in the 2007/2008 report and preliminary findings being shared at a meeting with the Council in the 2008/2009 report.

There is evidence from the 2009/2010 and the 2010/2011 annual reports of the third CHA findings being shared and used for strategic planning in the region. In particular, in 2010/2011 the Advisory Council reviewed the CHA results using the SWOT method (strengths, weaknesses, opportunities, threats) to help the board select criteria for the strategic plan. There was also an overview of some of the third CHA findings, including population trends and a section exploring the socioeconomic status of the population (Parkland Regional Health Authority, 2011b, p. 12). There was reference to the region needing to continue to work with

health partners and stakeholders in reducing disparities in the region. The 2010/2011 annual report included the most amount of information relating to the CHA and low income compared to any of the other reports for the region.

Community health assessment reports. Two CHA reports were analyzed from an IRHE lens exploring indicators, efforts to involve low-income populations in the community engagement process, and any efforts to involve partners who worked with low-income populations. The 2004 CHA report had less of a focus on IRHE compared to the 2009 report. Health indicators were analyzed by district. An income inequality statistic and the socioeconomic factor index were included in the report; neither statistic varied from the provincial average. There was limited information on community engagement strategies or qualitative information, although there was reference to members of the community who believed the socioeconomic challenges for PRHA were in the isolated communities, such as the North and the East districts.

The 2009 CHA report referenced a population health framework approach, in the form of a puzzle, to its planning, with income being highlighted as one of the more important determinants of health. Overall, the theme of income and health was apparent throughout the report. Income-related data was provided for many health indicators, although the information was not always visually available and easy to miss. There was acknowledgment of missing data from Indigenous peoples, although this was something the region was working on with their partners. Specific health indicators in PRHA were not reported by income levels, with most being explored at the district level. However, in several sections the authors refer to health conditions and income from other sources and research from Manitoba.

Several community engagement strategies (e.g., café-style community presentations, key informant interviews, workshops, focus groups) were employed to reach members of the PRHA in health discussions. Although the authors state that "the consultations attempted to create a dialogue with some of the region's more marginalized communities" (Parkland Regional Health Authority, 2010b, p. 3), evidence from the key informant interviews, coupled with a review of the qualitative comments from the community meetings in the report, suggest representation from more advantaged members of the region. For example, some of the comments from the community sessions centered on personal responsibility and judgement towards people with poor health and/or health issues. On the other hand, some qualitative feedback was consistent with an IRHE approach. For example, "There needs to be greater public awareness on issues such as the environment, the determinant of health and advertising directed towards children" (p. 75). There was no information in the report about any specific considerations made to reach individuals from low incomes.

Strategic plan 2006-2011. The six strategic directions in the plan included the following: healthy living; Aboriginal health; seniors' health; integrated, sustainable health system; system performance improvement; and human resources. Many of these categories were discussed in the annual report reviews.

Meeting minutes from CHA working group. Although only a few meeting minutes were available for review, it was apparent that the CHA process involved several staff and was resource-intensive. Of particular note is documentation concerning their efforts to include information from Indigenous communities, which was a large gap identified in the 2004 CHA report. Attempts were made to encourage participation, but they were largely unsuccessful. Issues highlighted included no engagement process and limited data available.

Findings from the key informant interviews.

CHA representatives. Of the three eligible CHA representatives, all participated in the interviewing process. Roles in the PRHA varied from planning/leading the entire CHA process to being involved in the community consultations to report writing. Most of the representatives were involved in the PRHA CHA process for several years. All participants knew the area very well and had lived in the region for a long time. The participants were familiar with the data available for their region and all were aware of the impact of income-related health inequities among residents of the region. As stated by one individual:

> I think from a health status perspective, as you go north, it becomes poorer, poorer health status and in a lot of cases it has been shown to be linked to income. So, Parkland compared to the others, we tend to be on the poorer health status side compared to the other regions.

Similar to other regions, there was recognition among participants of the limitations of the data in identifying income-related health inequities in the districts. For example, "We didn't get income by district, but I think because we got health status information by district, we sort of made that link. We sort of know where some of our poorer areas are…North, North-East". Most participants noted that, even though they saw some issues with the data, the residents of PRHA know where the poor areas are – this is their story and they cannot tell the story without community input and perspectives.

All participants were passionate about health equity and saw great value in applying this lens to the work of health assessment. However, many individuals also noted that even if you feel strongly and passionately about IRHE, the actual ability to put this work into practice is a very complex and challenging task. That said, there was discussion about the importance of

educating future leaders in the area of health equity. Some of the professional backgrounds that were considered ideal for an IRHE-focused CHA included population health and prevention, health promotion, human ecology, political science, and experience with non-profit groups. One individual expressed concern over the medical model-focused training for health care professionals. They discussed how this type of training can have detrimental effects on the CHA process in that it may end up having individuals focus on health services and/or life style perspectives rather than the broad picture of health. As one individual stated:

> And this is why some of these focus groups came up, I had a (colleague from a health care background) say to me "based on some of the data about you know fruit and vegetable intake, high obesity rate, high BMIs" and we have you know low physical activity rates and so she said to me, she made this offhand comment which kind of angered me, she said "well if they only knew the Canada Food Guide" and I said to her, I said "there's more to just knowing the food guide…I don't believe these women running these families don't know the information about health eating, there's other issues going on in their communities that are impacting their access to food. So that is why some of these, the questions do come up, because I said this data is not telling us everything…It's not telling us the true picture.

Participants were asked to comment on the CHA guidelines and their potential to identify and address IRHE issues. Similar to other regions, the participants knew of the guidelines, but felt unable to discuss the potential of the guidelines to steer the CHA process towards an IRHE lens. One individual commented that the guidelines could certainly be revised to include an IRHE lens and this would be helpful for planning purposes. As stated by one participant:

> You know and without reviewing the guidelines I think um, I think it would be, it should be easy if they're not there already, to look at what lens do you look at your information and are you considering income or equity period, gender, whatever, and what are those pieces that we might need to consider.

Participants often mixed up partners and community members and it became quite clear during the interviews that many of the organizations and groups that the region consulted with during the CHA process were likely not *true partners*. There were mixed feelings from the participants regarding special considerations for working with partners representing people from lower incomes. Based on the interviews and the context, a decision was made to contact one individual who was considered a partner with the RHA as it pertains to the CHA process. Unfortunately, the participant was unable to meet for an interview.

Participants were asked to discuss the special considerations that were made in their regions during the community engagement sessions to ensure that low-income populations were included. If any special considerations were made to include participants from lower incomes, it was mostly credited to the community member who helped to set up the sessions, and some could not even speak to the accuracy of such considerations. The lack of considerations and efforts to involve more community members related more to the capacity of the CHA department and less about individual preferences or values.

In addition, there were mixed opinions relating to the community/district health advisory councils and their representation from low-income populations. One individual recalled efforts to get a broad representation, but stated that recruitment is a huge issue in the region across the board.

Board members and senior management. Of the four board members and senior managers identified to be interviewed for this study, two completed interviews, one declined and one could not be reached. The board member and senior manager were asked a series of questions, such as their role in CHA, importance of IRHE, priorities in the PRHA, roles in IRHE-focused CHA work, and thoughts on improvements to the process.

The participants had several years of experience on the board and/or management level. Involvement in the CHA process over the years was a mixture of oversight, but also some involvement in community consultations, especially in the very early years of third CHA. Both participants recalled receiving and using the CHA information-either for program planning, policy and/or for accreditation purposes. Both participants felt that IRHE, as applied to the work of CHA, was very important, but indicated frustration over the lack of action, even among those with a passion for the SDOH, such as education and income. As stated by one individual:

> Well income inequity I think is a major component of our health determinants and I think especially we see that in Parkland. I already alluded to that. I mean I think it's really an important piece of what we find in our community health assessment. But it has been very unfortunate because, um, it, we haven't seen changes. I mean, it's not just in income inequity. It also related to education.

The participants talked about health from a SDOH orientation exclusively. As stated by one individual:

> Because if you don't use that data, what are you using to be able to prioritize? We talk about the health of our population – with the health determinants we know it's so much more than that and that's always been part of the challenge. If you sit there in your silo and say, well it's only about the health component, well, we've known it for years that

> it's the health determinants that drive health services. When you look at the health services they're just, what look at every small little piece in there, the health determinant. People are always shocked when we put those pieces together, you look and say 'wow'. We spend an awful lot of money in hospitals.

Partnerships with Indigenous peoples in the region was highlighted as key to the CHA process but also framed as a *work in progress*. On a provincial level, partnerships outside of health were suggested to make the CHA process more IRHE-informed. Participants also discussed the need for more provincial leadership (i.e., Manitoba Health) to inform an IRHE-focused CHA process. For example:

> Well I think that the health, what it should be doing, it should be guiding the health branch to be partnering with all the other branches for the various needs and services to make sure that we aren't just going off on one tangent or another. Um, where we are spending our dollars *has to improve*, because if all the money, if we just put all the money into health and don't put the money into the other inequities, we're not going to improve the health...So for me, it would, they should be setting and it should be one of the elements that should be used for our vision for this province sometime, where are we seeing our province going in the future?

Summary of themes from document reviews and key informant interviews.

System-level themes.

Other priorities. During the study timeframe, it was clear through the document reviews and interviews that the PRHA was trying to balance many different priorities, including the H1N1 crisis, developing and strengthening partnerships with Indigenous peoples, financial issues, recruitment issues, health service access, and working towards improving the health of

the population. While CHA was mentioned several times as feeding into the strategic planning sessions, there was limited information on CHA and IRHE issues throughout the study period.

