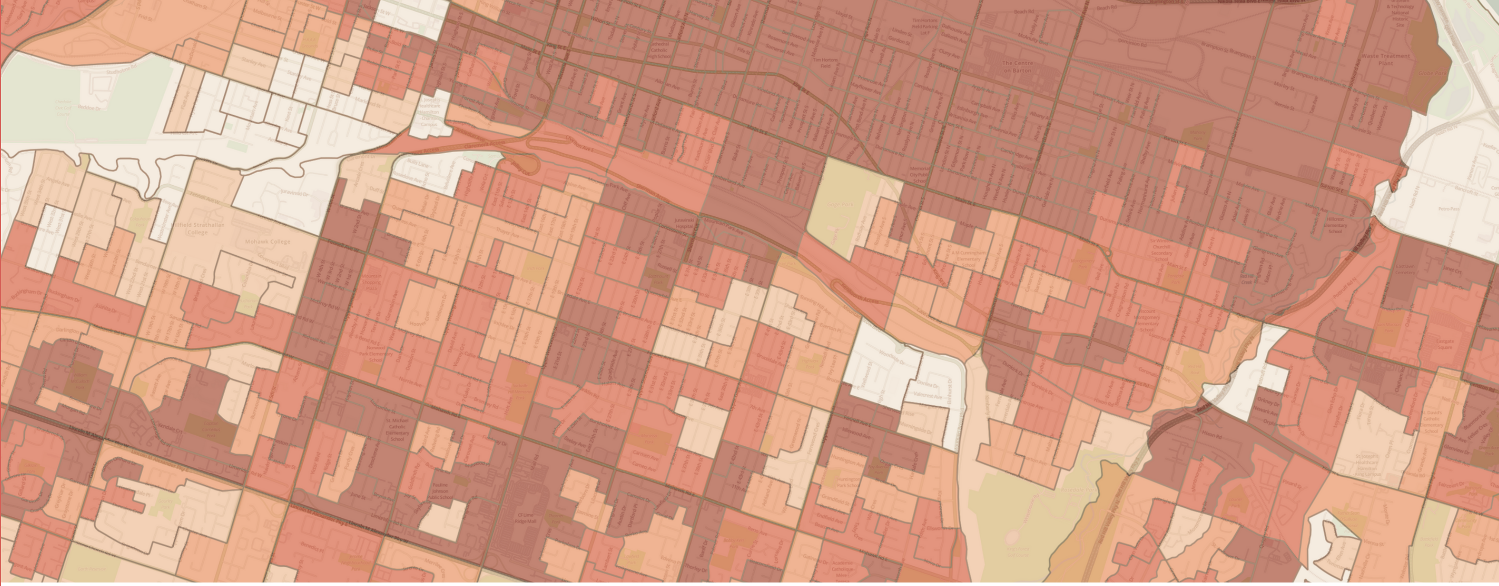

Integrated Health Equity Framework

for EDI-AR and SDoH at Hamilton Family Health Team

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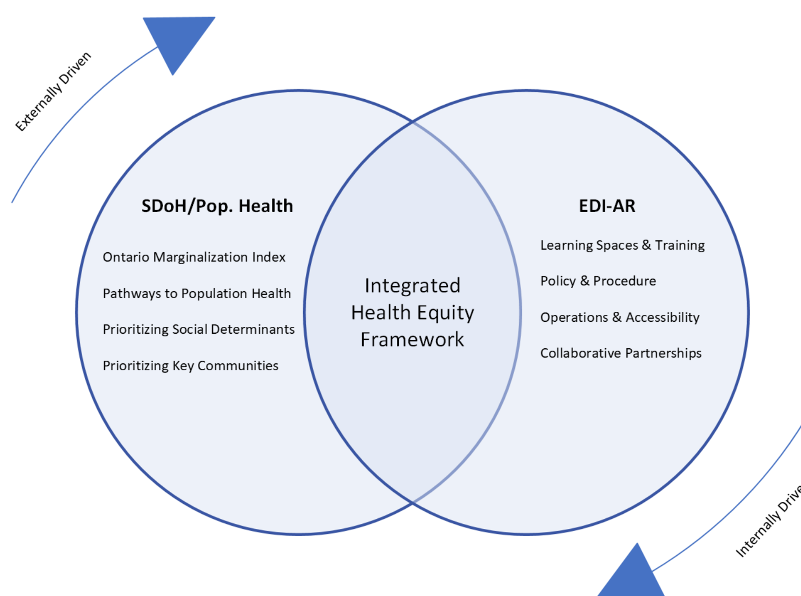
Framework Overview

