HPH Task Force MFH
Migrant
Friendly
Hospitals and Health Services

Standards for equity in health care for migrants and other vulnerable groups

Self-Assessment Tool for Pilot Implementation

This document has been prepared by Antonio Chiarenza, with the contribution of the project group on Standards for Equity in Health Care for Migrants and other Vulnerable groups: Elizabeth Abraham, Simone Atungo, Isabelle Coune, Julia Puebla Fortier, Manuel Garcia Ramirez, Bob Gardner, Margherita Giannoni, Paolo Giorgi Rossi, James Glover, Manuel Gonzales Fernandez, Eeva Hakkinen, Lidia Horvat, David Ingleby, Karima Karmali, Bernadette Nirmal Kumar, Christopher Le, Laura McHugh, Conny Seeleman, Marie Serdynska, Hans Verrept.

This document has been developed in accordance and in cooperation with the International HPH Secretariat.

For further information contact:

Dr Antonio Chiarenza (*Coordinator*)
Task Force on Migrant-Friendly and Culturally Competent Health Care
Regional HPH Network of Emilia-Romagna
AUSL di Reggio Emilia
Via Amendola, 2 - 42122 Reggio Emilia, Italy
Phone: +39 0522 335087
Fax: +39 0522 339638
E-mail: antonio.chiarenza@ausl.re.it
AUSL di Reggio Emilia Web site: www.ausl.re.it
HPH - TF MFCCH Web site: www.hphnet.org

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Participating countries in the first pilot test:

AUSTRALIA
CANADA
FINLAND
IRELAND
ITALY
NORWAY
SCOTLAND
SLOVENIA
SPAIN
SWEDEN
SWITZERLAND
THE NETHERLANDS

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[1] Sandro Cattacin, Department of Sociology, University of Geneva; Dagmar Domenig, Arkadis Foundation; David Ingleby, University of Amsterdam

Executive Summary

The Task Force on Migrant-friendly and Culturally Competent Healthcare (TF MFCCH) has developed a set of standards aiming at monitoring and measuring equity in health care for migrants and other vulnerable groups. The standards for equity provide opportunity for staff and services to question what they do, why they do it, and whether it can be done better.

A set of preliminary standards have been developed on the basis of an extensive critical literature review as well as several expert workshops and consultations. The preliminary standards have also been pilot-tested and evaluated by a group of 45 health care organizations from 12 countries in 2012. Based on feedback received, the standards were improved and presented at the International WHO-HPH (Health Promoting Hospital and Health Services) Conference in Gothenburg. With the approval of the international HPH network, the TF on MFCCH has finalized its Standards and is set to begin a new phase of work to aid health care organizations implement the standards.

The new phase serves to enhance practical utility of the standards, and so the Task Force has developed a Self-Assessment Tool (SAT) to help institutions evaluate, monitor and improve their activities on health equity. Institutions that participate in the pilot implementation of this tool will:

- Complete the self-assessment tool to benchmark organizational performance on each of the standards;
- Select relevant indicators useful to their organization to assess progress against the standards and assess the current or potential availability of data sources to enable reporting on the indicator;
- Analyze the results of the self-assessment to identify areas of improvement in each of the standards areas;
- Select one or two areas of improvement for the development of a draft plan to achieve a quantifiable improvement.

Institutions invited to participate in the pilot test are Hospitals, Health Care Services, Community and Social Centres. The period of activity for this process is March 2014 to October 2014. All relevant information and instructions can be found on the Tasks Forces sub-site on the international HPH Networks web site www.hphnet.org.

General considerations

Background

The Task Force on Migrant Friendly and Culturally Competent Health Care (TF MFCCH) is established within the International Network of Health Promoting Hospitals & Health Services (HPH).[2] The HPH is an international network set up by the WHO Regional Office for Europe in 1989 with the aim to improve the quality of healthcare by introducing health promotion activities for patients, staff and the community into routine hospital practice. Since 2008 the HPH network has broadened its scope to include health services generally. Today roughly 900 institutions are part of the network in various countries and continents.

The TF MFCCH was set up in 2005 to continue the momentum created by the Migrant Friendly Hospital project (2002-2005)[3] in which 12 European countries developed models of good practice to improve hospital services and promote health and health literacy for migrants in selected pilot hospitals. The novelty of this project was to introduce the idea that if we want to improve responsiveness, we must not only address measures to improve the knowledge and behaviour of individual patients and providers but also improve the overall organisation of service delivery.

The idea of creating a Task Force originated from the desire to continue working on these themes in a comparative international context after the conclusion of the MFH project, and to build on this experience in order to:

- Facilitate the diffusion of policies and experiences and stimulate new partnerships for future initiatives;
- Foster cooperation and alliances between health care organisations and other networks;
- Support member organisations in becoming migrant-friendly and culturally competent health care organisations, as recommended in the Amsterdam Declaration (2004).

The approach of the TF was informed by the evolving dynamics of the migration phenomenon in Europe. Although most migrants are healthy when they first arrive in their host country, they risk falling into poorer health compared to that of the average population because of the conditions surrounding the migration process (Smedley et al, 2003). These migrant groups are more vulnerable, due to their lower socio-economic status and the conditions of poverty they abandon are often to be re-encountered in their new host countries. This vulnerability

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[2] The Health Authority of Reggio Emilia (Italy) is responsible for the coordination of the HPH-TF MFCCH

[3] The outcomes of the MFH project can be found in the web site: www.mfh-eu.net

is at times caused by traumatic migration experiences, by the feeling of exclusion in the place of arrival, and often by a lack of adequate social support due to the absence of integration and specific socio-health policies (Mladovsky, 2009). This situation is worse still if the conditions of asylum seekers and undocumented migrants are taken into account. Social exclusion, discrimination, poor living conditions and poverty in general all impact on the health, mental health and social adjustment of migrants in the host community (WHO, 2010).

This vulnerability is further exacerbated by the lack of access to health services. Experience in recent years has shown that migrant patients and members of minority ethnic communities and other disadvantaged groups tend to receive lower levels of health care compared to host country nationals due to the lack of awareness of services available, the absence of appropriate accessibility to services, and the negative attitude of staff in the delivery of health services. Moreover, migrants often lack the necessary information to access hospital and clinic services, how they operate, as well as a lack of awareness of general health issues in the specific local context. Therefore, health organisations find themselves increasingly faced with the specific vulnerability of migrants who run a greater risk of not receiving adequate service in diagnosis, care and prevention because of their minority status, their socio-economic position, communication difficulties and lack of familiarity with health systems.

Key challenges for health service providers are:

- How do we make health care services accessible, responsive and appropriate to all patients?
- How do we ensure that health care services are effectively utilised?
- How do we ensure that health care staff have the appropriate skills and knowledge to deliver sensitive and equitable services?
- How do we reduce health-related inequalities in access, quality and outcomes.

Here, the role of the Task Force is to support member organisations in this process of developing policies, systems and competences for the provision and delivery of equitable and accessible health care services for migrants and other vulnerable groups.

Project rationale

From its inception the TF MFCCH, consisting mainly of health professionals and managers, struck up a strong alliance with the world of research dedicated to the study of health care for migrants, culminating in the TF participating in the Action HOME and ADAPT[4], two projects financed by COST, a European body focusing on research. In this context many meetings were held with a strong scientific bias aimed at analyzing existing research and policies in order to identify the challenges facing health services and the policies required to deal with migrants' health needs. The outcome of these meetings was the emergence of a consensus among professionals and researchers regarding the challenges that arise and the measures needed to:

- improve monitoring of the health of migrants and ethnic minorities;
- improve entitlements to health care and access to services;
- develop good practices to promote appropriate care and interventions;
- improve the participation of migrants and ethnic minorities in policy development and health services.

These policy measures are well known and there is a general consensus that they are required to enable health-care organisations to accommodate diversity. However, many remaining obstacles prevent the transformation of this knowledge into action. A number of countries in Europe have adopted national policies on migrant and ethnic-minority health care but the pace of implementation is very slow. In an analysis of reports from health-policy experts in 25 European countries, Mladovsky et al (2012) shows that, by 2009, only eleven countries had progressed beyond establishing statutory or legal entitlement to care to national policies to improve migrants' health. These reports clearly demonstrate that, even in those few countries where policies have been translated into action, there is both a wide disparity in the policy measures adopted and very little evidence about which initiatives are actually effective.

The idea of developing standards therefore originated from the need to acquire better evidence regarding the effectiveness of policy measures that address the health needs of migrants and ethnic minorities. To accomplish this task, it was necessary to both define effective criteria for responding to diversity in the new context of migration and develop a

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[4] COST Action HOME "Health And Social Care for Migrants and Ethnic Minorities In Europe" (2007-2011); COST Action ADAPT "Adapting European health systems to diversity" (2012-2015)

tool for assessing the effectiveness of the criteria. To this end, the TF started a new project to develop a tool that made it possible for health-service providers to monitor and measure their capacity to ensure equitable care and implement improvements. The final product will be a self-assessment tool that allows all professionals in healthcare organizations to carry out their own equity evaluation against a set of standards and to stimulate development.

Developing explicit, actionable and measurable equity standards can both be a crucial mechanism for operationalizing strategic commitments to equity in health care delivery and can enhance quality improvement and performance measurement initiatives as drivers of change. This process is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of an action plan, implementation and subsequent evaluation.

The conceptual framework

Over the past 50 years immigration and the nature of diversity has changed dramatically. Since the early 1990s there has been a marked rise in net migration and a diversification in countries of origin. Today, in comparison with the large migrant groups that characterised post-war migrations from the 1950s to the 1970s, new immigrant groups are smaller, more socially stratified, less organised and more legally differentiated.

If we take one European country we find increasingly smaller groups of migrants from new source countries alongside long-standing ethnic groups. The presence of many small national groups is even more evident at a local level where contact with health and social services takes place. Not only are there many different groups that need to be taken into account, but the differences within these groups may be even greater than the differences between one group and another. This new migration has brought an increased differentiation of diversity, and not just in terms of involving more ethnicities and countries of origin, but also with respect to a number of significant variables that affect inclusion or exclusion (Vertovec, 2008).

In this new situation the very idea of diversity, which originally related to small numbers of relatively homogeneous ‘ethnic groups’, has radically changed to include other dimensions of diversity such as immigration status, gradations in rights and entitlements, migration history, and socioeconomic status. Consequently, multicultural approaches to health care service provision do not seem capable of ensuring equitable care for the most vulnerable groups (Chiarenza, 2012). Nor do they seem able to respond to multiple-diversity needs, as individual needs are expressed by the intersection of differences such as origin, class, gender, age, ability, and other social distinctions (Yuval-Davis, 2006).