Lack of provincial leadership. Participants felt that Manitoba Health could take a more active role in ensuring that other departments work with Health in working to address the SDOH. Similar to the interviews with ARHA participants, most of the individuals interviewed in PRHA were not too familiar with the CHA guidelines but felt that there could be some improvement to make the CHA process more IRHE-focused.

Organizational-level themes.

CHA-related partnerships are unclear. Similar to other regions, there was confusion as to who the true partners were with PRHA as it related to the CHA process. Efforts to interview one of the eligible partners was unsuccessful.

*Indigenous partnerships are key.*The majority of the participants (CHA representatives and board/senior management) stressed the importance of partnering with the Indigenous communities from an IRHE-informed CHA process. Besides a focus on involving other departments and partners outside of Manitoba Health, no other group was discussed in as much detail as Indigenous peoples for the PRHA case.

CHA Leadership (can be learned). Participants talked about leadership of an IRHE-focused CHA process mostly from the perspective of specific professional training. Examples provided of good leadership from an IRHE-focused CHA usually involved someone who had a professional background in a specific area. Participants expressed the importance of education and how important this is when working with members of the community.

Independence is valued. In addition to the need for Manitoba Health to provide more leadership regarding a system framework for addressing the SDOH, all of the participants felt

that the regions should be leading the CHA process because they know their communities the best and did not feel that anyone else would have the same knowledge or perspective: "I am not sure if a person who has never lived in poverty, if they can have the same perspective." People who are connected to the communities and can tell the full story about health in their region; those are the leaders of CHA.

Capacity concerns. Similar to the ARHA, it was clear from the interviews and document data that the CHA process is an enormous amount of work and requires specialized skills. CHA representatives have other job responsibilities in addition to the CHA work, and other regional priorities can also lead to a very full workload. Applying an IRHE lens to the CHA process would likely require that the region focus its work to only include communities from lower incomes, unless more resources were available.

Individual-level themes.

An individual-level theme that arose from the interviews and document review data was the *SDOH* orientation. A *SDOH* orientation means talking about and framing conversations related to health in a broader-socioenvironmental context. For example, when asked to talk about health equity, participants with a *SDOH* orientation would frame their discussion around health in a broader sense and are less likely to talk about health care and services and lifestyle choices. When asked if, at any point, the CHA team talked about providing an IRHE lens to the CHA process, they all responded that they were just telling the Parkland story.

Concluding remarks regarding the PRHA case. The PRHA case is unique for a variety of reasons. For example, it is widespread and has a large geographic area, making communication a challenge. The region is rural, remote and there are significant health services access issues. There are constant recruitment issues in the region in general, making community

engagement an even greater challenge. The region is home to a culturally diverse population, including a significant Indigenous population. The region has a high dependency ratio and has a high senior population. There are IRHE issues throughout the region, with PRHA having some of the worse IRHE concerns in the province.

Based on the information gathered from the key informant interviews (both CHA representatives and board members/senior management) and the document reviews, it can be concluded that the region did not apply an explicit IRHE lens to the CHA process. However, several efforts were made in subtle ways, which contributed to a CHA process that considered IRHE. For example, the region attempted to analyze the data from an IRHE lens, but the information was difficult to find within the report. Partnerships, especially with Indigenous communities, were seen as a priority in the region, and were discussed in the context of an IRHE-focused CHA process. There were no explicit attempts to ensure that partnerships also represented people who worked with low-income populations. There was confusion from participants if partnerships were *true partners* as it related the CHA process or just in general. Efforts to interview the one participant who was endorsed by the region's key contacts as a *true partner* of the CHA process was not successful.

If any special considerations were made to include participants from lower incomes, it was mostly credited to the community member who helped to set up the sessions and some could not even speak to the accuracy of such considerations. The lack of considerations and efforts to involve more community members related more to the capacity of the CHA department and less about individual preferences or values.

Brandon Regional Health Authority (BRHA) Case Results

The Brandon region includes the urban city and three rural regions (i.e., Cornwallis, Elton, and Whitehead) comprised of 50,541 people. The city is growing (6% increase from 2001 to 2008) and is facing significant challenges, such as a dwindling agriculture industry, poverty in pockets of the city (e.g., Brandon Central), high mental health disorder rates, and a growing new immigrant population to the region (Brandon Regional Health Authority, 2009b). The city of Brandon is the second largest in the province, and it covers approximately 67 square kilometers (Brandon Regional Health Authority, 2004, p. 3).

Several indicators of poor health were found in some districts of Brandon, such as Brandon Central (see Figure 9). The premature mortality rate for Brandon Central was significantly higher than the Manitoba average in the 2001-2005 timeframe. In fact, Brandon Central had a premature mortality rate higher than all RHAs except for Churchill, Nor-Man, and Burntwood. The largest proportion of residents who reported their health as *fair/poor* live in Brandon Central, followed by Brandon West. The proportion of BRHA who reported fair/poor self-rated health was similar to the provincial average (11.3% vs. 11.6%). Life expectancy for both males and females was lower in Brandon Central compared to the province in 2001-2005 (Brandon Regional Health Authority, 2009b). The region had a Provider Advisory Council (PAC), which is a provincially legislated group comprised of 15 health care providers including appointees from rural municipalities and ARHA (Beattie, 2011). The BHRA did not have a community health advisory council.

Up until 1999, the Brandon Mental Health Centre was a very large institution serving many people and their families living with mental health issues. When the institution was closed, most of the patient population was forced to live in the community. It is unknown how this de-

institutionalization impacted Brandon and its residents (including the patients and families themselves), but MCHP data shows that the prevalence of mental illness in Brandon was the highest in the province (Martens et al., 2004). In addition, the prevalence of cumulative disorders among Brandon residents was significantly higher than the province in the second time period (2001/02-2005/06), and was increasing significantly over time (Fransoo et al., 2009). MCHP data shows a strong relationship between mental illness and income levels in Winnipeg and Brandon, although this pattern was not evident in rural areas (Fransoo et al., 2009).

The median household income for residents in the Brandon region was $40,732 in 2006, which is slightly lower than the provincial average of $41,661. Overall, there has been a consistent increase in average household income in the Brandon region (16% and 21% increases for 1996-2001 and 2001-2006; respectively). Median individual incomes for males in the Brandon region were higher compared to males in Manitoba. Although median incomes for females were similar to the provincial median statistics, they were significantly lower than their male counterparts; this trend was common among the regions. For example, in 2006 the median individual income for females in the Brandon region was $20,659 compared to $31,688 for males in the same region. This difference may be related to the differences in labour force participation rates between males (76%) and females (65%) in the region.

According to the LICO, Brandon Central, Brandon East, and Brandon North End tended to have higher percentages of low incomes. For example, 19% of families in Brandon Central reported low income compared to 5% of residents in Brandon rural. Across all districts in the Brandon region, low-income rates were higher among unattached individuals. Overall, the low-income rates in the Brandon region were similar to Manitoba's rates. However, pockets in Brandon (e.g., Brandon Central) reported higher low-income rates than the provincial average.

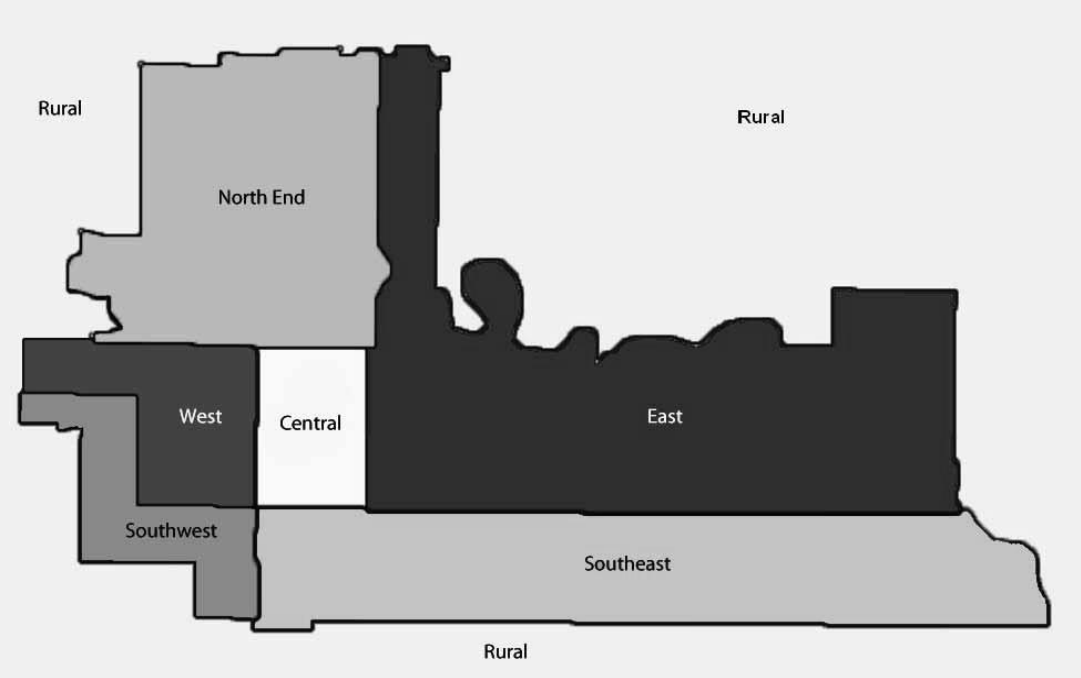

Figure 9. BRHA Districts. Reprinted from Brandon Regional Health Authority (2009b).

