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PROGRESS-Plus

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What is health equity?

HEALTH INEQUITY

- Systematic, socially produced (and therefore modifiable) and unfair,

  - Whitehead and Dahlgren Levelling up, part I: 2006

- *“The term ‘inequity' has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust.“- Whitehead, 1992*

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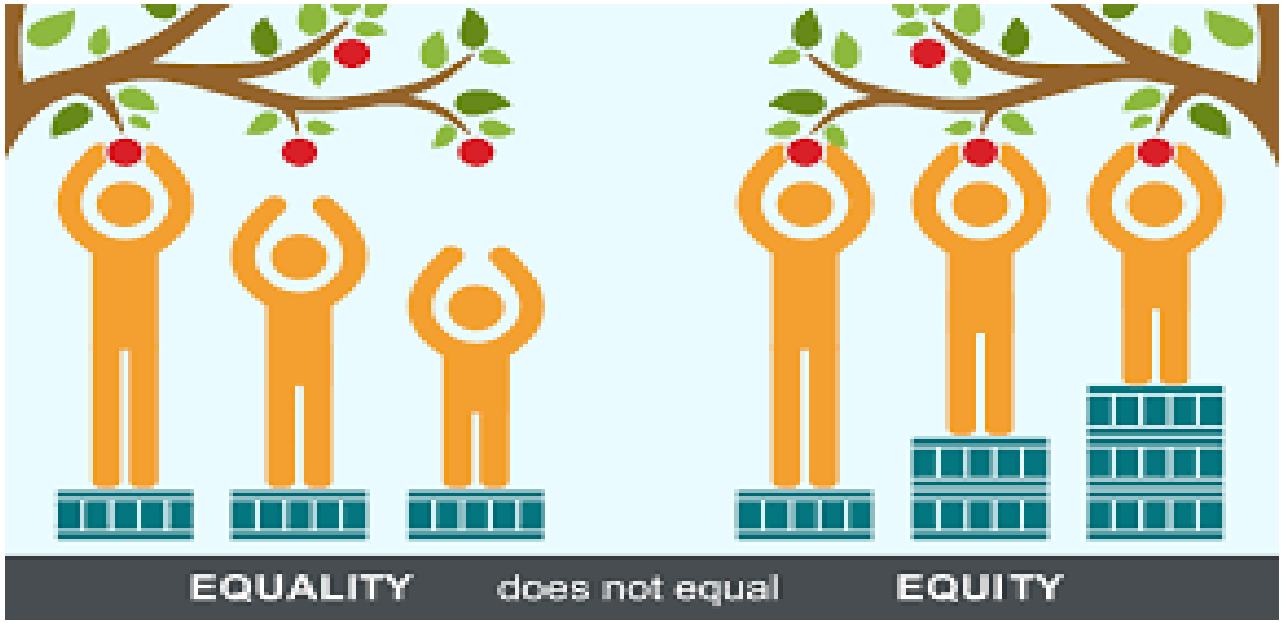

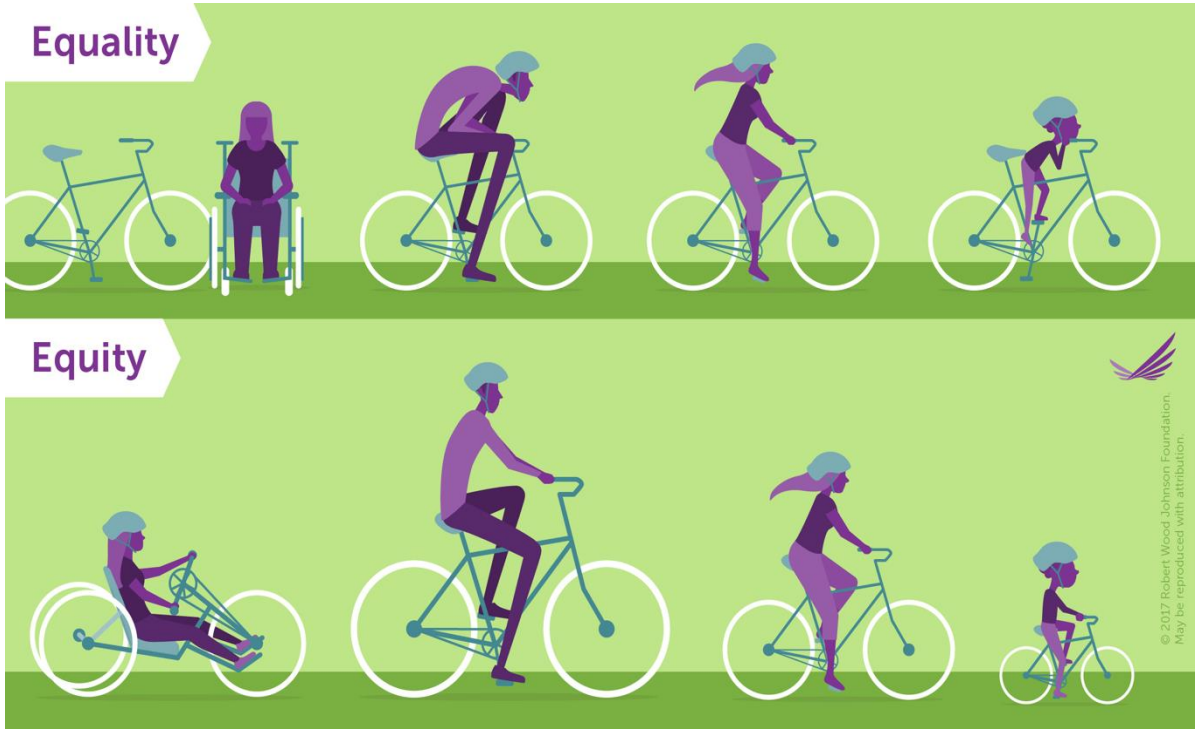

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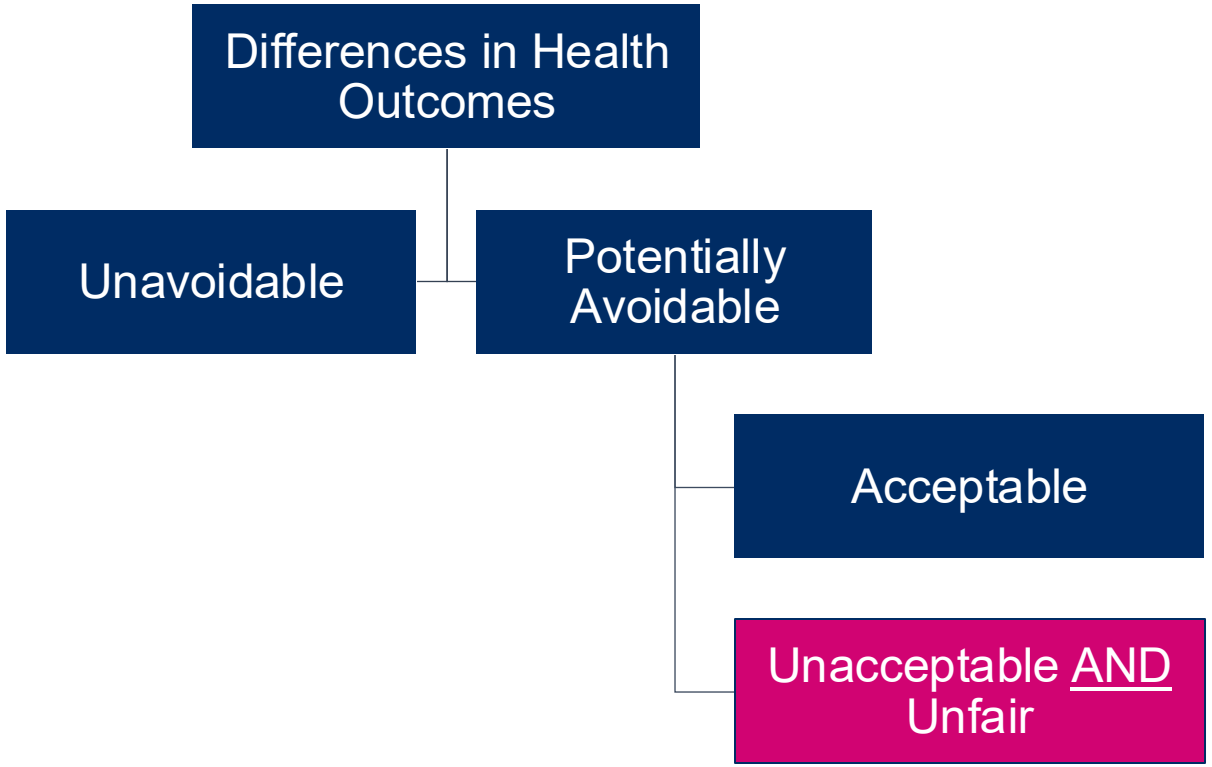
Health inequity



Inequity ≠ Inequality

Some differences are unfair while others are inevitable!