The Hamilton Family Health Team is committed to addressing and mitigating health disparities, promoting equitable access to inclusive care, and empowering patients to shape the ways that programs work to improve health outcomes for all people. A health equity framework builds a shared understanding of core equity concepts and creates momentum and guidance for health equity action. This integrated framework engages both Equity, Diversity, and Inclusion with an Anti-Racist focus (EDI-AR) and the Social Determinants of Health (SDoH) in the overall objective of addressing health inequities and their underlying causes: systemic discrimination. Our framework demonstrates reciprocity between internally- and externally-driven initiatives that continuously foster responsiveness to key areas of need within our community while informing organizational processes.



"From the Outside In" - SDoH at HFHT

- **HFHT will prioritize engagement with areas of the city that have faced inequity.** The Ontario Marginalization Index is one tool that will help with this population-level intervention.
- **Co-design, cross-sector alliances, and the responsible collection and use of equity data will be key facets of this work.** The "Pathways to Population Health Compass Tool" can be used to measure progress.
- **Issues of housing, income, nutrition, and care coordination will be major components of the work** since these have been shown to have the greatest impact on health outcomes.
- **Any population health work will seek to meet the needs of those who face the highest barriers to health,** including Indigenous, Francophone, racialized (particularly Black), immigrant and refugee, 2SLGBTQIA+, disabled, homeless & precariously housed, and drug-using populations, in lockstep with the Greater Hamilton Health Network.

"From the Inside Out" - EDI-AR at HFHT

- **Learning Spaces & Training**: organization-wide infrastructure and processes will be created to facilitate ongoing learning and development of EDI-AR principles and skills.
- **Policy & Procedure**: the review, assessment and development of transparent frameworks, policies, practices, and systems of accountability will be facilitated to create equitable and inclusive processes throughout the organization.
- **Operations & Accessibility**: long-term, sustainable operations and program supports will be developed to increase accessibility and cultural relevance for staff and patients, along with a sustainable infrastructure for EDI-AR work.
- **Collaborative Partnerships**: the integration of EDI-AR frameworks throughout organizational initiatives will be facilitated through internal collaboration, as will the building of meaningful EDI-AR connections with our community, fostering alignment with population health and EDI-AR objectives.

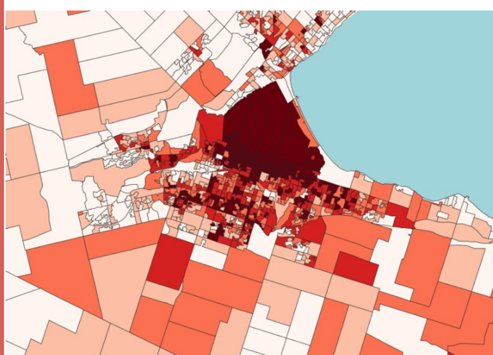
Integrated Health Equity Framework

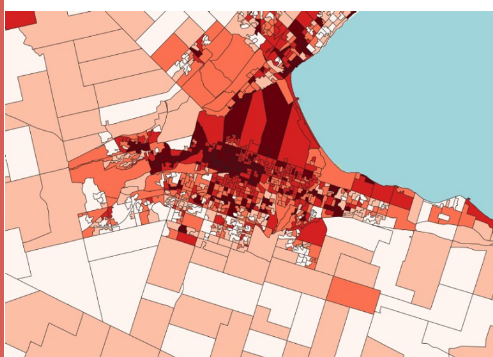
Guiding Questions

Equity, Diversity, and Inclusion
Guiding Questions

- How would I locate myself/ describe my identity? Where do I hold privilege and/ or marginalization (i.e. class, race, gender, ability, socio-economic status, etc.)?
- What values, attitudes or beliefs are informing my perspective on this particular interaction or organizational process, and what has shaped them (including intergenerational and historical dynamics)?
- As I step into this organization/ system, how is it structured? Where are the power structures, and how have I, my colleagues, and patients, been placed in this system in terms of role and power structures?
- What frameworks or ideologies guide the functioning of this organization/system/initiative?
- Whose voices and knowledge are being privileged, and how does that distribute power and resources?
- What inclusionary or exclusionary criteria do we have that could affect accessibility to our services and community resources?
- How do I manage misaligned perspectives of service recipients, organizations, services systems and myself?
- Where are there opportunities to bring that which is marginalized, to the center (i.e. people, voice, knowledge) in a meaningful and sustainable way?