Findings from document reviews. Although CHA team meetings occurred, minutes were not recorded as they were more focused on planning involving details about report layout and data analysis. Executive management meeting minutes and the strategic plan were not available. Documents reviewed included accreditation reports, board meeting minutes, annual reports, and the CHA reports (see Table 3).

Accreditation reports. Every three years the RHAs engage in the accreditation process, which evaluates the quality of RHA services against nationally accepted standards. Accreditation was prepared by the Canadian Council on Health Services Accreditation (2006), and by Accreditation Canada (2009b). The surveyors from the 2006 report indicated that CHA is a strength for the region, with teams regularly using the information in understanding clients, bed utilization, and in planning services. The Population Health Planner/Analyst was also mentioned as a strength, with the surveyors reporting that "this work (promotion of population health

philosophy in program planning and evaluation) needs to continue" (Canadian Council on Health Services Accreditation, 2006, p. 4). The strong linkages and partnerships with the community (including the ARHA) were also highlighted.

The 2009 reported that the BRHA only had access to dated information from 2004, with the current CHA process underway. However, actions based on strategic priorities and the CHA were highlighted and seen as a strength. The surveyors noted that the region did not have a population health improvement plan in place, but that "strong supportive community partnerships are in place that recognize and work collaboratively on the determinants of health to contribute to a healthy population" (Accreditation Canada, 2009b, p. 3). Some challenges for the region included some programs continuing to operate within their own silos and inconsistencies in communication between management and staff across the regions. Community partners mentioned that they would "appreciate more collaboration regarding aboriginal initiatives around education" (p. 5).

Board meeting minutes. Just over 500 pages of board meeting minutes were searched by key search terms relating to CHA and IRHE. Overall, and consistent with other regions, CHA was rarely mentioned (n = 36), unless the information was being presented or shared to staff. There were several references to CHA relating to strategic planning or any discussions on *evidence*. CHA is clearly valued and seen to contain very useful information. BRHA was the only region to include a few examples of CHA results being used (i.e., service delivery improvements, development of a teen clinic, wait list initiative) in the board meeting minutes. CHA was mentioned a few times as one strategy of BRHA for obtaining information on consumer needs. There were several references to the pandemic flu becoming a priority in the region and how this created some challenges to the CHA process.

The CEO mentioned the impact of low income on health a few times in the study timeframe. The Board Chair also wrote a letter to the Minister of Finance asking for an increase to the social assistance housing allowance in the upcoming budget due to concerns relating to the mental health clients in the region. The leader of the CHA process was mentioned in the minutes several times, usually relating to a project focusing on improving the social conditions of BRHA residents.

Annual reports. The 2004/2005 annual report highlighted the importance of CHA data in the CEO's greetings (Brandon Regional Health Authority, 2005, p. 2). The CEO mentioned that balancing the budget was a key priority for BRHA that year. One of the strategic priorities mentioned in the report focused on improving the health status of the community. One of the examples related to that priority was a bus pass program for income assistance recipients.

In the 2005/2006 report, the CHA findings were highlighted as leading to the development of the Chronic Disease Project; a project looking to improve the health of the Brandon region, although the approach taken appears to be from a healthy lifestyle perspective. In 2006/2007, the CEO mentions BRHA's commitment to a population health approach. Some of the CHA findings regarding determinants of health were summarized, although there was only one line on income.

The 2008/2009 and 2009/2010 annual reports rarely mentioned CHA, and instead focused on highlighting challenges relating to the changing demographics of the region and the economy. Although the third CHA report was released in 2010, there was only a few sentences devoted to it in the 2010/2011 annual report. The 2011/2016 strategic priorities were highlighted, with only one somewhat related to IRHE: "people-centered and evidence-based programs

supported and sustained by effective resource utilization" (Brandon Regional Health Authority, 2011, p20).

Community health assessment reports. Two CHA reports were analyzed from an IRHE lens exploring indicators, efforts to involve low income populations in the community engagement process and any efforts to involve partners who worked with low-income populations. The 2004 CHA report defines health assessment as an "ongoing process to identify the strengths and needs of a region" (Brandon Regional Health Authority, 2004, xi). The review of the report revealed that the income indicators were not provided at the district. Health indicators were not reported by income levels.

The community consultation strategy for this cycle included telephone surveying, in-home surveying (i.e., Kitchen Table Chats), and personal interviews. The purpose of the in-home surveys was to explore health with individuals living in the central area of Brandon and to learn more about the underserved population. The intention was to talk with new immigrants, First Nation and Metis populations, seniors, and those living in poverty. In the end, a total of 209 surveys were completed, but with only 10% representing First Nations and only 12% representing newcomers to Brandon. However, the in-home survey model is a great example of a community consultation done with an IRHE lens. Unfortunately, the third cycle CHA for Brandon did not have adequate resources to complete the Kitchen Table Chats.

Improvements to the districts (i.e., making them more useful and relevant) occurred with the release of the 2009 CHA report. In addition, low-income rates were available for the BRHA districts. Most health indicators were analyzed and reported by districts; some of this information was displayed visually, but some of it was in text. One indicator (i.e., having a physician) was analyzed by income. Community consultation was done through targeted focus groups, which

centered on improving service delivery and assessing health needs. A telephone survey was also completed in the region. This survey included 400 residents through random digit dialing. There were no efforts to oversample low-income or disadvantaged populations. One of the focus groups was done with new immigrants and the telephone survey was analyzed by income, although the comprehensive results were not available in the CHA report.

Findings from the key informant interviews. Semi-structured interviews were completed in-person with CHA representatives (n = 4), board members and/or senior management (n = 6). All interviews were done in-person and in locations convenient for the participants. No community partners were identified for interviewing.

CHA representatives. Roles in the BRHA varied from coordinating and leading the entire CHA process (and previous CHA) to participation through data analysis and presentation to formatting the report. All of the representatives were involved in the BRHA for at least two years, with some having significant experience in the region through various roles. The participants were familiar with the data in their regions. In particular, many participants referenced the high rate of mental health issues among Brandon residents. For example,

> I don't know if it's, I don't know what starts first, but Brandon has a way higher rate of mental health issues than the rest of the province. But there is a whole history behind that. Right, we used to have the Manitoba Mental Health Center, then they closed that. A lot of the people that lived there just stayed in the community. So, we have a higher population with mental health issues because this is where the services are. And because they have mental health issues they have no income. Because they cannot secure a job that would give them a high income.

Another participant added to the discussion around mental health among Brandon residents:

> Another thing that stood out first and foremost was mental illness. And ANY mental illness. Just choose any one of them and we're way higher. And there's lots of, there's lots of thought around the fact that we've got the diagnostics here, we've got the facilities here. I'm not sure it's quite that simple.

Review of the BRHA CHA report found no documentation of median income of individuals and households by district level, although participants seemed to be aware of the areas in the region that were likely lower income. For example, when asked about IRHE data in their region, one individual said, "When you have 90% of people living in the West End with a family doctor and 10% in Central". District level data for low-income prevalence was found in the report.

Except for the one year delay in obtaining data from the province, the participants expressed satisfaction with the data they received as part of the CHA process. One individual explained how they were able to move from three large districts to seven in the 2010 report and how this has been extremely helpful from an IRHE perspective:

> So, that led up, um, so then I used the Public Health Districts - because Public Health had adopted a neighbourhood nursing concept - so at that time they had these different neighbourhoods established, and they were based on, primarily three things: one was the birthrate; one was the number of schools; and the other was the number of seniors. To try and make the workload relatively equitable. And then there was a Public Health nurse assigned to each neighbourhood. So, I thought, well if they already have that map in place, why wouldn't we try and replicate it if we can? And so, then I needed to look up population numbers to make sure that we would be able to report, right? And so, what we ended up coming up with then, rather than East, West and Rural, were these districts,

> which I knew then would give me a better snapshot of people living in, within low incomes, and then what are the health inequities that, that could be geographically…

All participants agreed that the topic of health equity was important in general, and from the perspective of the work of health assessment. Most of the individuals stated that, even though the work of CHA is important, they often felt powerless regarding having the ability to make any progress from an IRHE perspective. In particular, one individual explained how the *action* piece of CHA has been a very important area that has been overlooked, "Yes. I, my department – it (IRHE) was very important in my department. There was an absolute commitment to address it. Where we fell short as an organization is, is in the taking action. Is doing something about it." Participants expressed concern over the capacity of Health to make a different in IRHE in their region. For example:

> I think it, it is very important but the problem is when you're doing the community health assessment process from a health organization, sometimes you're even powerless to actually influence income. I mean it takes kind of a completely different approach to the role of the regional health authority that has to take in society. To actually solve the problem…I think, at least from the team that was doing this, we have clear understanding of the determinants of health and population health. So, we know…that the influence that the region has to change that is just a small part of the big picture. You need way more, you need the whole society to work together. To actually improve it. You need government, you know, different levels of government, you need private industry to participate, like it's just, it's way bigger.

Participants also expressed concern over their ability to make change when CHA is seen as such a low priority in comparison to other acute care issues in the region. For example:

> Um, another problem – our organization is so focused on acute care and getting our wait times down and getting these people in, healed and back out the door, that I don't think, like I know it's on their radar, but I don't think it's something that they consider to be a huge problem right now…it's low on the totem pole. Yup. There's so much more, I wouldn't say more important, cause it's definitely important, but in their eyes, it's not important.

