Equity Focused Health Impact Assessment of Healthy Together Victoria

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Executive Summary

Healthy Together Victoria

Healthy Together Victoria (HTV) was established in 2011 to reduce the rising rates of overweight and obesity and related chronic disease in the Victorian population.

Obesity is a complex issue caused by multiple factors, many of which are beyond individuals' control.

HTV is a prevention platform that is working with whole systems in multiple sectors to develop and implement strategies at state and local levels. The purpose is to make positive differences in the environments in which Victorians live, work, learn and play to protect, sustain, and promote health. HTV is working with childcare centres, schools, workplaces, food producers and retailers, sporting clubs, businesses, local governments, NGOs, health professionals and more to create healthier environments for all. HTV is resourcing local government to lead concentrated community-level actions in 12 Healthy Together Communities (HTCs)[1].

Equity Focused Health Impact Assessment

In 2014 HTV had been in operation for three years and was well established. The HTV reference group decided that it was time to reflect on progress to date and to assess the potential impact of HTV on health inequities. It was decided to undertake an Equity Focused Health Impact Assessment (EFHIA).

The Health Equity Research and Development Unit (HERDU), from the University of New South Wales (UNSW Australia) was commissioned by the Victorian Department of Health and Human Services (DHHS) in August 2014 to conduct an EFHIA of Healthy Together Victoria, including an assessment of the following three Healthy Together Communities (HTCs):

- Healthy Together Whittlesea
- Healthy Together Greater Dandenong; and
- Healthy Together Wodonga.

The EFHIA was not intended to be an evaluation of the HTV nor of any of its components. Rather, the purposes of the EFHIA were to:

1. describe and predict the likely impacts of the HTV (and HTCs) on reducing inequities in health; and
2. recommend actions to increase the likelihood of HTV reducing inequities in health and/or to avoid increasing inequities in health.

Methods

Equity Focused Health Impact Assessment consists of a set of structured steps, illustrated in relation to the HTV EFHIA, below:

[1] For more information on Healthy Together Victoria go to: http://www.healthytogether.vic.gov.au/

Screening and scoping

- Establishment of a state EFHIA reference group and three local reference groups (Healthy Together Whittlesea, Healthy Together Greater Dandenong, and Healthy Together Wodonga) to inform and guide the EFHIA;
- Deciding on the definition of inequities in health as 'differences in health outcomes and differences in exposure to risks to health that are systematic, persistent, preventable, and that are considered to be unfair and unjust'.

Identification and assessment

- Gathering and analysing evidence from a variety of sources and assessing the evidence to identify the likely impacts of HTV and of each of the HTCs on health equity/inequity;
- Preparing a draft report (including recommendations) that was discussed with each reference group and modified.

Decision-making and recommendations

- Drafting a final report, including recommendations. The report was circulated to each reference group for further review and agreement before a final report being completed in May 2015.

Major Findings and Recommendations

The EFHIA found that there is a high likelihood that HTV in its current form, including its current organisational and workforce capacity, the priorities established, and strategies being implemented, will achieve positive health impacts at the population level. However, the assessment also found that if the current HTV prevention system and implementation strategies continue without modification, some social groups will benefit more than others and some groups that are already marginalised are likely to be unintentionally 'left behind.'

Table 1, below, describes the findings of the EFHIA and proposes recommendations for actions that will increase the likelihood of HTV reducing inequities in health.

Table 1: Equity Findings and Recommendations

1. **Integration of equity in HTV framework**	
Finding: There is no narrative or clear policy statement of HTV's commitment to and role in reducing inequities in health. There is no agreed definition of inequity, and no description of its determinants. This results in a wide range of ideas being used explicitly and implicitly and a lack of coherent, focused action.	**Recommendation:** HTV add a definition of, rationale for, and commitment to taking action to reduce inequities in health to its core business. In addition it will be necessary to negotiate with partners to define their roles in reducing inequity using a transparent process.
Finding: Achieving equity and/or reducing inequity are not currently explicit goals of HTV and so are easily lost and poorly monitored.	**Recommendation:** HTV has developed a strong platform for prevention that is powerful and positive. In its next phase of development, HTV should consider whether it is necessary and timely to expand its platform to include reducing health inequities as a core goal of HTV. This may

	require significant effort and leadership on the part of DHHS to gain reach agreement between stakeholders.
Finding: All equity outcomes rely on a strong universal platform for prevention, universal inputs, and equally supportive physical, social, and economic environments for health. To reduce inequity it is necessary to add to universal inputs – sometimes with more intensive, longer-lasting, but similar inputs; and sometimes with different, specifically tailored inputs. It is likely that a mix of outcomes will be sought, and therefore a mix of inputs (or interventions) will be needed.	**Recommendations:** Strong support should continue for the ongoing universal roll out of the HTV prevention system. Review and revise interventions to optimise the likelihood that they will achieve the outcomes being sought. Complement whole-population approaches with explicitly designed approaches for vulnerable populations as part of whole-of-systems approach to prevention.
Finding: A similar level of thinking, planning, and partnership building that underpins the design and delivery of HTV will be required to strengthen the organisational capacity to reduce inequities in health.	**Recommendation:** HTV leadership should decide on how to embed its commitment to reducing inequities in health within its existing platforms (logic models, frameworks, and building blocks) and on how to translate the commitment into the organisational capacity needed to reduce inequities in health.
Finding: The HTV and the HTC workforces have a clear understanding of the social determinants of health (SDOH) but there is less awareness that it is the distribution of the SDOH that is responsible for health inequities.	**Recommendation:** HTV has established a strong workforce development strategy and it will need to invest similarly in training and up-skilling the existing workforce (in HTV and in partner organisations) to expand their capacity to act to reduce inequities in health.
2. Use of equity data in HTV	
Finding: Concise data on local and state inequalities is fragmented and focuses primarily on risk behaviours. More limited data are routinely presented on the distribution of social	**Recommendations:** Population profiles for each HTC should be developed to identify inequalities in the distribution of social, economic[2], and environmental factors that influence health, as

[2] The indicator used to assess socioeconomic status should be composite – Socio-Economic Indexes for Areas (SEIFA) for example.

and economic determinants of health. While staff are aware of the complex determinants of inequity, better use of data would strengthen a systems approach to reducing inequities in health.	well as inequalities in health. Data should be as locally-specific as possible.[3] The profiles should also be used to report on population-wide progress. Evaluations of particular interventions should report on differential impacts.
3. Implementation strategies to reduce inequities in health	
Finding: There is a perception that the strong universal prevention platform, supplemented by targeted intensive activities, will reduce inequity. But there is no clear process for ensuring that actions are balanced between those intended to achieve individual, mixed, or structural changes, for ensuring that all appropriate settings are engaged, or for ensuring that groups that are not engaged in settings are also being reached.	**Recommendation:** A process for identifying priority actions to reduce inequities in health (based on assessment of the determinants of inequities) should be developed and reviewed routinely. The process for identifying priorities and the investment of resources should be transparent and the structure responsible for decision-making should include representation of all relevant stakeholders and particularly, those of communities that are marginalised.
Finding: Within each of the settings in the HTV initiative there are many interventions that focus on assisting individuals to make individual choices to change their health behaviours.	**Recommendation:** Expand the activities to achieve a balance between individual and structural interventions that are most likely to have an impact on reducing inequities.
Finding: The same strategies or activities, even when delivered more intensively over a longer period and in a range of settings may not lead to reduced inequities over time. They may lead to increased inequity in the short-term, and may not change the size of the gaps between groups even if it leads to overall improvements in the health of the population. This suggests the need to review and revise the strategies to 'fit' the aspirations and needs of marginalised communities in particular. In addition, although globally-recognised strategies for improving population health are	**Recommendation:** Examine current approaches to determine which partners, leaders, and community members are not represented in the decision-making about priorities and implementation. Identify ways in which to increase the inclusion of currently marginalised groups in addition to other stakeholders to articulate the harmful impacts of obesity and chronic disease on their lives; identify effective actions to reduce and prevent these impacts; and contribute to the development of the next phase of HTV and its evaluation. Identify the determinants of inequities in the health of a population and in marginalised

[3] For example, in one HTC there is a growing number of two-income households with high mortgage payments that result in low levels of disposable income and under-nutrition. This phenomenon is specific to this HTC in 2015. In another HTC, there is a much higher proportion of residents who speak a language other than English at home.

being used, it will be necessary to actively include marginalised group representation in the articulation of the problem and decisions about strategies and investment.	communities and develop logic frameworks for proposed solutions before taking action.
Finding: There are many examples of activities being well adapted to local conditions. The partnerships developed by HTV/HTCs with other government sectors, NGOs, the private sector and the community sector are vital to the success of HTV. The partnerships between community health, NGOs and local governments are among the most significant at local levels.	**Recommendation:** The adaption of strategies needed by each HTC to reach all members of the local population should be supported and documented. Differential strategies (including those intending to change structures and/or policies) may be needed in order to reduce inequities in outcomes. HTV/HTCs should work with partner organisations at state and local levels to identify determinants of inequities and opportunities to strengthen existing strategies to reduce inequities, and to implement additional solutions – many of which are likely to be adopted/delivered by agencies other than health.
Finding: The original identification of HTV communities and allocation of resources is linked to need.	**Recommendation:** Resource allocation based on need should be supported.
4. Monitoring to identify and assess progress toward reducing inequities in health	
Finding: HTV is based on a population health approach that assumes that population-wide strategies such as those being used currently will directly and/or indirectly (and over time) positively reach and influence the whole population through a trickle down of information and the inevitable exposure to changes in social, physical and economic environments. However, although the settings approach being used by HTV means that large sections of the community will be (and are) reached there is little focus on population groups that are marginalised and have poor links with mainstream social institutions.	**Recommendation:** The settings themselves are different from place to place (for example not every school setting is the same) and have a tendency to mirror the SES of the community in which they exist. Develop a process for reviewing the strengths and weaknesses of the population approach to reduce inequity in health, so that marginalised populations can be identified and remedial action considered. Whether or not this impacts the uptake of the HTV programs should be analysed by the data that is available.
Finding: HTV staff are aware that the interventions they plan, develop and implement can have unintended consequences.	**Recommendation:** Close monitoring and reporting of differential outcomes should be routine.

Introduction

This report presents the findings and recommendations of an Equity Focused Health Impact Assessment (EFHIA) of the Victoria Government's Healthy Together Victoria (HTV) initiative.

The Health Equity Research and Development Unit (HERDU) from the University of New South Wales (UNSW Australia) was commissioned by the Victorian Department of Health and Human Services (DHHS) in August 2014 to conduct an EFHIA of HTV and of three selected HTCs:

- Healthy Together Whittlesea
- Healthy Together Greater Dandenong; and
- Healthy Together Wodonga.

Over the last thirty years Australia has amassed evidence of what actions taken in which places, and by which organizations or people, are likely to succeed in improving the health of populations. Over the same period, evidence of the powerful role of sectors other than health in creating healthy environments for populations has emerged and the determinants of health are now understood to include many factors that are beyond the mandate of the health sector to control, and are beyond the capacity of individuals to influence (1). However, it has proven challenging to deliver effective interventions to whole populations – to implement population health strategies of sufficient scale and intensity, over sufficient time, and with universal reach.

HTV was established and designed to meet these challenges and has developed an ambitious new systems approach to protecting, sustaining, and promoting the health of the whole population of Victoria. HTV aims to encourage, support, and enable all the systems that influence health to create environments for health in the places and spaces in which people live, learn, work, and play. The development and implementation of HTV has required significant strategic preparation, technical and organisational skill, political will, resources, and energy on the part of the population health sector and many partners. The prevention platform that has been built has provided a strong base from which to examine the likely impact of HTV on inequities in the distribution of health in Victoria.

The purposes of the EFHIA were to describe and predict the likely impacts of the HTV (and HTCs) on reducing inequities in health, and to recommend actions to increase the likelihood that the implementation of HTV will result in reduced inequities in health, or in the avoidance of increasing inequities in health.

Methods

Establishment of reference groups

Upon project initiation, the HERDU team established a state EFHIA reference group and local reference group at each of the three selected Healthy Together Communities sites.

Screening and scoping

A screening and scoping meeting was held with the state reference group and with each of the three HTC reference groups in November 2014. Each of the reference group meetings concluded with decisions about which of the specific components being implemented at state and HTC level would be the primary focus of the EFHIA. The following components were selected:

- State level: Partnerships and Workplace Achievement Program
- Healthy Together Greater Dandenong: Children's Healthy Eating Program and Healthy Food Connect
- Healthy Together Whittlesea: Children's Achievement Program and Healthy Food Connect
- Healthy Together Wodonga: Health Champions and Healthy Built Environments.

Data collection and analysis

The findings of the EFHIA are based on:

- A selective literature review;
- Telephone interviews with key stakeholders nominated by the reference groups;
- Group discussions with HTV/HTC representatives and partner organisations regarding the specific components that had been selected by each site;
- A review of HTV documents;
- Ongoing discussion with senior policy makers and managers of Health Together Victoria.

Literature review

The literature review is included in the EFHIA report. The description of the methods used for the literature review is included in appendix A.

Telephone interviews

Senior staff of HTV identified stakeholders from a variety of locations and with a variety of roles in the design and delivery of HTV (state and local) to be interviewed. Eleven phone interviews were undertaken over 6 weeks. The interviews lasted between 30-60 minutes.

The questions were based on a series of standard questions that are used in EFHIAs:

- *What is the program trying to achieve?*
- *Is it likely to be successful? Is there evidence that it works?*
- *Is there any evidence of inequity?*
- *Who are likely to be the major beneficiaries of the program? Who are likely not to benefit from the program?*
- *Are there likely to be any unintended consequences?*
- *How could the program be improved to address equity?*

An additional question was included: *What do you understand by health equity?*

The interviews were recorded and transcribed. They were entered into NVivo and analysed thematically.

Group Interviews

At the request of the HTC co-ordinators, the HERDU team met with local stakeholders at each of the three HTC sites in November 2014 and again in February 2015 to explore the equity implications of each of the components identified at the screening and scoping meeting.

The participants in these discussions were selected by the HTC co-ordinators and their local HTC reference groups. The participants included HTC co-ordinators, HTC staff, representatives from partner organisations that were participating in the initiative being assessed, and two senior representatives from the Department of Health and Human Services. The one-hour discussions were recorded with the consent of participants. They were transcribed, entered into NVivo, and analysed thematically using a coding framework that was also used for the analysis of the stakeholder telephone interviews.

Document Review

A wide range of documents describing HTV, HTCs, and the initiatives being undertaken at state-wide and local levels were identified by DHHS and staff from the three local HTC sites and forwarded to the HERDU team. The documents included program guidelines, conceptual frameworks, strategic plans, resources, community profiles, and progress reports. The documents were reviewed to identify references to equity and/or inequity, and to identify actions being taken or proposed by the HTV prevention system that are likely to have an impact on reducing inequities in health. The findings were summarised and incorporated into the assessment and recommendations.

Discussions with policy makers and managers of HTV

There were ongoing discussions with senior policy makers and managers within HTV throughout the process to help clarify issues. The discussions informed the way in which recommendations were structured in order to ensure that, if adopted, they could be realistically implemented. These discussions did not influence the integrity of the findings.

Assessment

A third round of meetings was held with groups invited by the HTC co-ordinators at each of the sites and with the State Reference Group to discuss the findings and draft recommendations. The notes taken at the meetings were used to refine the assessment and recommendations that have now been reported in this draft, and which is being circulated for final approval.

Literature Review

The purpose of conducting an EFHIA of HTV's systems approach to health promotion is to establish whether HTV is reaching those who are most likely to be affected by the negative health consequences of being overweight or obese: that is, those with low socioeconomic status and other vulnerable or disadvantaged groups. The EFHIA will seek to establish whether the systems-based approach adopted by HTV is addressing the health inequity that exists in relation to the rates of overweight and obesity in Victoria.

The focus of this literature review is obesity, because it is the fasting growing health problem in Victoria and because it is connected to two of Healthy Together Victoria's key priorities: promoting healthy eating and physical activity. Obesity is a serious health issue that disproportionately affects people with low socioeconomic status and other vulnerable populations such as people with long-term mental illness. According to the 2007-8 National Health Survey 19.2% of Victorian children were overweight and 6.1% were obese. Therefore 25.3% of Victorian children are within an unhealthy weight range. However children living in areas of socioeconomic disadvantage were more likely to be in the unhealthy weight range, indicating that socioeconomic status is a risk factor for unhealthy weight among children (2). The 2010 Victorian Health Survey found that as income levels rose, there was a significant reverse social gradient in the proportion of persons being overweight, while there was a significant social gradient in the prevalence of obesity as income decreased (3). Other vulnerable or disadvantaged populations previously identified in Victoria included people of Aboriginal and Torres Strait Islander backgrounds, people from non-English speaking backgrounds, people in rural areas, and people with low socio-economic status and intellectual disability.

Purpose of literature review

This literature review undertook to inform the EFHIA on Healthy Together Victoria by seeking to establish what is known about the effectiveness of systems-based approaches to reducing inequities in health.

The questions guiding the literature review were:

1. What does a population-based prevention system look like?
2. What has been learned from previous systems-based prevention programs?
3. What would it mean to focus on inequity?
4. What are contemporary approaches to improving health equity?
5. What would an equity focused prevention system look like?

What does a population-based prevention system look like?

Systems are dynamic and complex. Most systems consist of networks of many interacting stakeholders with both different and shared interests. Agents in these networks constantly adapt to the actions of others and to a changing environment that is in turn affected by the actions of the agents (4). Such systems are not controlled centrally; they are self-organising. Systems thinking requires agents to see how their actions feed-back to shape the environment (5, 6).

There is now strong evidence that preventing (or reducing) ill health (or risks to health) in populations requires actions by multiple, interacting and complex systems and settings – in all

sectors of society. It has proven to be challenging for health systems everywhere to develop effective, sustainable, intensive, population-wide initiatives to create conditions for health for all.