Social Determinants of Health Guiding Questions





- Where possible, does the initiative, proposal, or intervention specifically engage patients in areas of Hamilton that experience marginalization?
- Where possible, does the initiative, proposal, or intervention include adequate consideration regarding:
  - Methods of capturing and reporting equity data (sociodemographic data pertaining to the social determinants of health)
  - Engagement with community partners or stakeholders who are also doing work to improve health, well-being, and equity in the community
  - Ways to co-design the program with people with lived experience (through PFG or other)
- Where possible, is the initiative, proposal, or intervention designed with considerations for people experiencing precarious housing, financial difficulties, nutritional difficulties or poor access to healthy foods, care coordination, or community outreach?
- Where possible, does the initiative, proposal, or intervention engage patients from Indigenous, Francophone, racialized (particularly Black), immigrant and refugee, 2SLGBTQIA+, disabled, homeless & precariously housed, and drug-using populations, inside and outside of HFHT practices?

Introduction

An Integrated Health Equity Framework

The following health equity framework tailored for the Hamilton Family Health Team aims to address and mitigate health disparities, promote inclusive care, and improve health outcomes for all residents. Ours is an 'Integrated' framework in that it provides clarity around the work done jointly by two coordinators promoting Equity, Diversity, and Inclusion with an Anti-Racist focus (EDI-AR) and addressing the Social Determinants of Health (SDoH). The framework envisions these two areas of focus as concurrent and intricately linked: as one internally-driven process that builds equity within, and one externally-driven process that promotes equity outside the organization.

From Theory to Operation

The Integrated Framework understands that the work of EDI-AR and SDoH are both engaged in the work of health equity, albeit with variations in focus, method, and outcomes. As we move from theory to practice, the Integrated Framework lays out two operational frameworks, geared for the distinct coordinator roles, detailing a practical roadmap for implementing strategies and initiatives in the service of our health equity goals. Internally, the EDI-AR operational framework rests on four key areas - training, policy & programming, operations & accessibility, and collaborative partnerships - and proposes a set of guiding questions for the organization. Externally, the SDoH operational framework rests on a number of tools and priorities to guide action towards intervening on upstream factors that lead to particular health outcomes.

By adopting a health equity lens and coordinating the work being done within the organization already, we can collectively enhance our capacity to deliver equitable and inclusive healthcare services and promote better health outcomes for all residents.

Theoretical Framework

Putting health equity into context at HFHT

As identified by Ontario Health (OH) and the Great Hamilton Health Network (GHHN), Health Equity is the ability for all people to reach their full health potential and receive fair and appropriate care, and is the absence of unfair systems and policies that cause health inequalities. Health equity has been identified as a priority for GHHN, whose Equity Framework aligns with the OH Equity Framework while adding focus on anti-oppression and a population-health approach:

> *"As a Steering Committee, we... moved the imperative from equity, diversity and inclusion to anti-racism, anti-oppression, sex/gender discrimination and the need to address imbalances and systemic barriers. We are firmly committed to the population health approach with a focus on populations that face the most significant barriers to health. We believe that this commitment is critical to achieving equitable health outcomes for all." (p.4).*

> *"There is consensus amongst the members of the GHHN EDI ARAO Steering Committee and the communities they engaged in this project that a population health approach, a social determinant approach and an anti-racism and anti-oppression approach must be embedded in the principals of health equity work." (p.6).*

Furthermore, among other social determinants of health acknowledged by the GHHN, systemic oppression is a social determinant of health that needs to be addressed in primary healthcare through health equity frameworks and initiatives, rooted in the principles of EDI and AO:

> *"The GHHN acknowledges that oppression, including racism and hatred in all its forms, makes people sick. GHHN commits to addressing systemic racism and oppression, challenging the status quo, addressing systemic barriers, and changing practices so that all people have access to equitable health outcomes." (p. 19)*

Such an approach aligns with the present reality at HFHT where coordinator time is allocated towards EDI-AR and the SDoH. From the beginning it was understood that these two areas of focus shared a great deal of overlap in the sense that they promote health equity; and yet have distinctions in focus and methods that should not be ignored. Our theoretical framework brings this mutuality to the fore, noting how work done from one side towards health equity impacts