Participants were asked to comment on the CHA guidelines and their potential to identify and address IRHE issues. Most participants knew of the guidelines, but only a few were able to talk about them in more detail. One individual talked about how the intent of the guidelines were to map out a population health framework to the CHA process, and within that context, they are a great tool, especially when orienting new staff. However, taking the guidelines a step further would be helpful from an IRHE perspective:

> Yeah, but, I mean, that tells you what it is, but it doesn't say at all how the framework, the guidelines should, should tackle that. And the two things that I think would, the two threads that would be very important to integrate into a Community Health Assessment is, is the income lens and the gender lens. I think those are two that we just, really need…But there's almost a 'companion guide' that is needed, that is then, the operations… the operational framework or something – I don't know what we would call it, but it's the next step from this which is where the income lens I think needs to go.

Although there was evidence of partnerships, and the prioritizing of partnerships in the regions, from both the interviews and the document reviews, it was challenging to identify partners who could be connected to the CHA process. In fact, one participant gave a few examples, but then retracted as she felt it would be "stretching it if I said they were partners;"

instead she referred to them as *key informants*. When asked if there was a need for more formalized partnerships in the CHA process, most agreed that it could be helpful from an evaluative perspective (i.e., what are the partners doing with the CHA report) and to provide a different perspective. For example:

> New and fresh ideas of what to put in there, and everyone looks at things differently. We get so silo'd in our views, or 'this is how we've always done it, and this is the information that should go in it'. When you build, er, when you have partnerships with other people it's good to get their opinion.

No individuals were able to provide the names of organizations that would be considered true partners with the RHA as it pertains to the CHA process.

There were a few focus groups and a community telephone survey as part of their CHA community engagement process. Participants were asked to discuss the special considerations that were made in their regions during the community engagement sessions to ensure that low-income populations were included. No individuals were able to identify any significant specific actions that were taken in the community sessions to ensure members from low incomes were more easily able to participate outside of ensuring that the focus groups were available in a variety of locations. One thing that was identified as somewhat relevant was that the telephone survey was also analyzed by income.

One individual mentioned that the common community consultation process that is often followed by other regions in the province (i.e., meet with the community to look at the data from the report and to potentially validate the data and/or give more details from community discussions) did not work for their region. In fact, from an IRHE lens, talking with community

members from all levels of incomes and hearing their perspectives was discussed as more valuable compared to engaging in discussions when it won't ultimately change the data.

Board members and senior management. Of the nine board members and senior managers identified to be interviewed for this study, six completed interviews, one declined and two could not be reached. Board members and senior managers were asked a series of questions, such as their role in CHA, importance of IRHE, priorities in the BRHA, roles in IRHE-focused CHA work, and thoughts on improvements to the process. All participants had several years of experience on the board and/or management level, and provided a wide variety of backgrounds and perspectives. Most participants recalled receiving the information and indicated using the CHA information either for planning or programming. One individual felt that the senior management level should have more input on the areas of focus within the CHA process.

All participants felt that an IRHE-focused CHA was very important and several said that, although they did not intentionally look at the data from an IRHE lens, they expected that the social gradient would be evident in the report. All individuals also saw great value in the information in the report. For example:

> Well, I, I think, like I think it's very important what, I mean, what we saw in that data was um, you know, especially now that it's organized, um, by communities within a city. We, it allows you to know where you need to really be focusing and targeting your, your strategies. Um, so maybe we're not dealing with, you know, the population of, you know, 55,000. But maybe we're dealing with this pocket in this part of town on this issue, you know.

The lack of direction from the provincial government was also discussed by several participants. For example:

> So, I mean. I mean, as far as I'm concerned, the, the province should be the one that should be setting some, uh, consistency in terms of, um, you know, there, there, like not to stop a region from collecting other specific information but you know, all must collect this, set some standard. And then I, you know, as far as I'm concerned, the, the province should be, uh, interested in the findings and should be, you know, hopefully providing funding and support based on, based on what key issues that are identified there.

Participants also saw great value in the community involvement process, and often quoted the "Kitchen Table Chats" that were used in the 2004 cycle. Similar to the CHA representatives, many individuals felt that one of the big gaps relating to an IRHE-focused CHA process was in the lack of action. This lack of action was related to the fact that the CHA process has been largely owned by Manitoba Health and the RHAs. Several participants gave examples of how, through effective partnerships, the CHA process might be more likely to be a tool of change. For example,

> Well, I think there's certainly more of that bridging that should be taking place, but I know we did meet with the city of Brandon because, I mean, our health problems are certainly their problems as well, in terms of, you know, child obesity, which is usually, again, kind of income related kinda stuff. Um, like I said, I know we made approaches to the MMF, although I don't, I'm not aware of what…

Finally, several participants mentioned that the cumbersome amount of data and the dated information was problematic to ensuring the information would be valuable and therefore used.

Summary of themes from document review and key informant interviews.

System-level themes.

Other priorities. In addition to ensuring the region was fiscally responsible, one of the more significant priorities for the province during the study timeframe was the H1N1 influenza virus (see summary for ARHA). Accreditation was also another political priority for the province, with two surveys (2006, 2009) during this study's timeframe, with the latter one being done closely along with CHA. Annual reports identified that the region was focusing on partnerships, acute care, and balancing budgets. In addition, unless discussing the role of the population health representative and few comments by the CEO, document review data lacked any reference to IRHE or the SDOH. Participants expressed that other priorities such as indicator reporting and training always seemed to rise above CHA-related activities.

Lack of provincial leadership. The CHA guidelines, which were a result of a working group coordinated by the province, were discussed, although most participants were not aware of them in any detail. One participant, who was more intimately aware of the guidelines, mentioned that having an operational guidelines document would be most helpful in guiding the region in IRHE-focused practice. A few participants also talked about needing more leadership from the provincial government.

Organizational-level themes.

CHA-related partnerships are unclear. The BRHA also struggled with the concept of partnerships as it related to the work of CHA. Although document review data identified partnerships as one of the region's priorities, the majority of these partnerships were related to health services access and programming. When pressed for names of partners in the CHA process, one individual stated, "until you just asked me that I never did. Um… they were key informants. Yeah, I think I would be stretching it if I said they were partners". Although document reviews suggested that the region was working with multiple partners to address the

determinants of health, the key informants expressed that this was an area needing greater attention from an IRHE-focused CHA perspective. No specific organizations were identified for interviewing as part of this study. According to the key representative in the region there were no partners living in the region available for an interview during the data collection process.

CHA Leadership (can be learned). In addition to the need for staff who are trained in population health, a theme that arose from the data was the IRHE-focused work takes a particular skill set on a personal level as well:

> Because she knows what's going on in the community. She is out there, she's talking to the people. She is passionate about it, which really helps. It's…she's been all over the world, and she understand social structures, and, yeah, the community, way better than any of us could. I honestly don't think there is anyone else in this organization that could write a CHA and do a good job at it. Cause she just sees it differently than the rest of us.

Capacity concerns. There was a sense from the participants that the region could not address the SDOH alone, and because CHA has been primarily driven and housed in the Health departments, there was an overwhelming sense of despair on the inability to make changes. CHA representatives also discussed how resource-intensive the process was and how they often would be working 'off the side of their desk' or on the weekends just to get the report completed.

Community engagement is key. It was clear from the document reviews that the region values the CHA process and considers the findings of the CHA to be evidence for strategic planning. In addition, several staff discussed the importance of involving the community, although the details of how to do this from an IRHE-focused lens were not clear. The BRHA region was the only case to identify that the community consultation process requires a review as to the overall purpose of such an endeavor, especially from an IRHE-focused lens. There were

sensitivities raised around stigmatization and how it was important to ensure that any involvement of the community is done respectfully. The Kitchen Table Chats that were done in the 2004 cycle were mentioned as a very useful component of the CHA process.

Individual-level themes.

The BRHA interviews revealed a wide variety of perspectives on defining health. *Access to health services, lifestyle approach,* and *social determinants of health* were all orientations that arose from the interview and document review data on an individual level. A lifestyle orientation means health is framed from the perspective of personal choice and responsibility.

Having a key staff in the region focus on population health tended to influence others in the department. One individual mentioned that her thoughts and perspectives on health changed as a result of working with someone so passionate about the SDOH. However, an *access to health services* orientation appeared to be the dominate framework.

Concluding remarks regarding the BRHA case. The BRHA is unique to this study because it was the only urban case examined in this study, had high mental health issues, and had a growing population. Based on the information gathered from the key informant interviews and the document reviews, it can be concluded that the region did not apply an explicit IRHE lens to the CHA process. Only a few health indicators were analyzed by income in the third cycle CHA report. There was confusion from participants regarding if partnerships were *true partners* as it related the CHA process, or just with the RHA in general. No partners were identified for interviewing. The telephone survey data from the community was analyzed by income, but this information was not widely available nor were there any special considerations to use this information in any of BRHA's community consultation efforts.

Chapter V: Discussion

The purpose of this study was to explore how RHAs incorporated an income equity lens in their CHA processes, and to identify the facilitators and barriers to incorporating an income equity lens into the CHA processes within regions in Manitoba. Three unique RHAs were examined in this study. Each region was chosen purposefully to allow for cross-case comparisons. BRHA was chosen as it is an urban center in the province with a higher prevalence of mental health issues. PRHA was chosen due to its remoteness, cultural diversity and low income. The rural region of ARHA was chosen due to its large geographic area.

Two conceptual frameworks were used in this research: a human rights-based approach and the IRHE Framework to CHA, to explore a health to equity lens to CHA. The human rights-based approach supports the rights of the socially disadvantaged by ensuring they are counted by being included in the selection, measurement, and monitoring of indicators. The human rights-based approach also supports the inclusion of disadvantaged groups in discussions around health, decision-making, policy, and governance. The IRHE Framework includes factors that contribute to taking action on the SDOH and guided the research and coding of the data. This study is the first to evaluate the entire CHA process with an IRHE lens. Hebert-Beirne et al. (2017) explored the qualitative component of CHA through an equity lens and has provided recommendations for engaging the community in identifying and addressing health inequities.