HTV developed a prevention system based on five building blocks: workforce; leadership; information; partnerships; and finance. (See Figure 2).

Figure 2: HTV Prevention System (7)

The HTV Prevention System has its own clearly defined characteristics and is distinct from the health care system, although both sub-systems are parts of a health system. It recognises that these systems interact and feedback loops promote adaption and change, so that, for example new information about effective interventions influences both the health care and prevention systems. In a systems approach there will be many ways in which this adaption comes about, some of them unanticipated.

HTV located its prevention system within local government – itself a system (or series of systems) with broad roles and responsibilities for the equitable delivery of services and programs that affect the lives and health of their constituents. The location within local governments was intended to activate a new prevention system that has the potential to bring about widespread innovation. Harris identifies three ways in which local government is a strong base for a universal prevention system: (i) as a venue where activities can be organised and populations reached; (ii) as a setting (an organisational structure that can be influenced and refined to be more supportive of health); and (iii) as dynamic systems through which residents solve local problems (8). HTV also identified priority settings (within systems) in which HTV would work to enhance capacity to contribute to improving the health of and to reducing risks to the health of their constituents - workplaces, child care settings, schools, and communities.

Figure 3: The multi-agency, multi-faceted health promotion policy and practice at multiple levels of the prevention system (7)

The HTV prevention system is based on the commitment to ensuring that every Victorian lives, learns, works, and plays in environments (physical, economic, and social) that enable them to make informed, positive health choices. The HTV has operationalised this commitment by linking and working across systems and settings in multiple sectors to change the social norms, policies, environments, and practices that influence healthy eating and physical activity (and the health) of all Victorians. HTV is one of the few examples anywhere in the world of preventive system-based interventions to be implemented at scale (see Figure 3).

The underlying causes of the disproportionately high (inequitable) rates of obesity and overweight among people from low socioeconomic groups and some other social groups are interrelated and complex. Equally complex, multi-faceted approaches are needed if it is to be possible to reduce inequity. In the past, such approaches to intervention have been viewed as multi-level interventions rather than as interacting systems.

Three key methods for studying complex systems include: system dynamics, network analysis and agent-based modelling (9). System dynamics uses informal and formal models with computer simulation to uncover and understand endogenous sources of complex system behaviour. Network analysis focuses on the measurement and the analysis of relationships and flows among actors, including people, organisations, and other information-processing entities. Agent-based modelling uses computer simulations to examine how elements of a system (agents) behave as a function of their interactions with each other and their environment. Conceptually, these models have been useful in suggesting possible mechanisms by which contexts (e.g. neighbourhoods, communities, and residential environments) influence health and health behaviour (9).

The system dynamics method has been used to explore the interactive effects of multiple policies and interventions on smoking rates (10-13). These studies reveal that polices do not work in

isolation and therefore multiple, evidence-based actions need to be taken if we are to continue to lower smoking rates (14).

Network analysis methods have been used to identify the types of ties and network structures that are most associated with smoking. Ennett & Bauman showed that adolescents who were most isolated from their peers were most likely to smoke (15). Lakon and colleagues suggest that networks influence smoking by structuring flows of emotional support (16). Network analysis has also demonstrated that engagement with an online network of international tobacco-control advocates was positively associated with the likelihood of formal adoption of the Framework Convention on Tobacco Control (17). Agent-based models could be built to test the dynamic effects of tobacco retailer density reduction through distinct policy approaches such as attrition, increased licensing fees, or buffer zones around schools (18).

Finegood developed a multi-level intervention framework as a solution for the complex problems of obesity and chronic disease prevention (19):

Figure 4: Sample Actions According to the Intervention Level Framework for Obesity and Chronic Disease Prevention

Intervention level	**Examples of action statements at that Level**
Paradigm	Reframe obesity as a consequence of environmental inequities and not just the result of poor personal choices
	Develop systems approach that recognises the role that social conditions, politics, and economic forces play in prevention and treatment
Goals	Establish targets to achieve healthy weights for children through physical activity and healthy food choices
	Build trust across the multiple sectors that need to work together to address obesity and chronic disease prevention
	Reduce inequities in the determinants of health that lead to inequities in health status
	Create a social expectation to emphasise prevention as more important than minimally extending life through expensive procedures
System structure	Identify a lead department or agency for federal interdepartmental action on healthy weights for children
	Enable coalitions of health, environmental, labour, poverty and public policy advocates to work together on common beneficial prevention projects
	Harmonise primary, secondary and tertiary prevention program messages and policies across jurisdictions
	Implement the appropriate mix of individually-focussed and environmentally-focussed effort

Feedback delays	Assess effectiveness of self-regulation of marketing to children
	Establish legislative or regulatory action to enforce workplace standards for mothers who choose to breastfeed
	Conduct more research on natural policy and program experiments
Structural elements	Establish a comprehensive public awareness campaign on healthy weights for children
	Implement a mandatory, standardised, simple, front of package labelling requirement on pre-packaged food for easy identification of nutritional value
	Establish regulations to limit trans-fat content in foods
	Expand funding available to local governments for safe walking and cycling programs

This approach is useful because it demonstrates what needs to be done at every level of organisations, systems, and social movements to enable change. The approach unpacks the complexity of what has made public health interventions successful in resolving (or at least reducing) some population health problems. However, although Finegood's multilevel framework is complex, it does not include explicit actions to reduce inequity, and although it articulates need for intersectoral partnerships and coalitions it does not specify the systems and settings through which the actions would be carried out. Nor does it include an explicit focus on reducing socioeconomic inequity in the distribution of obesity.

What systems-based approaches have been effective? What are the lessons?

While there were no papers identified that linked system approaches to improving health equity, the literature review did identify 13 papers that took a system approach to preventing or controlling obesity in populations. These 13 papers presented the results of three studies: (i) Be Active Eat Well, 2003-2006 (20); (ii) The Hartslag Limburg Project: 1998-2003 (21); and (iii) EPODE (22). These three studies are important examples of systems-based or informed interventions that aim to address population levels of obesity and are summarised below. In each case study the aim, partners, setting, target populations, and results are presented and the implications for equitably addressing obesity in populations are discussed. While the studies did not focus on health inequity in particular, the EPODE study is currently developing resources in this area.

i) Be Active Eat Well: 2003- 2006

Aim: A community capacity-building program in a disadvantaged community in Victoria, Australia designed to build the community's capacity to create its own solutions to promoting healthy eating, physical activity and healthy weight in children and their families.

Target population: Children aged 4-12 years in four preschools and six primary schools.

Setting: Schools.

Strategies: The nutrition, physical activity and screen time strategies included social marketing, programs and policies. Some of the programs and policies included school nutrition policies around water, fruit breaks and canteens; canteen menu changes; community gardens; walking school buses; training school staff including teachers and canteen staff; healthy breakfast days; and incorporation of Be Active Eat Well Strategies into the Municipal and Area Health Plans. The strategies were flexible so as to adapt to varying local contexts (e.g. participants' age, locality, ethnicity, existing capacity and resources).

Results: The intervention group had lower increases in body weight (mean: −0.92 kg, 95% CI: −1.74 to −0.11), waist (−3.14 cm, −5.07 to −1.22), waist/height (−0.02, −0.03 to −0.004), and body mass index z-score (−0.11, −0.21 to −0.01) than comparison children. These anthropometric changes were not related to socioeconomic status in the intervention group. However, the comparison group showed greater gains in anthropometry in children from lower SES families.

Implications: A community capacity-building approach has the potential to build the policies, environments and community ethos over time, more than externally designed and applied programs. The project resulted in a reduction in the social gradient with weight gain, which implies that community-wide interventions do not always increase inequities in obesity rates among children (20).

ii) The Hartslag Limburg Project: 1998-2003

Aim: A community intervention was conducted in four districts of Maastricht, Netherlands to reduce cardiovascular risk factors vis-à-vis nutrition, physical activity and smoking.

Target population: The project was a multi-level intervention that targeted patients, health care providers, and the environment at schools, workplaces, community and healthcare facilities. 2,400 men and women aged 20-59 years participated in the project.

Setting: The project was a community based intervention. Settings included schools, workplaces, health care facilities and the community.

Partners: The project partners were the municipal authorities, the Regional Public Health Institute, community social work organisations, the community healthcare organisation, general practitioners, Maastricht University and University Hospital, and various local organisations, clubs and companies in the Maastricht region.

Strategies: Nine local health committees were established. Four of these nine committees were located in low socioeconomic status areas. A total of 790 interventions were conducted, of which 50% took place in the low-income areas. The project aimed to target low-income and high-risk individuals (21).

The community adopted changes such as labelling low-fat foods in markets, providing healthier food choices in cafeterias, increasing levels of exercise education in schools and increasing government spending for school sports teams, making smoke-free areas, public-private collaboration with retail stores and increased municipal funding for low socioeconomic status areas. Health care providers were trained on newly developed counselling protocol. Individuals were provided opportunities for group education, computer-tailored education, weekly walking and cycling groups, and nutrition

education tours in supermarkets. Multimedia campaigns were held to increase awareness on lifestyle modification for cardiovascular risk factor management (21).

Results: At the individual level, there was a reduction in BMI, waist circumference, blood pressure, energy intake and an increase in time spent walking. It was argued that as this study had a comparatively long follow up period of five years, the improvements in risk factors could be monitored over time (23). Despite a reduced fat consumption, the intervention group reported lower self-efficacy expectations towards decreasing their fat intake compared to the control group (21).

The impact evaluation compared physical and mental quality of life (QoL) between the cases and controls. There were no beneficial effects on people's physical and mental quality of life after five years of intervention. In fact, subjects in the intervention group with a moderate/high SES show a decrease in their mental health QoL compared with the reference group, which had an increase in QoL (24). Apparently the beneficial changes in CVD risk factors associated with the intervention did not translate into a better perceived QoL. Maybe the cardiovascular and lifestyle risk changes were too modest to influence people's QoL. Seasonality cannot explain the outcome of the study, because the pre and post intervention measurement of subjects in intervention and control groups took place in the same month.

Outcome evaluation revealed that organisational involvement in health promoting activities were higher for the intervention region compared to the control region, and concluded that changes at the organisational and policy levels seem more effective than individual-level changes.

Implications: These findings might indicate the stochastic nature of complex systems, whereby an element of randomness leads to a degree of uncertainty about the outcome, and the same results do not occur for a given set of inputs. For example, in the National Weight Control Registry report of the United States, a large number of participants reported that 'they just decided to do it (lose weight)' which characterises a random event, in addition to predictable reasons like medical or ongoing discontent (25).

iii) EPODE

Aim: EPODE is a large-scale, centrally coordinated and locally implemented, multifaceted and multilevel community-based intervention program aimed at reducing childhood obesity by directing and encouraging local environments, childhood settings, and family norms to facilitate the adoption of healthy lifestyles in children (i.e. the enjoyment of healthy eating, active play and recreation).

Strategies: EPODE has a multi-activity, multi-setting and multi-stakeholder approach. EPODE works on four integrated levels: the level of the central organisation, the level of local organisation, the community level and the child level. Each level provides input to the next level. Outputs or outcomes of each level should reflect and provide feedback to the performance of the implementation (inputs and activities) of that level or of preceding levels (26). EPODE philosophy is based on multiple components, including a positive approach to tackling obesity, with no cultural or societal stigmatisation; step-by-step learning; and an experience of healthy lifestyle habits, tailored to the needs of all socioeconomic groups.

The EPODE methodology is the result of a study that was initiated in 1992 in two towns in Northern France (Fleurbaix and Laventie). The French study was conducted in different phases. The first phase was implemented from 1992 to 1997 and aimed to evaluate the effects of a school-based nutrition education program on the eating habits of the whole family (21, 22).

The second phase of the study was implemented from 1997 to 2002. The school-based intervention from the first phase continued and every two years, the families in the intervention towns were provided with a clinical examination and were administered questionnaires about food habits, eating behaviour and physical activity (22).

The third phase of the study was implemented from 2002 to 2007. People with lifestyle risk factors (overweight, high blood pressure, high level of sedentary behaviour, unhealthy eating habits, hyperlipidaemia and smoking) were identified through a health check-up, offered at home in the intervention towns. Those at risk were offered family-oriented advice on healthy eating and physical activity provided by a dietician, who referred to the general practitioner in cases of identified health problems (including childhood obesity). The town councils supported actions in favour of physical activity, new sporting facilities were built and sport educators were employed to promote physical activity in primary schools; walking-to-school days and family activities were also organised. Various local stakeholders (general practitioners, pharmacists, shopkeepers, sporting and cultural associations) set up family activities focused on a 'healthy lifestyle'.

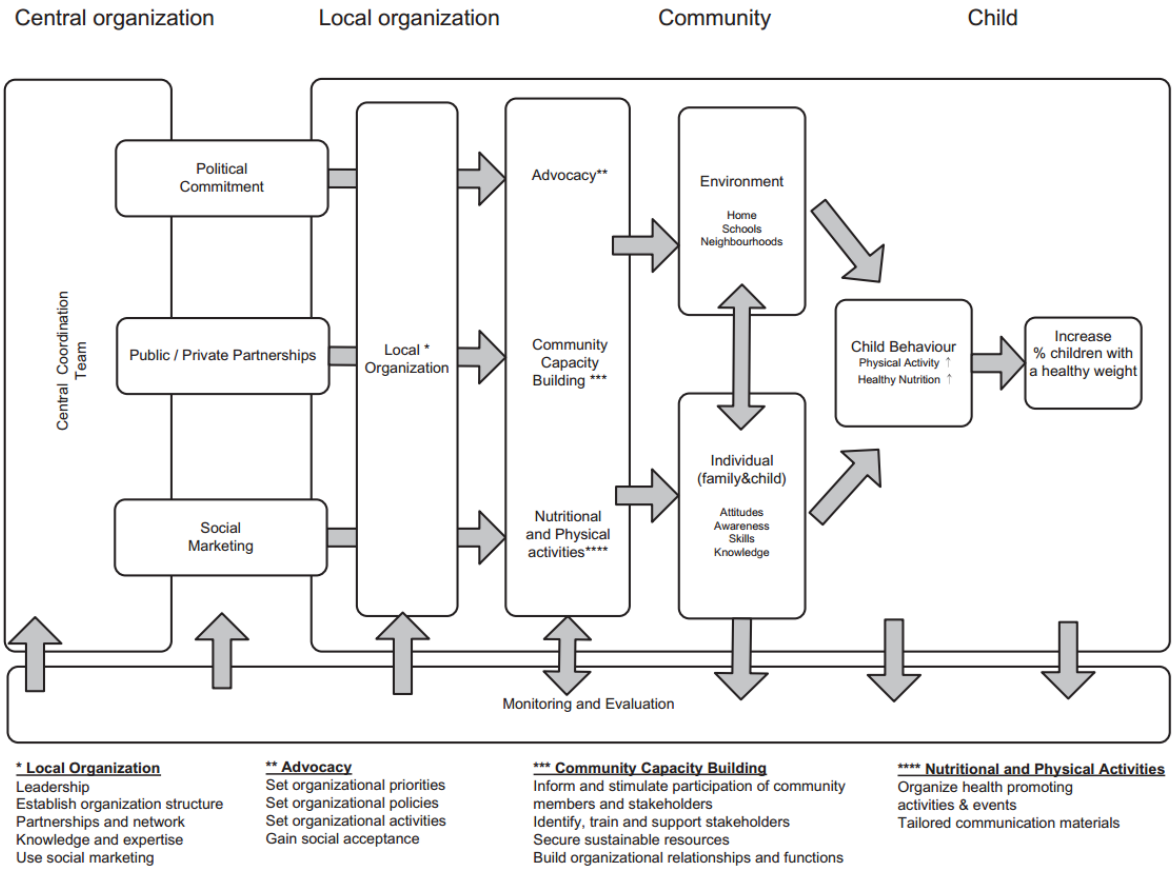
In 2002, 2003 and 2004, 515, 592 and 633 children respectively were measured in the two intervention towns (participation rate of 95–98% of all eligible individuals). In the control towns, a total of 349 children were measured in the 2004 school year (98% of the towns' school population). The two sets of towns did not differ in terms of social class distribution. The overweight prevalence for boys and girls together was significantly lower in intervention towns (8.8%) than in the comparison towns (17.8%, $P<0.0001$). When adjusted for age and height, BMI was significantly lower in both girls and boys in the intervention towns compared to the comparison towns.

Based on the results of the pilot study in the two towns, the EPODE methodology was further implemented in eight French towns (Asnières-sur-Seine, Beauvais, Béziers, Evreux, Meyzieu, Roubaix, Royan and Vitré) starting in 2005. Children in age groups from four to five and 11 to 12 (n=23,205) were weighed and measured annually between 2005 and 2009 by school health professionals. While national data available in France indicated an overall stabilisation in the prevalence of overweight children and obesity, results from the eight French EPODE towns showed a significant decrease of 9.12 % ($p<0.0001$) in overweight children and obesity between 2005 and 2009. Encouragingly, children who attended schools in deprived areas showed a downward trend of 2% ($p=0.38$) in the prevalence of those who were overweight (including obesity), compared with an increase in the prevalence of those who were overweight and childhood obesity in children from disadvantaged households at the national level (26).

Other studies have since depicted the transferability of the EPODE methodology in other settings and cultures. The VIASANO program, based on the EPODE methodology, was launched in 2007 and 2008 in two towns in Belgium. During the school year 2007/2008, children in year 1 and 3 of nursery schools (n=1,300) were weighed and measured by the School Health Prevention Services, as well as another 1,484 children in 2009/2010. The prevalence of overweight children in nursery school

showed a decrease of 22% ($p<0.05$), from 9.46% to 7.41%. In the same period in the control towns, the prevalence of children who were overweight slightly increased, from 9.53% to 9.58% (27).