Changes in the target groups and in the dimensions of diversity led the TF MFCCH to consider a new approach to health care provision which could effectively reduce inequities in health and health care. The development of standards is a way to reflect this new approach and to support health care organisations facing these challenges. Existing standards often focus on specific target groups, risking of creating inequalities and incoherence between certain target groups, and of stereotyping some of these groups more then others. Furthermore, in practice, problems arise from the need to both accommodate all categories of difference and acknowledge the realities of people who have more than one risk factor of discrimination. Indeed, for healthcare organisations to deal with all kinds of differences effectively, they need to focus not only on one, but on all of the often-overlapping grounds or layers of vulnerabilities. The aim of the equity standards is to improve current ways of tackling inequalities in healthcare organisations by focussing on all kinds of differences. A focus on differences favours a case-by-case assessment of the needs of people who come in contact with healthcare organisations, regardless of which kinds of social characteristics they bring with them (Cattacin, Chiarenza & Domenig, 2013).

The changing environment made it necessary to identify new criteria of diversity responsiveness for the development of standards:

- **A new definition of the target group**. In addition to migrant and minority ethnic groups, the target of health equity activities must include all socially excluded or vulnerable groups at risk of inequities in health and health care.
- **A new definition of the dimensions of diversity**. This cannot be expressed by single variables like culture, language, ability, age, gender or legal status, but must include the dynamic intersection of all variables that can lead to marginalisation, social exclusion, deprivation, and disempowerment.
- **A new definition of effective policy measures**. Full responsiveness to diversity cannot be achieved by the implementation of policy measures focussing only on single target groups (migrants and ethnic minorities, people with disabilities, LGBT,…), but they must address all contributing factors that put vulnerable groups at risk of exclusion.

Presentation of the standards

In developing the equity standards, the project group identified five main areas that should be addressed to ensure the delivery of equitable services in healthcare:

Standard 1: Equity in Policy

Standard 2: Equitable Access and Utilisation

Standard 3: Equitable Quality of Care

Standard 4: Equity in Participation

Standard 5: Promoting Equity

1. The first standard, **Equity in Policy**, aims to promote equity by providing fair opportunities, reducing health inequities, and delivering sustainable and cost-effective policies. This standard aims to ensure the creation of an equity strategy and to mainstream the implementation of equity in all relevant organisational programmes and quality management systems. Therefore all monitoring systems and evaluation processes should reflect and support measures of equity policy. Moreover, an on-going workforce development should be promoted in order to allow for a deep institutional change towards equity, especially in adopting measures that create awareness of the impact of inadequate access and discrimination.

2. The goal of the second standard, **Equitable Access and Utilisation**, is to encourage health organisations to address barriers that prevent people from accessing and benefiting from health care services. On the one hand, there is a need to ensure physical accessibility and geographical distribution of services and facilities, including outreach interventions for the most disadvantage populations. On the other, there is a need to improve communication and information though effective interventions. Concerning language barriers, much has already been done which needs to be consolidated and maintained, however more attention should be given to information interventions that address health literacy. This standard encourages health organisations to address other barriers, which are more difficult to overcome, such as the power imbalance in patient-doctor communication, improving trust, respect, openness and empathy in the relationship with the patient. Other difficult barriers include legal and financial ones, which depend on rules outside health care services, such as lack of formal entitlements or insurance coverage. However, this standard encourages health care organisations to

take action where eligibility rules compromise human rights, suggesting that concrete solutions be provided to ensure that ineligible people receive appropriate information, care and support.

3. The aim of the third standard, **Equitable Quality of Care**, is that the organisation provides high quality, person-centred care for all, always acknowledging the unique characteristics of the individual and acting on these to improve individual health and wellbeing. Health providers should be able to take individual experiences and opinions into account in the co-construction of the care process, from diagnosis to discharge. Therefore, in the case of migrants, no simple knowledge-based training in which providers are taught the customs and values of particular ethnic minority cultures can prepare professionals to adequately respond to the needs that multiple diversity creates. Instead, health staff at all levels are encouraged to learn to work across differences and to invest in the relationship with the other in order to produce knowledge. In this approach, only the patient is uniquely qualified to help the health provider understand the intersection of race, ethnicity, gender, religion, class and to clarify the relevance and impact of this intersection in relation to the present illness experience.

4. The fourth standard, **Equity in Participation**, aims to ensure equitable opportunity for service users and community members to participate in service planning, delivery and evaluation. Promoting active participation does not mean liaising exclusively with well-organised community groups who may not be able to represent individual needs or the needs of the smaller, less well-organised, or completely marginalised groups. By assuming that ‘community groups’ are always homogenous entities whose members share interests, values and identities, we risk neglecting the fact that differences within communities pertaining to gender, ethnicity, religion, economic status, etc., can engender relationships which isolate certain individuals, denying them equal say or even access to participation. Therefore, this standard primarily aims to ensure the participation of those individuals and social groups at risk of being excluded in mainstream involvement activities.

5. The fifth standard, **Promoting Equity**, encourages engagement by the organization to promote equity activities in other sectors of society. Organizations should actively participate in networks, think tanks and research initiatives related to equity, such as partnerships to deliver innovative services to disadvantaged populations and inter-sectoral collaborations to address the wider determinants of health.

First pilot-test: assessing the standards

In 2011 a set of Preliminary Equity Standards were developed by an international project group: Elizabeth Abraham, Marie Serdynska (Canada), Antonio Chiarenza, (Italy), Bernadette Nirmal Kumar, Christopher Le, Ragnhild Spilker (Norway), Manuel Santina Vila, Manuel Garcia Ramirez (Spain), James Glover (UK), Manuel Gonzales Fernandez (Sweden), Marie-Louise Essink-Bot, Conny Seeleman (The Netherlands), with the contribution of the following experts: David Ingleby (The Netherlands), Sandro Cattacin and Dagmar Domenig (Switzerland).

The process for the developments of these preliminary standards included a number of steps: the review of existing models and standards, the development of a conceptual model and the identification of the main domains for assessing equity in health care. These domains were then divided in sub-standards and for each substandard a number of measures were identified. These preliminary standards were piloted between April and October 2012 in 45 health care organizations: 5 in Australia, 10 in Canada, and 30 in Europe. The aim of the pilot–test was to evaluate **clarity**, **relevance** and **applicability** of the standards in pilot-organisations. For data collection a review form was used to assess ratings of measurable elements and to collect comments and suggestions for improvement.

The overall evaluation process was positive and provided important indications for the revision of the standards from pilot institutions. With regard to clarity, improvement has been suggested to wording and structure, as well as the need for explanation of controversial terms. For example, changes in the terminology, the emphasis used, the order and internal coherence of measurable elements. Concerning relevance a need for some revision of the proposed measurable elements was highlighted. It was suggested that new issues be introduced, such as equity policy for staff recruitment and careers; informed consent, health literacy as well as to include family members when person-centred care is addressed. Comments on the applicability of the standards provided important indications for effective implementation of the tool in health care organisations, with regards to national legislation, health systems organisation and socio-political contexts. Concerns have been raised on possible conflict with local norms and values, existing processes and resource restraints. For example, lack of favourable legislation or limitations imposed by existing legislation, as in the case of collecting user data; the clash with existing assessment systems or influential health reforms and the political climate. Finally, it has been stressed how important it is to explicitly state guiding concepts and ideas that underlay the whole philosophy or construction of the standards, such as defining the target group, diversity, community, culture and the general structure of the tool.

Standards Implementation: purpose, phases and roles

Second pilot-test: implementing the standards

The findings of the first pilot-test suggested important next steps to facilitate the implementation and dissemination of the standards to a wider global audience. The next phase of the equity standards project includes activities to:

- Strengthen the evidence base of the standards;
- Identify equity-based indicators that complement the five standards;
- Develop a self-assessment tool that health care organisations can use to benchmark structures, processes and results related to health equity;
- Undertake a second pilot-test to evaluate how institutions can utilize the standards and self-assessment process, as well as to explore challenges and opportunities for effective uptake in connection with existing policies and practices.

The Task Force invites health care institutions from around the world to participate in the pilot-test implementation of the standards. Participants will be able to:

- Complete the self-assessment tool to benchmark organizational performance on each of the standards;
- Select equity-based indicators useful to their own organisation to assess progress against the standards and assess the current or potential availability of data sources to enable reporting on the indicator;
- Analyse the results of the self-assessment to identify areas of improvement in each of the standards areas;
- Select one or two areas of improvement for the development of a draft plan to achieve a quantifiable improvement.

The period of activity for this process is March to October 2014. Participating organizations will be required to organize and brief their teams on the process in March 2014, with the self assessment and analysis period taking place from April – June, and improvement plan development and final submission taking place by 31st October 2014.

It is not the purpose of the pilot implementation to assess individual hospitals or health services. However, information about individual organisation's actual compliance with standards will be important to identify applicability and relevance of the self-assessment tool itself. This information will be used by the TF MFCCH to improve the tool. The data will not be communicated to other parties and the analysis will be anonymous.

Phases of implementation (March - October 2014)

Phase 1: ***Preparation (March – April 2014)***

National coordinators identified, pilot organisations selected, project leaders engaged, all documentation prepared, sent-out, translated and staff involved and briefed about the project.

Phase 2: ***Assessment of standards compliance (April-June)***

Standards compliance being assessed using the self-assessment tool by a multidisciplinary Assessment Team who is responsible for assigning a score to all measurable elements.

Phase 3: ***Selection of performance indicators (April-June)***

1 to 3 indicators are selected from the sample or from indicators already in use at local level, or developed according to local priorities. Detailed description of the indicators selected is provided: rationale; numerator; denominator; data source. (Descriptive sheet)

Phase 4: ***Reporting the assessment results (July)***

The project leader fills in the online evaluation form provided by the TF MFCCH. This form will gather results from the assessment of standards compliance and the selected indicators.

Phase 5: ***Identification of improvement areas (July-August)***

Based on the assessment of compliance with standards and selected equity indicators, the project leader, together with the assessment team, will identify areas of improvement in each of the standards areas. (Documentation sheet)

Phase 6: ***Development of action plan (September-October)***

The project leader, together with the assessment team, will select one or more areas of improvement for the development of a draft plan to be submitted to the organisation management. (Template)

Phase 7: ***Reporting the description of improvement actions (End of October)***

The project leader fills in the online evaluation form provided by the TF MFCCH. This form will gather results from the evaluation of improvement areas, as well as description of the improvement plan.

Roles and Responsibilities

Role of the TF MFCCH coordinator

1. Produce the working material for the pilot implementation
2. Encourage countries and health care organisations to participate in the pilot implementation;
3. Identify coordinators at regional and national levels;
4. Coordinate the pilot test implementation in the participating countries;
5. Provide for instructions and tools for pilot testing;
6. Collect data from pilot-organisations;
7. Support participation and to analyse the results sent to TF MFCCH using the online evaluation form;
8. Provide feedback to pilot-test organisations;
9. Organise workshops for dissemination of outcomes

Role of the regional /national coordinator

1. Identify and contract with 5 to 10 test hospitals / health services in each country, depending on the size of the country and situational factors. Institutions of a different size and with an appropriate geographic distribution should be selected.
2. Provide guidance to organisations taking part in the pilot test implementation and to provide feedback on the results.
3. Translate the test material into the national language, where necessary.
4. Ensure that pilot-organisations feed in data in the online evaluation form.