The findings from the key informant interviews and document reviews revealed that an IRHE lens was not incorporated to a large extent in the three regional CHAs, despite consensus from all participants that this is important work. Although there was mention of the connection between income and health in the CHA reports, the majority of the data explored health indicators by geography rather than income. Community consultation processes may have had

intentions to involve members of the community from lower incomes, but the CHA representatives were not aware of any specific strategies employed to ensure such representation. Themes generated from the data show similarities and differences across the three regions. The themes generated from the data are organized into three levels: systemic, organizational, and individual-level. These levels are similar to those recommended by Raphael and Brassolotto (2015). Table 6 provides an overview of the themes by RHA.

Table 6

Themes by Regional Health Authority (RHA)

Themes from Model	**ARHA**	**PRHA**	**BRHA**
Systemic			
Other priorities	√	√	√
Lack of provincial leadership	√	√	√
Organizational			
CHA partnerships are unclear	√	√	√
Indigenous partnerships are key	√	√	
Leadership is inconsistent/Disconnect from CHA	√		
CHA Leadership (can be learned)		√	√
Capacity concerns	√	√	√
Independence is valued		√	
Community engagement is key	√	√	√

Themes from Model (con't)	ARHA	PRHA	BRHA
Individual			
Access to Health Services Orientation	√	Primarily SDOH Orientation	√ (Lifestyle Orientation also identified)
Themes Outside Model			
CHA reports seen as too large with dated information	√	√	√
CHA process missing action, "so what"	√	√	√

Similarities across the RHAs

System-level themes. Across all of the cases a lack of provincial leadership regarding IRHE-focused work was mentioned. Although there have been advances in the province in this regard (Kettner, 2011; Routledge, 2015), there remains a gap in concrete action taken towards addressing income-related health inequities with the support of evidence from the CHA findings. This gap in concrete action has been found in other areas of Canada (NCCDH, 2014) despite growing interest and awareness of the SDOH and IRHE. For example, participants in the follow-up scan by NCCDH stated that despite a growing attention to health equity since 2010, this momentum has not resulted in any concrete action on reducing inequities in health. In addition, all participants mentioned that the RHAs face competing priorities, especially in the third CHA cycle, and many CHA staff worked on this project 'off the side of their desk' and during evenings and weekends. The documentation from each RHA clearly revealed that improving health care and access to health care for Manitobans required significant time and resources. All RHAs were challenged by the influenza H1N1 crisis, acute care and health service delivery

concerns, and financial issues. These competing challenges during a CHA process have also been noted in the literature (Wetta et al., 2014) where CHA continues to be an important but resource intensive process. In addition, the CHA guidelines were mentioned as an important mechanism to promote an IRHE-focused CHA process.

Organizational-level themes. In some regions, there was a sense of hopelessness about the topic of income-related inequities, with some participants expressing apathy. Although nearly all participants agreed that IRHE was important, many felt that they as individuals and the regions in general were extremely limited in their ability to actually make any changes to the health of their region without other partners. McIntyre et al. (2013) also discovered evidence of apathy among public health workers in their discussions of SDOH. Some participants discussed a desire to have more formal linkages with specific partners for CHA. No partners in any region were available for interviewing for the present study. Some partners did not return emails or calls for an interview after several attempts. Some partners declined participation as they felt they did not know enough about the process and/or did not feel like they were true partners of the CHA. Most of the partnerships mentioned by the participants, or found in the documents, were partners of the RHA in general, and did not seem to be specifically connected to the CHA process. Current research on intersectoral partnerships, especially as they pertain to health equity, is relatively new and there are no evidence-based guidelines for what is most effective (Collins & Hayes, 2013; Ndumbe-Eyoh & Moffatt, 2013).

All RHAs discussed leaders who were known to have an equity focus to their work, largely because the CHA leaders were passionate people with unique personal and professional traits. Although all regions did not apply an explicit IRHE lens to their process, it was apparent that one of the regions had applied such a lens to their community consultation process in a

previous cycle. The BRHA had a dedicated population health planner who provided enormous leadership in this regard; it is clear that personal and professional skills and attributes can make a difference in this type of work (Raphael & Brassolotto, 2015). Another theme common to all RHAs was the resource intensive nature of the CHA process and how applying an IRHE lens would require even more resources, or perhaps a narrowing of the CHA scope. Finally, the CHA process was highly valued by all RHAs, and often classified as a key source of evidence for the region. The community consultation process was seen as a critical piece to the RHA planning cycle, although the details of this process varied from region to region.

Individual-level themes. All participants were eager to talk about health, and often interviews went off-topic, focusing on some of the issues in health services and health care delivery. Several participants also framed health as *access to health care services* compared to broader heath perspectives, which was not surprising given the same findings from the document reviews.

Differences across the RHAs

Organizational-level themes. There was more discussion about partnering with Indigenous peoples in the ARHA and the PRHA cases than in the BRHA documents or interviews. There was also some evidence of challenges and struggles for these types of partnerships, although they were seen as critical to the health of the region. As such, some of the regions displayed more knowledge about special considerations for community consultation from an IRHE lens.

Perhaps due to their high number of individuals with mental health issues, the Brandon region displayed more sensitivity around stigma and ensuring that any community consultation with people from low incomes was carefully thought through and were not further stigmatizing.

There was also a greater sense of hopelessness, yet urgency for more action on the SDOH, which may have been due to the fact that income-related health inequities are more visible in an urban centre. Although there is no way to know for sure, it may have been that issues relating to IRHE in Brandon are specific to the intersection of low income and mental illness, resulting in a unique phenomenon that created more emotion from participants.

Interviews from PRHA revealed a consistent message from the participants of the value of independence in doing CHA work. This may have been a result of feeling threatened with the upcoming amalgamation and organizational changes, although this was not stated by any participants. ARHA also reported inconsistencies with leadership as it pertained to an IRHE-focused CHA process. For example, while some Board members felt they did not know enough about the CHA process, some participants said they felt supported by their involvement and leadership.

Individual-level themes. There was a wide variety of personal beliefs about health and the topic of IRHE, and this also varied across the regions. Although all regions displayed an *access to health services* orientation to some degree, some regions had a significant number of staff who felt passionate about the SDOH. In the BRHA case, there were staff who talked about health in the context of lifestyle and responsibility. Themes from PRHA suggested that many of the staff understood how income can impact health and how having lived experience provides a unique perspective.

Factors that Influence IRHE-focused CHA

Barriers. On a systemic level, regional priorities (e.g., the H1N1 crisis, access to health services) that are rated higher or compete with the CHA process serve as a barrier. A lack of provincial clarity and leadership on an IRHE-focused CHA likely prevented some explicit work

in this area. For example, having a health equity lens applied to the guidelines, or even as part of a provincial framework, would have given CHA staff more direction. Raphael and Brassolotto (2015) recommend that provincial leaders mandate specific action on SDOH and include a mechanism for accountability regarding implementation.

On an organizational level, confusion over the purpose of partnerships relating to CHA and how that would work for an IRHE-focused CHA process served as a barrier. This confusion has also been identified in the literature (Collins & Hayes, 2013; Ndumbe-Eyoh & Moffatt, 2013). In some regions, there was evidence of practices that created challenges partnering with some of the residents impacted by income-related health inequities. Having the CHA process driven solely by the health sector was also seen as a barrier. Finally, a lack of resources were also seen as a barrier to engaging in an IRHE-focused CHA.

Individuals were eager to discuss some of their thoughts on an improved CHA process outside of the discussion on IRHE. Overall, most participants felt that the CHA report was too big and cumbersome and provided outdated information to the regions. A cumbersome product, combined with a topic that was hard for people to feel invested in given their inability to contribute to change, led to a feeling of hopelessness and sadness over a lack of action.

There were few references to CHA in the document reviews and board meeting minutes unless a presentation was given, or if someone from the region was giving an update on the community consultations to the board. Annual reports would include the CHA data during the year that it was released, but would rarely reference the process outside of the report. Some board members and senior managers expressed concern that they did not know enough about the process to participate in the interviews, and some said they would like to be more involved in the

future. A formal link between the regional CHA teams and the RHA board/senior managers may lead to an improved process.

Finally, an *access to health services* orientation by participants in two regions, could be seen as an individual-level barrier to an IRHE-focused CHA process. It is not known to what degree an *access to health services* orientation may impact the capacity of RHAs to move towards addressing health inequities. Research by Raphael and Brassolotto (2015) suggests that individual level attitudes and preferences of key health staff can impact the work on SDOH and health equity, as was found in this study as well. The impact of such beliefs likely would depend on the decision-making authority of the particular person and the management model of the organization. It is also important to note that one region displayed a lifestyle lens and this could also be seen as an individual-level barrier to an IRHE-focused CHA process.

Although some literature suggests that larger system-level factors play more of a role regarding barriers (NCCDH, 2011), an exploration study of the impact of individual-level factors would be helpful. As health inequities continue to increase and the general public continues to show a "very limited understanding of social determinants of health (and their connections)…" (Snyder, Cheff, & Roche, 2016, p. 11), a focus on universal education may be helpful and may lead to unexpected action on the SDOH. Some research has found a great awareness of the SDOH among the general public (Lofters et al., 2014) and yet there remains a general consensus from experts that there is a continued lack of action on the SDOH (NCCDH, 2014). Other researchers suggest that a focus on interventions is more important, considering there has been such limited action despite there also being more education, awareness, and interest (McIntyre et al., 2013).