1. Natural, biological variation.

2. Health-damaging behaviour if freely chosen, such as participation in certain sports and pastimes.

Inequalities

1. Lifestyle restrictions.

2. Exposure to unhealthy, stressful living and working conditions.

3. Inadequate access to essential health and other public services.

Inequities

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What are some examples of factors which stratify health opportunities?

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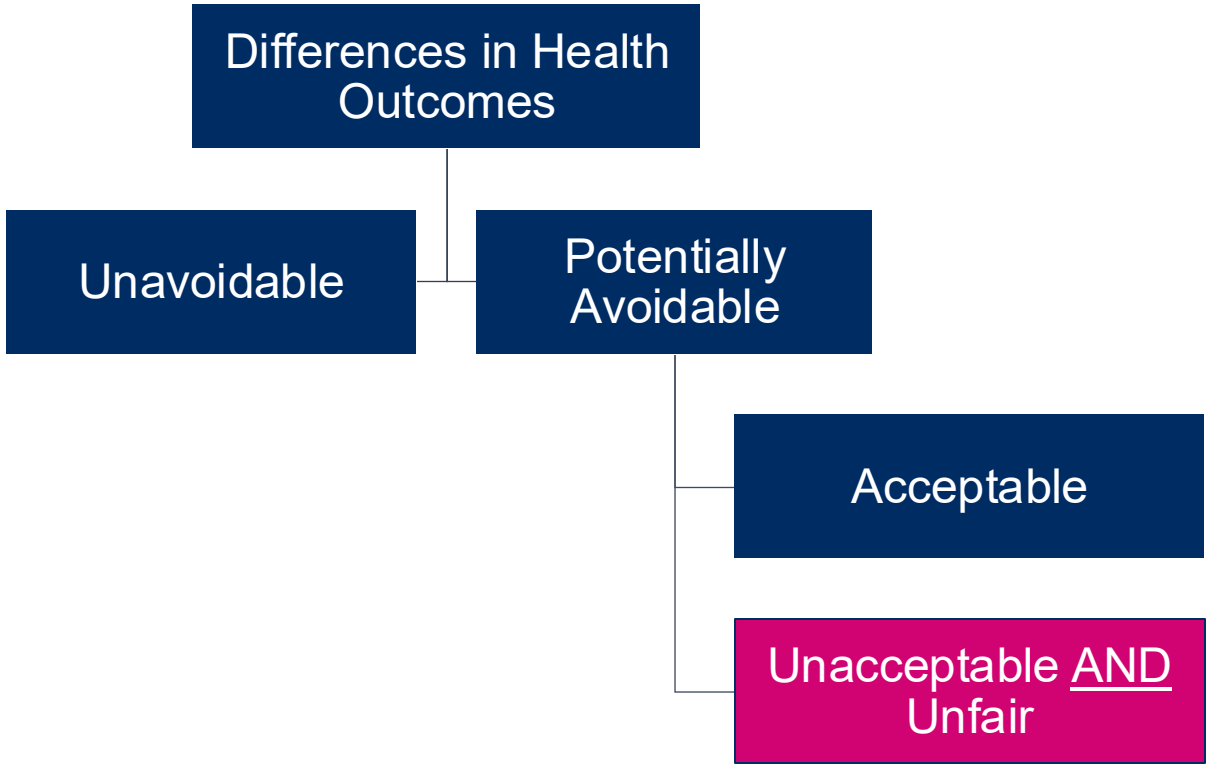
Health inequity



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What are some examples of factors which stratify health opportunities?

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PROGRESS-Plus


Place of residence


Race/ethnicity/culture/language


Occupation


Gender/sex


Religion


Education


Socioeconomic status


Social Capital

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History of PROGRESS

Injury Control and Safety Promotion
2003, Vol. 10, No. 1–2, pp. 11–12

1566-0974/03/1001–2-011$16.00

SHORT REPORT

Road traffic crashes: operationalizing equity in the context of health sector reform

Tim Evans[1] and Hilary Brown[2]

[1]Director, Health Equity Program, The Rockefeller Foundation, New York, NY, USA and [2]Program Coordinator, Health Equity Program, The Rockefeller Foundation, New York, NY, USA

Background

Gradations in health status and health care among population subgroups exist across time and space in all countries of the world. Disparities persist in the risk of disease, morbidity and mortality rates, and social consequences of ill health, as well as access to treatment and quality of care received. In some circumstances, differential levels of health do not invoke questions of fairness and are thus considered *unequal*. However, when normative judgment deems such differences as fundamentally unfair or avoidable, they are considered they are beginning to figure more prominently into the agenda of public health practitioners and also will be factored into health sector reform. The differential between road traffic crashes in developing and developed countries is well established; low- and middle-income countries account for approximately 85% of all traffic deaths.[1] However, the scarcity of data on variations within countries in the risk of falling victim to traffic crashes forces a reliance on anecdotal evidence. Such evidence suggests that pedestrians,

"Variations in health can be seen across a number of socially stratifying forces captured by the acronym PROGRESS, *standing for place of residence, religion, occupation, gender, race/ethnicity, education, socioeconomic status, and social networks and capital."*

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History of PROGRESS

Published by Oxford University Press in association with The London School of Hygiene and Tropical Medicine *Health Policy and Planning* 2007;**22**:348–351

doi:10.1093/heapol/czm028

10 best resources on . . . health equity

Davidson R Gwatkin*

Accepted 25 May 2007

An astute bureaucratic pundit named Rufus Miles once observed that 'where you stand depends on where you sit' (Miles 1978). This 'Miles Law' deserves to be kept centrally in mind when considering not only traditional bureaucratic behaviour, but also health equity; for one's judgment about what's 'best' in the health equity area is unavoidably shaped by his/her institutional experience, background and interests.

Rather than challenge such an unfortunately well-established reality, better for an author to admit at the outset just where (s)he has sat. This author must accordingly confess to having long sat at operationally-oriented external assistance agencies rather than at academic institutions. The consequence has been a preference for pieces that, in the tradition of this journal, can help shape health policy and planning; rather than for the many valuable but more abstract or technical readings on health equity that deal with basic concepts or advanced

described as refinements to rather than as significant departures from the original Whitehead definition.

Another important, conceptually-oriented reading from the 1990s is one that has not yet been written. Rather, it exists as brief sections of several papers and presentations by Timothy Evans and Hilary Brown, usually titled something like **PROGRESS**. This is an acronym, with each letter standing for one of the several dimensions of health inequality that the authors consider important: inequality by **p**lace of residence, by **r**ace, by **o**ccupation, by **g**ender, by **r**eligion, by **e**ducation, by **s**ocio-economic status, and by **s**ocial capital. Much further development will be required before this or any other list can be considered definitive. But even in its present, rudimentary form, it has attracted a significant following in organizations like the International Clinical Epidemiology Network (WHO 2004), the Cochrane Collaboration (Tugwell *et al.* 2006; Doull *et al.* 2007a,b), and elsewhere (Chowdhury 2005).