Figure 5: The EPODE logic model (22)



The inputs and activities for the EPODE logic model are: political commitment, public-private partnership, social marketing, and monitoring and evaluation, which are also known as the four pillars of EPODE. The central coordination team is responsible for coordinating and implementing the connection between the four pillars. Activities comprise national coordination and dissemination of the program; national societal and political agenda setting; public and private funding of the program implementation and coordination; creation of communication materials; data collection, analysis and evaluation of the local program; training of local program managers; and the scientific substantiation and recruitment of new cities.

The central coordination team is based within a social marketing agency; employees are professionals experienced in nutrition, health education, social marketing, press relations, monitoring and evaluation, communication, physical activity and text writing. The central coordination team is supported by a scientific committee. The scientific committee assembles professionals and scientists in the field of nutrition, physical exercise, behavioural science and paediatrics. This scientific committee is consulted in the content of training and the development of social marketing materials (26).

The local organisational level is coordinated by the local program manager appointed by the Mayor and funded by local government. The local program managers improvise to adapt to changing local

circumstances, for example age, socioeconomic group, different cultures, and different geographical areas.

The groups represented in the local organisation are: health professionals (e.g. general practitioner, dietician, school doctor and school nurse), community key figures, parental associations and interested professionals from local public and private organisations (26).

Activities associated with advocacy are aimed at obtaining: a broad political commitment to the program and promoting the urgency of overweight and obesity prevention in children; policy support from departments outside the health sector to the program and program aims; and social acceptance of the program and of the program aims. The EPODE program stimulates participation and active involvement of all community members (i.e. teachers, school board, local industries, small and medium enterprises, general practitioners, nurseries, pharmacies, sport clubs, welfare and parental associations) and builds their capacity through: informative meetings; disseminating communication materials in the community to promote change in cognition and attitude of the target group and their social system towards healthy nutrition and physical activity in everyday life; regular training sessions provided by the central coordination team for the local program manager; roadmaps and toolkits developed by the central coordination team and delivered at the local level to support social networks and the local organisation; the initiation of activities by the community; and securing sustainable resources (means and people) (26).

Nutritional and physical activities (e.g. sporting events at school or in the neighbourhood, nutrition classroom courses and communication tools) are primarily directed at the children with suspected spill-over effects to parents. All activities are approved by the central coordination team and reviewed by the central scientific committee. The activities are intended to create a positive change in attitude, increase knowledge on what constitutes a healthy diet, build an understanding of the daily amount of physical activity required for good health, and increase skills to eat healthily and be physically active. The implementation of the activities directed at children and their parents (social environment) takes place at several settings namely neighbourhoods, schools and at home.

There are examples of where programs have not disproportionally advantaged the more advantaged groups. It is not clear how this may have happened and EPODE is currently developing a series of tools to address equity within its programs (22).

It is essential that efforts to prevent obesity do not leave behind the most disadvantaged members of society. Therefore multifaceted structural interventions that target both community settings and the state are necessary if is to be possible to reduce the inequitable distribution of obesity.

How systems approaches can reduce inequity in the distribution of obesity in populations

Research on inequity, obesity and a systems approach to understanding determinants of, and/or to reducing the inequitable distribution of obesity in populations is beginning to emerge. Three examples of descriptive research are presented below.

Christakis and Fowler describe the spread of obesity through social networks (28). The authors investigated a large network of individuals in a population-based cohort of adults over a period of 32

years, and they found that subjects' weight gain was a function of weight gain in persons to whom they were socially connected.

Auchincloss and colleagues used agent based model simulations to explore income differentials in nutrition as a function of both food prices and preference, and found that both healthy foods and favourable prices (i.e. healthy foods priced cheaper than unhealthy foods) had to be present to improve diet and eliminate the diet differential by income (29).

Yang et al. used an agent based model to study the role of the social and built environments on SES differentials in walking behaviour, incorporating feedback mechanisms so that, for example, individual walking behaviour is enforced as the number of other walkers increases (30). They also found that low-SES neighbourhoods have a low safety level, resulting in less walking among the lower-SES groups even when SES is not spatially correlated with land-use mix.

These examples demonstrate the potential benefits of adopting systems approaches to reduce inequity in the availability of, access to and consumption of food, for example; or to improve the safety of local neighbourhoods to encourage walking.

Local government in particular has been singled out below as an important sector to work with due to their contribution to the local built environment and enabling communities to participate in the development of social infrastructure.

What is a systems approach to reducing health inequity and/or to increasing health equity?

Equity has been included within the HTV Prevention System as a principle. Defining inequities in health, identifying the determinants of inequities, and specifying explicit outcomes that are being sought from interventions are challenges being faced by public health policy makers and practitioners globally. A further challenge is to identify how outcomes (reductions in inequities in health) are to be achieved. Recent interest in addressing the social determinants of health, too, has resulted in a rapidly growing conceptual and intervention basis for action.

What is health equity?

Health equity is a description of fairness and justice – it does not mean that all people can (or even should) have the same health status. Rather, it has been described as "all people will have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided" (31).

In practice, the policy goal for achieving health equity across a population is to reduce or eliminate differences in health that are considered to be avoidable, unfair, and unjust. Actions to increase health equity are concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible (32).

What is health inequity?

The term health inequity has often been used interchangeably with the terms 'health inequality', 'health variation' or 'disparities' to describe differences in the health of populations or groups.

However, there is an important conceptual difference between 'inequalities, variation, and disparities' and 'inequity'.

The terms 'inequalities, variations, and disparities' are descriptions of observable, measureable differences in the distribution of any characteristic (height, weight or age, for example) in a population; in the distribution of a social good (e.g. schools, or income) in a population; or in the social and economic characteristics of different neighbourhoods (for example). Inequalities or disparities are not inherently unfair or unjust – and not all are avoidable.

Inequity, on the other hand, is a description of the fairness and justice of the differences or inequalities – whether the differences or inequalities are considered to be unfair, unjust, and avoidable depends on a judgement based on values, knowledge, and experience.

The social determinants of health are the goods, services and conditions known to be essential for humans to survive and thrive, and are distributed by societies through their institutions (governments, the private sector (market), and civil society). The fairness and justice of that distribution is socially constructed and contestable – what is considered to be fair and just varies depending on the values and experiences of the people who are deciding.

Whether a difference/disparity/inequality between people or places is considered to be inequitable or equitable is therefore always a judgement about whether the difference is fair and just. In the health sector there is growing agreement that health equity has been achieved only when people have been given equitable opportunities to attain and maintain optimal health across the life span – not only when they have had equitable opportunities to access and benefit from health care.

The answer to the question as to which health inequalities are considered to be inequitable can change over time as new ideas and new technologies emerge. Crucially, different decision-makers make different decisions about when inequalities are inequitable – based on their personal values and ideologies, as well as the context within which they are deciding. Who decides is, therefore, a significant determinant of whether inequalities in health are considered to be inequitable.

Because of the reluctance to make such value judgements explicit when describing socially constructed differences as unfair or unjust, in many countries differences in health outcomes are referred to as health disparities or health differentials. That allows them to describe a measureable difference in, say, health outcomes that allows for the measurement and monitoring of changes in patterns of health inequality without having to make a transparent value judgement as to whether a particular outcome is unfair, unjust or amenable to active social intervention.

Contemporary approaches to reducing inequities in health

The increasing focus on identifying effective actions to reduce inequities in health is leading to increased sophistication in the analysis of the determinants of inequity, and in the identification of actions/strategies/approaches that are likely to be effective in reducing inequity – in the shorter and longer term.

Choosing between different goals to reduce inequity

The quickly emerging body of knowledge has been based on recognition of differences in the intended goals of policies and programs implemented to reduce inequities in health. Each of the

three understandings of the goals of equity interventions listed below points to a different starting point for action, to different types of action selected, and to different outcomes being measured:

- remediating health disadvantage
- reducing gaps between groups; and
- reducing the social gradient.

Remediating health disadvantage means implementing universal systems or responses that are intended to protect or improve the health of the entire population with some targeted actions for groups that are already experiencing health disadvantages - such as people living in poverty, single men, people who are unemployed or people who are unable to obtain relevant health information or to use services effectively. The goal of remediating health disadvantage is to improve the health of disadvantaged groups so that they do not fall further behind others who are more advantaged. The provision of a strong universal health care system and a prevention system is one approach to achieving this goal.

When focusing on reducing gaps between socioeconomic or other social groups, however, the goal of intervention is to improve the health of the most disadvantaged *at a faster rate* than the population's average to level up the health of disadvantaged groups to that of the population average. A combination of universal services/programs and specific interventions that are tailored to meet the needs of specific groups is the approach to achieve this goal. The social gradient describes the positive relationship between socioeconomic status and health status – the gradient of highest to lowest groups on a socioeconomic gradient is mirrored closely by highest to lowest groups on a gradient of health status. The goal of intervention here is to progressively narrow the gap between the most and least advantaged. This means providing universal services, programs, and interventions and modifying them to make them more effective for specific social groups. This might mean, for example, providing health checks routinely for everyone, but providing them to Aboriginal people at an earlier age. This approach is also called proportional universalism where people have differential access to universal services based on need.

Implications for intervention

There is emerging sophistication as well, in understanding the ways in which different policy options can lead to reducing inequities in health, to the maintenance of existing inequities, or to increasing inequities.

Universalism, meaning that the same inputs are made available equally to all members of a population, has been a powerful approach used in public health over the last two centuries. Examples include infectious disease control measures, sanitation and Medicare that are provided equally to everyone – although not all population groups benefit equally. More recently, in a refinement of understanding of universalism, specific universalism has guided the implementation of policies and programs to redress existing inequities in access to and benefits from universal measures by ensuring that the 'universal' measures are, in fact, equally available to groups that had not been reached by inputs that were 'the same for everyone' (33). For example recognising the need for, and investing sufficient resources to ensure that all remote Aboriginal communities also had effective sanitation. Gradually, more nuanced approaches have emerged to supplement and complement universal inputs to reduce inequities in health (33, 34).

Benach et al developed a typology of four groups of policies that have been suggested as options for action to reduce health inequities. These are:

1. targeted policies and those addressing the health gap by improving the health of the poorest groups fastest,
2. universal policy with an additional focus on the health gap, for example prioritising access to services and allowing an additional budget in disadvantaged areas,
3. redistributive policy where a universal policy is directed to the underlying determinants of inequities, for example raising the minimum pension rate,
4. proportionate universalism where the focus of the policy is on health problems or determinants whose occurrence increases with social disadvantage. In this example policies are universal, however their intensity is proportionate to levels of disadvantage. For example, a needs-based geographical allocation of services in the context of a comprehensive universal health care system (34).

After applying the typology to different scenarios the authors concluded that policies stemming from category two and category four may maximise population health benefits, whilst category three concentrates on a reduction in health inequities. The authors do not present one category of intervention as the preferred option; rather they argue that the choice of policy intervention 'will depend on the nature of the health problem, its context and the potential effectiveness and efficiency of the solution' (34).

Carey and Crammond identified a need for greater specificity in identifying policy options that are capable of reducing and ultimately of preventing inequities. Beginning with a description of the relationship between the broad universal and targeted policy approaches taken by governments (in particular) to ensure their citizens welfare and wellbeing, Carey and Crammond go on to identify the multiple forms of policy approaches that have emerged in practice (33). Like Benach, they point to the need to match policy responses to the problem and intended outcomes. Certainly, Benach and Carey and Crammond highlight the fact that much more nuanced approaches to the reduction of inequities in health are necessary if they are to succeed.

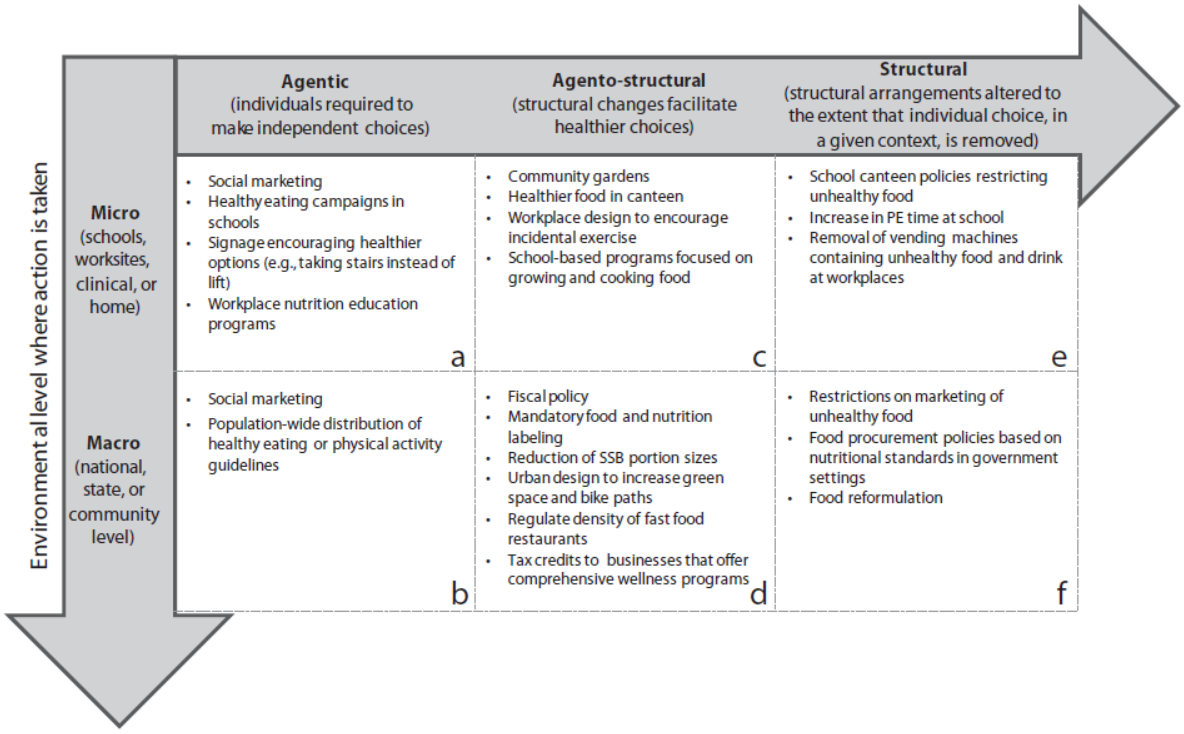
In summary, it is necessary to differentiate between the need for interventions that are universal in design but that are delivered with greater intensity and over longer periods to specific high-risk groups (proportional universalism) and interventions that are different in design because the perspectives, experiences, and needs of some population groups are different from those of the 'majority' (targeted interventions). In short, is the intervention more of the same but at different intensity and duration or is it different and tailored to specific needs of a group? It is important to be specific about what actions are needed because no matter how intensive an intervention that is inappropriate for particular groups and locations and problems is delivered, it cannot succeed.

Backholer et al made a significant contribution to our understanding of the importance of theoretical approaches in developing interventions to address inequity (35). Backholer developed a theoretical framework to assess the multi-strategic obesity prevention interventions for their likely impact on the socioeconomic gradient of weight. Their review of evidence found that interventions that change environments, norms, and products are more likely to reduce socioeconomic inequities in weight than interventions that rely on individual agency to achieve their effect. They constructed a model

that differentiates between interventions that depend upon individual agency to achieve their effect and structural interventions that obviate the need for individual agency (or reduce it).

Agentic interventions that rely on persuading and informing individuals to make personal choices about their health behaviours have been shown to increase socioeconomic inequalities. Structural interventions, such as food procurement policies and restrictions on unhealthy foods in schools, have shown equal or greater benefit for lower socioeconomic groups. Many current obesity prevention interventions belong to the agento-structural type – a mix of both approaches. Although they do change the environments in which health behaviours occur, they still require a level of individual agency to make behavioural changes. Examples of agento-structural interventions include workplace design to encourage exercise and fiscal regulation of unhealthy foods or beverages. The evidence of the impact of these interventions on the health of people of low socioeconomic status is, however, unclear. Backholer et al confirmed that limiting further increases in socioeconomic inequity in the incidence and prevalence of obesity will require the implementation of structural interventions (35).

Figure 5: Framework for the likely impact of obesity prevention strategies on socioeconomic inequalities in population weight (35)



Note. PE = physical education; SSB = sugar-sweetened beverage. Parts a and b show interventions more likely to increase the socioeconomic gradient in weight. Parts c and d show interventions in which the impact on the socioeconomic gradient in weight is uncertain. Parts e and f show interventions unlikely to increase the socioeconomic gradient in weight.

The social determinants of health inequity

There is strong evidence of a positive relationship between the distribution of the social determinants of health and the distribution of health outcomes within populations (36, 37)

However, the determinants of inequities in health are separate from these and fall into three categories.

a) The inequitable distribution of the social determinants of health

The social determinants of health include constitutional and legal rights, equitable opportunities to access and use material resources, and information. However, although all citizens in Australia are guaranteed constitutional and legal rights, people who are not citizens do not. Opportunities to access and use material resources (including information) and the benefits and costs of social decisions about 'who gets what' are not distributed fairly or justly (38, 39) .

- **How does this lead to health inequity?**

Direct: some social groups do not have enough education, employment, income, food, housing, health care, etc. to become and stay healthy. They live, learn, work, and play in environments that are risky and/or that are under resourced compared to those available to others, and compared to need.

Indirect: not having enough social resources (personally, or in the usual environments and settings in which life is lived) is a marker of social exclusion, of denial, denigration, and is used by others to ascribe negative social status – discriminate and stigmatise. That, in turn, leads to shame, anger, low self-esteem, and loss of hope and sense of rightful place in society.

b) Misrecognition and lack of presence, including voice, and influence (lack of power)

Social groups that have been marginalised and have limited presence, voice and influence in the structures and processes that decide on which social problems are included on the public agenda, on the ways social problems are framed, and to influence decisions (40). There can be weak vertical networks and sometimes, dysfunctional horizontal networks in marginalised communities (41, 42).

