Healthy Eating Research

Increasing Equity Impact in Community-Based Nutrition Research

FRIDAY, SEPTEMBER 25, 2020

12:00-1:30 P.M. ET

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HER Program Goals

1. Establish a research base for policy, systems, and environmental change strategies that advance health equity in the areas of diet quality and nutrition.
2. Build a vibrant, multidisciplinary field of research and a diverse network of researchers.
3. Ensure that findings are communicated effectively to inform the development of solutions with the goal of promoting health equity.

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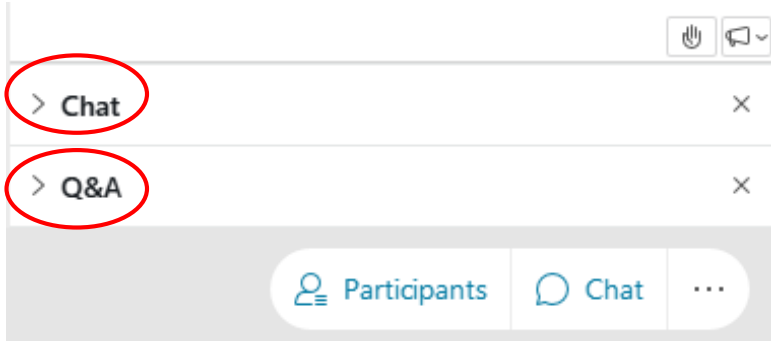
Logistics

- Participants will be muted
- Ask any tech or logistics questions for the host in the chat bar
- 20-30 minutes of Q&A at the end of the webinar – ask questions for the presenters in the Q&A bar
- Recording and slides will be available at http://healthyeatingresearch.org/



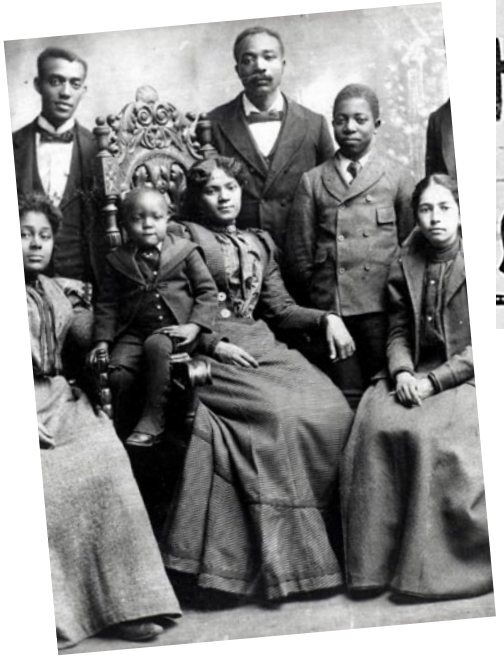
Natasha Frost, JD, Public Health Law Center

Zinzi Bailey, ScD, MSPH, University of Miami Miller School of Medicine

Caree Cotwright, PhD, RDN, University of Georgia

Shiriki Kumanyika, PhD, MPH, Drexel University School of Public Health

Moderator: Angela Odoms-Young, PhD, University of Illinois at Chicago



ANGELA ODOMS-YOUNG, PHD

UNIVERSITY OF ILLINOIS AT CHICAGO

"Racism affects health in profound ways that are over and beyond any of the measures, through systems that have been built up over the years and are now "locked in place, replicating social inequality…Race is not a useful genetic category, but it's a profoundly useful social category.

What race we belong to tells us much more about our society than about our biological make up…At every level of income and education, there is still an effect of race, even wealthy black Americans are statistically less healthy than affluent white people. Health disparities are large and persistent over time."

"About 220 African-Americans die every day in the United States who would not die if their death rates were similar to those of white people"

~David Williams, PhD
Quote from "David Williams Studies Health Disparities in America, American Psychological Association, February 21, 2018