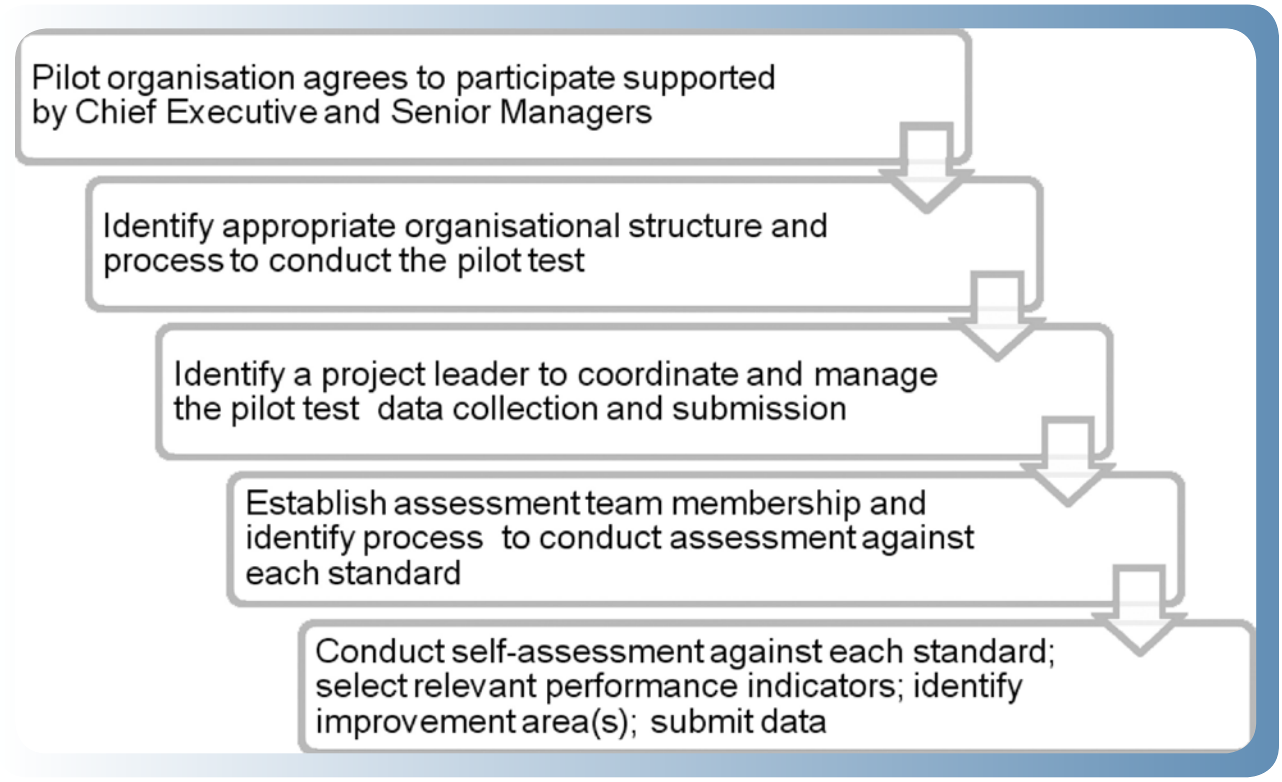
Role of the pilot organisations

1. Identify appropriate **organisational structure and process** to conduct the pilot test.
    - Organisations may already have appropriate mechanisms in place that will support the implementation of the pilot test (e.g.: quality, equity, diversity, user engagement bodies, ...).

  - Essential to the success of this project is the commitment of the chief executive, governing body and senior managers of the health care organisation, to ensure the implementation of the pilot test and to release the necessary resources to undertake the task.

2. Identify a **project leader** to manage the pilot-test and data collection process and complete the online evaluation form.
   - It is crucial that a project leader within the health care organisation is appointed to lead the process and support other staff in carrying out the self-assessment. Ideally, this person may already be responsible for the 'Equality and Diversity' programme or other 'migrant-friendly' initiatives in the organisation as the project needs to be run as any other equity/quality improvement activity.
3. Establish an **assessment team** to oversee the assessment process. To enable assessment against the 5 standards a broad membership is suggested. For example, a combination of the following staff could be involved in the assessment team:
   - Hospital/health service management, and staff representatives (nurses, medical doctors, administrative staff).
   - Representatives from specific relevant departments/professionals such as quality management, human resources, communication, community health, social work, health promotion.
   - Representatives of service users and the community, selected to ensure coverage of target vulnerable groups.
   - A lead person may be nominated for assessment against one standard or more lead persons may be responsible for more than one standard.
4. The **assessment team members** implement the following tasks:
   - Conduct the self-assessment.
   - Select relevant performance indicators.
   - Use the results to identify areas of improvement for each standard and contribute to an overall equity improvement plan for the organisation.
   - Forward data to project leader.

The pilot process is demonstrated below in Figure 1.



Pilot organisation agrees to participate supported by Chief Executive and Senior Managers

Identify appropriate organisational structure and process to conduct the pilot test

Identify a project leader to coordinate and manage the pilot test data collection and submission

Establish assessment team membership and identify process to conduct assessment against each standard

Conduct self-assessment against each standard; select relevant performance indicators; identify improvement area(s); submit data

Figure 1

Data collection

Data needs to be collected to assess compliance with the standards, to select performance indicators and to evaluate areas of improvement.

Standards

Regarding data collection to assess standards, the self-assessment tool contains for each standard and substandard a number of measurable elements and indicates evidence that may be used to assess the standard as being **fully, mostly, partially, hardly or not fulfilled**.

- **Fully**: The organisation has implemented the relevant element.
- **Mostly**: The organisation has implemented many of the relevant element.
- **Partly**: The organisation has implemented some of the relevant element.
- **Hardly**: The organisation has implemented few of the relevant element.
- **No**: The organisation has not implemented the relevant element.

Pilot organisations should note that very few organisations will be at a "fully implemented level" for many of the measures. Therefore, the Self-Assessment Tool is a means for organisations to begin a journey towards greater equity in healthcare.

N.B. Results of the assessment of compliance with the standards must be fed into the online evaluation form by July 2014.

Indicators

Sample indicators are provided for each of the five standards as a guide for organisations. These sample indicators reflect the overall standard they are related to. Furthermore, indicators should relate to outcomes (process/output), i.e. results that could be achieved if compliance with a standard had been in place consistently. Organisations are invited to select 1 to 3 indicators either from indicators already in use in their organisation or from the sample indicators provided, or newly developed according to local priorities. Organisations should clearly specify and describe which indicators they would use to the same degree of detail as for the sample indicators already included in the self-assessment tool.

N.B. Results of the selection of indicators must be fed into the online evaluation form by July 2014.

Areas of improvement

The assessment team is asked to identify areas of improvement for each standard based on the assessment of compliance with standards. A documentation sheet is provided for organisations to collect information on areas of improvement identified and also to identify both the hindering and facilitating factors (Policy, Legislative, Organisational, Administrative/Economic).

N.B. Results of the evaluation of improvement areas must be fed into the online evaluation form by September 2014.

Action plan

When the self-assessment is completed, the assessment team will be able to select one or more priority areas for development where the health organisation has self-identified that it is not meeting the standards or sub-standards.

An action plan can then be developed to address those issues and should be outlined using the Template provided. A framework model for the improvement plan is available from the Task Force sub-site on the HPH Network website: www.hphnet.org - e.g. STAKEHOLDERS GAPS, SWOT analysis (organisations are, however, free to use this model or others that are more familiar to them, as preferred) - . It is important that actions on the plan relate to local priorities or targets and the health organisation's own available resources. The action plan should also be integrated into the existing management system of the organisation to monitor development.

The aim of the pilot-test is not to evaluate the validity of the action plan, but to facilitate its implementation at a local level, connecting the assessment process to continuous improvement, enabling organisations to address and improve equity performance beyond the pilot-test phase.

N.B. Description of the action plan (s) must be fed into the online evaluation form by end of October 2014.

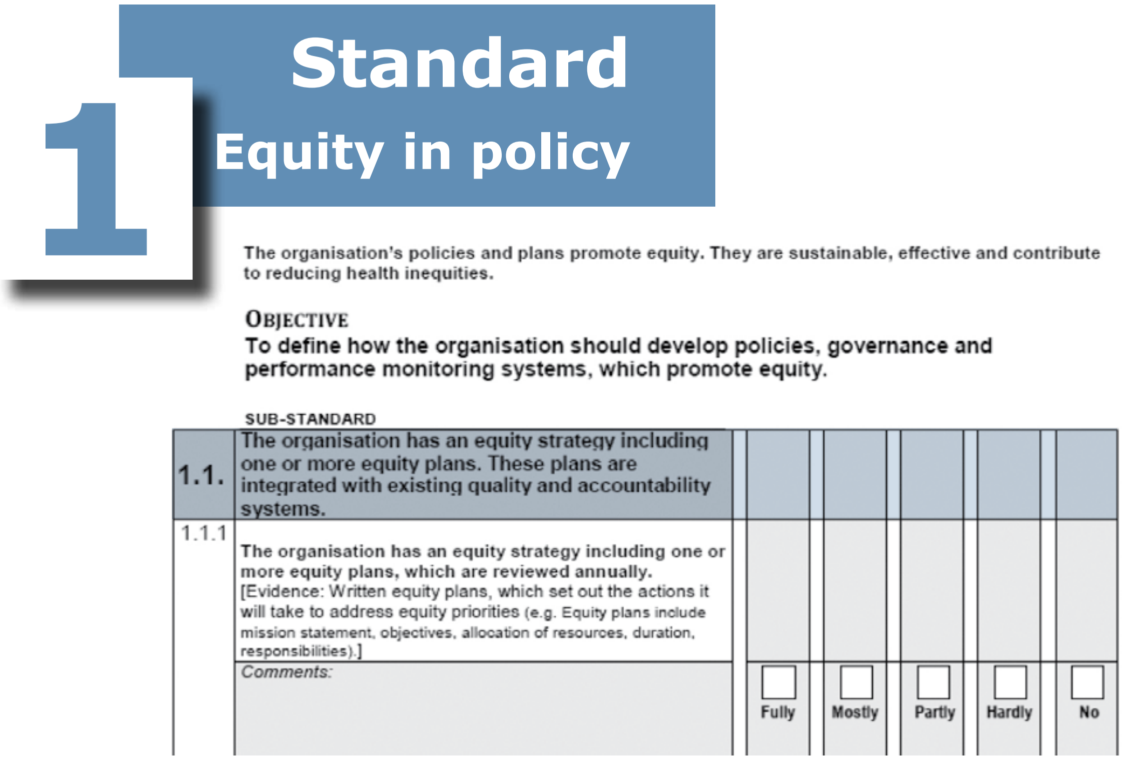
Feedback on the pilot test

At the end of the process the project leader, together with the assessment team, is asked to provide feedback on the pilot test by responding to a brief questionnaire.

N.B. Feedback on the pilot test must be given using the online questionnaire by end of October 2014.

Structure of the standards

Each **standard** has a set of **sub-standards**, and each sub-standard has one or more **measurable elements**, which require an answer of ‘Fully, Mostly, Partly, Hardly or No’. **Demonstrable evidence** is required to show compliance with the sub-standards. **Examples of evidence** against which sub-standards may be evaluated have been added in square brackets. A box for **comments** is located next to the measurable elements where problems, goals, responsibilities, details on evidence and follow-up actions must be documented. This qualitative information provides important background for the identification of areas of improvement and the development of the action plan.