- **How does this lead to health inequity?**

Direct: lack of fair, just presence/representation, and voice in decision-making by groups that have been marginalised means decisions are made without reference to their particular experiences, circumstances, needs, and solutions (43-45). This leads to wrong problem definition and wrong solutions (43). This is particularly important when the marginalised groups are small minorities with very divergent (from mainstream) needs. Decision-makers who are unaware of their ignorance, and/or who assume that everyone is the same and should be treated equally fail to recognise the need for presence, formal representation, and influence in decision-making.

Indirect: the symbolism of the lack of powerful presence in decision-making (i.e. beyond consultation), lack of formal methods to seek and confer representation, and lack of power to influence decisions confirm powerlessness, hopelessness, shame, anger, and despair. In summary, the indirect impacts on health are the social and psychological damage associated with 'being viewed as irrelevant to social decision making'(46).

c) Contextual injustice – institutional and personally mediated discrimination, racism, stigmatisation

Organisations (structures) and the people who represent or work for the organisations (agents) discriminate negatively, systematically, and routinely against some social groups. Some social groups have experienced the stigmatisation, racism, and exclusion for generations; others for more limited periods. Organisations codify discrimination and exclusion through their policies and practices over time and the individual agents then follow and implement these without, necessarily, recognising

the racist or stigmatising impact. Individual agents may, as well, hold negative, discriminatory beliefs or values that influence their practice.

As a consequence of historical, long-lasting oppression members of marginalised social groups, themselves, hold negative views of themselves and others in their group. Lateral violence is one consequence of this.

- **How does this lead to health inequity?**

Direct: The structures, policies, processes used by social institutions (in all sectors – public, private, non-government, and civil society) are reflections of the historical context in which they were developed, often reflecting goals, methods, processes that may have been defensible at the time but that have been shown to be inequitable. Some examples of inequities that are embedded in contemporary institutional, social, economic, and political conditions include tax policy favouring the wealthy; welfare policy punishing the poor; education policy tolerating significantly lower investment in public schools (than in private); health policy favouring individual behaviour change initiatives above structural, environmental, and policy change) (39).

Indirect: The knowledge, attitudes, beliefs, and values of decision-makers in the public, private, non-government and civil society sectors influence decisions about priorities, investment, policies, and programs. The socioeconomic status, professional cultures, and the level and ease of access to social resources of all kinds blind decision-makers to differences experienced by and needed by others. These factors also influence the extent to which people believe that for example, ill health and early death are consequences only of personal rather than of social choices.

Strengths and weaknesses of a settings based approach

HTV is committed to providing opportunities for health in the everyday environments where people live, learn, work, and play - including children's services, schools, workplaces, recreation facilities, local government, and other large social institutions. Through such settings it is possible to create physical and social environments that protect and promote health – providing information, safe work, play, study environments, and accessible health care, for example. This approach has the great advantage of having substantial reach into the population and capacity to influence social norms. It is through such settings that society distributes many of the social determinants of health – education, employment, income, and food, for example.

However, the settings themselves such as individual schools, community health centres, and workplaces are not distributed equitably – nor are the individual settings, themselves, equitably resourced. Some schools are comparatively wealthy; others are comparatively poor. The settings, themselves, may be ill equipped and without additional support to adapt to undertake new actions to improve their capacity to protect or promote health.

Furthermore, there are many groups in the community who are only marginally attached to some of these settings; for example people who are not in the labour force, people who are unemployed or under-employed, people with disabilities, and people in the criminal justice system. Older people too, may not be attached to the social institutions through which HTV is working, primarily.

It may not be possible to reach such social groups through existing social institutions, or, even if it is possible to reach the groups, their life circumstances are likely to mean that the advice, support, or

service that is being offered is insufficient or inappropriate. The powerful roles of internalised racism (47) and lateral violence (48) are often hidden from the view of contemporary social institutions and their agents.

Without the direct engagement of marginalised groups in identifying problems and solutions, it is unlikely that it will be possible to improve their health effectively. In identifying the appropriate actions it is critical to understand that health inequities arise not only as a consequence of 'material deprivation' but also as a consequence of their lack of representation in the institutions making decisions affecting their lives and of their lack of influence over such decisions. Both the structural and interpersonal discrimination experienced by people who have been marginalised contribute to their poor health.

Use of RE-AIM to increase the likelihood of achieving more equitable outcomes in implementation

The results of this literature review suggest that it will be necessary to integrate initiatives/interventions that are focused, explicitly, on reducing inequities into the suites of HTV intervention initiatives. The literature review confirmed that HTV has designed and is implementing a complex, comprehensive, evidence-based intervention that draws on the best of contemporary knowledge of 'what works' to improve the health of populations. But the literature review also exposes the need to add explicit, equally complex interventions in order to reduce inequities. The REAIM framework is suggested as a way to explore how this could be done (49).

For any given outcome the 'suite' or design of interventions may differ according to the social group, location, and/or health outcomes being sought. The REAIM framework suggests that:

1. There should be a mix of individual focused and structural strategies
2. Implementation should:
   R: Reach the whole population, including, explicitly, into the social groups that have been identified as most in need.
   E: Include interventions that are designed or adapted explicitly to be effective in improving the health (or reducing risks to health) of marginalised social groups.
   A: Ensure that interventions intended for marginalised social groups are adopted as intended and with sufficient resources (including time) to achieve results.
   I: Be guided by governance structures that include representation from marginalised social groups and that ensure their influence in implementation of decisions.
   M: Maintain the intervention over time and monitor to ensure that all social groups are benefiting from the HTV investment – and that the gap between the lowest socioeconomic group and that of the other four socioeconomic quintiles is closing.

The RE-AIM framework may be useful for assessing the likelihood that the system-based interventions that are the core of the HTV strategy are effective in reducing inequities in health.

Figure 7: RE-AIM Framework

Dimension	Response
R: Reach	Who does the program reach?

E:	Effectiveness	Is the program more effective with some groups than others? Are programs informed by evidence?
A:	Adoption/ Adaption	Are components adopted in the program in a strategic or responsive way? How are the programs adapted to local conditions?
I:	Implementation	How is the program developed? Which social groups are included and which groups are excluded from the structures and processes deciding on priorities, strategies, and implementation?
M: M:	Maintained Monitored	How are positive impacts of an 'intervention or strategy' being maintained? How are progress and impact being monitored? Are there some core indicators that will identify inequity and point to directions for positive action in the future?

Conclusion

Healthy Together Victoria takes a systems-based approach that requires building strong partnerships with local systems, including local government, that are central to achieving HTV goals. The HTV has built a Prevention System that includes other (than HTV) health and community services, government departments, NGOs, community organizations, and organisations in the private sector. The partnerships take many forms and evolve over time. This provides a strong foundation from which to address the complex range of determinants of rising rates of obesity and of other contemporary public health problems. As HTV has matured there are now opportunities to explore how to include effective action to reduce inequities in health within this systems approach.

Systems thinking has the potential to dramatically disrupt and positively reorient actions currently being taken to promote the health of populations, and to deliver evidence-based interventions that reach and influence, positively, the health of everyone in a population (and not just a proportion of them). It does this by shifting investment in actions that can be taken by and within the settings in which people spend time during their lives. As an emerging orientation to reducing public health problems or to improving the population's health, the systems approach exposes the interdependence of social organisations in achieving their goals. Working to influence whole systems (rather than single components of a system such as a school, or a health service or a sporting club) highlights the fact that the relationships between organisations (and their agents) are dynamic and often unpredictable. It also demonstrates that solutions to public health problems (such as obesity) may emerge that could not have been foreseen or that may not have been possible previously.

The literature review revealed that there is limited evidence of systems thinking having been applied to initiatives to reduce inequities in health but there are signs that this is changing. Exploring the ways in which systems (and their agents) arrive at, apply, and change their values is one area for further investigation.

Backholer et al have developed a framework that links structural, agento/structural, and agento-specific strategies and enables effective analysis of which is likely to succeed (in particular contexts) to reduce socioeconomic inequities in obesity (50).

The role of partnerships between organizations is a critical plank in the HTV prevention platform. Although there is a growing understanding of the factors that facilitate and sustain partnerships for health, there has been little exploration of the extent to which reductions in health inequity have been achieved through partnerships. In what ways, for example, can the health sector contribute to reducing inequities in the distribution of social housing? Or, in what ways can the health sector contribute to reducing inequities in the proportion of Aboriginal and Torres Strait Islander young people being imprisoned?

If we look at the building blocks to effectively and equitably reduce inequities in the health of populations (including in the prevalence of obesity), policies need to reinforce one another and be implemented as part of a comprehensive strategy that respects political and social connections. Cohesion and empowerment are important mechanisms for reducing obesity rates particularly among people who are isolated or from low socioeconomic areas that have higher rates of obesity. In order to reduce obesity across the population, the responses need to be as complex as the determinants – especially if HTV is to achieve positive results within a decade.

There was very limited evidence in the systems literature that linked the use of a systems approach to improving the health of populations and reducing health inequity. However, the general literature on definitions, goals, policies and actions to reduce health inequities does provide some insight into how this could be done:

1. Finding a common understanding of what is meant by health inequity and health equity can be expected to be challenging, not only because they are complex concepts but because, unlike equality and inequality, equity and inequity are ultimately value judgements.
2. Placing further emphasis on the mechanisms for making and sustaining change. By their very nature systems-informed programs involve many different organisational structures with multiple economic, political, social justice and sustainability drivers. Within each of the organizations, actors from multiple disciplines each have their own perceptions and ways of working. This means that effective action to reduce inequities in health will be developed only through ongoing discussion and debate within HTV (and with its partners) if the achievement of health equity it is to become a foundation value, commitment, and priority principle of all the actions taken by HTV.
3. Deciding how the intended outcomes of any one (or all) of the HTV components are to be measured:
    a. by improvements in the health of the whole population,
    b. by the extent to which the gap between the social groups in the lowest socioeconomic quintile and all other quintiles has narrowed (or closed), or
    c. by a reduction in the steepness of the gradient and in the gaps between each of the groups along the gradient.
4. Ensuring that wherever possible, strategies include structural changes (in policy, practice, or environments) that make positive health choices simple, that make quality education, affordable housing, and quality health care (for example) accessible, and that reduce the need for individuals to make positive health choices in the absence of supportive environments.

5. There is evidence that it has been possible to reduce the social gradient in weight gain in children, which implies that community-wide interventions do not always increase inequities in obesity rates.
6. REAIM, albeit with more work, may provide a framework for assessing the potential of HTV and its initiatives and strategies to reduce inequities in health, by helping to navigate the complex partnerships and processes that are essential to system change. Feedback that monitors the reach of interventions across the whole population and to marginalised social groups, and guides adaption to the particular needs of those groups will contribute to the evidence of what actions are needed to reduce inequities in health on a population scale. Equally, the HTV will contribute to evidence of the capacity (organisational and workforce) that is needed by a prevention system (whether within the health sector or within another sector) to reduce inequities in health and, ultimately, to achieve health equity.

Assessment Findings & Recommendations

Through interviews with stakeholders, review of HTV documentation and consideration of the literature, we were able to identify some of the potential impacts of the current structure and implementation of HTV on reducing inequities in health. The evidence gathered confirms that HTV is achieving changes in systems and environments that are likely to result in positive, population-wide, improvements in health. However the evidence also showed that it is possible that some social groups (who are already marginalised) are likely to benefit less than others, and that some social groups are likely to benefit most.

This section identifies the potential impacts of HTV (as a whole) on the health of Victorians, and on inequities in health. It proposes recommendations and next steps in adapting HTV to increase the likelihood of reducing inequities in health.

In summary, the analysis found that:

- **Reducing inequities in health is not currently an explicit goal of HTV.**
- **There is no comprehensive narrative outlining the rationale for, commitment to, and benefits expected from, action to reduce inequities in health.**
- **There is a high level of recognition that the population approach, especially as it is being operationalized by action with and through settings, has the potential to exclude marginalised social groups. In addition to improving the health of the whole population it will be necessary to supplement and complement HTV's universal initiatives with more selective interventions that focus on changing the determinants of the inequities in health (particularly among smaller, marginalised social groups).**
- **There is recognition of the need for structural change across many sectors (including health) to increase the quality and accessibility of the determinants of health (education, housing, employment, etc.) to marginalised social groups.**
- **Effective action on to reduce inequities in health will require investment across each of the building blocks of HTV (leadership, information, financing, partnerships and workforce).**
- **There are not clear processes in place within HTV for identifying the actions that will be needed to reduce inequity or to monitor the impacts of HTV on inequities.**

The section that follows provides a brief assessment and recommendations for three separate Healthy Together Community initiatives, one in each of the sites. These are:

- Children's Achievement Program in Healthy Together Whittlesea;
- Health Champions in Healthy Together Wodonga; and
- Children's Healthy Food Connect in Healthy Together Greater Dandenong.

It is important to note that all the recommendations in this EFHIA have been based on the assumption of continued funding for and sustainability of HTV. Many of the recommendations offer approaches to build upon existing strategies. Without the HTV Prevention System itself, and the systems-based approaches being implemented to improve the health of the Victorian population, the strength of attempts to reduce inequities in health will be limited and the likelihood of success will also be limited.

Table 8: HTV Equity Findings and Recommendations

1. Integration of equity in HTV framework			
1.1			
Theme	**Evidence Base**	**Implication**	**Impact**
No comprehensive narrative or policy statement outlining need for and commitment to reducing inequities in health as a core policy goal of HTV.	Interviews Document Review Literature Review	There is no narrative or policy statement of HTV's role in reducing inequities in health, including no definitions of equity and inequity, which results in a wide range of ideas being used explicitly and implicitly.	Without an explicit commitment to reducing inequities in health it is possible that HTV will inadvertently increase inequity, or maintain status quo, or be less effective than it could be in reducing inequities.
Recommendation: HTV add a definition of, rationale for, and commitment to taking action to reduce inequities in health to its core business. In addition it will be necessary to negotiate with partners to define their roles in reducing inequity using a transparent process. **Possible next Steps:** HTV Leadership at the state level should develop a narrative that places its commitment to reducing inequities in health explicitly within the conceptual frameworks, technical and workforce capacity of HTV. HTC sites can then take actions that are relevant to local context.			
1.2			
Theme	**Evidence Base**	**Implication**	**Impact**
Reducing inequities in health not a major goal of HTV.	Document Review Interviews	Reducing inequities in health is not a goal of HTV and so is easily lost and poorly monitored.	Without making reducing inequities in health an explicit policy goal, it will not be systematically addressed, and it is a missed opportunity to use systems logic to its optimal effect on equity.
Recommendation: HTV has developed a strong platform for prevention that is powerful and positive. In its next phase of development HTV should consider whether it is necessary and timely to expand its platform to include reducing health inequities as core goal, keeping in mind that this may be difficult due to differing views within and between stakeholders. **Possible Next Steps:** Use a two-step process to, first develop consensus across HTV to commit to reducing inequities in health; and second, to include other partners, stakeholders and the community in the conversation about whether HTV should expand to include an explicit commitment to reducing inequities in health.			

1.3			
Theme	**Evidence Base**	**Implication**	**Impact**
Action to reduce inequities in health can aim to achieve one of a variety of outcomes: - Improving the health of the whole population (this was identified as the primary goal of HTV) - Closing the gap between those with the poorest health and the state average - Closing the gap between those with the poorest health and those with best health - Not making outcomes worse for the population or those with poorest health.	Literature Expert Knowledge Interviews	To achieve any of the outcomes intended to reduce inequities in health it will be necessary to have a strong universal platform for prevention and health advancement, that delivers universal inputs, and that works toward achieving equally supportive environments/conditions for health for all. However, to reduce inequity it is necessary to add to universal inputs – sometimes more intensive, longer-lasting, but similar inputs; and sometimes different, specifically tailored inputs. It is likely that a mix of outcomes will be sought, and that a mix of inputs (or interventions) will be needed.	While HTV is likely to improve the health of everyone in the population it may do very little to reduce existing inequities.

Recommendations:

- **Strong support should continue for the ongoing roll out of HTV's system for prevention.**
- **Review and revise interventions to optimise the likelihood of their achieving the outcomes being sought.**
- **Consider complementing whole-population approaches with vulnerable-population approaches**

Possible Next Steps: The conceptual and empirical knowledge bases for action to reduce health inequities are expanding rapidly. HTV should reform its existing platform (including logic frameworks, building blocks, and principles) to increase its capacity to reduce inequities in health. A suggested first step is the development of a discussion paper that includes recommendations for an effective workforce development process (particularly when the workforces may be in sectors other than health).

1.4			
Theme	**Evidence Base**	**Implication**	**Impact**
Effective action requires investment across the building blocks of HTV (leadership, information, financing, partnerships and workforce).	Literature HTV theoretical model,	A similar level of planning, thinking, capacity and partnership building that underpins the design and delivery of HTV will be required for its approaches to reducing inequities in health.	Without making reducing inequities in health an explicit goal, it will not be addressed systematically, and the opportunities to use system logic to its optimal effect will be missed.
Recommendation: HTV leadership should decide on how to embed its commitment to reducing inequities in health within its existing platforms (logic models, frameworks, and building blocks) and on how to translate the commitment into the organisational capacity needed to deliver on equity outcomes. **Possible Next Steps:** Leadership at the state level should develop a narrative and policy statement that includes commitment to reducing inequities within the existing HTV conceptual framework and explains how organisational capacity will need to be enhanced to reduce inequities in health.			
1.5			
Theme	**Evidence Base**	**Implication**	**Impact**
Assumption that by working in settings HTV is addressing the social determinants of health and that this is inherently reducing inequities in health.	Interviews Literature	There is a good understanding of the social determinants of health (SDOH) but less awareness that it is the distribution of the SDOH that leads to inequity.	Not all members of the population (or sub-populations) are actively included in the settings selected by HTV. There is the potential to miss opportunities to work on SDOH that exist outside the explicit HTV settings.
Recommendation: Just as HTV has established a strong workforce development strategy, it will need to invest similarly in training and up-skilling the existing workforce (in HTV and in partner organisations) to expand their capacity and influence to reduce inequities in health. **Possible Next Steps:** Work with the HTV workforce development network to identify the best ways to up-skill the existing workforce to address equity and establish an effective process for providing ongoing technical assistance to address equity.			