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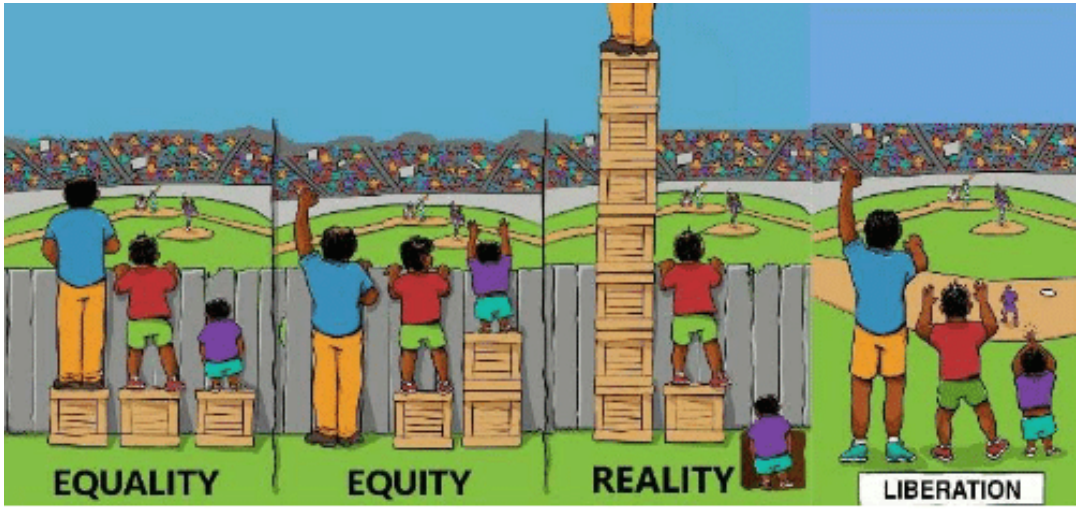
Overview

1. What is the definition of health disparities, social determinants of health, health equity, and health inequity?
2. Why is it important to look at diet through an equity lens?-the role of cultural/historical trauma and colonization in creating inequity, specifically racial inequity.
3. How do we look at nutrition and diet through an equity lens?

What are the definitions of health disparities, social determinants of health, health equity, and health inequity?

The Federation of Egalitarian Communities:

https://communelifeblog.wordpress.com/2018/10/19/aspirational-egalitarianism/



Health Disparities	Health Inequities	Health Equity	Social Determinants	Structural Determinants
Differences in the incidence and prevalence of health conditions and health status between groups based on: •Race/ethnicity •Socioeconomic status •Sexual orientation •Gender •Disability status •Geographic location •Combination of these	**Avoidable** differences in health status or distribution of health resources between different populations groups within countries or between countries that are **systematic and unjust.**	Everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”	“Place-based social and economic conditions in which people are born, live, age, work, play, & worship whose distribution across populations/communities effectively determines length and quality of life. **Material circumstances**-housing and neighborhood quality, consumption potential (financial means to purchase healthy food, warm clothes, etc.), and the physical work environment. **Psychosocial circumstances**-psychosocial stressors, stressful living circumstances and relationships, social support and networks. **Social cohesion**-the existence of mutual trust and respect among society's various groups and sections; it contributes to how people and their health are cherished. **Health system quality and access**-exposure and vulnerability to risk factors, access to health services and programs to mediate the consequences of illness in individuals' lives	Those attributes that generate or strengthen a society's stratification and define people's socioeconomic position. These mechanisms shape the health of a social group based on its location within the **hierarchies of power, prestige, and access to resources**. Their designation as "structural" emphasizes the causal hierarchy of the social determinants in the production of social health inequities.

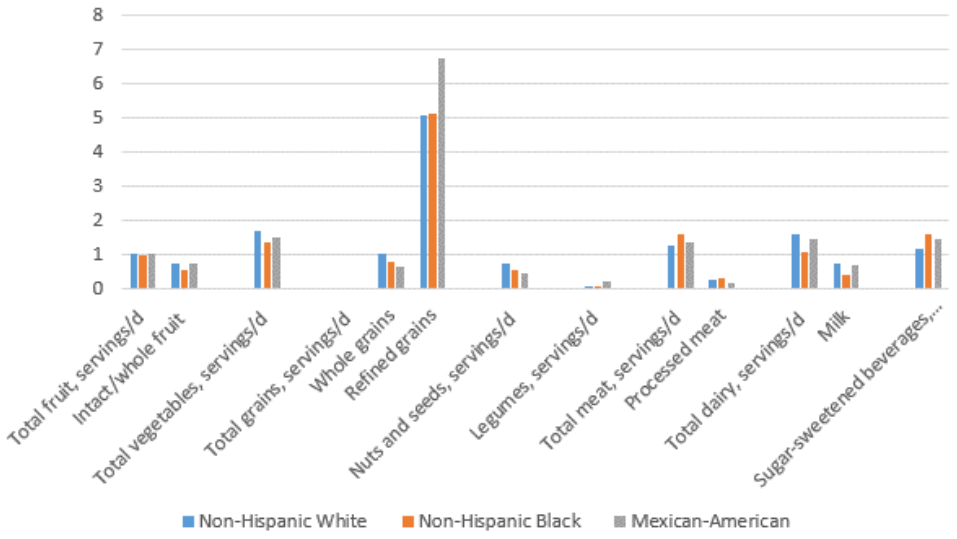
CDC, WHO, RWJF

Why is it important to look at nutrition and obesity through an equity lens?