1 Standard

Equity in policy

The organisation's policies and plans promote equity. They are sustainable, effective and contribute to reducing health inequities.

OBJECTIVE
To define how the organisation should develop policies, governance and performance monitoring systems, which promote equity.

SUB-STANDARD

1.1.	The organisation has an equity strategy including one or more equity plans. These plans are integrated with existing quality and accountability systems.					
1.1.1	The organisation has an equity strategy including one or more equity plans, which are reviewed annually. [Evidence: Written equity plans, which set out the actions it will take to address equity priorities (e.g. Equity plans include mission statement, objectives, allocation of resources, duration, responsibilities).]					
	Comments:	☐ Fully	☐ Mostly	☐ Partly	☐ Hardly	☐ No

Main standards. The main standards address the main domains identified: Equity in Policy; Equitable Access and Utilisation; Equitable Quality of Care; Equity in Participation; Promoting Equity.

Sub-standards. Sub-standards operationalize the main standard and break it down into its principle components. The number of sub-standards per standard main vary from 1 to 5.

Measurable elements. Measurable elements are those requirements of the sub-standard that will be reviewed and assessed to be Fully, Mostly, Partly, Hardly or Not fulfilled. The measurable elements simply list what is required to be in full compliance with the standard. Listing the measurable elements is intended to provide greater clarity to the standards and help organisations educate staff on standards and prepare for the self-assessment process.

References

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Using the Self-Assessment tool

The self-assessment process

Main steps of the self-assessment process:

1. General information of the pilot organisations is collected.
2. The assessment team is established and the relevant workload documented.
3. Compliance with the standards is measured by assigning a score to the level of implementation of a list of measurable elements.
4. 1-3 indicators useful to the organization to assess progress against the standards and assess the current or potential availability of data sources are selected and described.
5. Areas for improvement for each of the 5 standards based on the information gathered through the assessment process are identified and described.
6. An action plan addressing at least one priority area among the ones identified through the assessment is developed and described.
7. Feedback on the pilot test is provided.

General information about your institution

Questions	Answers / answer categories	Your Comments
COUNTRY		
ORGANISATION	Name of organisation: Name of corporate organisation (if applicable): City/town: Postal code: Province/Region/County:	
Contact information	☐ Keep contact information confidential Name of contact person: Postal address: E-mail address: Phone (include country code):	
What HPH network does your institution belong to (if applicable)	HPH National Network: HPH Regional Network:	
What type does your institution belong to	☐ Large integrated Health Authority ☐ General hospital ☐ Specialized hospital (e.g. children's hospital, psychiatric hospital) → *if yes, which specialization:* ☐ University/Teaching hospital ☐ Health Centres (e.g. rehabilitation clinic, nursing home, hospice) → *if yes, specify:* ☐ Community health and Social centre (e.g. health promotion centre, health literacy, social centre,…) → *if yes, specify:* ☐ Other type → *if yes, specify:*	
Who is the owner / provider of your institution	☐ Public, state / region ☐ Private owner, non-profit ☐ Private owner, for profit ☐ Other type → *if yes, specify:*	
What is the catchment area of your organisation	☐ Region ☐ City/town/municipality ☐ Mixed area ☐ Other type → *if yes, specify:*	
Please describe your organisation in figures:	☐ **Hospitals and health services:** ☐ Number of beds ☐ Number of inpatients admissions last year ☐ Number of outpatients visits last year ☐ Number of Emergency visits last year ☐ Number of FTE staff ☐ **Community health and social services:** ☐ Number of clients last year ☐ Number of visits last year ☐ Number of FTE staff	

Questions	Answers / answer categories	Your Comments
A wide range of factors can create barriers to accessing good quality health care. A number of these are listed here. Which of these factors does your organisation regularly need to take account of in its attempts to provide equitable care? Please give an indication of their relative importance.	☐ Childhood ☐ Adolescence and youth ☐ Old age ☐ Gender (male, female, transgender) ☐ Sexual orientation (LGBT) ☐ Class (occupation and employment status) ☐ Economic situation (income, wealth and poverty) ☐ Housing and geography (deprived or underserved areas) ☐ Migrant status (e.g. legal migrant, asylum seeker, refugee, newcomer) ☐ Lack of entitlement to healthcare (e.g. undocumented migrant and uninsured) ☐ Ethnicity and race ☐ Country of origin/birth ☐ Aboriginal or indigenous origin ☐ Religious affiliation ☐ Language proficiency ☐ Low information and health literacy ☐ Disability (physical, sensory, intellectual) ☐ Specific health situation (mental health problem, HIV/AIDS, obesity, ..) ☐ Substance addiction (alcohol, drug, …) ☐ Other factors → *if yes, specify:*	
If you have checked any of these factors, are there specific combinations of them which put individuals at a particularly high risk of receiving inequitable care?	1. ☐ . ☐ . ☐ . ☐ . …….. 2. ☐ . ☐ . ☐ . ☐ . …….. 3. ☐ . ☐ . ☐ . ☐ . ………	

Assessment team members

Role in the project	**Title** **(e.g. Head of service, MD, Nurse, …)**	**Organisation/ Department** **(internal / external)**

Project leader		

1

Standard

Equity in policy

The organisation's policies and plans promote equity. They are sustainable, effective and contribute to reducing health inequities.

OBJECTIVE

To define how the organisation should develop policies, governance and performance monitoring systems, which promote equity.

SUB-STANDARD

1.1.	**The organisation has an equity strategy including one or more equity plans. These plans are integrated with existing quality and accountability systems.**					
1.1.1	**The organisation has an equity strategy including one or more equity plans, which are reviewed annually.** [Evidence: Written equity plans, which set out the actions it will take to address equity priorities (e.g. Equity plans include mission statement, objectives, allocation of resources, duration, responsibilities).] *Comments:*	☐ Fully	☐ Mostly	☐ Partly	☐ Hardly	☐ No
1.1.2	**The equity strategy is included in the overall strategy of the organisation.** [Evidence: The overall strategy makes specific reference to equity strategy (e.g. The equity strategy has equal weight to quality improvement and risk management objectives and is integrated with them).] *Comments:*	☐ Fully	☐ Mostly	☐ Partly	☐ Hardly	☐ No
1.2.	**The organisation's research, monitoring and evaluation systems measure equity performance.**					

1.2.1

The organisation collects data on the way people access its services to understand how service utilisation patterns reflect the demography and meet the needs of its client population. [Evidence: Data are available about who is and who is not using its services according to the same need (e.g. Compare data on access of service users with statistics about social stratification, gender, nationality, origin, religion, aboriginal, ethnicity, disability and age breakdown of the population).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

1.2.2

The organisation collects or has access to data on the health status and inequalities in its client population. [Evidence: Data or information is available about the health needs of relevant populations, which allow health inequalities to be identified (e.g. Epidemiological and socio-demographic data in relevant areas/districts and target population groups; Quantitative and qualitative information).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

1.2.3

The organisation uses this data to continually improve equity in the accessibility and quality of health care. [Evidence: Evidence-based outcomes showing service equity improvements (e.g. Documented variation in the number and range of individuals accessing a diabetes or asthma clinic).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

1.3. The organisation should ensure that its plans, policies and decisions promote equity in all aspects of its activities.

1.3.1

The organisation has procedures in place to evaluate the impact of its plans, policies and decisions on equity. [Evidence: Document setting out its process and tools for carrying out equity audit or impact assessment (e.g. Health Equity Audit; Equity Impact Assessment Tool; Evaluation reports showing equity data).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

1.3.2

The organisation's leaders and decision makers actively promote and support equity in their work. [Evidence: Equity is included in performance management arrangements for all leaders and decision makers (e.g. Guidance for managers requires them to have at least one performance indicator, which addresses equity).].

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

1.4. The organisation ensures that staff at all levels, improve awareness, acquire knowledge and build capacity to address inequities in health care.

1.4.1

The organisation has a comprehensive programme for equity education. [Evidence: Education plans show appropriate training is delivered to all staff, including senior staff (e.g. The plan sets out which staff should receive basic awareness training, and which should receive more advanced training on specific equity issues).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

1.4.2

The organisation's core education and training includes learning about equity. [Evidence: Core education and training is reviewed and modified for inclusion of equity issues where this is appropriate (e.g. Equity is part of the core induction training and training updates).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

1.4.3

The organisation monitors and evaluates the effectiveness of its equity education. [Evidence: Data is available on the number of staff who has completed equity training. Mechanisms are in place to evaluate changes in staff attitudes, knowledge and skills (e.g. Credit system for on going learning and professional development; Pre and post-assessment of training; Patient feedback, Complaints or other similar sources to evaluate training).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

1.5. The organisation’s workforce policies and practices are fair and equitable, and respect for the dignity of all staff and volunteers is promoted.

1.5.1

The organisation’s workforce policies ensure equal opportunities in recruitment, selection, career advancement, workplace benefits and other aspects of employment, for all existing and potential employees. [Evidence: Workforce policies have been impact assessed; policies explicitly include measures to improve equity for disadvantaged or under-represented groups (e.g. Copies of impact assessments of employment policies; extracts from policies showing reference to specific groups such as women, disabled people, people of different sexual orientations).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

1.5.2

The organisation actively promotes dignity and respect at work, for staff and volunteers. [Evidence: The organisation has a Dignity at Work Policy or similar which includes specific measures to protect staff and volunteers from bullying, harassment and discriminatory behaviour (e.g. The policy includes measures to eliminate sexual harassment, racist or homophobic abuse and other behaviour which breaches the dignity of staff and volunteers).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

Selection of indicators to complement standard 1

Select 1-3 indicators, useful to your organization to assess progress against the standard and assess the current or potential availability of data sources, either from indicators already in use in your organisation, or newly developed according local priorities, or from the sample indicators provided.

The selection or development of indicators should be guided by the following questions:

1. How can the indicator be chosen to relate to the overall standard?
2. Is it important (in terms of equity impact)?
3. Is it useful for equity (quality) improvement?
4. Is it scientifically sound (reliable, valid, sensitive, specific)?
5. What is the burden of data collection?
6. How can the indicator be described (rationale, numerator, denominator, data source)
7. How can the data for the indicator be collected (routine data, survey methods, audit)?