2. Use of equity data in HTV

2.1

Theme	Evidence Base	Implication	Impact
Existing data not used as well as it could be to strengthen an equity approach. **There is limited evidence that the differential impacts of programs, initiatives and strategies on priority populations are considered and reported.**	Interviews Document Review – i.e. population profiles	Concise data on local and state inequalities is fragmented and focuses on behaviours without broader attention to the social and economic determinants of health. While staff are aware of complexity of causes of inequity, better use of data would strengthen a systems approach to reducing inequities in health.	Without data describing inequalities in the distribution of health or its determinants (behavioural and social) it is difficult to decide which of these are inequitable, and then, to decide on priorities for action.

Recommendations:

- **Population profiles that identify inequalities in the distribution of social, economic, and environmental determinants of health should be identified and/or developed.**
- **Income is a poor marker of socioeconomic status especially as people age, and should be replaced by Socio-Economic Indexes for Areas (SEIFA) or another agreed composite indicator of socioeconomic differences.**
- **Data should be as locally specific as possible.**
- **Procedures should be developed for routinely identifying/ addressing potential differential impacts on health of different types of intervention strategies.**

Possible Next Steps: Audit the existing data (What data is collected? Who are the custodians of the data? How is the data analysed and used? Where are the data reported? What new data are is needed?). Establish a small working group to identify indicators and make recommendations for improvement.

3. Implementation strategies to reduce inequities in health

3.1

Theme	Evidence Base	Implication	Impact
No clear process for identifying actions to reduce inequities in health.	Literature review Document review Interviews	There is a perception that the strong universal prevention platform, supplemented by targeted activities,	There is a risk of over-investing in actions that rely only on individuals making positive health choices

		will reduce inequity but there is no clear process for ensuring that actions are balanced between individual, mixed, and structural; and for ensuring that appropriate settings are engaged and that groups that are not engaged in settings are also being reached.	routinely, rather than in actions that influence systems and settings to change their policies and practices to create conditions that enhance the likelihood of reducing inequities in health.

Recommendation: A process for identifying priority actions to reduce inequities in health should be developed and reviewed routinely. The process for identifying priorities and the investment of resources should be transparent and involve relevant stakeholders including a range of community voices.

Possible Next Steps: Map current HTV actions using a theoretical model to ensure that the population-wide responses include a balance of structural and individual strategies (51).

Identify explicit actions to reduce inequities that that can be integrated into existing approaches (this could be using an audit tool or check list) that also considers consistency with HTV objectives. (Possible tools are listed in Appendix B).

3.2

Theme	Evidence Base	Implication	Impact
There is a strong emphasis on strategies that focus on individual choices and health behaviour.	Interviews Documentation Literature	Within each of the settings in the HTV initiative there are many individual level interventions that focus on individuals needing to make individual choices to change their health behaviours.	In isolation, behavioural approaches are the least effective in bringing about lasting changes in the health of populations, and particularly in the health of the most marginalised social groups.

Recommendation: Identify the balance between individual and structural interventions that will be needed to increase the likelihood of reducing inequities.

Possible Next Steps: Use a theoretical model to ensure that a balance is achieved between individual and structural strategies.

3.3			
Theme	**Evidence Base**	**Implication**	**Impact**
A full range of the strategies known to be necessary to improve population health has been incorporated into the HTV approach. **None has been adapted explicitly to reduce inequity. Rather, it has been assumed that by delivering these strategies universally, there will be a reduction in inequity.** **Structural actions that facilitate individual choices in HTV:** • Community Engagement • Cross-sectoral partnerships • Leadership • Settings as a process to address SDOH • Life course perspectives • Implementation **Structural actions that don't require individual choice in HTV:** • Policy development • Investment to reach, intensity and scale.	Literature Documentation Interviews	The same strategies or activities, even when delivered more intensively over a longer period and in a range of settings may not lead to reduced inequities in health – it may lead to increased inequity in the short-term, and it may not change the size of the gaps between groups even if it leads to overall improvements. This suggests the need to review and revise the strategies to 'fit' the aspirations, needs, and contexts of marginalised communities in particular. In addition, although globally-recognised strategies for improving population health are being used, it will be necessary to actively include marginalised group representation in the articulation of the problem and decisions about strategies and investment.	Without consideration of who is involved and what approaches are taken to address equity, it is possible for inequities to be perpetuated though HTV.
Recommendation: Examine current approaches to determine whether any partners, leaders or communities/social groups are missing from decision-making about priorities, actions, and implementation. Explore ways in which marginalised social groups can be more centrally engaged in articulating problems (e.g. the determinants of obesity and chronic disease) and in developing and implementing effective solutions (to reduce obesity, and chronic disease).			

Possible Next Steps: Review current decision-making bodies such as the HTC governance groups and processes to determine whether partners, leaders and community members (from marginalised groups in particular) are missing from decision-making about priorities, intervention strategies, and implementation.

3.4

Theme	Evidence Base	Implication	Impact
Adaptation	Interviews	There are many examples of activities being well adapted to local conditions.	There is the potential for initiatives being adapted to local conditions that may inadvertently ineffective in reducing inequities in health.

Recommendation: The adaptation strategies needed by each HTC to reach all members of local populations should be supported and documented.

Next Steps: Explore how each component of the HTV platform can be adapted to include an explicit emphasis on reducing inequity. In the longer term it will be useful to document the adaptation required to include a focus on reducing inequity while at the same time maintaining integrity to the original HTV goals.

3.5

Theme	Evidence Base	Implication	Impact
Resource allocation is based on need.	Interviews HTV program design Document Review	The original identification of HTV communities and allocation of resources is linked to the average socioeconomic status of the populations of LGAs.	This has been seen as, and is, a sound basis for further action to reduce inequities in health.

Recommendation: Resource allocation based on need should be supported.

Possible Next Steps: Continue this approach.

4. Monitoring for Equity

4.1

Theme	Evidence Base	Implication	Impact
Assumption that population and settings approaches will address equity. **There is a high level of recognition that the population approach, especially as expressed in settings has the potential to exclude many vulnerable sections of the population despite it being a very effective strategy.**	Interviews Literature	Fundamental to the HTV approach is a belief that current approaches will directly and/or indirectly reach the whole population through a trickle down of information and inevitable exposure to changes in social, physical and economic environments. The settings approach means that large sections of the community will be reached (and they are) but there is little focus on who are excluded as some population groups and/or individuals have poor links into mainstream social institutions.	HTV may unintentionally set up or reinforce systems of social exclusion, and not reach groups that may not be present in the HTV explicit settings.

Recommendation: The settings themselves are different from place to place (for example not every school or workplace is the same) and have a tendency to mirror the socioeconomic status of the community in which they are located. Develop a process for reviewing the strengths and weaknesses of the population approach to reducing inequities in health, so that marginalised populations can be identified and remedial actions considered. Whether or not this impacts the uptake of the HTV programs should be analysed by the data that is available.

Possible Next Steps: Build into the existing reflective practices regular consideration of the ways in which the HTV/HTC actions are having an impact on reducing inequity. HTV should consider extending its partnerships to include additional settings, organisations, or services that already have effective structures and processes that are working effectively with marginalised social groups. (e.g. hair dressers or pharmacists or volunteers).

4.2			
Theme	**Evidence Base**	**Implication**	**Impact**
Interventions should not make inequity worse.	Literature Interviews	HTV staff are aware that their actions can have unintended consequences.	Without strengthening the platform for and actions to reduce inequities in health, some social groups may be inadvertently left behind
Recommendation: Close monitoring and reporting of differential outcomes should be routine. **Possible Next Steps:** Develop a monitoring and evaluation plan that enables quantitative and qualitative measurement of progress toward reducing inequity.			

Challenges for HTV in expanding the capacity of its Prevention Platform to reduce inequities in health:

- Will responsibility for actions to reduce inequities in health be the responsibility of a specialist group or program within HTV, or will responsibility be built into everyone's business?
- Should a population-based approach to reducing inequities in health incorporate targeting?
- When are special approaches needed for specific groups?
- Who gets excluded through a settings approach?
- How can universal and targeted approaches be used strategically?
- How are actions on the Social Determinants of Health expected to have an impact on reductions in inequities in health?
- What actions can be taken to reduce inequities in health with limited funding ?
- What factors other than reduced funding may present threats to the sustainability of HTV?

Healthy Together Whittlesea - Healthy Together Achievement Program for Primary Schools and Early Childhood Services

The Whittlesea Healthy Together Achievement Program for primary schools and early childhood services is proceeding well with a high number and proportion of primary schools and early childhood services in the Whittlesea local government area already signed up. The sign-up of all schools and early childhood services in Whittlesea is, and will continue to be, a major plank in a strong prevention system in Victoria.

The next phase of the Achievement Program will include supporting all of the signed up schools and early childhood services to adopt or implement the steps recommended in the Achievement Program cycle so that they can meet state-wide benchmarks. It will be important to observe and measure the extent of this uptake by schools and early childhood services.

The next phase of Healthy Together Whittlesea will include deciding on the additional capacity that will be needed within the Healthy Together Achievement Program for Primary Schools and Early Childhood Services in Whittlesea to reduce inequities in the health of the children in primary schools and early childhood services. The additional capacity will include working through its partnerships with other local systems. This will complement efforts to strengthen equity within the prevention system at the state level.

What follows is a summary of evidence, predicted impacts, and recommendations that are likely to increase the likelihood that the Healthy Together Achievement Program for Primary Schools and Early Childhood Services can play a significant, positive role (through the HTV system) in reducing inequities in health – that is, to contribute to HTV's initiatives resulting in greater distributive justice (closing the gap; flattening the gradient) (52, 53), greater procedural justice (marginalised communities active in decision-making) (54, 55), and in contextual justice (organisations changing to reduce institutional and personally-mediated discrimination/racism) (47, 53).

Table 9: Healthy Together Whittlesea Achievement Program for Primary Schools and Early Childhood Services

THEME	EVIDENCE BASE	PREDICTED EQUITY IMPACTS	RECOMMENDATIONS
Measurement and reporting Are there observable, measureable differences in the demographic, socioeconomic and characteristics of the schools/services that have signed up (and/or not signed up) to the Achievement Program? Are there observable, measureable differences in the demographic, socioeconomic status and health status of the children attending the schools that have signed up to the Achievement Program? **Aim:** description of observable, measureable differences at baseline and over time.	Interviews Document review	Universal inputs such as the Achievement Program for schools and early childhood services are a vital plank in the HTV prevention system and in achieving improvements in health across the population. Early childhood services and schools have multiple roles in ensuring and promoting children's health and wellbeing. However, schools and services (and their students) are not 'starting' from equitable bases. Some may not be providing optimal education (for multiple reasons), and be unable to add further initiatives into their core business; some may be capable of providing optimal education and, in the foreseeable future, be able to take up the Achievement Program in part; others may be capable of adding in new initiatives immediately. If the characteristics of the schools and their students and communities and differences in capacity to provide education (and education for health) are not recognised, existing inequities in both education and health outcomes will persist.	Consider complementing the existing analysis of CEIPS data, My Schools data, and locally-collected data, with use of the Index of Community Socio-Economic Educational Advantage, to identify inequalities – observable, measureable differences in the socio-demographic and socio-economic characteristics of the populations being serviced by the schools/services, and in the facilities and resources available to the schools and services.[4] Decide whether the inequalities between students and between schools are unfair, unjust, persistent and avoidable. Decide which schools (and students) will require additional support (and of what kind) in order to optimise children's education and health.

[4] Explaining ICSEA. New South Wales Department of Education and Training. 2010. wwwschools.nsw.edu.au

THEME	EVIDENCE BASE	PREDICTED EQUITY IMPACTS	RECOMMENDATIONS
Governance What structures and processes are in place to make decisions about the direction and implementation of the Achievement Program in primary schools and early childhood services? What are the demographic, cultural, and socioeconomic characteristics of the people currently engaged in making decisions? What actions are needed to make the governance of the Achievement Program in primary schools and early childhood services more equitable? **Aim:** Procedural justice (who participates).	Interviews Document review Literature (Theory and expert opinion. There is limited empirical evidence of the impact of inequitable governance structures and processes on the equity of health outcomes).	Without the active presence of communities that are most marginalised in society (and in the groups that make decisions about children's services and schools) decision-makers have too little knowledge of the causes of problems and of relevant, feasible solutions. The exclusion of marginalised groups from an equal role in social decision making is an independent determinant of health. The exclusion is a marker of negative discrimination, disrespect, and disregard – causing shame, anger, and low self-esteem. Cultural recognition and respect are fundamental human needs without which individuals are unable to achieve self-actualisation and are therefore unable to become functioning members of society (55, 56).	In consultation with marginalised communities establish, review and revise the structure and composition of the bodies responsible for influencing and making decisions about the direction and implementation of the Achievement Program in primary schools and early childhood services to include social groups that are missing. Over time, work with marginalised communities to support them to increase their capacity to participate in and influence the decisions being made at both HTC and state wide HTV levels. This is envisaged as a three part process: • First, that may require internal action on the part of communities (to generate their own, independent public policy aims, and to decide on representation) (47, 55); • Second, to strengthen communication between previously marginalised groups and social decision-makers (54, 55, 57, 58); and

			• Third, ensure the presence of community members from marginalised groups in all the engagement with community and parental networks and services. *Note: This is one of the Healthy Together Whittlesea's strengths.*
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Strategies Expand the strategies being used by Healthy Together Whittlesea (Children's Achievement Programs) to add tailored/targeted actions that are explicit to reducing inequity. **Aim:** Distributive justice (equally shared costs and benefits, including opportunities).	Interviews Document review The literature (beyond our review). A very brief exploratory search on Google using the terms 'reducing health inequities through schools' revealed promising empirical evidence of actions that are likely to increase health equity among children by working in and through schools and early childhood services.	The prevention system being built by HTV is an essential platform upon which to build actions to reduce inequities in health. Universal inputs, however, do not inherently result in reductions in pre-existing inequities, and may increase inequity (at least in the short term). Universal approaches, even those that are proportional, may not be sufficient to reduce inequities in education and health experienced by children from marginalised population groups, or whose schools are insufficiently resourced. Marginalised groups have limited influence on the design of current initiatives as part of the Achievement Program for primary schools and early childhood. Without the addition of explicit, tailored approaches within the ambit of the Achievement Program, it is probable that existing inequities will be replicated (at least) and may be extended.	Use the Backholer et al model to assess the balance of strategies – to ensure that over all, the HTV is making healthy choices easier for everyone (35). Identify the different types of redistribution that are achievable through the application of different types of strategies intended to reduce inequities in health (33) and select the most appropriate for the context. For example, positive selectivism may be most appropriate – directing greater resources to groups with greater need (not necessarily, only those who are poorest), and tailored explicitly to groups' experiences and aspirations. Identify and embed recommended actions (policies, programs and strategies) to increase the

			likelihood that schools and early childhood services will contribute to reducing inequities in health. For example, specific initiatives might be based on: • a comprehensive school health program (59); • using a personal, social, and health education (PSHE) and citizenship curriculum to create an inclusive environment for all children (60); • providing social and emotional support for parents and children; • consideration of minority groups in needs assessment, resource allocation, and health care planning and provision;(61) and • Aboriginal and Torres Strait Islander community leadership and engagement throughout (52).
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Organisational development - taking a systems approach to reducing inequity among children through the application of the HTV model.	Whittlesea Guidelines on Equity	Early childhood services and schools as systems contribute to the persistence of inequities through their existing internal policies and practices that become invisible to the system and its agents - so that they can unwittingly perpetuate 'institutional and/or personally	Review policies and practices to expose the means by which some social groups are excluded from active engagement in these systems: for example, as teachers, principals, curriculum developers,

Aim: Contextual justice – removing inequities embedded in institutional, social, economic, and political conditions.		mediated discrimination' (47). The education and early childhood sectors, as a system, too, are possibly perpetuating inequities through their existing policies and practices, and through their agents.	or as health professionals, or managers or researchers. Or, to expose the mechanisms (e.g. curricula or usual practice) which deny respect for history, language, culture, and aspirations of a range of population groups. Revise policies and practices -**s**ome actions taken by others have included affirmative action, cultural humility training, redirected finances, collective impact partnerships, etc. (57). HTV, through its partnership with the education and early childhood sectors, facilitate review of policies and practices to identify where inequities may be arising, and to identify and advocate for effective responses.
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Evaluation: measuring progress toward achieving procedural, distributive, and contextual justice	The literature	Equity can be achieved only when all three types of justice have been achieved. Identifying indicators of progress toward all three will be a necessary component of the initial preparation to increase the likelihood of HTC reducing inequity in health through its Children's Achievement Program initiatives (61).	Indicators of progress toward each form of justice be developed and pilot tested.

Healthy Together Wodonga - Health Champions

The Health Champions initiative was selected by Healthy Together Wodonga to be a focus for the equity focused health impact assessment at the local government area level. The Healthy Together Wodonga program logic and program model were developed as a strategy through which HTCs can communicate directly with diverse population groups about positive health choices, and support the population groups to demand changes in the policies and practices of local settings, organisations and environments to create conditions for health. Although there is no explicit logic in the HTV framework that describes Health Champions as a strategy to reduce inequities in health, Healthy Together Wodonga has deliberately recruited some of its Champions from marginalised population groups.

Twenty percent of the population of Wodonga is of low socioeconomic status. Some social groups are more likely to be in the low SES population over generations than others (62). Although Health Champions have a role in the universal roll out of HTV, there is need for particular attention to be paid to their role in the population groups within the lowest socioeconomic quintile.

The theory underpinning the role of Health Champions in the current HTV system is probably diffusion of innovations – with the champions being characterised as 'early adopters' who are open to the idea of change, who are convinced of the benefits of adopting the innovation (in the case of HTV's focus on healthy eating and physical activity), and who have adopted the innovation themselves. Through their networks (personal and professional), early adopters influence others (early and late majority), positively, to try out and then adopt the change. In essence, health champions have been characterised as 'messengers' who inform and persuade others to adopt health behaviours (63).