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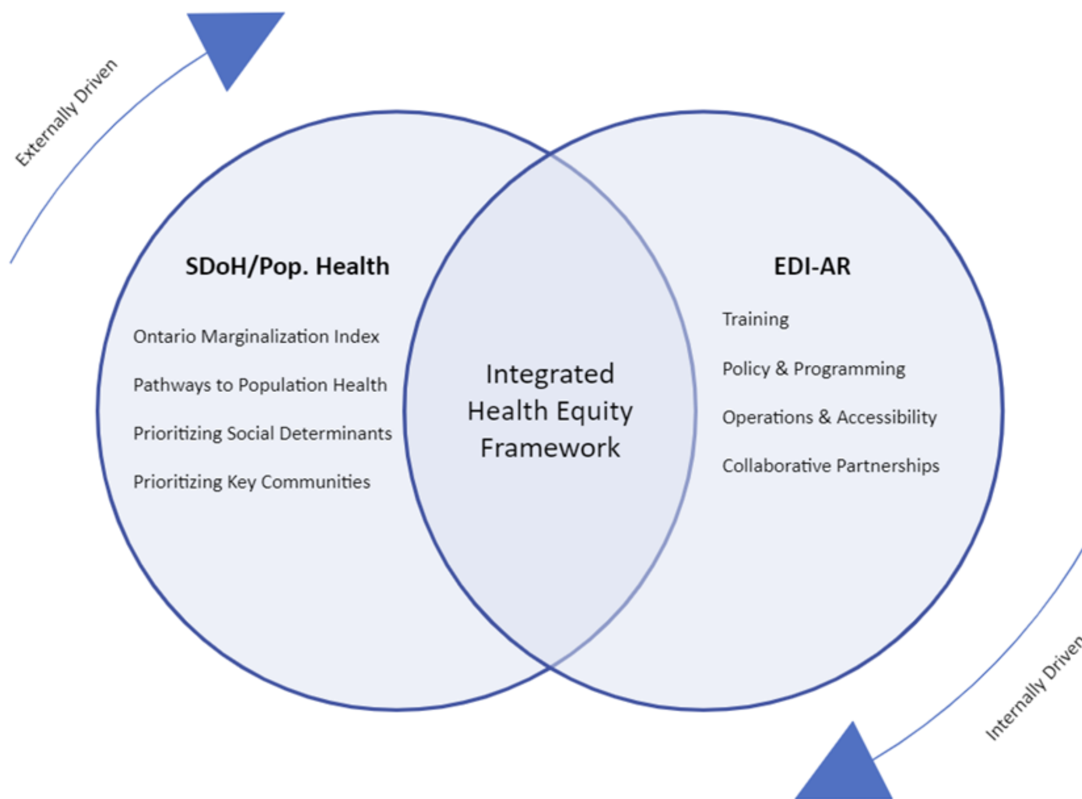
the other. Work done by EDI-AR has historically been more focused on practice and policy internal to the organization, but has ramifications for patients and patient networks involved in HFHT services. Similarly, work done towards addressing the SDoH is more externally-focused, identifying upstream factors bearing on health outcomes and population-based barriers to service, which leans heavily on work done internally by EDI-AR.

This framework is grounded in anti-racist and anti-oppressive theory and practice. It seeks to address systemic barriers, power imbalances, oppressive ideologies, and inequitable distribution of resources at all levels. It acknowledges that our work towards justice, equity, diversity, and inclusion will include these two processes of change - one internally-driven, and one externally-driven. These are not seen as distinct, but rather inherently co-engaging with the work of health equity.



The internally-driven process, led by the EDI-AR coordinator, identifies four key priorities for the organization alongside a set of guiding questions that should be useful for decision-makers: training, policy and programming, operations and accessibility, and collaborative partnerships. The externally-driven process, led by the SDoH coordinator, similarly promotes four areas of engagement and a suite of tools that will guide the work done in the community, social, and political spheres.

EDI-AR Operational Framework

A guide for internally-oriented action

Grounded in this shared theoretical understanding of health equity at HFHT, we can now begin to operationalize EDI-AR in the organization. This operational framework is built on the Recommendations Report that was completed in the first year of the HFHT EDI work from Empower Strategy Group; work that involved staff and practice feedback, an informal organizational gaps analysis, and review of current literature on some existing frameworks.

Anti-racism is based on the same principles as anti-oppression, EDI and health equity. Implementing anti-racism interventions in healthcare should be a multi-level approach beginning with policy and organizational interventions, as well as community, interpersonal and individual levels, simultaneously, over a long period. This requires education and infrastructure development. Integrating anti-racism at different levels of organizations also requires embedding EDI-AR principles and practices throughout the organization, from board and senior leadership, to front line staff, practices, and patients. This includes self-reflection tools and unconscious bias training at the individual level. At the organizational level suggestions include focusing on structures and processes internally, including creating a consultation group, amending human resource policies, hosting workshops and conferences to effect organizational change, and language translation. Other suggestions echo the development of organizational infrastructure, including policies and processes, addressing power imbalances, tailoring programs and services to local contexts, actively countering discrimination, community and patient engagement, and enhancing access to social determinants of health. These latter initiatives will fall within the scope of both EDI and the population health work. In summary, there is a recognition of the need for organizations to "self-assess and 'build organizational commitment to be inclusive, open, and progressive' while acknowledging power dynamics" (Hassan et. al., 2021).