*"**Another important, conceptually-oriented reading from the 1990s is one that has not yet been written.** Rather, it exists as brief sections of several papers and presentations by Timothy Evans and Hilary Brown, usually titled something like **PROGRESS**…an important reminder that health equity has many significant dimensions beyond the gender and economic ones that have come to dominate the literature"*

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ELSEVIER

Journal of Clinical Epidemiology 67 (2014) 56–64

Journal of Clinical Epidemiology

Applying an equity lens to interventions: using PROGRESS ensures consideration of socially stratifying factors to illuminate inequities in health

Jennifer O'Neill[a,*], Hilary Tabish[b], Vivian Welch[a], Mark Petticrew[c], Kevin Pottie[d,e], Mike Clarke[f], Tim Evans[g], Jordi Pardo Pardo[a], Elizabeth Waters[h], Howard White[i], Peter Tugwell[j,k,l,m]

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Abstract

Objectives: To assess the utility of an acronym, place of residence, race/ethnicity/culture/language, occupation, gender/sex, religion, education, socioeconomic status, and social capital ("PROGRESS"), in identifying factors that stratify health opportunities and outcomes. We explored the value of PROGRESS as an equity lens to assess effects of interventions on health equity

Study Design and Setting: We assessed the utility of PROGRESS by using it in 11 systematic reviews and methodological studies published between 2008 and 2013. To develop the justification for each of the PROGRESS elements, we consulted experts to identify examples of unfair differences in disease burden and an intervention that can effectively address these health inequities.

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PROGRESS

P = Place of residence	‘Place’ refers to where someone lives and includes whether they live in a city or a rural area or the country (e.g. high-, middle-, or low-income) and the characteristics of the home environment, neighbourhood, city, region, country.
R = Race, ethnicity, culture, and language	Race, culture & ethnicity are socially defined concepts. Each of these factors can impact health & may have greater negative impacts on the health of people in minoritised or marginalised groups. E.g. cultural beliefs and practices or language barriers can disadvantage certain groups from accessing health information and services; and cultural norms may influence health-related behaviors including dietary habits and exercise.

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PROGRESS

O = Occupation	Occupation encompasses different situations including out of work, underemployment, informal or casual workers, and unsafe working environments. Occupational status in an organisation is strongly related to mortality and a range of health outcomes. Certain occupations have been shown to be associated with higher mortality/morbidity than others.
G = Gender and sex	Sex, or biological differences between males and females, is not necessarily inequitable because differences exist that are unavoidable. Gender refers to socially constructed roles and traits that society generally associates with the sexes. Inequities in health that are driven by socially defined gender roles include differential exposure to household hazards and stagnant water. Because of women's role in the household, they may experience greater exposure to indoor air pollution, which increases rates of asthma.

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PROGRESS

R = Religion	Religion does not indicate inequity when, for example, a person declines health based on religious beliefs. However, some individuals, do not have the opportunity to make choices about their religion, e.g. Children may not be given a choice to refuse health services because of religious beliefs, but their parents make the decision.
E = Education	People with a higher level of education are more likely to have healthier lifestyles, including being more physically active, receiving primary health care, and not smoking. Well-educated people are also more likely to have more knowledge about health and preventive health measures
S = Socio-economic status (SES)	Higher SES usually means improvements in many determinants of health such as better living conditions and access to fresh and nutritious foods. Inequalities in income impact a person's life chances and therefore impact health.
S = Social capital	Social capital refers to social relationships and networks. It includes interpersonal trust between members of a community, civic participation, and the willingness of members of a community to assist each other and facilitate the realization of collective community goals and the strength of their political connections, which can facilitate access to services. Social capital is interrelated with SES. As income inequality within a community increases, social capital decreases

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PROGRESS-Plus

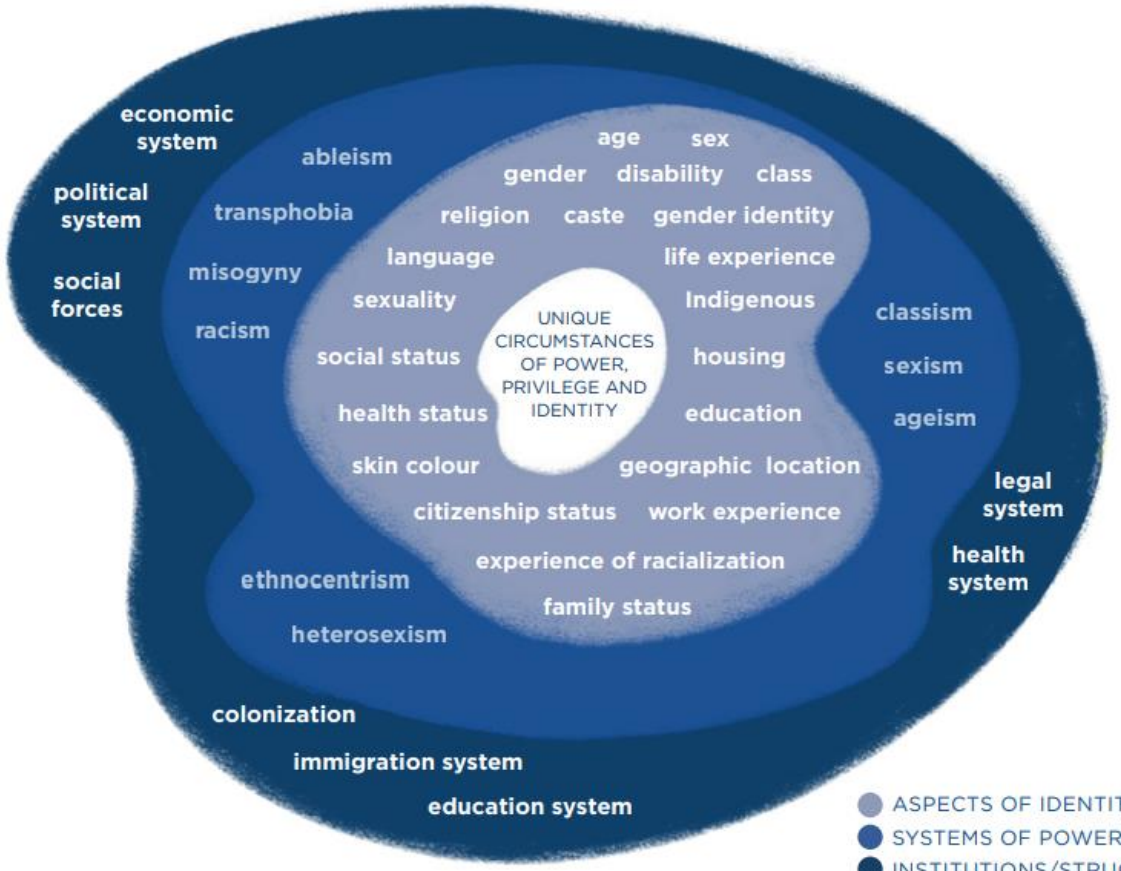
1. **Personal characteristics** associated with discrimination and/or exclusion (e.g. age, disability);
2. **Features of relationships** (e.g. smoking parents, excluded from school);
3. **Time-dependant relationships** (e.g. leaving the hospital, respite care, other instances where a person may be temporarily at a disadvantage).

Intersectionality

- A concept originally introduced by Black feminists as a way to describe the interrelated effects of sexism, racism, classism, and homophobia (Combahee River Collective, 1977).
- Refers to the overlapping, additive or multiplicative effects that these experiences can have on health outcomes (Bowleg, 2012; Bauer, 2014; Crenshaw, 2017; Mishra & Pandya, 2022).