What follows is a summary of evidence, predicted impacts, and recommendations that are likely to increase the likelihood that Health Champions can play a significant, positive role (through the HTV system) in reducing inequities in health – that is, to contribute to HTV's initiatives resulting in greater distributive justice (closing the gap; flattening the gradient) (52, 53); greater procedural justice (marginalised communities active in decision-making) (54, 55); and in contextual justice (organisations changing to reduce institutional and personally-mediated discrimination/racism) (47, 53).

Figure 10: Healthy Together Wodonga Health Champions

THEME	EVIDENCE BASE	PREDICTED EQUITY IMPACTS	RECOMMENDATIONS
Measurement and reporting Are there observable, measureable differences in the demographic, socioeconomic and characteristics of the communities in which Health Champions are working? Are there observable, measureable differences in the demographic, socioeconomic status and health status of the Health Champions? **Aim:** description of observable, measureable differences at baseline and over time.	Interviews Document review	Universal inputs are a vital plank in the HTV prevention system and in achieving improvements in health across the population. However, communities are not starting from equitable bases – in terms of opportunities to access and use high quality, reliable health information.	Look for inequalities – observable, measureable differences in the socio-demographic and socio-economic characteristics of the populations being serviced by the Health Champions and of the Health Champions, themselves. Decide whether the inequalities are unfair, unjust, persistent and avoidable. Decide whether changes are needed to the Health Champions initiative, including changes to who is selected (and for what role).
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Conceptualise/theorise the role of health champions in reducing inequities in health.	The literature	If Health Champions are viewed as 'messengers' rather than as agents of community and organisational change , then their impact will be confined to people who are able to act on their own to make the changes needed for better health. Without the support of the social, economic, and physical conditions in the settings in which people live, learn, work, and play, then impact at scale is unlikely to occur.	Reconceptualise the role of health champions to include explicit focus on reducing inequities in health. Health champions, for example, have roles, potentially, in the actions needed to achieve distributive justice, procedural justice, and contextual justice. Develop logic models to map the potential role(s) of health champions in relation to each of these forms of justice (equity).

		People who are politically and socially marginalised, socioeconomically disadvantaged, and who live, learn, work, and play in settings and environments that are unsupportive of positive health choices, and/or that pose active risks to health are much less likely to volunteer to be health champions and/or much less likely to be able to (or want to) respond positively to the 'messages' provided by Health Champions.	
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Governance / leadership What structures and processes are in place to make decisions about the direction and implementation of the Health Champions initiative? What are the demographic, cultural, and socioeconomic characteristics of the people currently engaged in making decisions? What actions are needed to make the governance of Health Champions initiative more equitable?	Interviews Document review	Without the active presence of communities that are most marginalised in society decision-makers have too little knowledge of the causes of problems and of relevant, feasible solutions. The exclusion of marginalised groups from an equal role in social decision-making is an independent determinant of health. The exclusion is a marker of negative discrimination, and conveys disrespect for and disregard of some social groups – causing shame, anger, and low self-esteem. Cultural recognition and respect are fundamental human needs	In consultation with marginalised communities establish, review and revise the structure and composition of the bodies responsible for making decisions about the direction and implementation of the Health Champions initiative to include social groups that are missing and not represented. Over time, work with marginalised communities to support them to increase their capacity to participate in and influence the decisions being made by HTC. This is envisaged as a three part process: • First, that may require

Aim: Procedural justice (who participates and who decides).		without which individuals are unable to achieve self-actualisation and are therefore unable to become functioning members of society (55, 56). The converse is also true – communities that have cultural respect are healthier (64).	internal action on the part of communities (to generate their own, independent public policy aims, and to decide on representation) (47, 55); • Second, to strengthen communication between previously marginalised groups and social decision-makers (54, 55, 57, 58); and • Third, ensure the presence of community members from marginalised groups in all the engagement with community networks and services.
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Recruitment of health champions **Aim:** Procedural justice (who participates and who decides)	Interviews Document review	The techniques for identifying Champions influence both who is likely to become a champion, and the nature of their role. People from marginalised groups and communities (and organizations) are less likely than those from more advantaged groups to volunteer (or to be selected or elected) as health champions.	Review the criteria and system for identifying and recruiting Health Champions to ensure inclusion and support, in particular, for champions from marginalised communities. Consider a range of methods for identifying Health Champions (65) linked with their intended roles and revise the current processes to include people who represent marginalised communities. This would include obtaining the consent of communities in

			expectation that Health Champions are a mechanism by which communities can advocate for effective responses to need, and by which they are. and are perceived to be, active in social decision-making.
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Strategies – based on the revised theoretical and evidence bases for the role of health champions, embed tailored/targeted actions that are explicit to reducing inequity. **Aim** Distributive justice (equally shared costs and benefits, including opportunities)	The literature	Health Champions, themselves, are likely to be innovators and early adopters – and not, therefore, representative of marginalised groups. Their knowledge, experiences, and networks may not reach deeply into marginalised communities even if they appear to be members of those communities. A narrow conceptualisation of the role of health champions as 'messengers' under-estimates the potential scope of their roles in ensuring that marginalised communities have the opportunity and capacity to have a voice in deciding on what actions are needed to improve their health.	Draw on the literature to identify and embed recommended actions (policies, programs and strategies) to increase the likelihood that health champions create opportunities for marginalised communities to learn about the need for and to make positive health choices (53, 66). Review the literature to identify options for increasing the contribution of Health Champions to improve health equity through HTV – beyond the role of health trainers to include a role in creating community capacity (see Governance, above) (54, 55).
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Organisational development: - taking a systems approach to reducing inequity among children through the application of the HTV	The literature	The agents working within organisations designing and delivering programs and services to communities are influenced by	Reflect on own cultural identity and recognise the impact this has on professional practice. Mandate training for all staff in

model. **Aim:** Contextual justice – removing inequities embedded in institutional, social, economic, and political conditions.		their own organisational cultures, and their own personal and professional cultures and experiences (47).	cultural humility. Review policies and practices of HTC (and partner organisations) to expose the means by which some social groups are excluded from active engagement in these systems. Revise policies and practices – ensuring cultural safety, introducing affirmative action, collective impact partnerships (for example) (57).
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Evaluation – measuring progress toward achieving procedural, distributive, and contextual justice **Aim:** To measure and report on progress toward each of the three forms of justice.	The literature	Equity can be achieved only when all three types of justice have been achieved. Identifying indicators of progress toward all three will be a necessary component of the initial preparation to increase the likelihood that the Health Champions initiative will contribute effectively to reducing inequities in health.	Indicators of progress toward each form of 'justice' be developed and pilot tested.

Healthy Together Greater Dandenong - Children's Healthy Food Connect

The Children's Healthy Food Connect initiative was selected by the Greater Dandenong HTC as a focus for the equity focused health impact assessment at local government area level. Children's Healthy Food Connect is an integral component of the Achievement Program – working, primarily, through schools and early childhood services. Greater Dandenong has demonstrated that through the Achievement Program and its connection with schools a range of opportunities emerged to improve children's and families' access to and consumption of nutritious food. The initiatives are innovative and locally specific, and arose from multiple drivers – parents, oral health professionals, and local food vendors, for example. In Greater Dandenong, it has been noteworthy that disadvantaged schools have been more likely than affluent schools to invest in children's wellbeing and in the HTC initiative. Healthy Together Greater Dandenong reported a high level of awareness and commitment on the part of school staff about the particular needs of students and families.

Greater Dandenong is the lowest ranked LGA (IRSD)[5] of the HTC sites. Universal initiatives (such as the Achievement Program) are critical to the success of HTV and a vital platform from which to take action to reduce inequities in children's access to and consumption of nutritious food. Healthy Together Greater Dandenong has already begun to implement evidence-based strategies to change environments, build a food recovery system, and engage with marginalised groups.

What follows is a summary of evidence, predicted impacts, and recommendations that are likely to increase the likelihood that Children's Healthy Food Connect can play a significant, positive role (through the HTV system) in reducing inequities in health – that is, to contribute to HTV's initiatives resulting in greater distributive justice (closing the gap; flattening the gradient) (52, 53); greater procedural justice (marginalised communities active in decision-making) (54, 55); and in contextual justice (organisations changing to reduce institutional and personally-mediated discrimination/racism) (47, 53).

[5] Index of Relative Socio-Economic Disadvantage (http://www.abs.gov.au/websitedbs/censushome.nsf/home/seifa

Figure 11: Healthy Together Greater Dandenong Children's Healthy Food Connect

THEME	EVIDENCE BASE	PREDICTED EQUITY IMPACTS	RECOMMENDATIONS
Measurement and reporting - Are there observable, measureable differences in the demographic, socioeconomic and characteristics of the schools/services that have signed up (and/or not signed up) to the Achievement Program? Are there observable, measureable differences in the demographic, socioeconomic status and health status of the children attending the schools that have signed up to the Achievement Program? **Aim:** description of observable, measureable differences at baseline and over time.	Interviews Document review	Universal inputs (such as the Achievement Program for schools and early childhood services) are a vital plank in the HTV prevention system and in achieving improvements in health across the population. Early childhood services and schools have multiple roles in ensuring and promoting children's health and wellbeing. However, schools and services (and their students) are not starting from equitable bases. Some may not be providing optimal education (for multiple reasons), and be unable to add further initiatives into their core business; some may be capable of providing optimal education and, in the foreseeable future, be able to participate in Children's Healthy Food Connect; others may be capable of adding in new initiatives immediately. If the characteristics of the schools, their students and communities, and differences in capacity to provide education (and education for health) are not	Use the Index of Community Socio-Economic Educational Advantage to look for inequalities – observable, measureable differences in the socio-demographic and socio-economic characteristics of the populations being serviced by the schools/services, and in the facilities and resources available to the schools and services. Decide whether the inequalities are unfair, unjust, persistent and avoidable. Decide which schools will require additional support (and of what kind) in order to optimise children's education, including participating (in this case), in Children's Healthy Food Connect.

		recognised, existing inequities in both education and health outcomes will persist.	
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Governance - What structures and processes are in place to make decisions about the direction and implementation of the Children's Healthy Eating initiative in schools and early childhood services? What are the demographic, cultural, and socioeconomic characteristics of the people currently engaged in making decisions? What actions are needed to make the governance of the Children's more equitable? How representative of the demographic/ socioeconomic and cultural composition of the population is the membership of governance structures? **Aim:** Procedural justice (who participates).	Interviews Document review The literature (Theory and expert opinion. There is limited empirical evidence of the impact of inequitable governance structures and processes on the equity of health outcomes).	Without the active presence of communities that are most marginalised in society (and in the groups that make decisions about children's services and schools) decision-makers have too little knowledge of the causes of problems and of relevant, feasible solutions. The exclusion of marginalised groups from an equal role in social decision making is an independent determinant of health. The exclusion is a marker of negative discrimination, disrespect, and disregard – causing shame, anger, low self-esteem. Cultural recognition and respect are fundamental human needs without which individuals are unable to achieve self-actualisation and are therefore unable to become functioning members of society (55, 56).	In consultation with marginalised communities establish, review and revise the structure and composition of the bodies responsible for making decisions about the direction and implementation of the Children's Healthy Food Connect initiative to include social groups that are missing. Over time, work with marginalised communities to support them to increase their capacity to participate in and influence the decisions being made by HTC, beginning, in this case, with Children's Healthy Food Connect. This is envisaged as a three part process: • First, that may require internal action on the part of communities (to generate their own, independent public policy aims, and to decide on representation) (47, 55); • Second, to strengthen

			communication between previously marginalised groups and social decision-makers (54, 55, 57, 58); and • Third, ensure the presence of community members from marginalised groups in all the engagement with community and parental networks and services.
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Review the strategies being used to improve children's access to healthy food and, where needed, add tailored/targeted actions that are explicit to reducing inequity. **Aim:** Distributive justice (equally shared costs and benefits, including opportunities).	Interviews Document review The literature	The prevention system being built by HTV is an essential platform upon which to build actions to reduce inequities in health. However, the distribution of well-functioning social institutions and social networks/groups through which the HTC strategies are to be delivered or implemented is likely to be inequitable. Universal inputs do not inherently result in reductions in pre-existing inequities, and may increase inequity (at least in the short term). Universal approaches, even those that are proportional, may not be sufficient to reduce inequities in education and health experienced by children from marginalised	The strategies being used should be reviewed against the Backholer et al model to ensure a balance (35). Identify the different types of redistribution that are achievable through the application of different types of strategies intended to reduce inequities in health (33) and select the most appropriate for the context. For example, positive selectivism may be the most appropriate in this case – directing greater resources to groups with greater need (not necessarily, only those who are poorest), and tailored explicitly to groups' experiences and aspirations. Identify and embed recommended

		population groups, or whose schools (and other social networks and institutions) are insufficiently resourced. Some marginalised groups (for example, new refugees) may not have had time to form stable community organisations. Other marginalised groups have been oppressed for decades (more in some cases) and may have become subject to high levels of lateral violence (67). Marginalised groups have limited influence on the design of current Children's Healthy Food Connect initiatives. Without the addition of explicit, tailored approaches it is probable that existing inequities will be replicated (at least) and may be extended.	actions (policies, programs and strategies) to increase the likelihood that schools and early childhood services will contribute to reducing inequities in children's health, and to increase their access to healthy food. For example, specific initiatives might be based on: • a comprehensive school health program (59); • children's inclusion through a personal, social, and health education (PSHE) and citizenship curriculum (60); • providing social and emotional support for parents and children; • consideration of minority groups in needs assessment, resource allocation, and health care planning and provision (61); and • Aboriginal and Torres Strait Islander community leadership and engagement throughout (52).
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Organisational development - taking a systems approach to reducing inequity among children	Whittlesea Guidelines on Equity	All institutions and systems contribute to the persistence of inequities through their existing,	Review policies and practices to expose the means by which some social groups are excluded from

through the application of the HTV model. **Aim:** Contextual justice – removing inequities embedded in institutional, social, economic, and political conditions.		internal policies and practices that become invisible to the system and its agents - so that they can unwittingly perpetuate 'institutional and/or personally mediated discrimination' (47).	active engagement in these systems: for example, as teachers, principals, curriculum developers, health professionals, managers or researchers. Or, to expose the mechanisms (e.g. curricula or usual practice) that deny respect for history, language, culture, and aspirations. Revise policies and practices through the new governance mechanism. Some actions taken by others have included affirmative action, cultural humility training, redirected finances, collective impact partnerships, etc. (57).
THEME	**EVIDENCE BASE**	**PREDICTED EQUITY IMPACTS**	**RECOMMENDATIONS**
Evaluation: measuring progress toward achieving procedural, distributive, and contextual justice. **Aim:** To measure and report on progress toward each of the three forms of justice.	The literature	Equity can be achieved only when all three types of justice have been achieved. Identifying indicators of progress toward all three will be a necessary component of the initial preparation to increase the likelihood of HTC reducing inequity in health.	Indicators of progress toward each type of justice should be developed and pilot tested.

Discussion

The EFHIA began by screening and scoping the goals and methods of HTV and deciding to focus on describing and predicting the likely impact of these methods on the reduction of socioeconomic inequities in the distribution of obesity in the Victorian population.

The screening and scoping step of the EFHIA resulted in the decision of the Reference Group to focus on eight components of HTV. These components included two components in each of three of the HTC sites (Wodonga, Greater Dandenong, Whittlesea, and two components at the State level).

However, in the course of gathering evidence from multiple sources about the implementation of the HTV prevention systems approach it became clear that HTV's conceptual, technical, and infrastructure platforms and the range and depth of actions that had been taken at State and local levels required the HERDU team to revise its analysis to focus, instead, on HTV as a preventive system. The scale of HTV's organisation and the range of actions being taken to achieve change, through settings, structures, environments, communities, and individuals has opened wider opportunities to consider the likely impact of such a system on reducing inequities in health. The preventive system created by HTV has formed a strong platform upon which to base future actions that will not only improve the health of the population, but will reduce inequities in health.

The literature review revealed very limited evidence of systems approaches to reducing inequities in obesity in populations. Nor were there any other examples of large, state-wide prevention systems working across sectors and settings – public and private, non-government and civil society – to create universal environmental conditions and social norms for health (healthy eating and physical activity in particular) across whole populations.

The interviews, group discussions, and document review revealed that HTV has included equity as a principle in its conceptual framework. Each of the HTC sites and each of the specific initiatives being implemented has taken steps to reach socioeconomically disadvantaged groups or socially excluded groups – either directly (e.g. education, information, inclusion), or indirectly (e.g. fresh food recovery and distribution). However, at each HTC site the stakeholders engaged in the work were keenly aware that the primary goal of HTV is to reach, influence, and enable positive changes in the health (healthy eating and physical activity) of the whole population. That goal has been given priority by HTV and the majority of resources have, logically, been invested in expanding the scale, reach and intensity of actions intended to create optimal conditions for health for the whole population at scale.

The extent to which HTV has succeeded in developing its own capacity as a prevention system, in developing active partnerships with multiple other systems and sectors, and in reaching settings and population groups and organisations to support them to change policies and practices to contribute to improving population health is impressive. Moreover, its universal approach – creating positive social and economic conditions, environments and networks for everyone – is an essential base upon which to build more specific initiatives to reduce inequities in health (and in its determinants). One of the strengths of the HTV approach to universalism is its capacity to respond to local conditions and contexts.

One of the characteristics of the HTV system that stood out through the EFHIA was the consistent, systematic narrative about the rationale for and delivery of HTV described by staff from local government and the stakeholders from other partner organisations. The location of the workforce within local government is enhancing the range of actions that have been possible as a consequence of working with the mandate of local government (as well as the health sector). The significant investment in conceptual thinking, technical development, planning, identifying relevant partners, and building and sustaining partnerships, and the investment in a skilful, well-supported and networked workforce are all characteristics of the HTV system that form a platform from which success is likely.