DIET AND HEALTH DISPARITIES

Population mean consumption of food groups of interest by race/ethnicity among US adults ≥20y by NHANES survey cycle, 2011-2012

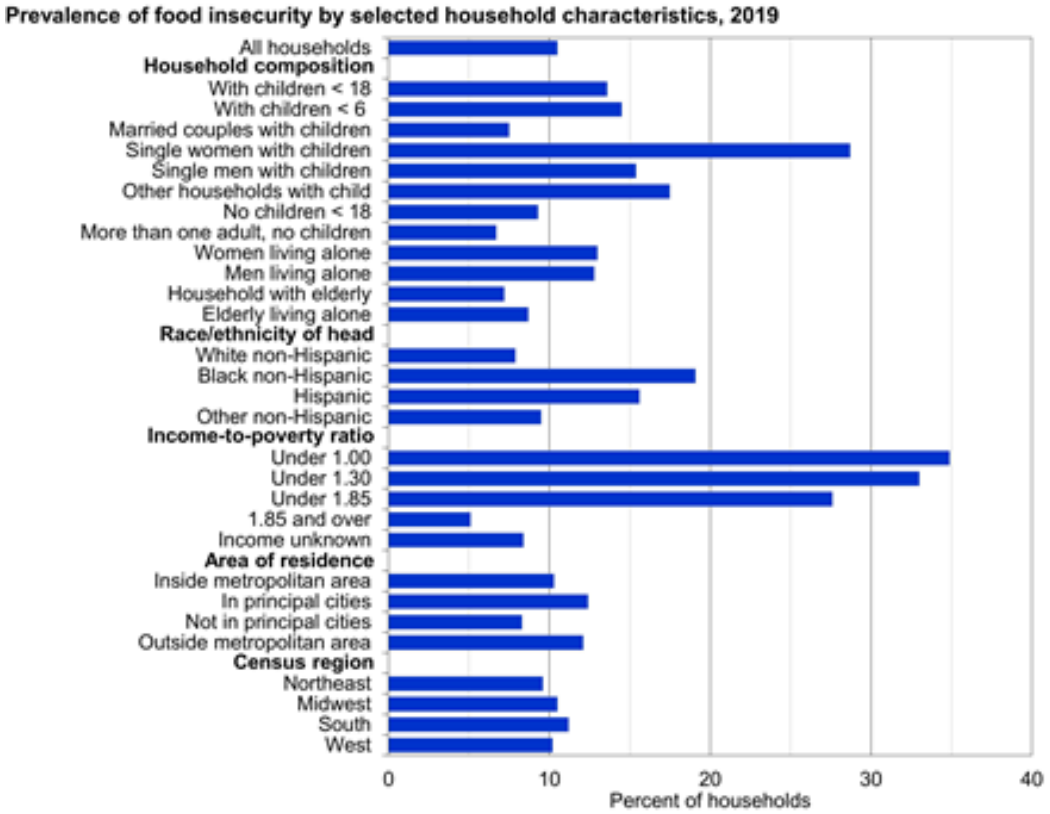
- Despite improvements over the last decade, only a small numbers of Americans are meeting the recommended levels for most dietary factors.
- Fewer than 1 in 6 adults are consuming sufficient vegetables, fruits, or seafood and 1 in 50 are consuming sufficient whole grains.
- Blacks fall short of recommendations for several food groups/nutrients