Equity in Policy (Descriptive sheet)

Indicator	Description	Numerator	Denominator	Data source
1.	•	•	•	•
2.	•	•	•	•
3.	•	•	•	•

Sample Indicators

Indicator	Description	Numerator	Denominator	Data source
% of indicators with an equity focus in the organisation performance measurement system	• Promote the integration of equity indicators into quality improvement processes.	• Number of indicators with an equity focus included in the regular reporting activity on performance measurement.	• Total number of performance indicators	• Audit process and plan. • Service performance and quality data.
% of equity targets in the organisation incentive policy.	• Promote the integration of equity targets into staff incentive policy.	• Number of equity targets in performance-based incentive policy for managers/staff remuneration policy	• Total number of targets on which the incentives policies are based.	• Audit process and plan.
% of staff trained on equity assessment, planning and improvement.	• Increase staff capacity to provide equitable, accessible and responsive services.	• Number of staff (including senior management) who have participated in equity training in the last twelve months.	• Total number of staff (including senior management) employed within the organization.	• Organizational training policies. • Audit of internal and external professional development activities planned, provided, evaluated by organization and undertaken by staff.
% of management reflecting the diversity characteristics of the service area demographic profile.	• The organization monitors the extent to which managers reflect the diversity of the area the organization serves.	The number diversity characteristics of the service area reflected in the organization's management personnel.	The four specified diversity characteristics: 1. Gender 2. Ethnicity 3. Country of origin 4. Religion or belief	• Demographic profile of population, staff, employees and management. • Recruitment policies and practices.

Description of areas for improvement

Standard 1: Equity in Policy (Documentation sheet)

	Action needed	Hindering factors	Facilitating factors
Overall STD			
SubSTD 1.1.			
SubSTD 1.2.			
SubSTD 1.3.			
SubSTD 1.4.			
SubSTD 1.5.			

Factors relating to policy, legislative, organisational or economic issues may be considered.

Workload of the assessment team for standard 1

Title (e.g. Head of service, MD, Nurse, ...)	**Organisation/ Department** (internal / external)	**Hours dedicated to complete assessment**

2 Standard
Equitable access and utilisation

The organisation promotes equitable access to and utilisation of services.

OBJECTIVE

To encourage the health organisation to address barriers which prevent or limit people accessing and benefiting from health care services.

SUB-STANDARD

2.1.	**The organisation strives to provide equitable access to and availability of health services.**					
2.1.1	**The organisation continually seeks to identify and monitor access barriers to its services.** [Evidence: Data collection to identify and monitor barriers, which prevent or discourage people from making use of services (e.g. Access or architectural audits for buildings; Language needs assessments; Information material audits; Findings from impact assessments).]	☐ Fully	☐ Mostly	☐ Partly	☐ Hardly	☐ No
	Comments:					
2.1.2	**The organisation has minimised architectural, environmental and geographical barriers to its facilities.** [Evidence: Formal procedures or policy for ensuring that buildings and facilities are assessed for their accessibility and geographical distribution (e.g. Clear signs and directions; Welcoming environments; Diversity friendly; Wheelchair accessible; Facilities are close to public transport; Services are provided to rural areas).]	☐ Fully	☐ Mostly	☐ Partly	☐ Hardly	☐ No
	Comments:					

2.1.3

The organisation ensures access to care for marginalised and disadvantaged people. [Evidence: Formal procedures for ensuring access to available services for the more disadvantaged people or people at risk of discrimination (e.g. Drop-in primary health care unit based in hospital, Care pathways for HIV/AIDS patients or disabled patients; Access to appropriate addiction treatment services; Use of case management workers).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

2.1.4

The organisation provides outreach communication to marginalised and disadvantaged people. [Evidence: Relevant information about available outreach services; Evidence of how well these are used (e.g. Meetings with hard to reach groups; Information on services for refugees, and asylum seekers, aboriginal peoples, sex workers, homeless people, LGBT; Mobile clinics).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

2.1.5

The organisation evaluates the impact of interventions and programmes targeting reduction of access barriers. [Evidence: Quantitative and qualitative evaluation of intervention outcomes; Assessment criteria are identified (e.g. Pre and post evaluation of implemented measures; Enhanced satisfaction experienced by patients and carers).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

2.2. The organisation continuously develops, implements and monitors initiatives to reduce communication and information barriers.

2.2.1

The organisation provides easily understood written material and navigational signs taking into account health literacy level and language of patients. [Evidence: Policy and/or standards for translation and communication with patients and the public (e.g. Procedures for involving users in developing written materials; Guidelines for written communication; Support with internet based health information; Information about preventive services and health education programmes; Navigation support services; Use of Community Health Educators).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

2.2.2

The organisation has a clear policy setting out how it will ensure that patients and carer can communicate with health services staff where language may be a barrier. [Evidence: Written policy on interpretation, translation, intercultural mediation and communication support (e.g. Guidelines for staff in organising interpreters or communication support; Eligibility criteria for accessing interpreting or intercultural mediation services).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

2.2.3

The organisation accommodates the communication needs of patients with hearing, visual, cognitive and speech impairments [Evidence: Written policy on interpretation, translation and communication support (e.g. Support for patients with reading and writing disorders and mental and physical disabilities).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

2.2.4

The organization monitors and evaluates the performance and quality of communication support services. [Evidence: Documentation for tracking volume increase; Performance records of interpreting provision; Qualification criteria for interpreters; Defined criteria for interpreting quality; Defined interpreting code of conduct (e.g. Patient and staff surveys addressing awareness, satisfaction, resources, and perceived needs; Evaluate the advantages and disadvantages of using the service; Competence standards for interpreters).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

2.2.5

The organisation ensures staff ability to work with interpreters and other communication support staff. [Evidence: Training for staff about how to work with interpreters (e.g. Pre-post assessment to evaluate impact of training; Involving an interpreter in induction training for new staff; Promoting the interpreting service in internal communications).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

2.3. The organisation is able to ensure that healthcare is provided where eligibility rules or lack of insurance compromises human rights.

2.3.1

The organisation monitors situations where people are unable to access services because of lack of eligibility. [Evidence: Information and data collection about people who are ineligible for health care (e.g. System to identify and keep track of people who are ineligible for financial or legal reasons, such as non-insured people; undocumented migrants; asylum seekers).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

2.3.2

The organisation provides appropriate support for people who are ineligible or lack insurance for services. [Evidence: Concrete solutions to ensure that ineligible people receive appropriate information, care and support (e.g. Informal provision of health care; Referral to local civil society groups or NGOs; Services for irregular migrants where legislation permits this).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

Selection of indicators to complement standard 2

Select 1-3 indicators, useful to your organization to assess progress against the standard and assess the current or potential availability of data sources, either from indicators already in use in your organisation, or newly developed according local priorities, or from the sample indicators provided.

The selection or development of indicators should be guided by the following questions:

1. How can the indicator be chosen to relate to the overall standard?
2. Is it important (in terms of equity impact)?
3. Is it useful for equity (quality) improvement?
4. Is it scientifically sound (reliable, valid, sensitive, specific)?
5. What is the burden of data collection?
6. How can the indicator be described (rationale, numerator, denominator, data source)
7. How can the data for the indicator be collected (routine data, survey methods, audit)?

Standard 2: Equitable access and utilisation (Documentation sheet)

Indicator	Description	Numerator	Denominator	Data source
1.	•	•	•	•
2.	•	•	•	•
3.	•	•	•	•

Sample Indicators

Indicator	Description	Numerator	Denominator	Data source
% of adults with self-declared unmet needs for health care services in the past 12 months stratified by sex, age, country of origin/ethnicity, neighbourhood deprivation	• Identify adults who reported that they had experienced unmet need for health care service in the past 12 months due to either financial barriers (too expensive), waiting times (unable to get an appointment within 2 months) or travelling distance.	• Number of adults with medical problems who reported unmet needs for health care services in the past 12 months stratified by sex, age, country of origin/ethnicity, neighbourhood deprivation.	• Total number of adults with medical problems who sought health care services in the past 12 months stratified by sex, age, country of origin/ethnicity, neighbourhood deprivation.	• Survey
% of users identified as requiring an interpreter who received one in the last 12 months	• Quantify the number (proportion), type and specific language interpreting occasions. Including face-to-face, telephone and video interpreting.	• Number of users identified as requiring an interpreter and who received an interpreter during the last 12 months.	• Total number of users presenting at the health service identified as requiring interpreter services in the last 12 months.	• Patient language data collection • Interpreting events/occasions in organization, (by department/specialty service etc.).
% of written information appropriate to literacy level of population served	• To ensure that all new health information literature that is developed is plain language proofed and approved.	• Number of written, revised or adopted health information literature during the last 12 months that is plain language developed.	• Number of written revised or adopted health information literature developed in the last 12 months.	• Audit of health information and communication models and strategies.
% of people ineligible or uninsured accessing health care services.	• Quantify the percentage of ineligible or uninsured users/patients receiving health care services.	• Number of people ineligible/lack of insurance accessing health care services.	• Total numbers of people receiving health care services.	• Emergency department data or admission data to health care services.

Description of areas for improvement

Standard 2: Equitable access and utilisation (Documentation sheet)	Action needed	Hindering factors	Facilitating factors
Overall STD			
SubSTD 2.1.			
SubSTD 2.2.			
SubSTD 2.3.			

Factors relating to policy, legislative, organisational or economic issues may be considered.

Workload of the assessment team for standard 2

Title (e.g. Head of service, MD, Nurse, ...)	**Organisation/ Department** (internal / external)	**Hours dedicated to complete assessment**

3

Standard

Equitable quality of care

The organisation provides high quality, person and family-centred care for all, acknowledging the unique characteristics of the individual and acting on these to improve health and wellbeing.

OBJECTIVE

To support the organisation develop services that are responsive to the diverse needs of patients and families along the whole care pathway, ensuring a safe environment and continuity of care.

SUB-STANDARD

3.1.	**The assessment of the patient's needs takes into account individual and family characteristics, experiences and living conditions.**					
3.1.1	**The patient's health needs are identified according to individual/family characteristics, experience and situation.** [Evidence: Needs assessment procedures include information about individual/family characteristics and background of each patient (e.g. Health records include information such as age, language preference, health literacy level, physical ability, cognitive impairment, ethnicity, aboriginal status, religion, socio-economic status, social context).] *Comments:*	☐ Fully	☐ Mostly	☐ Partly	☐ Hardly	☐ No
3.1.2	**Patient's psychosocial needs are identified according to individual/family characteristics, experience and situation.** [Evidence: All patients are asked about psychosocial needs, and these are documented in health records (e.g. Individual/family situation and living conditions; Routine assessment of individual psychosocial functioning and vulnerability; Investigation of individual beliefs and practices).] *Comments:*	☐ Fully	☐ Mostly	☐ Partly	☐ Hardly	☐ No

3.2. The organisation's workforce is able to deliver care that takes into account individual patients' ideas and experiences of health and illness.