The timing of the EFHIA is, therefore, significant. HTV, as a prevention system, has reached a stage of maturity and has amassed sufficient evidence to demonstrate the power of this approach to promote the health of a whole population, and has defined and created the capacity needed to deliver such an approach.

At the same time, there has been growing understanding not only of the social determinants of inequities in the distribution of health (and its determinants), but also of the reasons such inequities occur and persist.

Our understanding of actions that are capable of reducing inequities in health is moving rapidly and it is no longer enough to simply do the same or more with different priority groups or develop strategies to reach difficult to reach groups (with the existing services or programs). HTV has been able to shift some of this type of thinking - moving away from single-strategy actions focused on improving the quality of individuals' health choices, toward multi-level strategies that focus on changing systems to provide a much wider group of people with the opportunities and resources we know they need to become and stay healthy.

Having integrated and analysed information from the stakeholder interviews, meetings, literature, and documentation, the EFHIA assessment identified the likely impact on reducing inequities in health in Victoria if the HTV system, including its delivery systems, were to continue as is. These impacts have been delineated in Table 8 "HTV Equity Findings and Recommendations."

However, the summation of the findings is that, although it is likely that some individual initiatives being taken by HTV sites to reach and influence marginalised groups will succeed in improving their health (healthy eating and physical activity), it is unlikely that there will be observable, measureable changes in inequities in health (or, more proximally, in the determinants of inequities in health) at the population level. There is even a possibility, particularly in the short term, that inequities may increase.

HTV has highlighted the potential to achieve much more. And if it is to be possible to avoid the perpetuation of current inequities in health it will be necessary to be as ambitious and committed to this as it was to the original conceptualisation and operationalisation of the HTV system itself. The importance of this was highlighted in Minkler's famous community-based empowerment networking project in the Tenderloin District of the US, in which she found that:

> "The victories of organizations like the Tenderloin Senior Organizing Project are significant…but they are also dwarfed by the magnitude of the problems confronted, which

can only be adequately addressed through a more fundamental societal-level commitment to reducing the social inequities that lie at the base of such problems" (61).

Implications for the future

The two interdependent findings of the EFHIA are that:

a) the HTV prevention system and the universal roll out of actions to create social, economic, and environmental conditions that support health in the settings and places in which everyone lives, learns, works, and plays are crucial to the future health of Victorians; AND
b) a similarly ambitious and well conceptualised, planned, developed and resourced system will be needed to achieve the goal of reducing inequities in health – and more, to prevent their recurrence in the future.

The capacity to reduce inequities in health should be embedded within the HTV system – not a separate entity. However, there is need for the same depth of conceptualisation, the same focus on developing logic frameworks, and a similar investment in systematic technical and workforce development, to build the narrative and momentum necessary to reduce inequities in health.

Definitions of health equity and inequity (and of their determinants) need to be discussed, understood, and agreed upon, and then to be built into relevant policy documents.

The literature review highlighted the importance of distinguishing between policy and program goals. Beyond the goal of HTV to improve the health of the population, is the 'equity' priority to close the gap between those with poorest health currently and the population average? Or is it to reduce the socio-economic/health gradient in health across the population. Deciding on the priority goal in the short and medium term at least is necessary because the starting points and strategies used to achieve each are different. (See the literature review).

There are emerging, useful typologies that contribute to understanding what different policies (and practices) are likely to contribute to the achievement of equity goals (33, 68).

Although there is strong support for the universal delivery platform as a basis for program and service delivery, these typologies and frameworks assist in deciding what, in addition, is needed to reduce inequities in the distribution of the determinants of health (and in health). Deciding explicitly on the approach that is most likely to succeed is an important step toward understanding why inequities arise in societies and to then respond appropriately.

There is also an emerging understanding of the relative contributions that specific population health strategies can make to reducing inequities in the distribution of the social determinants of health (and of health). Backholer et al (35) developed a model that illustrates, clearly, why it is so important not to rely only on strategies that require people to make individual health choices (agentic), but to ensure that there are also structural interventions that obviate the need for individuals to make choices within unsupportive, challenging social, economic, and physical environments.

The focus in recent years on the social determinants of health as a key strategy for reducing health inequity is being challenged. The social determinants of health influence everyone's health, health inequity arises when these determinants (housing, health care, education, etc.) are inequitably

distributed. What is often missing from analysis is why this is so. Why do societies that are wealthy and in which there is evidence of successful action to improve the health of the population seem unable to overcome the inequitable distribution of their social and economic resources? Important reasons, albeit not the only ones, are the lack of influential presence of the social groups most disadvantaged in decision-making structures and processes, the lack of representation in governance groups, and the psychological and physical burdens created by long-term, persistent discrimination (46).

HTV uses a settings approach to maximise the reach to every member of the population and to ensure that people can live their lives in ways that maximise their opportunities for health. Working with major social institutions has many advantages in terms of reach and influence (as institutions), but some people are not included in these institutions (school, workplace, community organizations, for example). Moreover, those who are not, are also likely to be disadvantaged – people in prison, with disabilities, with mental illness, or who are homeless. Working with settings is a powerful universal approach, but if it is to contribute to improving equity, the range of settings must be broadened, and alternatives for people who are outside all settings must be found.

Settings, too, are not only a venue in which to reach and influence their constituents directly. As contexts (organizations that hire people, that establish and implement policies, and that purchase services or establish partnerships with communities, for example), settings are powerful influences on equity. For example, within settings, which social groups are represented in decision-making structures? Do internal workplace policies discriminate against some social groups? Is the social, economic, and cultural composition of the workforce representative of the community in which the organisation is working? These are all examples of mechanisms through which settings, in addition to carrying out their core business, can have an impact on health equity.

Among its building blocks, HTV has included an information system, and processes for developing a skilled workforce that is encouraged to experiment, reflect on, and share learning that will not only expand the effectiveness of HTV, but will also contribute to the body of global evidence. Harnessing and adapting these building blocks to increase action to reduce inequity will expand the potential of HTV to have broader impacts on actions to increase equity across a population health system.

The data collection, analysis and reporting system developed by HTV has the potential to be used more effectively to identify inequalities in the distribution of the determinants of health and in the distribution of health at the state level. This will enable more explicit decisions to be made about priorities, policy goals, and strategies for action.

Using indicators such as those used in the report entitled A fairer Victoria 2008: *strong people, strong communities* (69) would also enable monitoring of progress, reporting on the reach of initiatives (such as the achievement programs) and their differential uptake/completion in different locations, by type, (e.g. public/private school; or large/small workplace), and their differential effect on different social groups within their constituencies (students, workers) for example.

To build the system for reducing inequities in the distribution of health (and in the distribution of its determinants), the HERDU team recommend a mid-term review of HTV as the first step. This mid-term review could include a broad-ranging, deep consideration of the definition of, rationale for,

conceptualisation of, logic pathways, goals, and building blocks required to enable HTV to take effective action to reduce inequities in health.

Conclusion

The equity focused health impact assessment described and predicted the likely impacts of the HTV (and HTCs) on reducing inequities in health, and has recommended actions to increase the likelihood of reducing (or not increasing) inequities in the health of Victorians.

Based on evidence from the literature, interviews, and HTV documentation, the EFHIA found that, as would be expected in establishing and implementing a large-scale, innovative, population health initiative such as HTV, it has proven to be difficult to include a clear, complementary focus on the additional capacity and actions that will be needed to reduce inequities in health.

The recommendations are intended to add to each of the building blocks of HTV to build a prevention platform that reaches the whole population and creates environments that protect and promote health; and add additional opportunities and resources to assist marginalised social groups and communities to access and make best use of the social determinants of health.

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Appendices

Appendix A – Methods for Literature Review

The following search terms were used in researching articles for the literature review:

In Medline, the following search terms were used: (Complex adaptive systems OR System integration OR Cooperative behaviour OR Community-institutional relations OR Interdepartmental relations OR Inter-institutional relations OR Program delivery OR Delivery of health care, integrated OR Systems evaluation OR Program delivery OR Impact assessment) AND (Smoking cessation OR Weight management programs OR Weight reduction programs OR Physical activity programs OR Alcohol management OR Binge drinking prevention and control OR Drug education OR Nutrition programs OR Better eating OR Healthy eating OR Disease prevention OR Preventive health services OR Early intervention, education OR Health education OR School health services OR Health promotion OR Consumer health information OR Patient education OR Teach-back communication OR Lifestyle modification) AND (Schools OR School based programs OR Community health services OR Child health services OR Community networks OR Migrant health services OR Health services, Indigenous OR Primary health care OR Local government area or Municipality OR Workplace).

Appendix B – Examples of Equity Audit tools

1. European Public Health Alliance. What role for health care systems in reducing health inequalities? http://www.epha.org/a/1907.

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Appendix C – Stakeholder Interviews Summary of Findings

How is equity understood?

There is wide variability in the ways in which people defined equity or inequity – in what is meant by 'equity' and in what is considered to be inequitable or equitable. There was also wide variation in understanding of the 'causes' or determinants of inequity (and equity), and of whether the focus of action to reduce inequity is on equitable inputs, or equitable impacts or outcomes.

> *People are more, ah, typically in the growth areas people live closer to a fast food outlet than they live to a supermarket or point of access for fruit and veg…Well it – it stands – it makes sense when I say the food's not saturated in the poorer suburbs here. ..So it's very strategic placement of unhealthy food outlets and it makes a lot of sense but that's what they're grappling with because the proportion conservatively speaking is a two to one ratio - - - - - for unhealthy to healthy food…But then conversely over in the growth areas it's more of a food desert scenario as well with access to healthy foods…So it's almost like the [haves] and [have] nots separating it.*

> *… when we look at our disadvantage, we're not just talking socio-economic disadvantage…So it's actually done across about 12 different disadvantage indicators. That includes disability, that includes cultural - - -- - - whether you can speak English or not. It includes - yes, money, the amount of money, it include whether you're, ah, whether you're illegal or legal to be here. So - - - - - when we're - it may sound like, you know, when we're talking, or you may think that when we refer to disadvantage, we're actually talking about…we're talking just the socio-economic component, but we're actually not. We're talking about all…of those put together.*

> *Um, I think – I think, for me, I don't know if I described it well enough before but the difference between equity and equal – equal is you get the same amount, everybody gets the same amount. Whereas, equity identifies or understands the diversity and that some people need more or less or bigger or, you know, deeper. And, so providing something to – to people that they need, based on their needs, not on what's equal.*

There was striking agreement and cohesion among the interviewees about the purposes, methods, evidence, implementation, and intended outcomes of HTV. This stood in contrast with the approach to equity and inequity, which was much less clearly articulated, and about the actions to be taken to increase the likelihood of reducing or preventing inequity.

> *…no-one can be everywhere at any time and - - -And – and provide services that do tailor to all of the needs.*

> *…there's been no systematic application of inequity thinking, even though that outside the portfolio there's been some thinking and it's been ad hoc but, you know, this is an opportunity to be more systematised with it.*

> *You know, I think because it's - because it's a partnership between community health and - and local government…there is a lot of, kind of, committed workforce that*

already have…a philosophical or professional kind of commitment to equity. But it's not reinforced in – within, kind of, the documentation or the model itself and it actually is perhaps partly due to the fact that there's not a lot of documentation around it. But it hasn't really been articulated either that equity is important. Really a lot of the emphasis from the very beginning was on reach, reach, reach and it's like - and some of the arguments around equity will be, well, if we change the system then everybody will benefit. Um, yeah, that's true to an extent but there still needs to be a focus on, you know, marginalised, disadvantaged groups.

Um, and again, what we talked about yesterday, about getting the balance right between, um, having this broad reach population, you know, targets that are ambitious around reaching the whole of our population and how do we ensure that we're not widening the gap. So how do we ensure that we - we also have a focus on targeting those most disadvantaged across all of our work. What I would say is we don't do that consistently. Um, we've got bits and pieces of examples of trying to achieve that, but I would say we don't have a systemic way of doing that across all of our work.

But I think we're starting to realise now that, um, the need to perhaps test how things have gone in implementation. Just to whether – although we might be directing resources predominantly to the areas, for example, that have the greatest need, within those areas we're questioning what the uptake has been. And I think at a programmatic level… the broader model, kind of, had that…equity lens, in terms of how to allocating resourcing. But then, within each of the Communities, and within the way we've established some of the programs, I'm not sure that there's been a such a deliberate approach to think about particular populations or – or to think about, I suppose, communities within the communities that – that may need, sort of, more targeted support.

Some participants felt that equity was addressed implicitly in their work.

So in many ways that's, sort of, why, you know, our staff don't necessarily think all the time equity, but the fact is they're trained in public health or health promotion. I think all - yeah, all - all of our staff are. Um, and so health equity is implicit within that training - - -- - - around social determents of health.

… I think we're all very aware of it and I think we're all very mindful and that it is a lens across a lot of what we do. But I think the model is set up in a way that it tries its best not to discriminate.

People often thought that equity was being addressed in the project design of HTV; the fact that the HTC sites are disadvantaged communities was an equity consideration.

… in the way that Healthy Together Victoria was originally established, and the funding to the, um, to the trial Healthy Together Communities, and, you know, the way those Communities were selected was on the basis of, you know, distributing resources to areas that need it most.

So just by even, I guess, being in this particular municipality, Healthy Together Victoria have already, sort of, identified the most disadvantaged communities - - -

Participants expressed a concern around not wanting to 'widen the gap' through their HTV work. However, less was expressed about strategies within HTC to 'close the gap.'

– so I think it's about closing the health gap in terms of…getting more of the population, um, not just making the top – the healthiest people healthier, but getting the people less healthy, moving them up along.

I would hate to see some communities, um, not taking on the learnings or the approach or being resourced in this way and therefore maybe so almost widening the gap between those who had Healthy Together versus not, if that makes sense.

Um, for us it's about ensuring that we are not, um, creating disparities.

…I don't necessarily think we give the same thing to everybody. I think we should be where the need is and where there – where there is greatest need for whatever reason, be it geographical or economic, or skill-based, or – but then we should be putting extra effort in to make sure that there isn't … an increase in gaps between, um, the population. So we need to make sure that … most disadvantaged groups in the population are, um, extra supported to … get better health rather than, um, fall behind, because it all … it is getting too hard to afford the food to, so, you know, those things about making sure we keep everyone along and not increasing that…health gap.

Participants expressed an understanding of the social determinants of health and felt that these were being addressed through the settings-based approaches, such as the Achievement Programs.

…the general idea is to … really, if we intervene at… multiple levels across the … socio-ecological system addressing both person factors and environmental factors, especially social, environmental factors, then – then we've probably got the best chance in terms of…addressing inequities.

In contract, some participants felt that the social determinants of health were not always being addressed through the program.

I think the issues of equity in terms of education, jobs, employment are – are really big ticket items, and so they – they are beyond, you know, that – that's not something we can necessarily say we're creating jobs, because we know that's very important to – to really get, you know, better, um, equity across the population.

Some participants felt that the social determinants of health weren't being addressed through HTV.

I still struggle with it in terms of its ability to answer bigger questions. Um, I see the absolute value in what we're doing, but I still can't get my head around – there's so many other issues, like finances, um, transport, and so there's these other things that sort of are directly related, but which we don't have any influence of.

Um, and I get around the access and the food deserts and whatnot, but I can write the most brilliant food policy, but it's not going to change your financial situation.

Some participants saw equity being addressed through equal access to initiatives, or equal input of the programs.

…if there's no health equity it means, like, you know, different resources and stuff aren't available to everyone.

It was understood that inequity and disadvantage are complex, with equally complex causes that require varied responses. However, participants found difficulty in understanding how to prioritize equity considerations.

…So it's hard to think about equity in here, because the disadvantage is so vast in this municipality.

But even here in particular, it's hard to think of, like, where would you apply more resources, because so much of the community need resources.

…I suppose, equity too is – is about – is about targeting certain – certain groups, or some of the – those most disadvantaged groups, 'cause we – we know that to get equity you actually have to put more work in to some of those disadvantaged areas. So I think that that's...difficult with a...broad brush approach. I think the difficult thing when you – you're in a municipality like this is that it's a disadvantaged municipality anyway, so do you target the most disadvantaged in the disadvantaged areas, or – so it's – it's even a question of what is equity, because you're already working in a…disadvantaged area - - - - - - so do you – so is equity just about having that universal approach to that…area, or do you then have to go and target some of those most disadvantaged people in your disadvantaged area?

…and I think it comes down to you can't do everything and you really – you have to decide where your resource goes and when you decide where your resource goes, you look at a whole range of things, you look at your reach, you look at your impact, you look at your – you know, your networks and sustainability, so – yeah, because you can't do everything, you just can't.

But in terms of a health - well, public health workforce, I think we also have to identify what - what manageable chunks that we can influence. And we can't - we can't everything for everyone and do everything for everyone. So, I think that's something that, you know, we - we all recognise that we're working within a social model of health and the social determinants of health, but we actually can't do something about all of them.

It was understood that the political and economic contexts in which they are working can at times present constraints to being able to work on equity.

…it's so difficult because, um, you do want the greatest reach and you want to have the biggest impact - - - - - and you want to give everybody the opportunity to get involved. And there's only so many of us and there's so many settings.

Um, I just don't know if it's - I don't know if it's necessarily front of mind for all coordinators and I think the decisions made by the coordinators and the local government, um, you know, the CEO or the directors, that's what potentially influences whether equity is considered or not, whether it's a big focus, and that's probably driven partly by the community which it's operating in.

And I've been, I mean, I've been in this space for a long time and I, um, I actually think looking at whole of government policies and looking at what we can do across government, we've got government policies that contradict what we want to do. So we should be changing planning laws so that the planning laws make it easier for communities to, um, ah, sort of plan for a healthy community, whereas now, that's not allowed, it's – it's really free market rule.