FEMINIST INTERSECTIONALITY

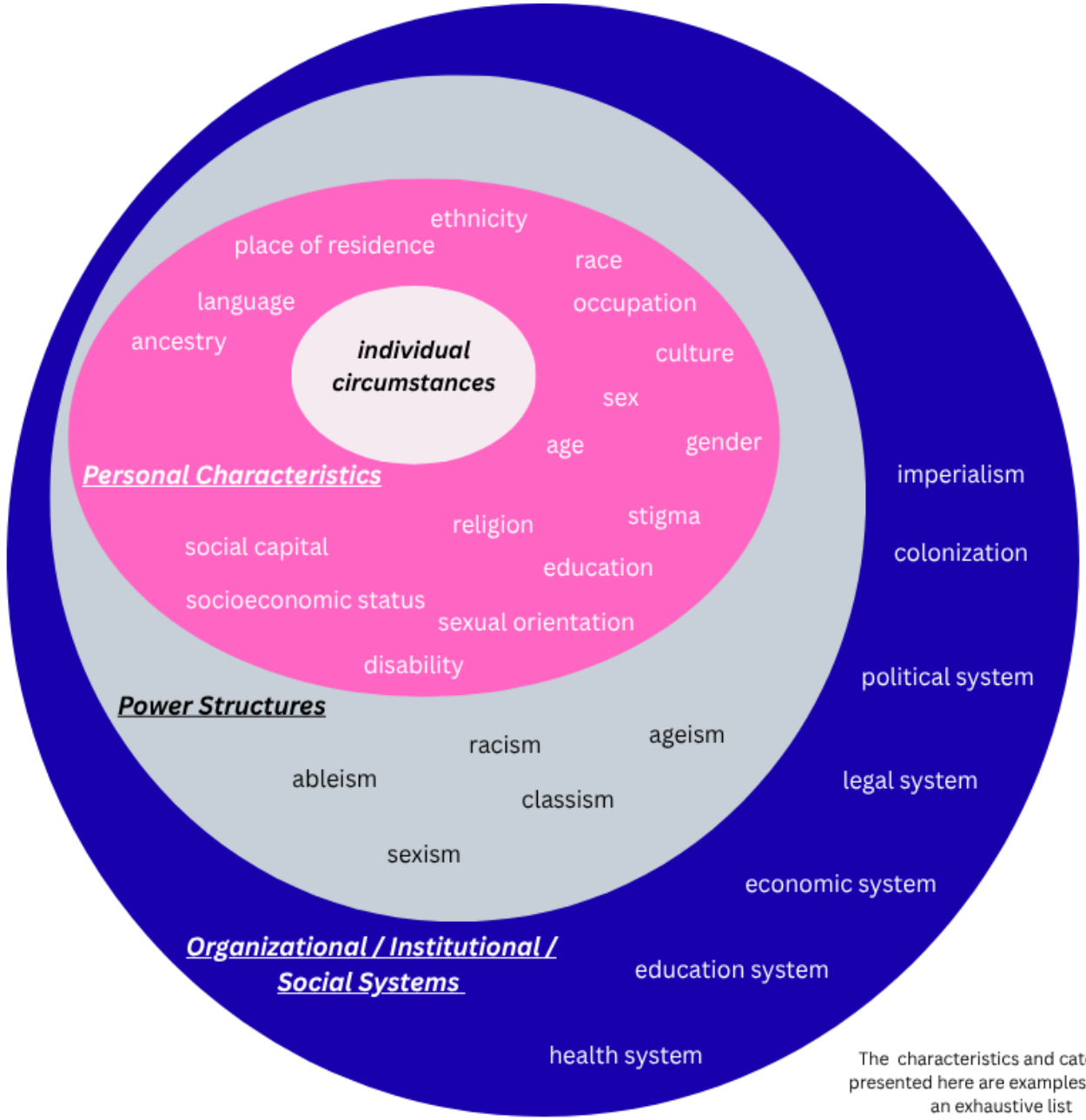
Feminist Intersectionality: A framework to analyze how different girls and women experience multiple forms of oppression or inequality. These multiple forms of oppression are simultaneous and cannot be separated from their experiences of sex- and/or gender-based discrimination.



FOR EXAMPLE

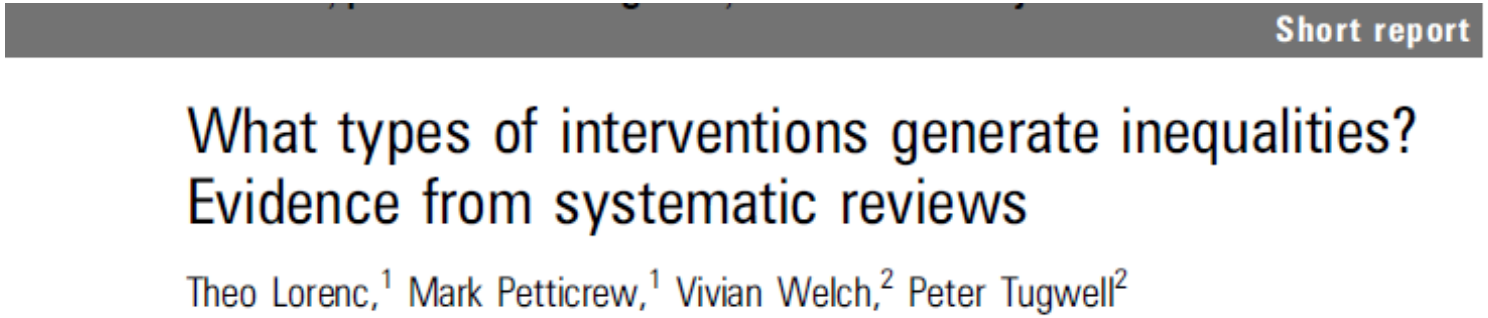
Multiple forms of oppression intersect, creating unique and varied experiences of discrimination.

Canadian Research Institute for the Advancement of Women 2021.
https://www.criaw-icref.ca/wp-content/uploads/2021/04/Feminist-Intersectionality-Primer-1.pdf



The characteristics and categories presented here are examples and not an exhaustive list

Intervention-generated inequities



Short report

What types of interventions generate inequalities? Evidence from systematic reviews

Theo Lorenc,[1] Mark Petticrew,[1] Vivian Welch,[2] Peter Tugwell[2]

- When inequities arise because of an intervention – i.e. may improve outcomes overall but increases inequities between groups

Intervention-generated inequities

- Some interventions may increase inequity
- For example, interventions / innovations are more accessible to those with higher literacy, digital access, or education; or fail to address barriers experienced by certain population groups such as:
  - Media campaigns
  - Printed educational material
  - Innovations piloted in urban centres and not adapted for rural or remote contexts
  - digital app intended for low-income populations but used mostly by tech-savvy, higher-income individuals

Health Equity Impact Assessment

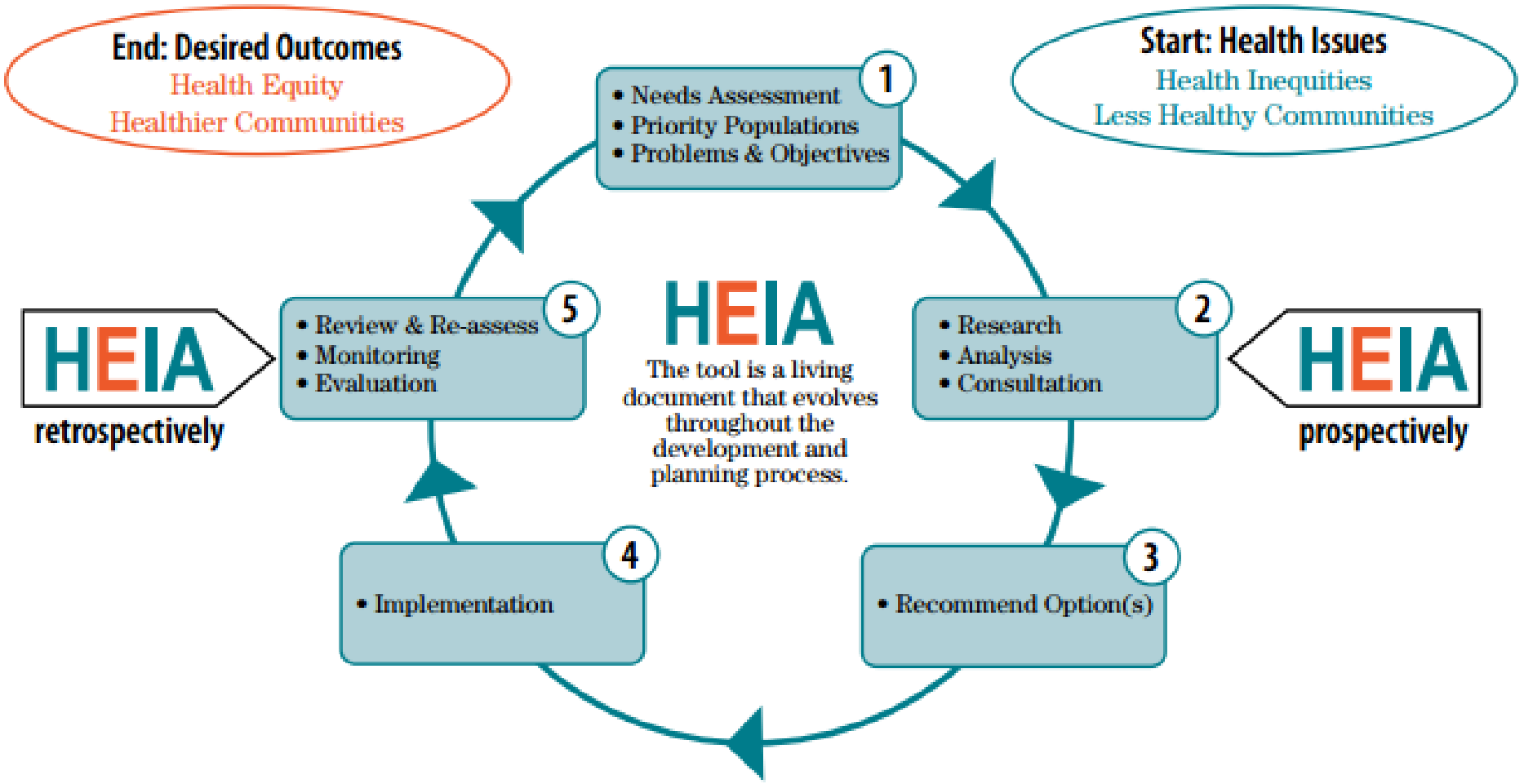
- A modified ‘Health Impact Assessment’ to go beyond “what are the possible health impact” to include considerations of the social determinants of health, health inequities, and disadvantaged populations.
- Identify possible unintended health impacts of decision-making (positive and negative) on specific population groups
- Planning tools are available for programs/services/policies to assess/analyze possible impacts on health equity and disadvantaged populations.