The EDI-ARAO Operational Framework guides internal organizational processes for internal stakeholders, partners, and also processes that affect health outcomes of our patients and beyond, thereby moving from internal to external and back. Examples of this include language translation services, accessibility policies and data collection. According to the EquityLink French Language Service training, language accessibility is a population health issue as it directly affects experiences in health care as well as health outcomes. Initiatives that pertain to more internal processes include HR policies such as recruitment, retention and onboarding, as well as internal EDI training and infrastructure.

It should be noted that the EDIAR operational framework has yielded an action plan that is comprehensive in terms of full integration of EDIAR throughout the organization. This action plan is intended to create processes in the organization both directly, and indirectly, through partnerships and collaboration, as well as activating and supporting co-ordination of initiatives with other departments and programs.

A summary of the literature, as well as common practices in EDI-ARAO work over the last few decades in many sectors and geographical areas, yields 4 major areas for EDI initiatives to create a comprehensive action plan: training/ learning, policy development, operations and organizational processes, and collaborative partnerships.

Training

Our goal is to create infrastructure in the organization for ongoing learning opportunities, including experiential guided learning, a community of practice, consultation, and conversations that can surface in everyday organizational processes like program and policy development or case management conversations. This supports learning with a balance of didactic information and experiential learning in a reciprocal process that feed each other. As supported by the literature, learning should be integrated throughout the organization: Board and leadership, staff, practices, and patient interactions, including both formal and informal opportunities. The literature and best practices from those leading EDI and ARAO work is consistent with the article by Hassan et. al. (2021), who note that training should be ongoing, mandatory, and tailored to need. They also identify topics to cover, such as racism, unconscious bias, stereotype, prejudice, critical self-reflection, privilege, cultural competence, appropriate humour, relational accountability, culturally safe healthcare, and how to address discriminatory comments.

The GHHN has provided a good description of the importance of learning in a process where understandings of unconscious bias and oppression at an individual level informs the understanding of systemic discrimination in organizations and systems, thereby shaping policy and program development, as well as collaborative partnerships:

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"The GHHN approach this work with humility and a deep commitment to listen, learn and unlearn. This includes but is not limited to seeking education and training on leadership fragility, impact of micro-aggressions, power, and privilege and how it plays out in the health systems and historical discriminations and its impact on health outcomes for specific populations. It also includes continuous learning on the health equity-informed population health approach and its specific impacts on the population segments within the GHHN, and the community and the population-specific organizations that serve them." (p.13).

Also important in learning is to "reduce attitudinal barriers and increase safety through EDI education and training at all levels... from onboarding through all stages of their employment". (North York General)

Policy and Programming

Hassan et al. identify the need to look at processes which include frameworks, policies, guidelines and recommendations at the system level, as well as systems of accountability. This is part of building infrastructure in the organization that can surface and address inequities. One common area identified in the literature for policy review and development are recruitment and retention. CAMH conducted an environmental scan and systems review "to identify the extent to which the institutions current recruitment... practices, policies, and procedures systems and structures are open, transparent, and follow" established guidelines. This is in an effort partially to make a specific effort to recruit from their identified marginalized groups, in recognition of the importance of representation in their staff body to foster inclusion, and ultimately inform organizational processes and program development. The need to establish more comprehensive conflict resolution policies, in part to build capacity within leadership to navigate EDI-AR issues in the organization, was surfaced in the recommendation report provided by the Empower Strategy Group. There is also a recognition that policy development could shape organizational culture. Accessibility is another area that is important to address, which can start with internal processes, while also impacting service delivery, and community collaborations.

Operations and Accessibility

The area of operations and accessibility broadly refers to those areas that impact organizational process, which was also identified in the GHHN health equity framework. More specifics are outlined in the action plan, but may include initiatives that affect service delivery, such as language accessibility and data collection, which are both priority areas for the GHHN. It could also include how to integrate Land Acknowledgments and protocols for meetings (i.e. pronouns for virtual meetings), wellness and safety, quality improvement measures and consultation processes.