Facilitators. Factors that serve as facilitators to an IRHE-focused CHA include some of the *provincial structures* that are already in place and could be used to leverage more action on the SDOH, such as revisions to the CHA guidelines, and through the coordination and support of CHAN through an IRHE lens. Provincial legislation mandating the CHA process is also seen as a facilitator, especially if the policy can be made stronger by including language on taking action on income-related health inequities.

Organizationally, CHAs are valued and respected, which can be seen as a facilitator to an IRHE-focused process. Each region had at least one key person who was passionate and educated about IRHE and could or did serve as a leader in this regard. Given the literature on the value of academic partnerships within the CHA process (Hebert-Beirne et al., 2017), *The Need to Know Team* in Manitoba can be seen as a facilitator in this regard. If adequately resourced, this academic partnership with the CHA representatives in Manitoba could advance health equity in the regions.

Study Limitations

This project was the first exploration of CHA in Manitoba through an IRHE lens. In addition, this study employed multiple cases to validate findings and used several sources of data to provide an in-depth analysis of this topic. Despite the strengths of the present research, there were several limitations. One is that this study was done retrospectively and required participants to recall details from the third cycle of the CHA, which was several years before the time of the interview. Although some participants, particularly the CHA representatives, were easily able to recall details from the CHA process, the time lapse did seem to make recall difficult for others who were less involved in the process.

Social desirability bias may have impacted some of the findings. Some of the participants may have felt the need to portray the CHA process, and their subsequent involvement, in a more positive manner than they truly believed. In addition, the findings from the annual reports could have been impacted by social desirability bias. Annual reports provide an opportunity for organizations to report on accomplishments for the year, and can often be used as a promotional tool. However, several annual reports from the RHAs appeared to be balanced in that they also included challenges of the region in their introductory message, and within the body of the report. The accreditation reports and board meeting minutes likely provided stronger and more objective evidence for this study. However, some of the reports and board meeting minutes were not available to be reviewed as part of this study. In addition, there was a lack of available CHA working group meeting minutes, which would have strengthened this study.

In May 2012, the provincial government announced that the 11 RHAs would be merging to five. This merger impacted the RHAs, which were chosen to be a part of this study, with all three unique RHAs merging to form the new Prairie Mountain Health region. As this reorganization of the RHAs was a significant change in Manitoba, the true impact was still not felt at the time of the interviews (Spring 2013), although changes to the board and senior management had occurred. The participation rate of the board and senior managers was significantly lower than that of the CHA representatives; this could have been for a variety of reasons, including organizational changes, and less involvement and therefore, less interest in the subject matter. The topic of IRHE and health services, coupled with the looming RHA merger, provided for some emotional interviews. Several times interviewees would go off-topic and many participants kept talking after the recording stopped. In one sense, this could be seen as positive as all participants clearly cared about their role in the RHAs and felt passionate about

the work that they do, but was problematic when analyzing the interview data. Field notes were constantly reviewed during the analysis of the interview data, and this provided important contextual information and allowed for more objective coding.

The relatively small number of participants interviewed could be seen as a limitation of this study. Key CHA representatives were asked to provide the names of potential interviewees who were most involved in the third cycle of the CHA. In the end, 37 participants were identified as potential interviewees. Although the response rate of the CHA representatives was 100%, it was more difficult to interview board members and senior management (60% response rate). As some potential interviewees did not return calls or emails, it is not possible to know the reason for lack of participation. Of those who gave reasons, several stated that they did not feel they would have enough knowledge to contribute to the study. This theme emerged several times during interviews with board members and senior management. Unfortunately, no partners of the CHA process in any region were interviewed. Thus, partner perspectives could not be examined. The concept of CHA partners was a difficult one in this study, with much of the discussion concerning health partners in general and not specifically partners related to CHA.

The topic of health equity has grown in the last five years. In particular, some significant work has been done in Manitoba after the third cycle of the CHA, but before the interviews for this study, and this may have impacted some of the responses. However, not one participant mentioned the then recent health equity-related, *Health Status of Manitobans* report in Manitoba (Kettner, 2011), and so it was assumed that its impact was limited. In addition, as mentioned above, several participants framed their discussions about health from an *access to health services* orientation, which is not consistent with messaging from the *Health Status of Manitobans* report or any current research in this regard. Besides the CHA guidelines, which

were coordinated by Manitoba Health, the remaining documents included in this study were from the RHAs. Ideally, a more comprehensive document review process, including reports from the province, may have been helpful, although CHA were rarely mentioned in reports or meeting minutes. The majority of the findings from this study come from the participants' interview data. Lastly, the use of CHA information was not part of the present study so this is a limitation worth noting. A recent outcome evaluation found that "…there continues to be insufficient awareness and use of CHA at Manitoba Health, despite the attempts to raise its profile through the information sessions, workshop, emails and finding aids developed by CHA consultants" (CHA Evaluation Working Group, 2013, p.21).

Despite these limitations, the findings of this study highlight key issues that continue to be important. For example, from the study it became evident that it is important to 1) apply an IRHE lens to regional CHA processes in Manitoba; 2) maintain and improve the provincial structures in place (e.g., CHA guidelines, and the CHAN) by adding a health equity component; and 3) have trained CHA staff in regions and at Manitoba Health. Although the RHAs have made some changes to the way they report data from an IRHE lens, many of the study implications to be discussed in Chapter VI are relevant to the Manitoba RHA context today. For example, the challenges with partnerships from an IRHE lens exists in the current context and the RHAs are looking for opportunities to improve this aspect of the CHA process. The lack of concrete action in regards to advancing health equity has been referenced in other contexts (NCCDH, 2014).

Chapter VI: Conclusion and Study Implications

This study was the first to evaluate the regional CHA processes through an IRHE lens. The purpose of this study was two-fold: 1) to explore how RHAs incorporated an income equity lens in the third comprehensive CHA process, and 2) to identify the facilitators and barriers to incorporating an income equity lens into the CHA processes within the selected regions in Manitoba. The results of this research show that the RHAs did not apply an explicit IRHE lens to the third cycle CHA process, although it was recognized by almost all participants as an important area of work. A variety of facilitators and barriers to a more IRHE-focused (or health equity-focused) approach to the CHA process were identified. For example, provincial structures such as the CHA guidelines, CHAN, and the CHA policy are all system-level facilitators of IRHE-focused work for the CHA process. Having an organization that values such a process was also seen as a facilitator. Finally, having educated and passionate CHA representatives can also be a facilitating factor to an IRHE-focused CHA.

Barriers for conducting CHA with a focus on IRHE include other regional and provincial priorities, a lack of provincial leadership, lack of clarity on partnerships relating to CHA, barriers to forming partnerships, the perception that CHA is a *health sector* activity, lack of resources, and a lack of broader awareness of an IRHE approach and the SDOH (within the RHAs and in general).

The information provided on barriers and facilitating factors may be useful to those who plan and conduct future comprehensive regional health assessments in Manitoba to improve the process, and to improve the health of Manitobans, particularly those who are socially disadvantaged. This research may also encourage a broader understanding of health and inspire more research into taking action to reduce income-related health inequities. The study findings

have important implications for policy, practice, and research related to CHA at the regional level, with a focus on IRHE.

Implications for Policy

One of the main themes that emerged from the key informant interviews was the need for more provincial support and leadership for an IRHE-focused CHA. Several suggestions were made, such as adapting the CHA legislation to include more of an IRHE focus. In addition, some of the study participants suggested that the CHA guidelines should also be revised to include an IRHE focus, which would then provide operational direction to the RHAs on such a process. Themes that were consistent with a system-level approach confirm previous findings on the importance of structural factors such as policy and legislated guidelines (Solar & Irwin, 2010). If conducting CHA using an IRHE becomes a provincial priority, it will be necessary to dedicate more resources to this under-resourced process. In addition, continuing to engage in evaluations to hold regions accountable for ensuring that CHAs include an IRHE-focus would also be helpful. Although the focus of this study was applying an IRHE lens to the CHA process, increasing the health equity lens to any components of this process is recommended based on the findings of this research.

Implications for Practice

Based on the findings of this study, several recommendations can be made regarding IRHE-focused CHA practice. A theme that was consistent across all regions was a need for more clarity on the purpose of CHA-related partnerships, including those outside of the RHA, and resources dedicated towards developing and maintaining these partnerships. An IRHE-focused CHA could include partnerships with key groups in the region who work with low-income populations and with other government departments and policy representatives who also have a

stake in the CHA findings. However, as mentioned by Jack (2005) and Gardner (2006), partnerships with socially disadvantaged populations require special considerations. In fact, the current research on intersectoral partnerships does not provide any recommendations for best practices in this regard (Collins & Hayes, 2013). Pilot projects exploring CHA partnerships would be incredibly valuable within Manitoba and also to the broader research community. It might also be helpful to explore the various policies and/or practices in the regions regarding partnerships and communication between RHA staff and Indigenous peoples and community members.