…I think…you've really got a lot of bosses in this role. Um, you've got, you know, local government because they employ you, ah, you've got Department of Health because they pay you, you've got, um, your community partner because you have to make sure that everyone's happy, and partnerships are very hard work when it is at that collaborative level.

What are they trying to achieve?

Participants clearly expressed that the goal of their work with HTV is to achieve population health outcomes.

I'd see it as having…a really broad benefit, but just little benefits, as opposed to - - - - - - say, one huge benefit for one particular group. I – I see it as being - - -
A: More an umbrella.
A: - - - sort of – yeah, sort of lots of benefits dotted across - - - - - - a whole range of groups, whether they be disadvantaged or not.Or whether they be stakeholders or partners or council. So - - - - - - it's more that umbrella, rather than a really - - - - - - intense investment in one particular area…

…we actually focus on getting broadest reach to all members of the community.

…you step back and if you look at the data, it tells us that everybody needs this initiative regardless of what socio-economic class they're from, um, or what shit they're grappling with.

So I guess, um, for us it's not about rich or poor, it's not about disabled, not – it's about, um, whole population.

Because it's, ah, a whole of population kind of intervention I would probably say - and we're aiming for large scale reach…

In order to engage with disadvantaged communities, participants discussed the ways in which the HTV program is able to 'trickle down' to people in various settings.

…if we've matched properly our stakeholders across the whole system, um, working with them, building their capacity and mobilising them, et cetera et cetera. Then that's going to trickle down into all of the sub population groups, hopefully.

But our legacy would be one that well we've created meaningful engagement with, you know, it might be a portion of our total 95 per cent target, um, but that there is meaningful engagement and for those that might not be picked up through the achievement program, they're engaged in alternative Healthy Together Victorian initiatives.

Participants expressed the sentiment that by improving systems, and creating equal access, everyone's health will improve ('a rising tide raises all ships').

…one of my mantras in my own head is when a system functions, it functions well for everybody.

Like, if we're looking at, um, the environments for health and the opportunities that come with that, if we're changing the environment, it's for the whole of - it's for the whole of population, like, everyone receives those benefits.

So part of the way of working is thinking about, um, I suppose, changing environments. And, I think that that can be quite supportive to, um, a focus on, sort of, the environments, rather than necessarily the individuals can be quite a great way to make sure that everyone, sort of, has equal access to that opportunity.

Um, but, yeah, that's – that's the only thing that we really do that's – but we provide the same resources for everybody.

Participants gave examples of ways that HTV has been effective in reaching out to address the needs of specific populations.

And that's what we've been trying to capture… given that - - - - - you know, we know that, ah, over a third of a low income wage or an actual Centrelink payment goes on food. So around us trying to make healthy food more affordable - - -- - - we really are trying to focus in on that group that don't have any – that, you know - - - - - - may use their money in other ways, rather than food or rent.

As part of the population level approach, participants expressed an interest in "levelling up" the disadvantaged groups.

…and how do we make sure that we have the right balance of population wide stuff and target interventions to make sure we're not just looking everyone up but - - -- - - the groups to be more on our level with the rest of the population. So that's sort of the thinking and what we're grappling with at the moment.

One participant also expressed the idea of proportional universalism as being part of their goals.

So they're almost used as a checking point for a mechanism that identifies who is most - - - - - who is most struggling and…who is most at risk, and who may not need this additional investment.

Some participants felt that equity was not explicitly a goal of HTV, or that it could not be addressed within the HTV framework.

…so, I don't think Healthy Together Victoria ever set out to create an equitable society. They set out to create a healthy one, under those system building blocks of leadership. And our role isn't to create equity for everyone.

Um, well, I think, you know, 'cause we're just targeting the general population - - - - - of adults, so we're really not, in our capacity at least, we cannot really target vulnerable groups.

Some participants expressed a feeling that equity was part of their work goals and their work reflected equity approaches.

So although health equity may not be at the forefront, it's still something that we're all aspiring - aspiring and working towards.

So, for me, it's – it's saying that it – I guess everyone – everyone needs this intervention, they just need different strategies based on their own needs or the – the different – um, the different groups.

What strategies are being used?

A key component of the HTV program, as expressed by participants, is the development of community engagement.

Ah, what's particularly good about it? I think that…it's a coordinated systems approach to prevention and it's recognising that, you know, us as the workforce alone can't do it all and that we need to absolutely, you know, engage, empower and capacity build, um, the community itself to take charge of its own health because we can't – you can't do it with six people.

I – I've loved that we've got an active and engaged community in there and they're really well connected…

So, um, I guess that's been one of, I think, the best things about the initiative…and that we're really here to resource support, link and connect, that we're not really here to…go and change everything because we – we can't but we will work in partnership with our community to create a healthier community.

Participants also said that working through cross-sectoral activity is a key strategy for HTV.

…Oh okay, and when you start to talk them about the issue and start to work with them on making the connections between their work and how it does impact on health, there's been generally an - a - a willingness to say, yeah, okay, well how do we work together to address that?

…but what we do is promote, like a – a dual mentoring role. So, the dietician might mentor the Aboriginal health worker on, you know, nutrition and health promotion theory, and, um, and the Aboriginal health worker will mentor the dietician on cultural practices and understanding the community. And – and I think it's those sort of relationships that would benefit the HTC site to, you know, to better engage the Aboriginal organisations and therefore, the Aboriginal communities.

So my understanding is that there was a lot of discussions with Community Health, with regional Department of Health and with local government about how we were going to do this. Um, and we were really, really fortunate early on in that our Community Health providers decided that they would align all their integrated health promotion dollars with the Healthy Together model. So, basically, that gave us an extra third of resource, so an extra third more or an – probably an extra half more actually to implement this model locally. So what we were – what we were saying is we're going to work in a coordinated way, we're not going to have fragmented work happening across prevention in our [community name suppressed]. We're going to try a really coordinated systems approach where we have clear goal alignments, um, and clear objectives and it's a cross-team collaboration…

Um, local government has been actually really receptive, um, because that's the other setting, of course, that we work across…so we influence planning policy…and legislation, um, and we've been able to do that quite effectively. So there's been a real willingness and an acknowledgement from local government that they do have quite a lot of influence over the – the built form and how we – how, I guess, we create environments and support health or we don't so that conversation's been had.

Leadership is one of the core strategies being used to achieve HTV goals, according to participants.

So it was the understanding that we needed community to be able to, um, take the lead on their own health and we've done that through, you know, particularly workplace leadership and, um, leadership within schools and, you know, getting parents on board.

So…an obvious example is, um, for a big organisation like [organisation name suppressed] to take a… position state-wide and say we will be implementing healthy choices in our 150 venues across the state, and we will be getting rid of three drinks in three years. So there – when you get more and more, um, big leaders making those decisions from the top up, then you start to see a shift in the environment.

Um, but at another level, having [department name suppressed] articulating wellbeing as a focus, like, I suppose, that's trickling down as well, is – is, sort of, having that leadership at a government level for, um, education settings for the government to be saying that health and wellbeing is education setting's business.

Another strategy that participants said was valuable to their work was the development of policy and policy implementation.

So, um, we're working very much at a – a population level in terms of influencing through local government and whether that's planning, policy, legislation or however we can to influence and through community development to influence the environments that we create across community.

So we've just developed an asylum seeker refugee statement, we're currently working on a diversity policy and also a cultural diversity strategy, of which it's great because I can fit a Healthy Together objectives lens over that or see what the implications would be - - -

Participants also expressed the importance of working on the social determinants of health, particularly through working in settings, to achieve the program goals.

Healthy Together Victoria is – is the whole of government effort to embed prevention as part of everyday community, business, policy, culture shift. So it's literally making issues to do with prevention, so healthy eating, physical activity and mental health to be embedded in the way we do our everyday life…and within our working life, within our study life, within our recreation life. So that – it should be that if – if Healthy Together Victoria succeeds, it should be that no matter where you turn in your life, in every aspect of your life…health is at the forefront of your decision-making, and it's part of the way the world is structured so that health becomes a core business…

…we absolutely have to move away from this notion of educating people; it's just nonsense, and it's used as a diverter by industry, and to just say, let's just educate everyone and we'll be all right, well that's nonsense, because of all the issues that stand in the way between somebody accessing a healthy diet, really, and – and eating it and getting it, versus some, um, someone else, you know.

Many participants expressed that one of the key strategies being employed to achieve HTV goals is through behavioural approaches.

But then we also work very closely with community through the settings and broader community on, um, you know, those health promotion behaviours and – and looking at, really, how we change behaviours or promote healthy lifestyle behaviours across our community.

Um, but yeah, the Healthy Living programs I think are probably an example where you can - that they're not the most equitable but that's almost because they rely on, you know, information and education rather than some of the other forms of health promotion strategy like policy, like universalism, like…they're very traditional.

Resource development and investment to scale were strategies that participants expressed as being key to HTV.

- - - and at a national level…what we're doing here…is trying to overcome that…funding threat by building in an accountability approach which – which is fit for purpose for prevention and this is really taking prevention into a – an outcomes accountability framework, away from an outputs accountability framework…there's a big, sort of,

policy area that, kind of, deals with that – that kind of thing, so, that's what it – part of that's a very strong feature of…the approach.

Many participants focused on the universal reach, intensity and scale of HTV as being core components of its strategy.

Um, I…think the way we work in terms of universal programs is – is really good and it…actually makes it – it's a leveller for everybody…

Workforce development, in both the HTV program but also in the greater community, was a strategy expressed by stakeholders.

So, in the future, we would hope that the environment is – is quite different; job descriptions are different, um, people at the top have a different view on how they position health as an important integral part and not an add-on if we've got time…

…and I think one of the critical points of difference, um, that we have with Healthy Together Victoria is in the – the large workforce that we have behind it as well. I think that's a real point of difference, in having those people who actually need and drive that work, um, it's actually based within local council.

Participants said that part of their strategies was to create targeted programs.

Um, so yeah, it was, kind of, an intensive program versus, kind of, that global lower level sort of intervention but it was promoted to the whole community and - and we worked in partnership with our maternal and child health nurses, so they were promoting it as part of their general sort of business across - that was the universal sort of approach. So yeah, that's probably the better language, universal and then the targeted approach.

So, HTC's might have, you know, ABCD that they want to – want to run but it's about targeting – developing sub programs of those larger programs that meet the needs of their particular community.

…when we have a decision about, um, ah, who would we – who – who we would work with and, um, we – we might put in extra effort in terms of disadvantaged groups to make sure that there's extra attention going or extra at least priority given to – so as with Jamie's Ministry, that was – we certainly didn't want people that could well-afford to get their own jolly cooking classes to be filling up all the spaces.

Um, so, we need to be able to make sure that we tailor Healthy Together community programs to meet the cultural needs or the needs of diverse cultures. It's not just – we just can't have that blanket approach and that's what uniformity of HTV, um, leads us to think that we can have that uniform approach and I don't think we can. I think we need to tailor it to particular communities, the particular needs of different communities within communities.

Some participants expressed that the HTV initiative is trying to take a life course perspective.

Yeah, I - I really think that the - the younger cohort, so that zero to 18 bracket, will be the big winners. Um, I think that the - the universalism of the Healthy Schools area and the early childhood centres is, you know, really, really good. Um, and now that's extending for us particularly, you know, we're looking at the programs that deliver from zero to, um, you know, three so that not only - not only is it when they hit an early childhood service but they're exposed to it from their maternal child health visits.

What approaches are being taken to maximise equity?

Participants explained that one of the key ways in which they address equity is through their reach to various population groups, including marginalised populations.

That's our role and that's why I think the bulk of our work is going to be about building the competencies of the, um, HTC sites to better engage with Aboriginal communities, not the other way around.

So we've got some – because we identified where we hadn't had good reach and then we used, you know, our [program name suppressed] vehicle to, I guess, get reach into those – those networks.

We actually are really well linked in to most of our community. We could reach into most of our community and where it's not strong yet, we're working on it.

…you know, we've tried to reach - tried to achieve good reach across our key settings…

Participants expressed a sense of using best available evidence to inform their equity work.

…that is drawn from the best evidence that we have in terms of looking at that evidence-based approach they are drawing from, um, the World Health Organisation's work around that…

So, um, no, there's not absolutely hard, tangible evidence. But I think, yeah, from my perspective it's the best available evidence that we have that would indicate a likelihood of success, kind of, all of the things aligned with State government, aligned with Local government, a systems approach, decent amount of resourcing, really balancing that kind of policy as well as practice as well as having partners involved and - and we're evaluating it along the way.

…the way I kind of address that or think about that is it's the best available evidence that we've got at this point in time. So, you know, building on experience from smoking, um, and - and tobacco control sort of measures, what - what we know works best, building on some of the communities that are showing promising studies in relation to obesity prevention.

Many participants stated that the HTV program allowed them to adapt the program to fit the needs of the local community.

…I think one of key themes is to - if something is not working, to change your approach….Or, you know, like, your target group, [name suppressed], would need a completely different strategy - - -

So we've had to adapt differently because of our community where I know, for example, in [community name suppressed], um, the languages and the different cultures and so they have faced a very, very different, um, I guess context, population context and the needs of that population differ significantly from the needs of ours.

…and I guess the beauty of what we've been able to do is really adapt to the needs, adapt to the context.

So we - we've been trying to adapt our content very much for, um, those who are most disadvantaged.

The participants explained that they were monitoring the programs to further inform their interventions, but some of them felt a lack of clarity on what was expected from them.

But if I've got no direction - - - - - - you know, like, um, what do I report against?

…what [organisation name suppressed] have also been doing, um, throughout the year is, um, sort of taking… a sample of workplaces that signed up, um, last year, and contacting them to, um, see how they are going, but also to – to probe them more, I guess, around, um, if they haven't been progressing, what some of those barriers are. So we've got some information around that as well, which we then use to feed into, um, things like the resources, um, and the website and the support, um, that they are providing, so to help again with that constant feedback around what changes might need to be made to support Workplaces.

…and, you know, we still don't have any evaluation and the idea was that we would have some regular feedback on our areas, um, and it just hasn't really eventuated so we still don't really have a – a systems logic or an evaluation framework that's signed off.

The issue is - one of the issues is not having access to the, kind of, real time or - or even close to real time data so we can know how we're tracking.

Some participants explained that monitoring was important, but they were looking more for population-level outcomes rather than equity considerations.

It's really population health surveys that are the key mechanism for us measuring our progress.

…two years in is – is certainly, I think, a bit…premature to actually have tangible outcomes in terms of we've reduced obesity. However, we can certainly see, um, some early indicators, particularly around the systems approach that we take, um, which would suggest that we are on track to actually have an impact on population health, I would say.

Many participants stated that their partnerships were critical for engaging with key populations, and relying on their partners reach, resources and experience was one of the ways in which they address equity.

> *Well, we don't have to be in there, she's in there doing fantastic work, um, under the Healthy Together banner. So, you know, we've got those connections.*
>
> *And that's because we realised we cannot work with this community just with the council and the health service because our community is so diverse, and so varied in terms of disadvantage, to try and reach some of those people we actually have to work through our other organisations…*
>
> *I think there's quite a good cross-section of partnerships… And they've tried to develop some things that are perhaps a bit more targeted to what they see the needs in their community.*
>
> *…but I suppose with extending our reach with our partners who do think about equity, we're starting to - to reach more people through - through them.*
>
> *But that's probably where the partnerships play such an important role, because locally, if I'm engaging, um, groups that work with those groups, and then they can use our resources in – in their everyday work, then hopefully those will be used in the - - -- - - you know, women's groups that represent different cultures, or hard to reach groups, those sorts of things.*

Participants explained that in the implementation of the HTV there was flexibility, but a need for greater involvement of stakeholders.

> *And I guess with this approach to there is a bit – a bit of experimenting, um, and – and, sort of, probing different ways of doing things.*
>
> *We just do it, yep. We just go, okay, well, that didn't work, we assess and, I guess, a bit of reflective practice; okay, well, maybe I wasn't the best person to go in there, let's try doing this now…so… it's very dynamic and flexible in the way that we operate.*
>
> *HTV on a whole… what would have been better I think…in the developmental stage was to involve peak organisations… I'm talking from the department's point of view in the early stages, would have been, have those yarns with people about, "This is what we'd like to develop… our Aboriginal communities would be integral to the success of this and would, you know, reap benefits from it… how do we make that happen?"*

Participants felt that a lack of resources for equity-focused work was a barrier to working with disadvantaged populations.

> *Like, really, we are stretched…We're doing a lot with the staffing level that we have. So if, you know, we can actually do more if we're funded…Um, and we could basically – we just need extra people to...- - -- - - have the time to open up the dialogue to target…the vulnerable groups…But we're only doing as much as we can with – with our capacity. So, really, quite often, it just boils down to that, what we can do with what*

we've got, and so you're just going for what you can, you know, the maximum reach and - - -And also what – I – I think also, um, in a way, it's what we're not directed to do, but our target groups, that's our funding, isn't it? …Like, we're funded to target X, Y, and Z, so we have to do X, Y, and Z, before we can move onto A, B, and C…And so we have to show that we're targeting that group. And there's always more you can do…So you can never finish with your target groups really. So - - -- - - it really needs to come from the department in a way that we – that they want us to target vulnerable groups…And therefore, the funding will come and then we'll be able to work on that area, but at the moment we can't…Also, um, what's evaluated by department, or any of it?...Because, I'll give you an example. I worked in [state suppressed] on a physical activity campaign, and the main measure was, have you increased the number of adults doing 30 minutes of activity a day?...So, instead of targeting the adults doing zero activity - - -- - - it just wasn't really useful for us, so it was just targeted those doing 20 to 30 minutes a day - - -- - - which isn't your – your most needy group at all, but - - -- - - that's, yeah, that's what we were paid to do essentially, so that's what you have to do, isn't it?...Yeah, it all comes down to what you're funded to do, but yeah…So it, sort of, needs to come from the department.

…we don't have those resources for specific groups, except for there's an Aboriginal stream of the campaign, the only one.