https://www.camh.ca/-/media/professionals-files/heia/health-equity-impact-assessment-workbook2012-pdf.pdf

5 Steps of a HEIA

1. Scoping
   - Special populations
   - Determinants of health
2. Potential Impacts
   - Unintended and intended effects (negative and positive)
3. Mitigation
   - Identify strategies to mitigate potential negative effects
4. Monitoring
   - How will you measure progress/impact?
5. Dissemination
   - How will you share your results?

Figure 1 – When to use HEIA



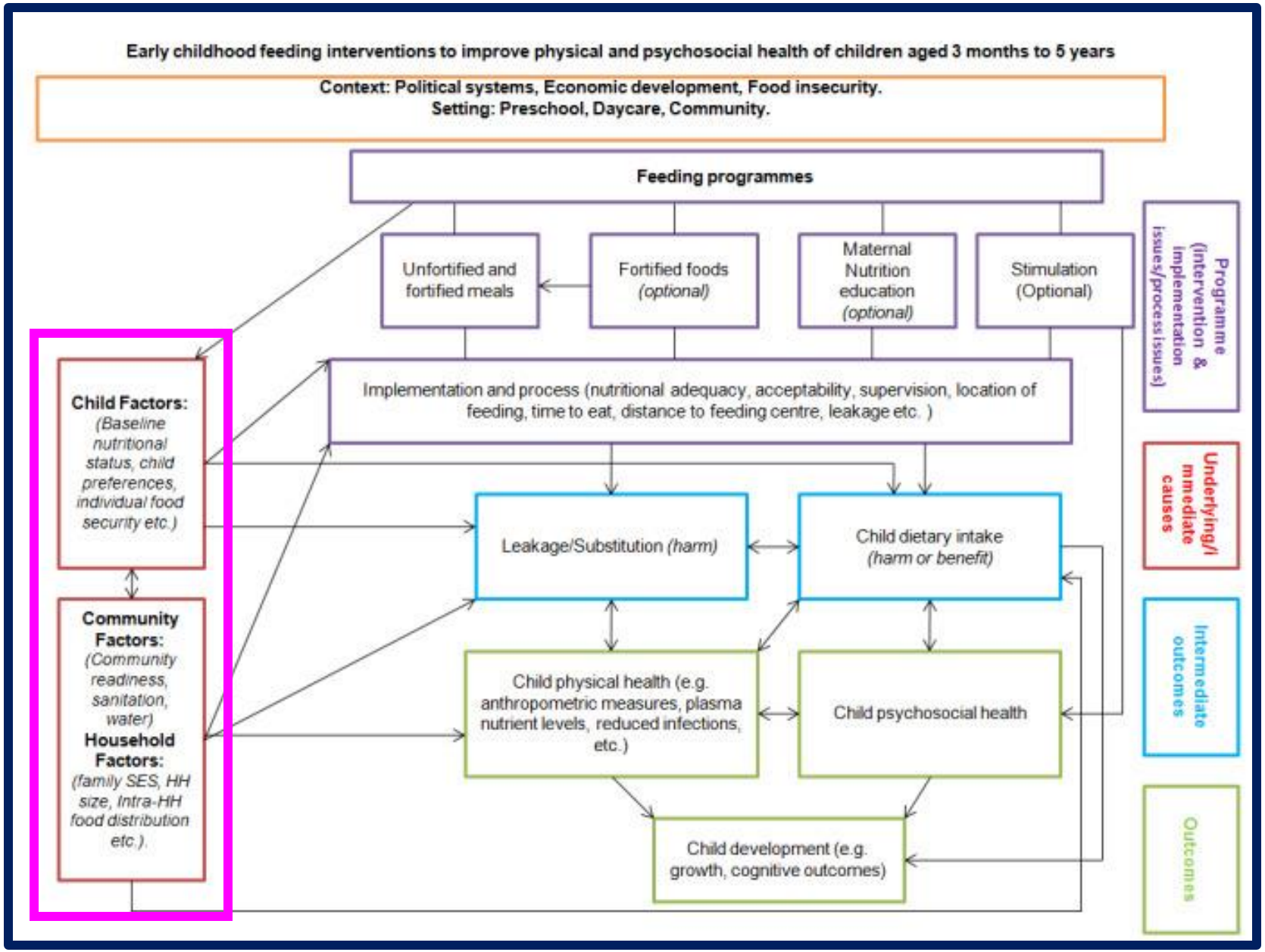
https://www.camh.ca/-/media/professionals-files/heia/health-equity-impact-assessment-workbook2012-pdf.pdf

HEIA Resources

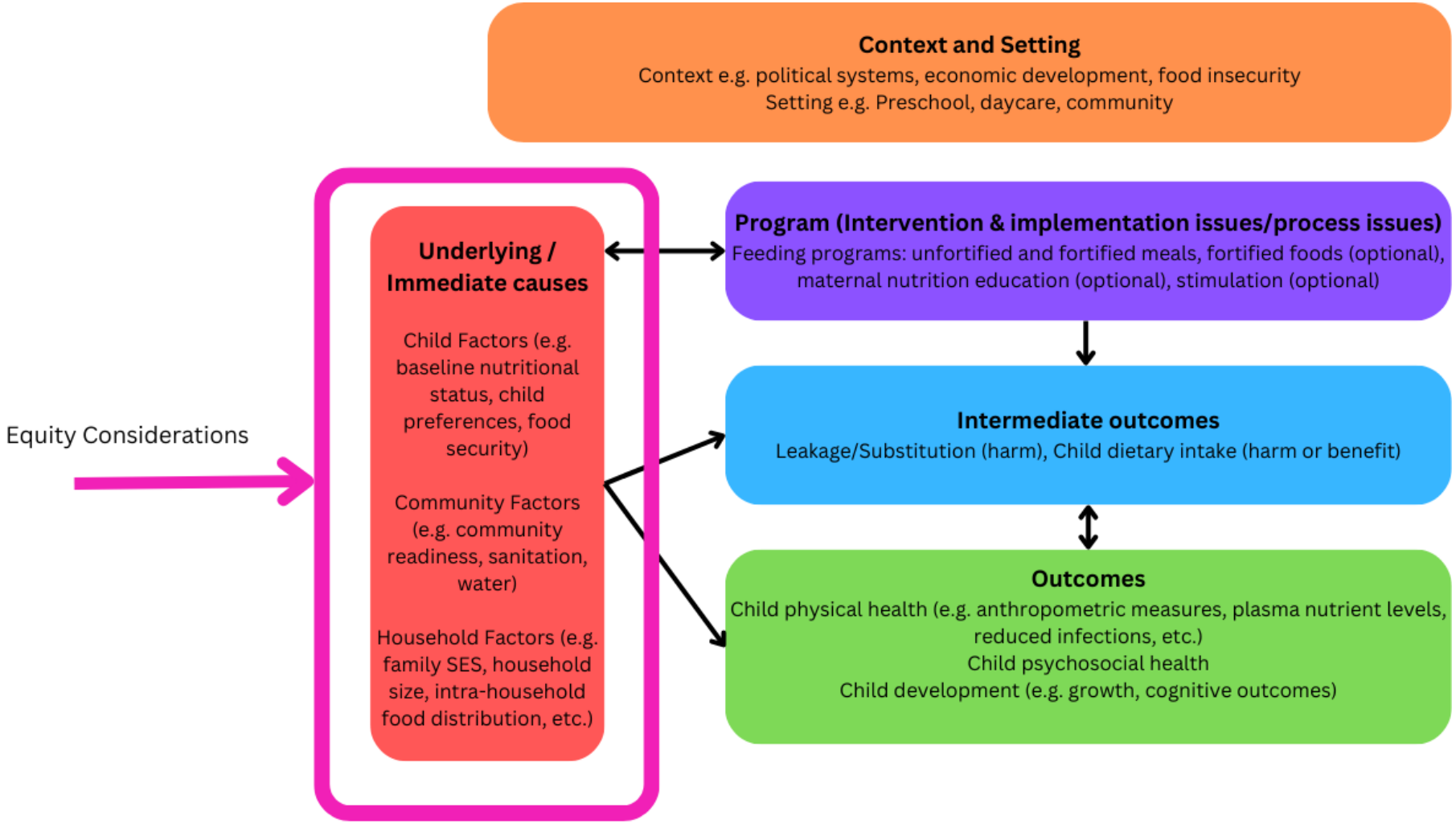
- Ontario Ministry of Health and Long-Term Care Toolkit (available on the Centre for Addiction and Mental Health website) https://www.camh.ca/-/media/professionals-files/heia/health-equity-impact-assessment-workbook2012-pdf.pdf