As alluded to previously: another area that has been noted by the literature, and the action plans of many partner organizations, is building infrastructure within organizations to sustain EDI, ARAO, and Health Equity work. There are many different models being employed by partner organizations. As such, it is important to identify what needs to be put into place for long-term sustainability of integrating EDI- ARAO work into our organization.

Collaborative Partnerships

The literature is clear in terms of the need to create collaborative partnerships with other community organizations, both to increase access to services, and inform organizational processes. The direction at the HFHT would be to engage in collaborative initiatives internally and externally that promote an integrated health care system and standardized mechanisms for EDI-ARAO learning, resource sharing, infrastructure, policies, and practices, as well as to break down silos between initiatives and services.

Within the HFHT, with regard to EDI-ARAO, as an organization that has such an extensive infrastructure, it is important to align and connect internal initiatives, and ensure that ARAO is a foundational lens and analysis that underpins all initiatives, both as part of our value system, and also moving toward our goals around health equity and population health. This was the approach of Empower Strategy Group that were employed for the initial environmental scan that was completed in the first chapter of the EDI work.

As we build an integrated service structure within Hamilton communities, as noted in the literature and is common in most EDI/ Health Equity Frameworks, it is crucial to seek both service partnerships and EDI-ARAO/ Health equity partnerships to inform organizational processes and community collaborations. The common phrase ‘nothing for us, without us” captures the need for representation so that we embed opportunities for diverse and comprehensive perspectives, rather than simply seeking consultation, while keeping current power structures intact. This approach lends itself to providing various levels of autonomous involvement from marginalized groups, from consultation to co-design, to having patient led initiatives. This is another example of a set of initiatives that will span the scope of both EDI-ARAO, Health equity or SDOH work that will reciprocally shape each other.

Foundational Process: Critical Reflection and Analysis

There can sometimes be a disconnect between health equity/ population health initiatives informed by research, and the application of an ARAO-EDI analysis that is embedded in critical theory. The latter can connect underlying issues and processes of marginalization to specific inequities. The core principles of critical theory - which overarches anti-oppression, anti-racism, and EDI - include the recognition and acceptance that power structures exist that privilege some and disadvantage others. ARAO furthers this in creating a commitment to addressing these power structures and creating transformational change. Without a proper understanding of this theoretical framework and the analysis that it yields, we run the risk of perpetuating and re-creating the same systems that created those inequities in the first place. This analysis can help to surface unconscious bias that can find itself infused into policy and program development. These biases are already embedded in current power structures and are perpetuated by following the status quo. In order to make these processes explicit, it is helpful to start with a process of positioning ourselves, and mapping power structures. Critical self-reflection can facilitate this by helping to position ourselves as individuals, and understand what has informed our construction of our identity (i.e. values, life experiences, conditioning, socialization, etc.), as well as how that might foster unconscious bias. We then want to develop our understanding of our own intersectional identities that hold power, privilege and marginalization, intersectionally, based on our positioning within socio-political power structures (i.e. class, gender, ability, sexual orientation, race, ethnicity, citizenship, etc.). The next steps are increasing attunement to, and continuously mapping, power structures, as we move through the world and systems. This allows us to find our positioning within our professional role, as an agent of the system, and in relation to colleagues and patients, and how this affects the narrative, knowledge, relationships, service agreements, and structures being built or reinforced. We do this with the understanding that different parts of our identities are activated as we engage with, and move through, different systems and interactions. Lastly, is to become attuned to where we are positioned as an organization in relation to patients and our service system community, and how that creates ideology and infrastructure.

EDI-AR Operational Framework

Guiding Questions

The following are some examples of questions to help facilitate a process of ongoing critical self-reflection, positioning, re-positioning, and mapping:

Critical Self-Reflection

- How would I locate myself/ describe my identity? Where do I hold privilege and/ or marginalization (i.e. class, race, gender, ability, socio-economic status, etc.)?
- What are my values and beliefs, and who or what has informed them (including intergenerational and historical dynamics)?
- Am I adequately represented in my environment? Do I see myself in the world (i.e. media, peers, colleagues, the stories I hear, etc.)? What does that mean for where I have privilege and/ or marginalization?
- How do I manage misaligned perspectives of service recipients, organizations, services systems and myself?