3.2.1

Individual and family characteristics and experience of each patient are taken into account in clinical practice. [Evidence: Equity related characteristics are integrated in clinical practice (e.g. Care plans include sensitivity to difference concerning individual patient; Guidelines are subjected to equity impact assessment developed in partnership with diverse patients).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

3.2.2

Care is considerate and respectful of the patient's dignity, personal values, knowledge and ideas about health and care. [Evidence: Patient experience feedback about dignity, respect and personal beliefs is being routinely requested by staff (e.g. Feedback about nutrition, religion and spiritual help, language assistance, pain management, rituals).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

3.2.3

The organisation has procedures for meeting the psychosocial needs of individual patients. [Evidence: Procedures for managing patients who are identified as being at risk (e.g. Guidelines for care management of vulnerable people; Systems for referral to support organisations, such as counselling or social services, Non Governmental Organisations, Victim support; Mental health or addiction services).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

3.2.4

The organization ensures that staff training includes best practice guidance on how to elicit the patient's story and ideas of illness and health care. [Evidence: Staff training includes learning on how to work across differences, illness narratives, relevance of considering individual characteristics and situation (e.g. Training content address the above mentioned issues; Patients' feedback show their stories have been taken into account).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

3.3. The organisation creates an environment where patients feel safe, with their dignity and identity respected.

3.3.1

The organisation strives to create an environment, which is inclusive for all patients regardless of individual identity. [Evidence: Policies to challenge discrimination, bullying, harassment and abuse and widely promotes these (e.g. Publicity materials; Patient information materials are inclusive for diverse patient groups; Facilities' interiors do not contain elements, which could be considered offensive or disrespectful to some individual cultures).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

3.3.2

The organisation accommodates patients' diverse needs in obtaining informed consent. [Evidence: An informed consent policy requiring accommodation of vulnerable patients in consent discussion (e.g. Use of plain, jargon-free language on consent forms; Consent forms translated into different languages; Use of interpreters, psychologists, social workers, liaison officers, speech pathologists).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

3.3.3

The organisation is sensitive to patient needs for privacy during care and treatment. [Evidence: Patients are advised about their own and other patients' right to privacy (e.g. Clear information about patient's right to privacy; Patient expectations of needs for privacy are identified and specific needs are recorded in patient records).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

3.4.	**The organisation takes into account individual and family characteristics, experiences and living condition to ensure effective discharge and continuity of care.**					
3.4.1	**The organisation ensures that the socio-cultural context and individual/family characteristics of each patient are taken into account at discharge.** [Evidence: Discharge procedures and communication clearly includes reference to the individual characteristics and social context of the patient (e.g. Discharge letter available in different languages; Discharge takes different family circumstances into account).] *Comments:*	☐ **Fully**	☐ **Mostly**	☐ **Partly**	☐ **Hardly**	☐ **No**
3.4.2	**The organisation has a planned approach to collaboration with other health service providers and organisations in order to ensure continuity of care.** [Evidence: Written plan for collaboration with partners to improve the patients' continuity of care (e.g. Plan for discharge; Protected discharge for alcoholic patients, homeless people).] *Comments:*	☐ **Fully**	☐ **Mostly**	☐ **Partly**	☐ **Hardly**	☐ **No**

Selection of indicators to complement standard 3

Select 1-3 indicators, useful to your organization to assess progress against the standard and assess the current or potential availability of data sources, either from indicators already in use in your organisation, or newly developed according local priorities, or from the sample indicators provided.

The selection or development of indicators should be guided by the following questions:

1. How can the indicator be chosen to relate to the overall standard?
2. Is it important (in terms of equity impact)?
3. Is it useful for equity (quality) improvement?
4. Is it scientifically sound (reliable, valid, sensitive, specific)?
5. What is the burden of data collection?
6. How can the indicator be described (rationale, numerator, denominator, data source)
7. How can the data for the indicator be collected (routine data, survey methods, audit)?

Standard 3: Equitable Quality of Care (Documentation sheet)

Indicator	Description	Numerator	Denominator	Data source
1.	•	•	•	•
2.	•	•	•	•
3.	•	•	•	•

Sample Indicators

Indicator	Description	Numerator	Denominator	Data source
% of specified characteristics recorded in patient files	• User/patient needs are identified using a social determinants of health framework and inclusive of key individual, and family characteristics as specified.	• The number of specified characteristics recorded in patient files.	• The ten specified characteristics are demonstrated: 1. Language preference 2. Ethnicity or Country of origin 3. Socio-economic status (occupation or education or employment status) 4. Migration status /insurance status 5. Health literacy 6. Living conditions (living alone, no family or social network) 7. Special needs linked to religion 8. Physical ability 9. Cognitive impairment 10. Psycho-social needs	• Patient files • Demographic data
% of users/patients reflecting the 10 specified characteristics who indicate their individual needs and preferences were met during the care process in the last 12 months	• The organisation implements a person centred approach in assessment, care, treatment, and informed consent.	• Number of users/patients reflecting the 10 specified characteristics who indicate their individual needs and preferences were met during the care process in the last 12 months.	• Total number of users/patients surveyed.	• User/patient survey data, feedback and complaints processes.
% of discharge plans that incorporate the unique needs of patients as per the 10 specified characteristics	• Discharge and care planning specifically supports key user/patient characteristics for continuity of care.	• Number of discharge plans that incorporate the unique needs of patients as per the 10 specified characteristics	• Total number of discharge plans over the last 12 months.	• Discharge plans reviewed or audited.

Description of areas for improvement

Standard 3: Equitable Quality of Care (Documentation sheet)

	Action needed	Hindering factors	Facilitating factors
Overall STD			
SubSTD 3.1.			
SubSTD 3.2.			
SubSTD 3.3.			
SubSTD 3.4.			

Factors relating to policy, legislative, organisational or economic issues may be considered.

Workload of the assessment team for standard 3

Title (e.g. Head of service, MD, Nurse, ...)	Organisation/ Department (internal / external)	Hours dedicated to complete assessment

4 Standard
Equity in participation

The organisation promotes the participation of all users, in particular for those at risk of discrimination and exclusion, in how services are planned, delivered and evaluated.

OBJECTIVE

To support the organisation in developing equitable participatory processes that respond to the needs and preferences of all users.

SUB-STANDARD

4.1.	**The organisation supports user participation in the planning, delivery and evaluation of its services.**					
4.1.1	**The organization identifies users at risk of being excluded from its participatory processes.** [Evidence: Collect data and information from local support groups and voluntary organisations; Supplement statistical data with information from community based networks or organisations (e.g. Database of support organisations: Migrant & minority ethnic groups; Aboriginal populations; Young people; Older people; Faith groups; People with disabilities; LGBT).] *Comments:*	☐ Fully	☐ Mostly	☐ Partly	☐ Hardly	☐ No
4.1.2	**The organization promotes the participation of users in particular those at risk of exclusion and discrimination** [Evidence: Recruiting disabled and other vulnerable groups in consultation bodies and service forums; Outreach work within 'grassroots' (hard-to-reach) groups (e.g.: Consultation with equal opportunities, human or disability rights commissions; Arrange meeting where target groups normally meet; Use inclusive methods that effectively outreach to hidden 'sub-groups' such as people who are housebound; in residential care or in rural areas).] *Comments:*	☐ Fully	☐ Mostly	☐ Partly	☐ Hardly	☐ No

4.2. The organization identifies and overcomes barriers to participation.

4.2.1

The organization identifies and meets the communication needs to effective participation. [Evidence: Review of communication barriers to participation; Communication methods to improve involvement and participation; Accessible information material for consultation (e.g. Information about involvement opportunities in different languages; Use of plain language; Use of Community Health Educators; Braille; Large print).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

4.2.2

The organization identifies and meets the support needs to effective participation. [Evidence: Review of organisational barriers to participation; Systems for identifying and recording people's support needs (e.g. Accessible venues; Transport arrangements; General assistance; Provision of food; Sign language and interpretation support; Timing of events).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

4.2.3

The organization ensures that staff training on user participation includes best practice guidance on how to engage with those at risk of discrimination and exclusion. [Evidence: User participation is part of the core staff training; Staff training includes learning on how to identify and overcome barriers to effective participation (e.g. Effective communication strategies; Effective consultation and engagement methods; Developing equal partnerships with key stakeholders and groups; Activities to build and support user capacity to undertake participation).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

4.3. The organization monitors and evaluates its participatory processes.

4.3.1

The organization monitors and evaluates participation of users that are at risk of discrimination and exclusion. [Evidence: Evaluation system to assess, prevent and eliminate potential barriers to participation (e.g. Mechanisms and tools to detect with users are most and least satisfied; Tools to assess the impact of user participation in future planning activities).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

4.3.2

The organisation reviews its participation structures and processes. [Evidence: Systematic monitoring of the participation process; Monitoring the level of compliance to involvement activities (e.g. Composition of advisory or consultation bodies; Register of involvement; Register of key stakeholders such as organisations representing patients, carers or community groups).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

4.3.3

The organisation has systems to record and use feedback from users and implements actions to improve planning, delivery and evaluation of its services. [Evidence: Systems and strategies to document and record user complaints and compliments; Users and community groups' feedback inform the organisations service planning processes, Equity Plan or strategy development (e.g. Assessment tools and measures for evaluating the impact of user and groups participation in service planning and health care delivery)].

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

4.3.4

The organisation provides feedback to users and the general public on the results of participation. [Evidence: Provide feedback in different formats according to people's needs (e.g. Dissemination of data and reports of participation activities and results, feedback meetings, with groups, use of appropriate communication strategies].

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

Selection of indicators to complement standard 4

Select 1-3 indicators, useful to your organization to assess progress against the standard and assess the current or potential availability of data sources, either from indicators already in use in your organisation, or newly developed according local priorities, or from the sample indicators provided.

The selection or development of indicators should be guided by the following questions:
1. How can the indicator be chosen to relate to the overall standard?
2. Is it important (in terms of equity impact)?
3. Is it useful for equity (quality) improvement?
4. Is it scientifically sound (reliable, valid, sensitive, specific)?
5. What is the burden of data collection?
6. How can the indicator be described (rationale, numerator, denominator, data source)
7. How can the data for the indicator be collected (routine data, survey methods, audit)?

Standard 4: Equity in participation (Documentation sheet)

Indicator	Description	Numerator	Denominator	Data source
1.	•	•	•	•
2.	•	•	•	•
3.	•	•	•	•

Sample Indicators

Indicator	Description	Numerator	Denominator	Data source
% of individual users and stakeholder organisations from diverse backgrounds involved in participation processes.	• Participation processes are inclusive of the diverse individual user backgrounds and key stakeholders in the population served by the organisation.	• Number of individual users and stakeholder organisations from diverse backgrounds involved in participation processes.	• The total population of users, potential users and representative stakeholder organisations from diverse backgrounds in service catchment area.	• Organisational – user profile, • Local demographic data • Regional, governmental agencies, frontline organisations, neighbourhood indices, migration data/patterns.
% of specified activities where users and stakeholders are active participants.	• Users and stakeholders are active participants in the governance, planning, improvement, and evaluation of services and programs on an ongoing basis.	• Number of specified activities where users and stakeholders are active participants.	• The 5 specified activities areas where user participation is demonstrated: 1. Quality improvement activities. 2. Organisational strategic planning. 3. Service and program development and review. 4. Developing and monitoring user feedback, and reviewing complaints 5. Development of user health information.	• Strategic, operational program plans and priorities. • Minutes of meetings e.g.: Community Advisory Group meeting minutes.
% of staff who have participated in staff training on participation strategies and best practice guidance for engaging with those at risk of discrimination and exclusion.	• Build staff capacity to effectively engage with vulnerable communities.	• Number of staff who have participated in staff training on participation strategies and best practice guidance for engaging with those at risk of discrimination and exclusion.	• Total number of staff who have participated in training within the last year.	• Audit human resource files to identify staff professional development activities. • Performance review processes and professional development plans.