- Wellesley Institute https://www.wellesleyinstitute.com/our-work/health-equity/heath-equity-impact-assessment/?highlight=health%20equity%20impact%20assessment

LOGIC MODEL EXAMPLE



Logic Model


Context and Setting
Context e.g. political systems, economic development, food insecurity
Setting e.g. Preschool, daycare, community
Equity Considerations
Underlying / Immediate causes
Child Factors (e.g. baseline nutritional status, child preferences, food security)
Community Factors (e.g. community readiness, sanitation, water)
Household Factors (e.g. family SES, household size, intra-household food distribution, etc.)
Program (Intervention & implementation issues/process issues)
Feeding programs: unfortified and fortified meals, fortified foods (optional), maternal nutrition education (optional), stimulation (optional)
Intermediate outcomes
Leakage/Substitution (harm), Child dietary intake (harm or benefit)
Outcomes
Child physical health (e.g. anthropometric measures, plasma nutrient levels, reduced infections, etc.)
Child psychosocial health
Child development (e.g. growth, cognitive outcomes)

Who to engage?

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Providers of care

Public

Payers of research

Payers of health services

Patients, caregivers, and patient organizations

"... an individual or group who is responsible for or affected by health- and healthcare-related decisions" (Concannon et al. 2019).

Program managers

Principal investigators (& their research teams)

Peer review editors

Product makers

Policymakers

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Examples

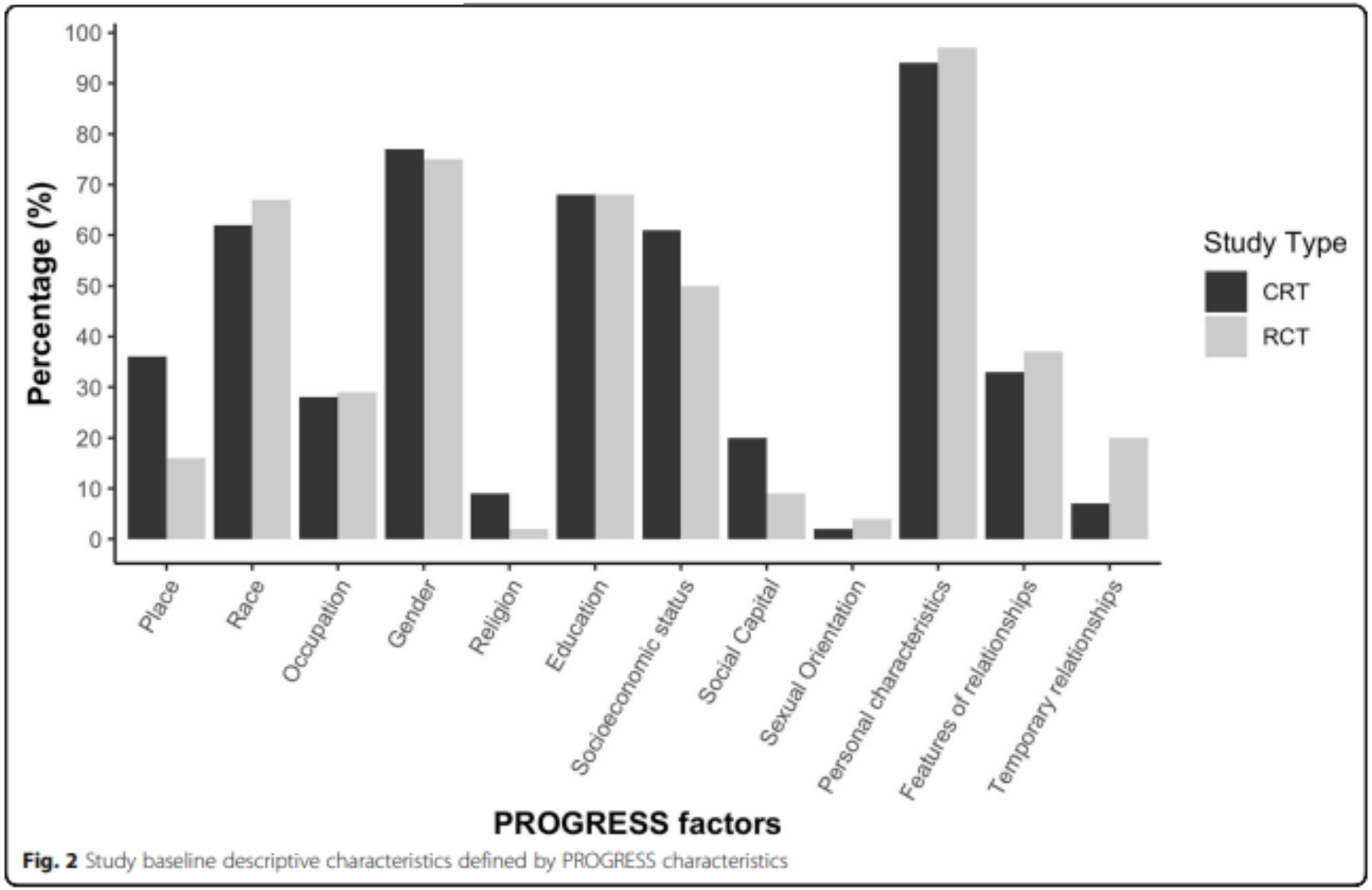

Fig. 2 Study baseline descriptive characteristics defined by PROGRESS characteristics

Petkovic et al. 2020. Reporting of health equity considerations in cluster and individually randomized trials