It was also clear from the findings that the CHA process is under-funded given the expectations involved and the strategic importance of the work. The CHA representatives and CHAN need to be supported more in the work that they do, especially from an IRHE perspective. This could also include specific health equity positions to support the work of CHA, similar to the positions mentioned in McPherson et al. (2016), or through academic partnerships which have been shown to improve the CHA process (Bowen, 2004; Caron & Tutko, 2013; Hebert-Beirne et al. 2017). The people in these health equity positions are leaders in the organizations responsible for developing and implementing initiatives to address health inequities. As mentioned in McPherson et al. (2016), this leadership is essential for taking action on the SDOH. Moreover, individual-level factors are important facilitators and barriers to addressing the SDOH, and exploring these factors within the CHA process might be helpful for identifying areas of improvement. For example, all participants talked about the impact of passionate staff as it pertains to IRHE work. In a past CHA cycle, one of the regions had a dedicated population health position which led to targeted interactions with socially disadvantaged populations and several other important initiatives addressing the SDOH. There is evidence to suggest a

significant impact of individual-level influences in addressing health inequities (Raphael & Brassolotto, 2015). The findings from this dissertation, although exploratory in nature, also support the importance of individual-level factors.

Through the leadership of CHAN's community consultation group, or though the assistance of the Local Health Information Group (LHIG) lead, further exploration of principles (e.g., building trust, two-way consultation, partnering with key people in the community) and techniques for respectful and meaningful community consultation through an IRHE and regional/district lens would be helpful.

Community engagement is also an area for potential improvement going forward. Arnstein's (1969) ladder of citizen participation provides a conceptual understanding about community participation through the model's eight levels of participation. Although this framework is over 40 years old, it is still used widely (Haruta & Radu, 2010; Mchunu, 2009; Wondolleck, Manring, & Crowfoot, 1996). The three components of the ladder are nonparticipation (i.e., manipulation and therapy), tokenism (i.e., informing, consultation, and placation), and citizen power (i.e., partnership, delegated power, and citizen control). The model emphasizes the significant gradients of citizen participation; something that is often overlooked. According to the guidelines, the purpose of CHA is to, "encourage collaboration with community members, stakeholders and a wide variety of partners involved in decision-making processes within the health care system" (Manitoba Health & Health Living, p. 8). After a review of the various CHA reports in Manitoba, there appears to be a lack of clarity and consistency among the various regions regarding community engagement. For example, in Brandon focus groups were held with specific populations (not necessarily representing those most disadvantaged), although IRHE-focused "Kitchen Table Chats" were conducted. Other regions

met with community members to share information and gather feedback on the preliminary CHA reports and on health needs and concerns. All of these methods of community involvement would fit in the tokenism component of Arnstein's model with the exception of Kitchen Table Chats, which could be seen as more engaging than tokenism. In order to engage the community in a meaningful way, the RHAs (and or LHIGs) may want to explore strategies and approaches which are higher on the Arnstein ladder.

From a capacity-building perspective, there needs to be broader RHA and public support of IRHE-focused work through enhanced understanding and awareness of the SDOH. This is now being focused on in some of the existing undergraduate and graduate educational programs at the University of Manitoba, which can serve as one training venue for the next generation of those in CHA-related positions, and/or on the regional boards and management-level positions. In fact, professional training of staff in *all health services* that supports a SDOH orientation/broader health perspective, versus a medical model, is recommended. CHA-specific training could also be offered to board members and senior managers to educate them on the process.

It is also recommended that CHA be a more formalized and ongoing priority for the regions and for the province. CHA needs to be more action-focused, including less cumbersome reports and more timely data. This could include leadership from CHAN in selecting the most informative health indicators to be analyzed by income level, consistent with the literature on measuring health inequities (Braveman, 2006; WHO, 2008). Since this study, there has been one more CHA cycle involving the new Prairie Mountain Health region. According to the Chair of CHAN, one of the more significant changes to the CHA process from a health equity perspective is that almost all of the indicators have been disaggregated by income quintile since the third

CHA cycle and are being further stratified to help the regions assess health equity with each successive cycle (H. Sparling, personal communication, November 6, 2017).

Although it is encouraging that the CHA reports are now exploring health indicators by income on a consistent basis, there are many health equity tools and measures which could be used to monitor health inequities in the province. For example, Asada et al. (2014) and O'Neill (2014) provide frameworks that could be further explored in the RHAs. Although many RHAs are now more aware of exploring health indicators by income, there are other social stratifying variables which can be used (in the presence or absence of income data) to identify health inequities such as place of residence, occupation, gender, and social capital. Although low income was the primary focus of this research, CHA reports may want to explore health indicators from a variety of layers of social disadvantage (i.e., intersectionality).

Implications for Future Research

In additional to policy and practice implications, this study provides many suggestions for future research. This was the first time a CHA was evaluated from an IRHE lens, and the action-oriented feedback suggests how important such an evaluation framework is for assessing the health of residents in a region.

This study used a multiple case study approach. The inclusion of three unique regions provided validation of some of the key themes, while also identifying some key differences among the regions in regard to IRHE-focused CHA practice. In addition to using multiple sources of data and multiple cases, a significant amount of time was invested in getting to know the staff in each of the regions and travelling to the various regional offices. This approach allowed for an in-depth understanding of the third CHA cycle in each of the regions and identified factors that either facilitated or impeded an IRHE-focused CHA process. It is hoped

that this research methodology will be used in future studies as it helped to provide the most comprehensive picture of issues that are complex, affecting the health of people living in different regions in the province. The study findings clearly indicate that the regions could improve their documentation of the CHA process to facilitate future research in this area.

Given the variety of tools used to measure income-related health inequities, it would be helpful for more research comparing and contrasting the different techniques so that policy and CHA could be driven by the best evidence. Several times during the interviews, the importance of meeting with the community members was discussed. Although the purpose of community consultation was not addressed in this dissertation, it was clear that most individuals felt that learning and hearing from people in the regions from a variety of perspectives is critical to the success of understanding the health of a particular area. There was even some opposition from a few participants to the 'tokenism' nature of the community consults during the CHA process. The constant feedback in the interviews about the value of talking with community members is consistent with the literature stating that poverty should be discussed broader than a statistic. Future research, in consultation with those from low incomes, may consider how best to incorporate the perspectives of people from a variety of income groups in the larger community health consultations.

More research would be valuable to explore the effectiveness of professional and public education on the SDOH and health equity. For example, does professional education ensure that IRHE is an important consideration within the CHA process? Will widespread public education lead to more focused and meaningful community consultations?

Finally, since the inception of this study, the Manitoba RHAs have completed their fourth CHA process, with reports completed in 2015. In addition, there has been an RHA merger, a

change in government and more changes along the way regarding health and health care in Manitoba. Further research is needed to assess and evaluate the impact of these changes on regional CHA from a health equity lens. Lessons learned from Manitoba may be of relevance to those in other jurisdictions who are involved in planning and implementation of comprehensive regional health assessments, with a focus on IRHE.

This research may encourage a broader understanding of health and health inequities, and inspire more research evaluating the key factors (individual, organizational, and systemic) that will move knowledge into action (Braveman et al., 2011; Kouri, 2008; Raphael & Brassolotto, 2015) as it pertains to health inequities. The Commission on the Social Determinants of Health called on all nations to eliminate health inequities in a generation (WHO, 2008). An improved CHA process, though the incorporation of a health equity lens, would be one step in achieving this goal.

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Appendix A: Interview Guide - CHA Representatives in the RHAs

Introduction

(note: A consent form on U of M letterhead that complies with ethical guidelines will be sent to each participant).

Thank you for participating in this interview. The purpose of this interview will be to obtain in-depth information about community health assessment from an income equity perspective in _____(*specify organization*) during the third comprehensive CHA. I will be focusing on the three key phases of CHA – that is, indicators, community engagement, and partnerships, but will also explore your perceptions on health and income equity in your region. This interview should take approximately two hours.

In addition to audio-recording our interview I will be taking notes of our conversation. If you are interested in reviewing the notes and/or transcripts after this interview, I can forward a copy at your request. (note: summarize the information from the consent form).

1. Please tell me about your role in _____ (insert RHA here) (probe: what do you do, how are you involved in CHA, how long have you been involved in CHA, etc.).
2. Please tell me what you know about health inequities in your RHAs during the third CHA (note: please remind the respondent to focus all answers thinking back to the timeframe during the third CHA only). Were there wide differences in health across the RHAs? [note: provide the Braveman (2006) definition]
3. Was there good quality data providing an overview of local health inequities (i.e., low income) in this RHA? In the districts? If no, please explain (probe: an example of low-income inequity "people from poorer areas in the RHA were more likely to have chronic disease compared to those from richer neighbourhoods").

4. How important is income equity to you as it applies to the work of CHA? What do you think of the statement, "everyone has the right to health"?
5. How important is income equity to the Department you work in? Do you feel there is a commitment to equity? Please explain.
6. Thinking back to the third CHA, who were the leaders when it comes to equity in your Department? Why would you consider these individuals to be leaders (note: please just refer to the role of the person and not their actual name)
7. How well do you think the community health assessment guidelines address health inequities and the potential for taking action to address them?
8. What is the purpose of having CHA partners? What is the purpose of having CHA partners who work with low income groups? (probe: Neighbourhood Renewal Corp, Samaritan House Ministries, Mood Disorders Association of Manitoba, Regional staff in Home Care, First Nation Health Centre, Addictions Foundation of Manitoba, Women's Institute, partnerships with New Immigrant groups). In your opinion, is this purpose agreed upon by the partners?
9. Which groups (note: those representing low-income groups) were you able to partner with during the third CHA? Which groups were you not able to partner with? Please explain.
10. Tell me about how you go about forming the partnerships, or what barriers you came across while attempting to form partnerships?
11. Would you be willing to share a list (and if you have contact information – provided there is permission to share) of all partners from the third CHA process? (if yes: please identify which partners work with low-income groups).