Description of areas for improvement

Standard 4: Equity in participation (Documentation sheet)

	Action needed	Hindering factors	Facilitating factors
Overall STD			
SubSTD 4.1.			
SubSTD 4.2.			
SubSTD 4.3.			

Factors relating to policy, legislative, organisational or economic issues may be considered.

Workload of the assessment team for standard 4

Title (e.g. Head of service, MD, Nurse, ...)	Organisation/ Department (internal / external)	Hours dedicated to complete assessment

5

Standard

Promoting equity

The organisation understands that it is part of a wider system and promotes the principles of equity through cooperation with other organisations and across sectors.

OBJECTIVE

To support the organisation in promoting equity in its wider environment through cooperation, advocacy, capacity building, disseminating research and effective practices.

SUB-STANDARD

5.1.	**The organisation is an active participant in networks, think tanks and research initiatives, which promote equity.**					
5.1.1	**The organisation promotes research on health interventions and health care innovations targeting vulnerability, in order to maximize their impact on the accessibility and the quality of care.** [Evidence: Information on inequities in health and health care and in the residential status are included as relevant categories in research (e.g. Equity issues are included among the criteria for prioritising research recommendation).] *Comments:*	☐ Fully	☐ Mostly	☐ Partly	☐ Hardly	☐ No
5.1.2	**The organisation builds solid relationships with community-based service providers in its area, and develops networks and partnerships to deliver innovative services to disadvantaged populations.** [Evidence: Integration plans of health care with social services; Partnerships with NGOs and other agencies for the care of irregular migrants; Targets for the organisation equity strategy relate to the equity activities of collaborative organisations (e.g. One Stop Services; Use of case or care management; Local Strategic Partnerships, Equity monitoring system is compatible with that of other agencies involved in joint working).] *Comments:*	☐ Fully	☐ Mostly	☐ Partly	☐ Hardly	☐ No

5.1.3

The organisation builds inter-sectoral collaborations beyond the healthcare system to address the wider determinants of health. [Evidence: Formal links with umbrella agencies of relevant areas/districts (e.g. Co-operation between agencies concerned with social inclusion and those concerned with health promotion and education; Shared social responsibility agreements; Inter-sectoral interventions).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

5.2. The organisation actively disseminates the results of research and practice relating to equity.

5.2.1

The organisation promotes dissemination of research outcomes and/or information about existing good practices in the development of health interventions towards people in vulnerable situations. [Evidence: Communication plan concerning the dissemination of research outcomes (e.g. Reports and publications addressed to different stakeholders such as the scientific community, decision makers, experts, and the general population).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

5.3. The organisation ensures that equity is reflected in all partnerships.

5.3.1

The organisation ensures that all partnership agreements and service contracts reflect equity standards. [Evidence: Contractors are required to provide evidence of their equity strategies (e.g. Equity issues explicitly included in official agreements; Staff of sub-contracted services are trained on equity issues).]

Comments:

☐ Fully ☐ Mostly ☐ Partly ☐ Hardly ☐ No

5.3.2

The organisation monitors partnership agreements and service contracts related to health care [Evidence: Systematic review of sub-contracting processes against the recommended equity standards. Monitoring the performance of contractors in relation to equity duties (e.g. Standards for equity in healthcare; Equity impact assessment reports).]

Selection of indicators to complement standard 5

Select 1-3 indicators, useful to your organization to assess progress against the standard and assess the current or potential availability of data sources, either from indicators already in use in your organisation, or newly developed according local priorities, or from the sample indicators provided.

The selection or development of indicators should be guided by the following questions:

1. How can the indicator be chosen to relate to the overall standard?
2. Is it important (in terms of equity impact)?
3. Is it useful for equity (quality) improvement?
4. Is it scientifically sound (reliable, valid, sensitive, specific)?
5. What is the burden of data collection?
6. How can the indicator be described (rationale, numerator, denominator, data source)
7. How can the data for the indicator be collected (routine data, survey methods, audit)?

Standard 5: Promoting equity (Descriptive sheet)

Indicator	Description	Numerator	Denominator	Data source
1.	•	•	•	•
2.	•	•	•	•
3.	•	•	•	•

Sample Indicators

Indicator	Description	Numerator	Denominator	Data source
% of research outputs that address the social determinants of health; measure inequalities in health; and health care use, in a two year period	• Promote the integration of equity indicators into research goals, outputs and outcomes.	• The number of research outputs that address the social determinants of health; measure inequalities in health; and health care use, in a two year period	• The number of research outputs in a two year period.	• Organisational equity strategy/policies • Research activities, submitted proposals, grants, etc.
% of partnership service agreements that demonstrate equity actions.	• Equity clauses are integrated into service agreements	• Number of partnership service agreements that demonstrate equity actions.	• The total number of partnership service agreements	• Audit partnership and service agreements.
% of financed projects addressing inequalities in accessing health promotion interventions in the last year	• To reduce inequalities in accessing health promotion interventions in (or by) the health care setting.	• Number of financed projects addressing inequalities in accessing health promotion in the last year.	• The total number of financed health promotion projects undertaken in the last year.	• Research activities, submitted proposals, grants, etc.

Description of areas for improvement

Standard 5: Promoting equity (Documentation sheet)

	Action needed	Hindering factors	Facilitating factors
Overall STD			
SubSTD 5.1.			
SubSTD 5.2.			
SubSTD 5.3.			

Factors relating to policy, legislative, organisational or economic issues may be considered.

Workload of the assessment team for standard 5

Title (e.g. Head of service, MD, Nurse, ...)	Organisation/ Department (internal / external)	Hours dedicated to complete assessment

Factors relating to policy, legislative, organisational or economic issues may be considered.

Overall assessment and Action plan

Overall assessment of standards compliance

Equity in Policy

1

	Fully	Mostly	Partly	Hardly	No
Total:					
	12	12	12	12	12

Equitable Access and Utilisation

2

	Fully	Mostly	Partly	Hardly	No
Total:					
	12	12	12	12	12

Equitable Quality of Care

3

	Fully	Mostly	Partly	Hardly	No
Total:					
	11	11	11	11	11

Equity in Participation

4

	Fully	Mostly	Partly	Hardly	No
Total:					
	9	9	9	9	9

Promoting Equity

5

	Fully	Mostly	Partly	Hardly	No
Total:					
	6	6	6	6	6

All Standards

	Yes	Almost	Partly	Hardly	No
Total:					
	50	50	50	50	50

Overall action plan - (template)

Areas of improvement addressed	
Description of proposed intervention	
Planning the development process	
Stakeholders involvement	
Resources and competences needed	
Estimated costs and potential funding sources	
Time line	
Responsibilities	
Indicators for assessing progress	

Feedback on the pilot test

QUESTION	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
The self-assessment was useful	☐	☐	☐	☐	☐
Through the self-assessment I have identified new potentials for equity improvement activities	☐	☐	☐	☐	☐
Equity standards are aligned with existing system drivers and priorities. (e.g. Quality Improvement Initiatives, National/Regional Strategies…)	☐	☐	☐	☐	☐
Equity standards can be embedded within existing processes and standards. (e.g. Accreditation)	☐	☐	☐	☐	☐
The work related to gathering data can be incorporated into practice	☐	☐	☐	☐	☐
The overall action plan can be incorporated into the organisation's equity strategy	☐	☐	☐	☐	☐
I recommend other organisations interested in health and healthcare equity to carry out a self-assessment	☐	☐	☐	☐	☐
The work load for conducting the self-assessment was appropriate.	☐	☐	☐	☐	☐
Indicators to complement equity standard can be measured with existing data collected.	☐	☐	☐	☐	☐

Are there any other issues about the self-assessment that you would like to bring to our attention?

GLOSSARY

TERM	Definition
ASYLUM SEEKER	A person who seeks international protection under the provisions of the 1951 Refugee Convention or related legislation. From the Office of the UN High Commissioner for Refugees: The terms asylum-seeker and refugee are often confused: an asylum-seeker is someone who says he or she is a refugee, but whose claim has not yet been definitively evaluated. (http://www.unhcr.org/pages/49c3646c137.html)
CARE/CLINICAL PATHWAYS	A clinical pathway is a method for the patient-care management of a well-defined group of patients during a well-defined period of time. [...] The aim of a clinical pathway is to improve the quality of care, reduce risks, increase patient satisfaction and increase the efficiency in the use of resources. (De Bleser et al. "Defining Pathways" 2006, http://www.ncbi.nlm.nih.gov/pubmed/17004966)
COMMUNICATION BARRIERS	Any barriers which prevent effective communication, including language barriers and those resulting from visual, auditory or vocal impairment.
COMMUNICATION SUPPORT SERVICES	Umbrella term for any service or device to reduce barriers to communication: Interpretation services, augmentive and alternative communication services (e.g., communication boards, speech generating devices), amplifiers the for hard of hearing, large print, etc.
CONTINUITY OF CARE	Continuity is the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient's medical needs and personal context. (JL Haggerty et al., "Continuity of Care: A Multidisciplinary Review," BMJ, 2003, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC274066/)
CORE EDUCATION	Staff training on essential skills and/or competencies.
CULTURALLY INCLUSIVE	A culturally inclusive environment requires mutual respect, effective relationships, clear communication, and explicit understandings of expectations. (Adapted from http://www.newcastle.edu.au/Resources/Divisions/Academic/Equity%20and%20Diversity/Documents/CDIP/GIF1.pdf)

DISADVANTAGED GROUP	Group within a society that is marginalized and has reduced access to resources and services such as education, health, credit and power. Some examples of disadvantaged groups are those affected by natural or man-made disasters (such as refugees, returnees or internally displaced persons), some ethnic groups, older adults, children, and disabled persons. Women and/or girls in these groups tend to have fewer opportunities than their male counterparts. (SACHET Pakistan: Society for the Advancement of Community, Health, Education and Training http://www.sachet.org.pk/web/page.asp?id=427)
DIVERSITY FRIENDLY	An environment that promotes and embraces individual differences, where every individual is respected.
ELIGIBILITY	This refers to two kinds of eligibility in health care. 1) Entitlement to join a scheme for protection against health risks. 2) Entitlement of an individual to receive services based on that individual's enrolment in a health care plan (Adapted from Mosby's Medical Dictionary 2009).
EQUITY	Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.
EQUITY EDUCATION	Staff training on the social determinants of health, on the reduction of disparities, and in the skills that are necessary to ensure accessibility and high quality clinical care (e.g. working with an interpreter; communicating with patients with low health literacy; developing awareness of own bias/stereotypes, etc.).
EQUITY IMPACT ASSESSMENT	A decision support tool which walks users through the steps of identifying how a program, policy or similar initiative will impact population groups in different ways. (Ontario Ministry of Health and Long-Term Care http://www.health.gov.on.ca/en/pro/programs/heia/)
FAMILY-CENTRED CARE	A philosophy of health care that places the family rather than the hospital and medical staff at the centre of the health care delivery system. (SL Hostler, "Family-Centred Care," Paediatric Clinics of North America, 1991 http://www.ncbi.nlm.nih.gov/pubmed/1945556)
HEALTH EDUCATOR	Health education is any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes. (http://www.who.int/topics/health_education/en/)