Rehm et al., 2016

Disparities in Diet and Related Health Outcomes

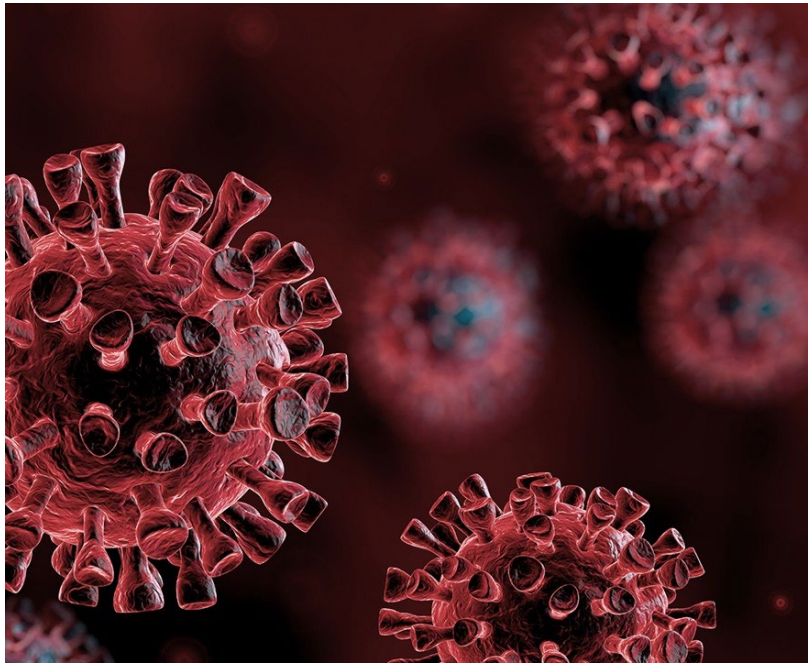
USDA, 2019



Estimates of Food Insecurity During the COVID Crisis (April 2020)

	All Respondents		Respondents with Children		Respondents witho Children	
	Food just didn't last (1)	Worried food would run out (2)	Food just didn't last (3)	Worried food would run out (4)	Food just didn't last (5)	Worri food would out (6)
Overall	23%	28%	34%	42%	18%	22%
White, Non-Hispanic	18%	22%	33%	39%	14%	18%
Black, Non-Hispanic	29%	34%	38%			32%
Hispanic	34%	43%	42%	52%	30%	37%
Other, Non-Hispanic	25%	29%	24%	35%	26%	25%

nbach & Pitts, 13 May 2020



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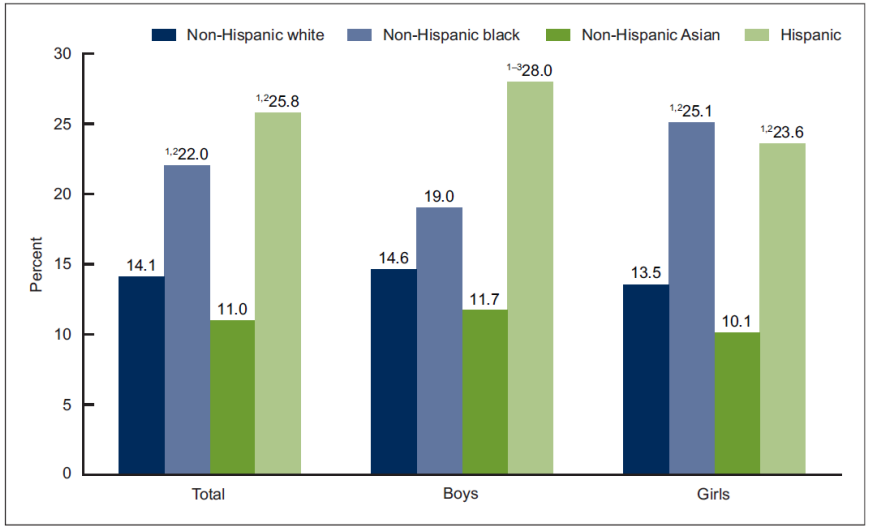
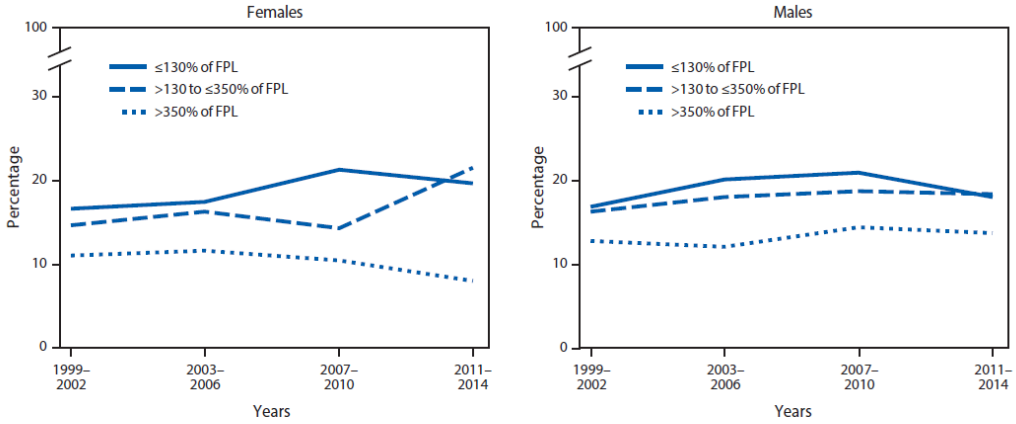


[1]Significantly different from non-Hispanic Asian persons.
[2]Significantly different from non-Hispanic white persons.
[3]Significantly different from non-Hispanic black persons.
NOTE: Access data table for Figure 4 at: https://www.cdc.gov/nchs/data/databriefs/db288_table.pdf#4.
SOURCE: NCHS, National Health and Nutrition Examination Survey, 2015–2016.