12. Overall, were you satisfied with these partnerships? Was there value added?
13. During the community engagement sessions were there any specific considerations made to ensure that low-income populations were included?
14. To what extent did the members of the community/district health advisory council (or alternative) in your region consist of representatives from low-income populations?
15. In your experience what are some things that (insert RHA here) did during the third CHA to address income inequities? What are some challenges to addressing income inequities? (probe: explicit strategies/policies, leadership, policies, capacity, systemic factors)
16. Is there anything else you would like to share with me or anything that I should know specific to this topic?

Appendix B: Interview Guide - Senior Management and Board

Introduction

(note: a consent form on U of M letterhead that complies with ethical guidelines will be sent to the participant)

Thank you for participating in this interview on your perceptions of community health assessment in _____(*specify RHA*) during the third comprehensive CHA. In addition to audio-recording our interview, I will be taking notes of our conversation. If you are interested in reviewing the notes and/or transcripts after this interview, I can forward a copy at your request. (note: summarize the information from the consent form). Okay, just to let you know, I will start by asking you a few general questions about your perceptions of the third CHA process in addition to some related questions about your perceptions of health and income equity in (insert RHA here). This interview should take approximately one hour.

1. Please tell me about your role in _____ (specify) (probe: what do you do, were you involved in the third CHA, etc.).
2. How important is income equity to you as it applies to the work of CHA? In your opinion, what would the RHA think of the statement, "everyone has the right to health"? [note: provide the Braveman (2006) definition of health equity and apply low income]
3. In your opinion, how important was health equity among the various priorities for your region during the third CHA? How important was income equity among the various priorities for your region?
4. How well do the current community health assessment guidelines address health inequities and the potential for taking action to address them? Are there any other strategies or policies that address income inequities in your region?

5. Thinking back to the third CHA, what would you say was the RHA's role in working towards addressing income inequities? The province? Local partners (who would these partners be)? Anyone else (probe: other health department, departments outside of health)? Who should be the leader in this regard?
6. In your experience what are some things that (specify RHA here) did during the third CHA to address income inequities? What are some challenges to addressing income inequities? (probe: explicit strategies/policies, leadership, policies, capacity, systemic factors)
7. Is there anything else you would like to share with me or anything that I should know specific to this topic?

Appendix C: Interview Guide – CHA Partners working with Low Income Populations

Introduction

(note: A consent form on U of M letterhead that complies with ethical guidelines will be sent to the participant ahead of time).

Thank you for participating in this interview on your perceptions of community health assessment in _____ (*specify RHA)*. In addition to audio-recording our interview, I will be taking notes of our conversation. If you are interested in reviewing the notes and/or transcripts after this interview, I can forward a copy at your request. (note: summarize the information from the consent form). Okay, just to let you know, I will start by asking you a few general questions about your role in the third CHA in addition to your thoughts on the partnership with (*insert specific RHA here*). This interview should take approximately one hour.

1. Please tell me about your role at _____ (specify organization). (probe: what do you do, how are you involved in CHA, etc.).
2. Please tell me about your partnership with (insert RHA here). How long have you worked with (insert RHA here)? Thinking back to the third CHA, what was the purpose of your partnership with CHA staff? Would you say there was a need for your partnership? Explain.
3. During the third CHA how satisfied were you with the partnership between your organization and (insert RHA here)? Explain (probe: strengths and challenges).
4. Did you feel there were other groups who work with low-income populations who were not involved (and should have been) in the CHA process? Which groups?

5. During the third CHA process, the RHA held community consultation sessions in your region to discuss the CHA process and results. Did you attend these sessions? If so, how satisfied do you think someone from a low-income would have been after attending the sessions? What are your thoughts on how low-income individuals were involved in this process? If you did not attend these sessions do you have any suggestions on how to involve individuals from low-income backgrounds?
6. Is there anything else you would like to share with me or anything that I should know specific to this topic?

Appendix D: Recruitment Letters and Consent Forms

Dear (insert name of person/partner working with low income populations in the specific RHA),

I am writing to request your participation in the research project, "Community health assessment (CHA) process in Manitoba through an income equity lens: A retrospective collective case study".

As a reminder, CHA is a legislative requirement as part of the *Regional Health Authorities Act* and involves the assessment of the health of the region. The process involves staff from the regions, but also partners from a variety of areas and the general public. The purpose of this research is to explore how Regional Health Authorities (RHAs) incorporated an income equity lens in their third CHA processes, and to identify the facilitators and barriers to this work within regions in Manitoba. This study will also provide recommendations for a health assessment process in Manitoba that provides more useful information for planning and involves improved partnerships and community engagement.

Through my contacts in this project, and through my own research, your name was mentioned as a possible participant to be interviewed for this project. We are looking to talk with someone who works with low-income populations. The purpose of the interview is to hear your perspectives of community health assessment in (insert RHA here). The interview is expected to last approximately one hour and will be audio-recorded. The interviewer will also take notes to ensure that all of the ideas are included from the discussion, and you will have the opportunity to review the summary of the findings from the interview. You will not be identified in any reports or public presentations related to this study.

If you have any questions about the study, please contact Jackie Lemaire at (mobile number). Thank you for your interesting in this project.

Sincerely,

Jackie Lemaire

Dear CEO - Western Region, Province of Manitoba,

I am writing to request the participation of the Western Regional Health Authority (RHA) to participate in the research project, "Community health assessment process in Manitoba through an income equity lens: A retrospective collective case study".

The purpose of this research is to explore how RHAs incorporated an income equity lens in the third comprehensive CHA process, and to identify the facilitators and barriers to this work within regions in Manitoba. This study will also provide recommendations for a health assessment process in Manitoba that provides more useful information for planning and involves improved partnerships and community engagement. It is hoped that examples of regional factors and experiences that promote an equity-focus will be useful to those areas where this is more challenging.

As part of this collective case study, access to documents (e.g., CHA-related meeting minutes, documents relating to community engagement sessions, documents/minutes related to Community/District Advisory Health Councils, etc.) will be extremely important. In addition, specific staff from each RHA (e.g., Board members, CHA representatives, VPs, etc.) who participated in the third CHA will be asked to participate in key informant interviews. The purposes of the interviews are to obtain in-depth information about community health assessment from an income equity perspective. These interviews are expected to last approximately one hour for Board members and Executive staff, and approximately two hours for those staff who work in the area of CHA. All interviews will be recorded on an audio-tape recorder. The interviewer

will also take notes to ensure that all of the ideas are included from the discussion. No person will be identified in any reports or public presentations related to this study, although RHAs might be identified.

Please consider this request as the work of the CHA Network depends on a thoughtful investigation of each CHA cycle. This cycle's evaluation is focused on equity, which is a very important component of health assessment. This research would be very helpful in improving the processes of CHA and working towards addressing health inequities in the RHAs.

If you have any questions about the study, please contact Jackie Lemaire at (mobile number). Thank you for your interest in this project.

Sincerely,

Jackie Lemaire

Research Participant Information and Consent Form

Research Project Title: Community health assessment process in Manitoba through an income equity lens: A retrospective collective case study.

Principal Investigator and contact information:

Jackie Lemaire PhD (Candidate)

Applied Health Sciences

Faculty of Graduate Studies

University of Manitoba

Research Supervisor:

Dr. Shahin Shooshtari

Assistant Professor

Department of Family Social Sciences, Faculty of Human Ecology

University of Manitoba

219 Human Ecology Building

(204) 474-8052

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose: The purpose of this study is to explore how the Western Regional Health Authority (RHA) in Manitoba measured health and involved people from the community and from partnerships through an income equity lens in the third comprehensive CHA process. We will want to study documents related to these areas. We will also want to talk to people who are involved in the Community Health Assessment (CHA) process, people who make decisions about programs and policies, and people who work with people from low-income groups who are affected by such policies and programs. This information will contribute to our understanding of how RHAs use an income equity lens in this process. We will also learn about those factors that help RHAs include an equity lens, and about those factors that create a barrier for this.

Procedures: You are being asked to participate in an individual interview. Before the interview you might be asked additional questions to ensure that you are the right person for the study.

The interview will take about one hour (two hours for CHA representatives). A member of the research team will interview you and this interview will be audio-recorded. In addition, the interviewer will take notes to ensure all of the important information is being gathered. The tapes will be transcribed into a document.

Risks and Benefits: There are no known risks to participating in this study. It is hoped that the information gained from this study will contribute to an improved health assessment process and more attention to income equity in Manitoba.

Confidentiality: All information gathered in this study may be published or presented in a public forum(s), but your identity will not be revealed. In addition, you will be assigned a study code that will be used on your documents to further protect your identity. All documents will be

kept in a locked secure area and only the researcher will have access to these records. All confidential documents will be destroyed one year after the study is completed.

Voluntary participation: Participation in this study is voluntary. You are free to withdraw from the study at any time without negative consequences.

Debriefing and Dissemination of Information: On request, a summary of the findings of the interview can be forwarded to you. Once the research is completed, formal presentations will first be made to the primary users of this research (i.e., CHA representatives, CHA Network, senior management of the RHAs) in locations and formats that are most suitable to the users. The results will also be integrated into a separate evaluation report that is focused on impact and use of the CHA in Manitoba. A three to five-page summary will also be made available to stakeholders, and will be posted on websites, and potentially via social media sites that are invested in promoting health equity and/or social determinants of health. You are free to contact the researcher at any time if you are interested in receiving more information about the dissemination of the findings.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba Research Ethics Board(s) and a representative(s) of the University of Manitoba Research Quality Management/Assurance office may also require access to your research records for safety and quality assurance purposes.

This research has been approved by the Fort Garry Campus Research Ethics Board. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

I agree to be contacted for future follow-up (if necessary) in relation to this study

Yes ____ No _____

Participant's Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____