Stepping into Systems: Mapping

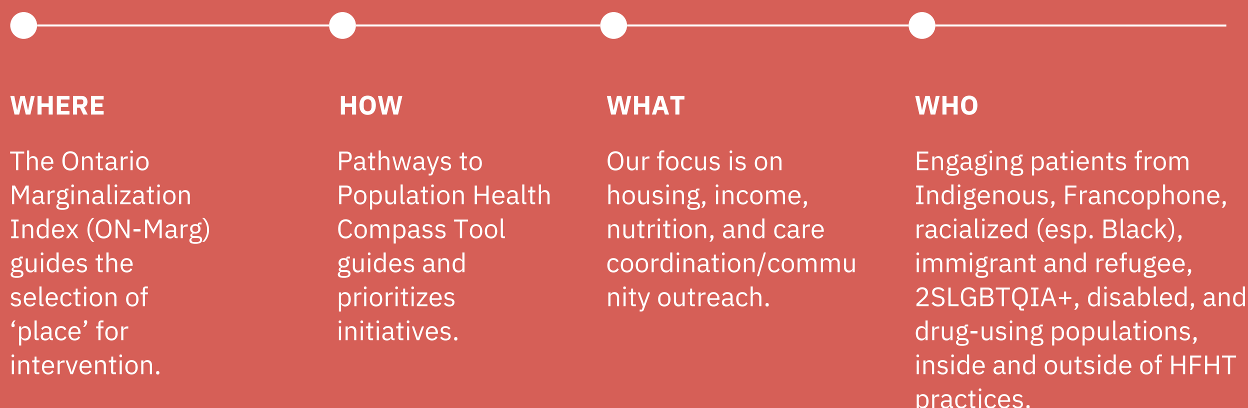
- As I step into this organization/ system, how is it structured? Where are the power structures, and how are people placed in this organization/ system?
- What frameworks or ideologies guide the functioning of this organization/ system?
- Where have I, my colleagues, and patients, been placed in this system, in terms of role, and power structures?

Engagement with People and Systems

- What attitudes or beliefs are informing my perspective on this particular interaction or organizational process?
- What parts of mine, my colleagues, and patients' identities, both privileged and marginalized, are being engaged or activated in this scenario?
- How are we positioned in relationship to each other (based on our identities and role), and the organization/ system we are in? How will this positioning shape this interaction or organizational process?
- Whose voices and knowledge are being privileged, and how does that distribute power?
- What is required to participate (inclusion criteria) in this organization (i.e. staff) or service (i.e. patients)?
- What exclusionary criteria do we have that could create lack of access, inequities, and marginalization?
- What dynamics or pressures within our organization, or within the larger service system, are shaping our approach to this scenario, interaction, or organizational process?
- Where are there opportunities to bring that which is marginalized, to the center (i.e. people, voice, knowledge) in order to share power and/ or address inequities?

SDoH Operational Framework

The SDoH Operational Framework aims towards being clear and precise as it guides action towards intervening on upstream factors that lead to particular health outcomes. It offers answers to the questions: **Where** should we direct our efforts? **How** do we target health equity? **What** types of initiatives ought to be prioritized?, and **Who** are we serving?



WHERE: The Ontario Marginalization Index (ON-Marg) guides the selection of 'place' for intervention.

The ON-Marg was developed to map health inequities at a population health level and can predict the kinds of health or social services that may be needed in a specific area. By using this tool, we can monitor inequities in an area over time, evaluate interventions, and assess the relationship between marginalization, health, and other outcomes.

Relying on StatsCan information, the ON-Marg gives a visual map of four key categories across Ontario:

- **Material Deprivation:** This category includes factors related to income and employment, such as the percentage of households living below the poverty line, the unemployment rate, and the percentage of households that spend a high proportion of their income on housing.
- **Residential Instability:** This category includes factors related to housing and living conditions, such as the percentage of households that are renters, the percentage of households that move frequently, and the percentage of households living in crowded conditions.
- **Ethnic Concentration:** This category includes factors related to diversity and segregation, such as the percentage of visible minorities in the population and the percentage of households in which the primary language spoken is not English or French.
- **Dependency:** This category includes factors related to social and family support, such as the percentage of single-parent households, the percentage of households with children, and the percentage of households with elderly residents who live alone.

Case example: in a discussion about which practices could be prioritized in the roll-out of the 'Care Connector' role, the ON-Marg mapping tool was used to identify practices located in areas that ranked high on material deprivation and residential instability.

HOW: Pathways to Population Health Compass Tool guides and prioritizes initiatives.

The Compass Tool is a guide for healthcare organizations wanting to identify new opportunities to make practical, meaningful, and sustainable advances in population health. Its results provide clear directives and shared language for future initiatives towards health equity, which is meaningful for an organization seeking internal alignment. The Compass Tool includes a series of statements that identifies the current state of the organization's activities to advance population health and health equity, grouped into components below. In particular, as it pertains to HFHT, areas pertaining to the measurement of sociodemographic and race-based factors, community partnerships and engagement, and co-design are anticipated to be early priorities.