HEALTH EQUITY AUDIT	A Health Equity Audit (HEA) is a review procedure, which examines how health determinants, access to relevant health services, and related outcomes are distributed across the population, relative to need. An HEA advises decision-makers at all levels of governance to prioritize resources in the planning of policies, strategies and projects in a way that reduces health inequities. A HEA distinguishes between health inequalities and health inequities, and the overall objective is thus not to allocate resource equally across the population, but to prioritize these according to actual needs of different segments or geographic locations. (NHS, UK - Health Development Agency – London Health Observatory)
HEALTH INEQUITY	Differences in health outcomes that are avoidable, unfair and systemically related to social inequality and disadvantage. There is no biological reason for the existence of these differences and all are changeable (Toronto Central LHIN Health Equity Discussion Paper) http://www.torontocentrallhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Health%20Equity%20Discussion%20Paper%20v1.0.pdf)
HEALTH INEQUALITIES	Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. It is important to distinguish between inequality in health and inequity. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, thus the resulting health inequalities also lead to inequity in health. (WHO, Glossary)
HEALTH LITERACY	The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. (Ratzan & Parker, "Health Literacy: A Prescription to End Confusion," Institute of Medicine, 2004)
HEALTH SERVICE/ HEALTH CARE PROVIDER	An individual or an institution that provides preventive, curative, promotional or rehabilitative health services in a systemic way for individuals, families or communities. (http://en.wikipedia.org/wiki/Health_care_provider)

ILLNESS NARRATIVES	Depicting illness in the form of narratives is a way of contextualising illness events and illness symptoms by bringing them together within a biographical context. (L. Hydén, "Illness and Narrative," Sociology of Health and Illness, 1997, first published online 2008 http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.1997.tb00015.x/pdf)
INFORMATION BARRIERS	Circumstances in which users are unable to access and use information necessary to make informed decisions about their health. (Examples: low health literacy, lack of extended hours for users who cannot leave work during operating hours of the healthcare organization; lack of translated documents such as consents to treatment and patient education; lack of support with internet-based health information, preventive services and health education programmes; lack of or poor navigation support services.
INFORMED CONSENT	A patient's authorization of a medical procedure. Valid informed consent incorporates five elements: voluntarism, capacity, disclosure, understanding, and decision. (M.G. del Carmen and S. Joffre, "Informed Consent for Medical Treatment and Research: A Review," The Oncologist, 2005 http://theoncologist.alphamedpress.org/content/10/8/636.long) Laws on obtaining informed consent vary from country to country.
INTERCULTURAL MEDIATOR/ MEDIATION	Intercultural mediation refers to all activities that aim to reduce negative consequences of language barriers, socio-cultural differences and tensions between ethnic groups in healthcare settings.
INTERPRETATION SERVICES/ INTERPRETERS	Refers to Accredited, Certified or qualified (trained and tested) medical interpreters, depending on jurisdiction, working in spoken and sign languages, providing linguistic support to facilitate effective communication between patients and healthcare providers and other staff, following a professional code of ethics and current standards of practice in their jurisdiction. Interpreters are language professionals who provide the service.
INTER-SECTORAL COLLABORATION	Collaboration among sectors, such as healthcare, community services, education, employment services, transportation, housing and correctional services.

IRREGULAR MIGRANT	The term 'irregular migration' typically refers to the cross-border flow of people who enter a country without that country's legal permission to do so. The term 'irregular migrants' typically refers to the stock of migrants in a country who are not entitled to reside there, either because they have never had a legal residence permit or because they have overstayed their time-limited permit. It can also refer to migrants who are legally resident but breaching the conditions attached to their immigration status. (Adapted from B. Vollmer, 2011, "Irregular Migration in the UK: Definitions, Pathways and Scale," University of Oxford http://migrationobservatory.ox.ac.uk/briefings/irregular-migration-uk-definitions-pathways-and-scale)
JOINT WORKING	Collaborative partnerships
LANGUAGE BARRIERS	In healthcare contexts, when a patient and care provider (and/or staff member) do not share a common or preferred language.
LGBT	Lesbian, Gay, Bisexual, Trans People (http://www.lgbt-ep.eu)
LIAISON OFFICER	A person that liaises between two organizations to communicate and coordinate their activities (http://en.wikipedia.org/wiki/Liaison_officer)
LOCAL STRATEGIC PARTNERSHIP	The main objective of an LSP is to set out the vision of an area and co-ordinate and drive the delivery of local services leading to improved outcomes for citizens that go beyond the remit of any one partner. The benefits of partnership working include increased opportunities for joint provision of services, the ability to attract external funding and increased influence over the policies and structures of partner agencies. (http://www.oecd.org/cfe/leed/37728868.pdf)
MARGINALISATION	Marginalisation (also referred to as social exclusion) is a concept used in many parts of the world to characterise contemporary forms of social disadvantage and relegation to the fringe of society. (Adapted from http://en.wikipedia.org/wiki/Social_exclusion)
MOBILE CLINICS	Mobile medical and dental clinics are used to expand community outreach in both rural areas and urban centres. Providers are able to deliver vital services, especially for underserved populations. (Adapted from http://www.mobilehealthclinicsnetwork.org)

MYSTERY SHOPPER	Mystery shopping or a mystery consumer is a tool used externally by market research companies, watchdog organizations, or internally by companies themselves to measure quality of service, or compliance with regulation, or to gather specific information about products and services. (http://en.wikipedia.org/wiki/Mystery_shopping)
NAVIGATION SUPPORT SERVICES	A patient navigator ensures health inclusion, typically by connecting patients with the right health services and ensuring that they have access to the host of available therapies and resources. Navigators are also there to ensure continuity of care and to get answers to questions patients have about their disease or condition. (Adapted from E. Walkinshaw, “Patient navigators becoming the norm in Canada,” CMAJ 2011, http://www.cmaj.ca/content/183/15/E1109)
NGO	Non-governmental organization
NON-INSURED	Refers to lack of eligibility to receive health services
OUTREACH SERVICES	Outreach is an activity of providing services to populations who might not otherwise have access to those services. A key component of outreach is that the people/organizations providing the outreach services are meeting the targeted populations at the locations where these populations are. (Adapted from http://en.wikipedia.org/wiki/Outreach)
PARTICIPATION	Participation occurs when users, carers and community members are meaningfully involved in decision making about health policy and planning, care and treatment, and the wellbeing of themselves and the community. It is about having your say, thinking about why you believe in your view and listening to the views and ideas of others. In working together, decisions may include a range of perspectives. Types of participation: Participation is conceptualised as a process occurring along a continuum from ‘information’ at one end to ‘control’ at the other end. The types of participation include: information (a precursor to participation); consultation; partnership; delegation; control. The nine principles of participation are: trust; respect; openness; equal opportunity; advocacy and support; responsiveness; dissemination; evaluation; shared ownership and accountability. (“Doing it with us not for us: Strategic direction 2010-13,” pp8-9, http://www.health.vic.gov.au/consumer/downloads/strategic_direction_2010-13.p
PERSON-CENTRED CARE	Person-centred care sees patients as equal partners in planning, developing and assessing care to make sure it is most appropriate for their needs. It involves putting patients and their families at the heart of all decisions. (The Health Foundation http://www.health.org.uk/areas-of-work/topics/person-centred-care)

PSYCHOSOCIAL	The term psychosocial reflects the dynamic relationship between psychological and social processes. Psychological processes are internal; they include thoughts, feelings, emotions, understanding and perception. Social processes are external; they are comprised of social networks, community, family and environment. (Act Alliance - Guide on Community Based Psychosocial Support http://psychosocial.actalliance.org/default.aspx?di=67133)
REFUGEE	As defined in the 1951 United Nations Convention Relating to the Status of Refugees (the Refugee Convention), a refugee is defined as a person who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country or return there because there is a fear of persecution...” (Human Rights Education Associates http://www.hrea.org/index.php?doc_id=418)
RESIDENTIAL STATUS	Residency is the act of establishing or maintaining a residence in a given place. Residency is a concept that affects the legal rights and responsibilities that are available to a person, including eligibility to vote, eligibility to stand for political office, eligibility to access government services, responsibility to pay taxes, and on and so forth. (http://en.wikipedia.org/wiki/Residency_%28domicile%29) Most countries have various types of residency status (e.g. permanent resident, refugee)
SAFE ENVIRONMENT	Free from discrimination and other forms of abuse.
SHARED SOCIAL RESPONSIBILITY AGREEMENT	Shared social responsibilities is the link between specific responsibilities in terms of the joint commitments to be taken in addressing the challenges of today: the fight against poverty, social, environmental and intergenerational justice, the preservation of universal rights and democratic institutions, harmonious co-existence in pluralist societies. (Adapted from Council of Europe, European Commission, “Conference Program of Shared Social Responsibility: securing trust and sustainable social cohesion in a context of transition,” 2011, http://www.coe.int/t/dg3/SocialPolicies/SocialCohesionDev/source/progconf_en.pdf)
SOCIAL CONTEXT	Social factors including not only the usual predictors of socioeconomic status (income and education), but factors such as illiteracy, immigration experiences, religion, social stressors, and social support networks. (Adapted from Green AR, Betancourt JR, Carrillo JE. “Integrating social factors into cross-cultural medical education,” Acad Med. 2002 Mar;77(3):193-7.)

SOCIO-DEMOGRAPHIC DATA	Data involving a combination of social and demographic factors, such as: sex, date of birth, ethnic background, socioeconomic status, educational background, marital status, living situation, citizenship/immigration/residency status, preferred language, sexual orientation and gender identity. (Adapted from A.K. Lofters et al., "Socio-demographic Data Collection in Healthcare Settings: An Examination of Public Opinions," Medical Care 2011)
THINK TANK	An organization or group that performs research and advocacy concerning topics such as social policy, political strategy, economics, technology, and culture. (Adapted from http://en.wikipedia.org/wiki/Think_tank)
UNDER-REPRESENTED (POPULATIONS)	In the healthcare context, groups or populations that are not proportionally represented in a patient population. Examples: racial and ethnic groups; individuals with disabilities; and individuals from economically, socially, culturally, or educationally disadvantaged backgrounds. (National Institute of Health, Policy Related to Diversity, http://grants.nih.gov/training/faq_diversity.htm)
UNDOCUMENTED MIGRANT	Undocumented migrants are those without a residence permit authorising them to regularly stay in their country of destination. They may have been unsuccessful in the asylum procedure, have overstayed their visa or have entered irregularly. (Platform for International Cooperation on Undocumented Migrants http://picum.org/en/our-work/undocumented-migrants)
USER	Users are members of the public who use, or are potential users of health care services and health information. That is, individuals, carers, family members, clients, residents, patients, citizens and other support people.
VULNERABLE GROUPS	Groups that experience a higher risk of poverty and social exclusion than the general population. Ethnic minorities, migrants, disabled people, the homeless, those struggling with substance abuse, isolated elderly people and children all often face difficulties that can lead to further social exclusion, such as low levels of education and unemployment or underemployment. (Social Protection and Social inclusion, Glossary. DG Employment, Social Affairs and Inclusion)
WIDER DETERMINANTS OF HEALTH	The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. (http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html)