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Examples

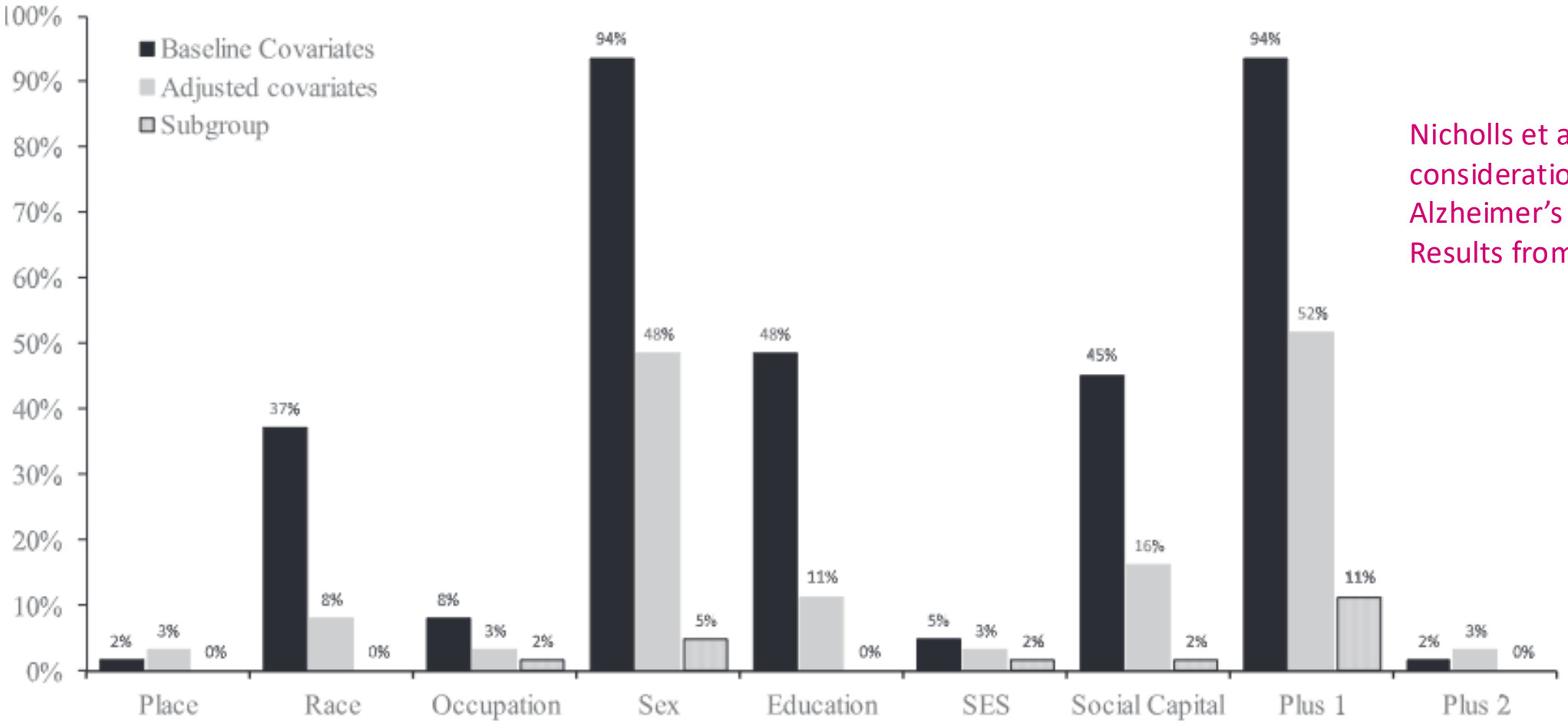

FIGURE 1 Equity-relevant characteristics reported at baseline and in covariate adjustment versus formally evaluated in subgroup analyses. Place, place of residence; Race, race/ethnicity/language/culture; Sex, sex/gender; SES, socioeconomic status; Plus 1, age/disability; Plus 2, features of relationship

Nicholls et al. 2022. Health equity considerations in pragmatic trials in Alzheimer's and dementia disease: Results from a methodological review

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Examples

Wang et al. 2023. Equity Considerations in COVID-19 Vaccination Studies of Individuals With Autoimmune Inflammatory Rheumatic Diseases

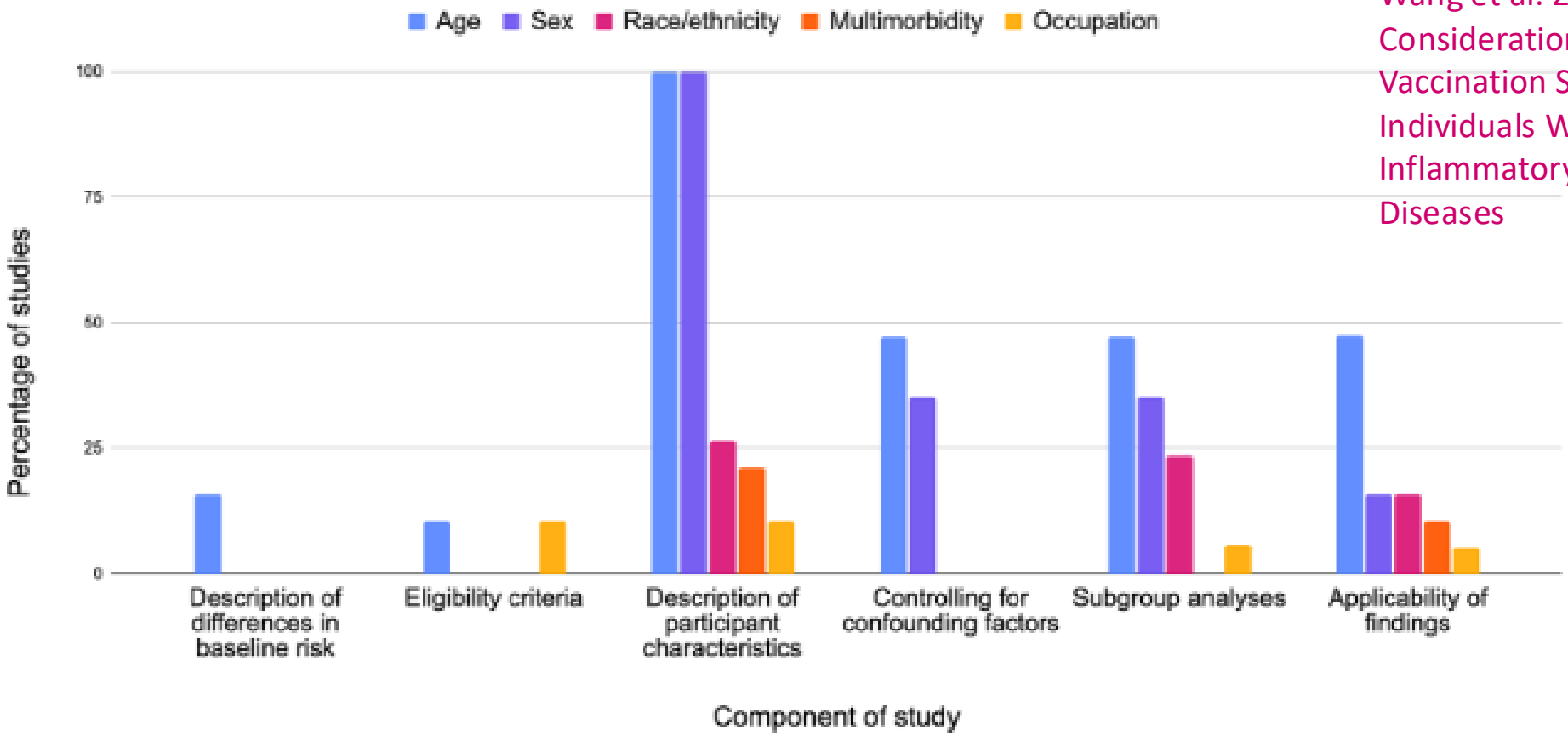


Figure 2. Distribution of PROGRESS-Plus factors across various study components in COVID-19 vaccine studies of individuals with autoimmune inflammatory rheumatic diseases.