- Stewardship
- Equity
- Payment
- Partnerships with People with Lived Experience
- Physical and/or Mental Health
- Social and/or Spiritual Wellbeing
- Community Health and Wellbeing
- Communities of Solutions

Case example: the Compass Tool asks the user to rate the organization's efforts to improve mental and/or physical health based on a number of statements. While it is true that "We use our data in improvement initiatives related to mental and/or physical health," it is not true that "Our strategic planning staff present basic GIS postal code data of key patient cohorts as part of our community benefit assessment."

WHAT: focus is on housing, income, nutrition, and care coordination/community outreach.

These types of initiatives have shown to be more strongly associated with positive outcomes and reduced spending and can be tailored to the resources allocated to our team. The GHHN health equity framework specifically identifies poverty as "the overall determinant of health," making income and income security a fundamental priority. Focusing on income broadens the scope of the work done in health equity to include not only those in social services but also the economic and political sphere. There are also a variety of recommendations and tools bearing on these domains of health determinants within primary care in Canada.

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Here, it is important to situate this health equity framework specifically in the context of Hamilton, Ontario. In 2023 the municipality declared a 'state of emergency' on three issues, one of which was housing (the other two being mental health and addictions). In 2017, Hamilton was one of the municipalities selected to participate in a pilot regarding Basic Income; early findings seemed to suggest a profoundly positive impact on health, housing, nutrition and diet, stress, and relationships. Finding strategies in these particular domains will have profound impacts for patients living in this city.

Case example: a student in one of the HFHT clinical programs was discussing ways that they might do independent research into the social determinants of health as it pertains to the clinical work they are doing. We were able to narrow down their research to explore ways that housing, income, and nutrition impact their clinical work.

WHO: engaging patients from Indigenous, Francophone, racialized (particularly Black), immigrant and refugee, 2SLGBTQIA+, disabled, and drug-using populations, inside and outside of HFHT.

The GHHN Health Equity Framework builds on the Ontario Health Equity Framework by identifying specific populations facing unique barriers to health services, while recognizing intersectionality and overlap amongst these populations. This area of focus dovetails most closely with the work done in EDI-AR, as we consider ways that the health care system has historically perpetuated racist and oppressive attitudes and practices; and also explore ways that we can shape more equitable and just healthcare for these patient groups. The “Health Equity Impact Assessment Tool” developed by Ontario Health is a clear and practical means to assess the impact that health initiatives, programs, and policies have on these historically marginalized populations.

Case example: in early conversations about applying this framework to existing program offerings, the Clinical Integration Table has found it useful to discuss ways that current programming does or does not meet program goals for these specifically-identified populations.

Framework Development Process

A note on future HFHT health equity work

Our framework is the result of deep and ongoing collaboration between two coordinator staff at HFHT: the EDI-AR coordinator and a program coordinator within the mental health section. It was built primarily on top of existing frameworks, orientations, and literature (both grey and published), and relies heavily on an assortment of existing equity tools in order to tangibly action equity principles. It is rooted in the EDI Consultants Recommendation Report prepared for the HFHT. Further, it seeks alignment with the Ontario Health (OH) and Greater Hamilton Health Network (GHHN) Health Equity Frameworks, given the HFHT's position within the broader regional healthcare context. Throughout its development, informal consultations took place between a small group of healthcare providers inside and outside of HFHT, as well as several subject matter experts within academia.

However, the development process of this framework itself is worth some scrutiny. We believe the framework does effectively ground us in a coherent theoretical frame and proposes useful steps forwards for the organization both internally and externally, though it is deeply important to note that it lacked a structured engagement process with additional partners outside of the codevelopers: importantly, beyond the lived experience of the codevelopers, this framework did not explicitly include input from patients, community members, or people with lived experience of inequities. This is an important weakness that should be stated clearly. Our framework acknowledges the importance of including 'those whose voices are not heard as often' in a meaningful process of co-development; so that populations experiencing inequity can prioritize methods and outcomes themselves, and be directly involved in shaping the narrative around their own health experiences.
In so doing, we hope to guard against becoming part of the very system that perpetuates these inequalities.

We believe this framework is simply a starting place for understanding and disrupting health inequity at HFHT. This framework should be revisited and revised regularly. Future iterations must strive for meaningful community engagement and co-development with communities facing oppression and inequity.