Key points

- Thinking about equity is needed from the beginning to the end
- Define health equity in context of your review and whether you will address equity questions
- Describe relevant PROGRESS-Plus characteristics for populations in studies
- Choose (or develop) methods to answer your equity-related questions

Tutorials

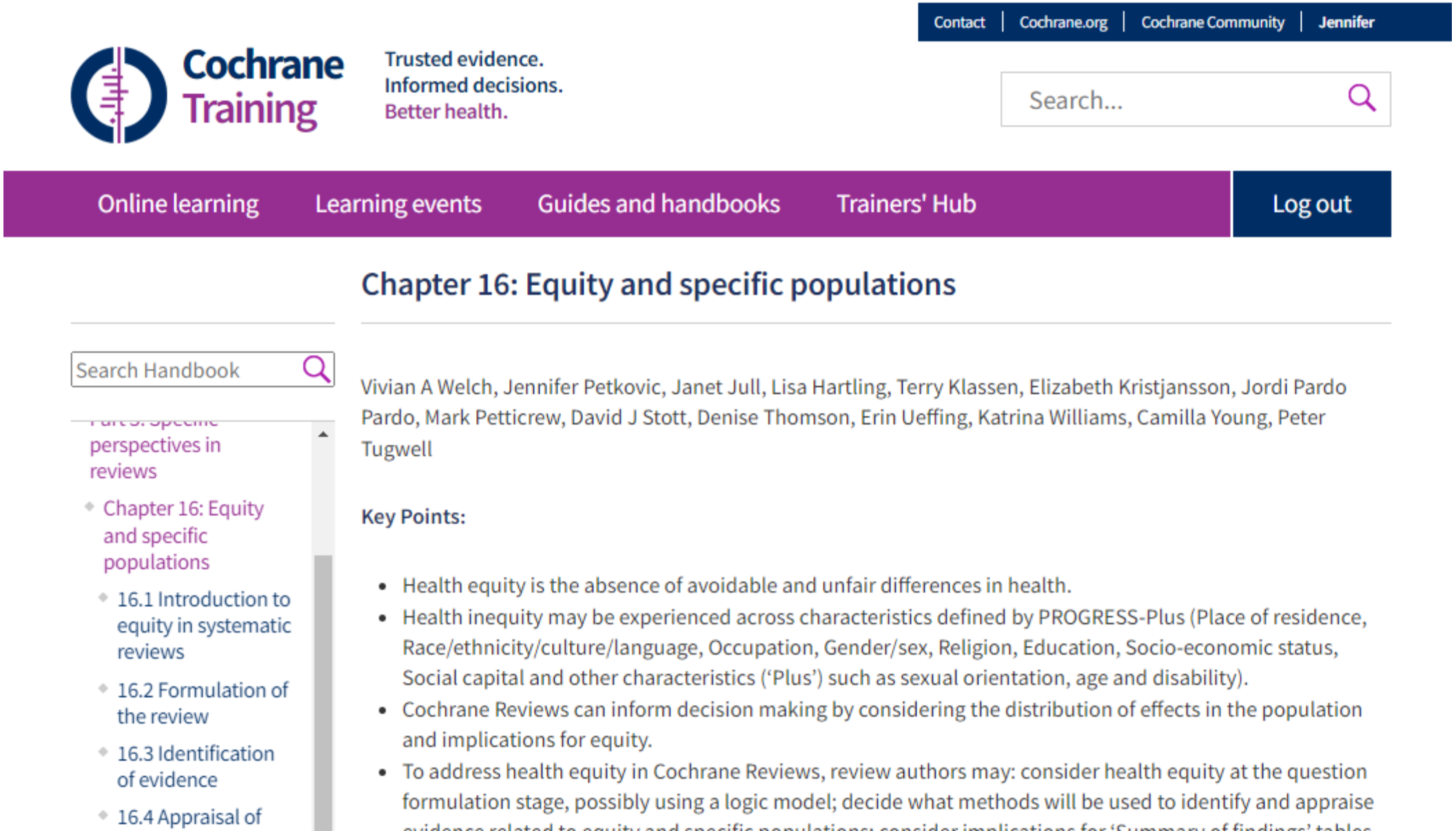
Health Equity in Systematic Reviews: A Tutorial—Part 2 Implementing Health Equity Throughout Your Methods

- Jennifer Petkovic, Jordi Pardo Pardo, Vivian Welch, Omar Dewidar, Lara J. Maxwell, Andrea Darzi, Tamara Lotfi, Lawrence Mbuagbaw, Kevin Pottie, Peter Tugwell
- Cochrane Evidence Synthesis and Methods; Volume 3, Issue 6

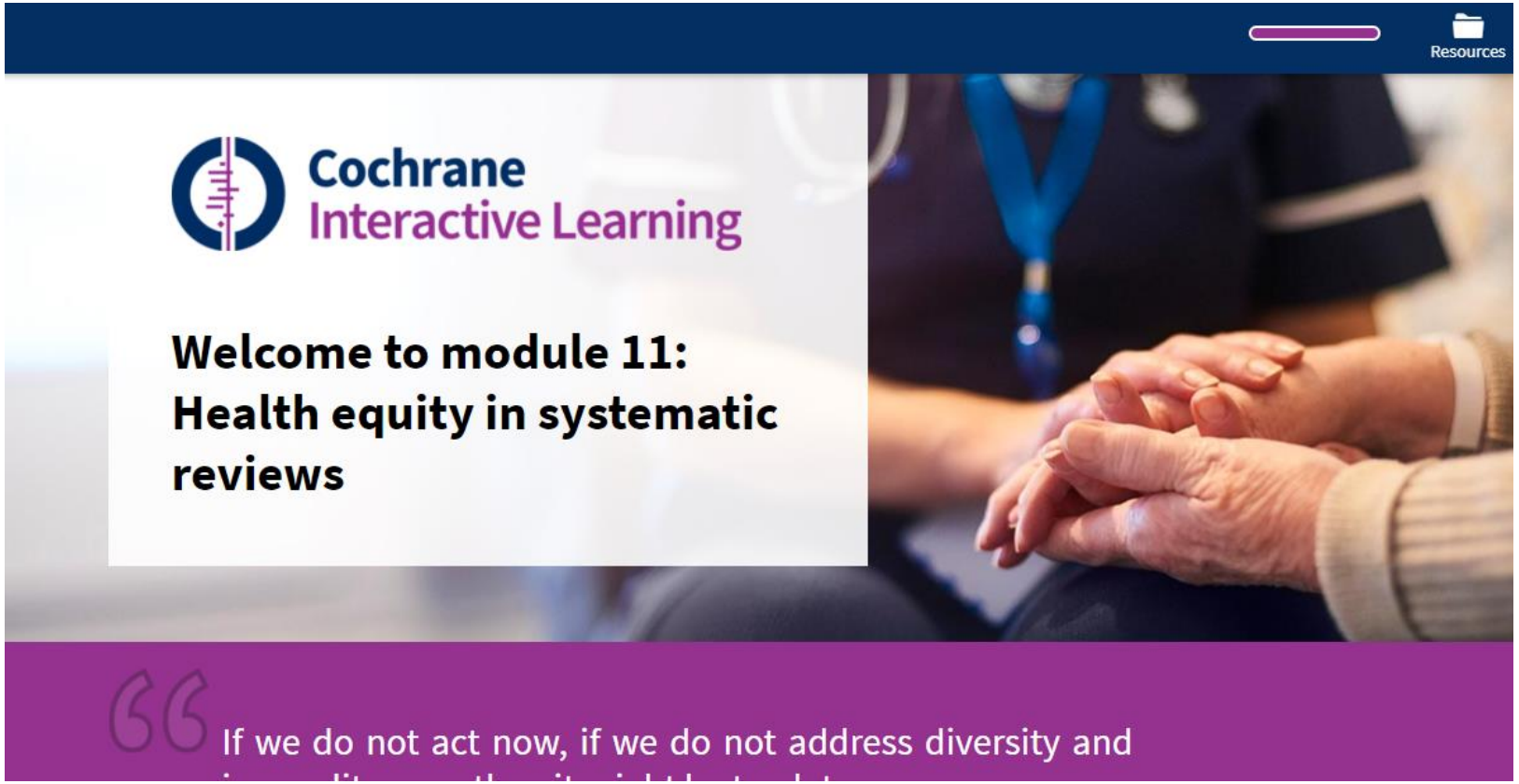
Health Equity in Systematic Reviews: A Tutorial—Part 1 Getting Started With Health Equity in Your Review

- Jennifer Petkovic, Jordi Pardo Pardo, Vivian Welch, Omar Dewidar, Lara J. Maxwell, Andrea Darzi, Tamara Lotfi, Lawrence Mbuagbaw, Kevin Pottie, Peter Tugwell
- Cochrane Evidence Synthesis and Methods; Volume 3, Issue 6

Equity is a Chapter in the 2019 Cochrane Handbook



- Interactive Learning Module – Introduction to health equity



Thanks!

jennifer.petkovic@uottawa.ca

https://methods.cochrane.org/equity/
https://theoche.ca/