NCHS Data Brief ■ No. 288 ■ October 2017

Prevalence of obesity among youth aged 2–19 years, by sex and race and Hispanic origin: United States, 2015–2016



Abbreviation: FPL = federal poverty level.
* Linear trend ($p<0.05$) for females ≤130% of FPL, >130% to ≤350% of FPL.
† Quadratic trend ($p<0.05$) for males ≤130% of FPL.

Trends*,† in obesity prevalence among youths (persons aged 2–19 years), by household income — National Health and Nutrition Examination Survey, United States, 1999–2002 through 2011–2014

Ogden et al., 2018

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Impact of Broader Inequity

Disability and Weight Status

- Obesity among children with developmental disabilities (29.7%) and autism (30.4%) also appears significantly higher compared with children in the general population (Bandini et al., 2005; Curtin et al., 2010; Segal et al., 2016).
- 20% of children 10 through 17 years of age who have special health care needs are obese compared with 15% of children of the same ages without special health care needs (NCSH, 2007).

Sexual Minority Status/Gender Identity and Weight Status

- Cisgender sexual minority male adolescents had lower or no additional risk for overweight or obesity, whereas cisgender sexual minority females demonstrated greater risk for overweight and obesity (Grammar et al., 2019).
- Among males, heterosexual individuals showed greater one-year BMI gains than gay males across all race/ethnicity groups. Among females, white and Latina bisexual individuals had higher BMI than same-race/ethnicity heterosexual individuals regardless of age; there were no sexual orientation differences in black/African Americans (Katz-Wise et al., 2014)

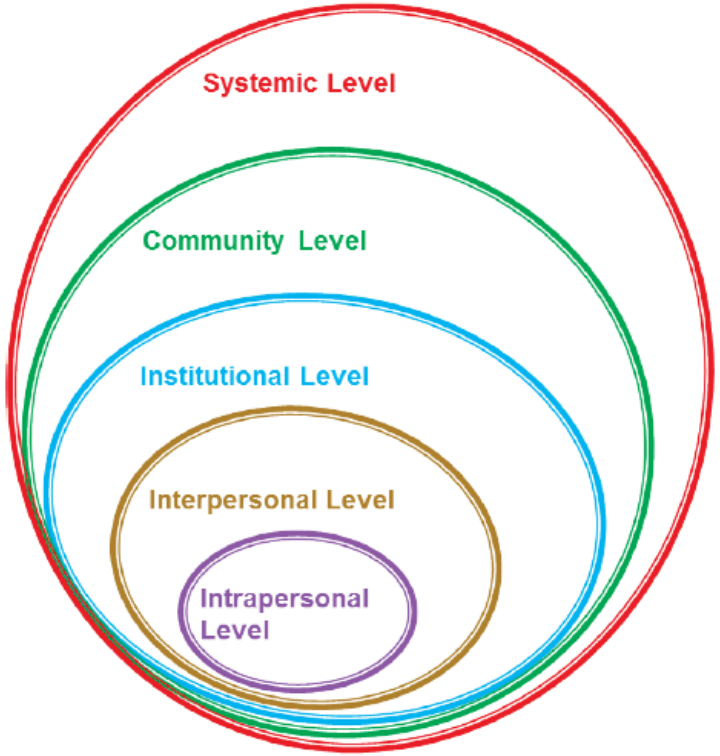
Intersectionality

- The prevalence of obesity among youth living in households headed by college graduates was lower than that among those living in households headed by less educated persons for each race-Hispanic origin group. However, obesity prevalence was lower in the highest income group compared with the other groups among non-Hispanic white females, but not among non-Hispanic black females, non-Hispanic white males, or non-Hispanic black males (Ogden et al., 2018).
- African American/Latinx individuals that identify as sexual minorities may be at greater risk for negative health outcomes due to experiences of minority stress based on being a member of multiple oppressed groups (Katz-Wise et al., 2014)
- African American/Latinx individuals with a disability are at great risk for overweight/obesity (Rimmer et al., 2010)

ROOTED IN SOCIAL AND STRUCTURAL DETERMINANTS

Communities in Action: Pathways to Health Equity (NAS, 2017)

- Historical and Political
- Persist over the Life Course



Systemic Level
- Immigration policies
- Incarceration policies
- Predatory banking

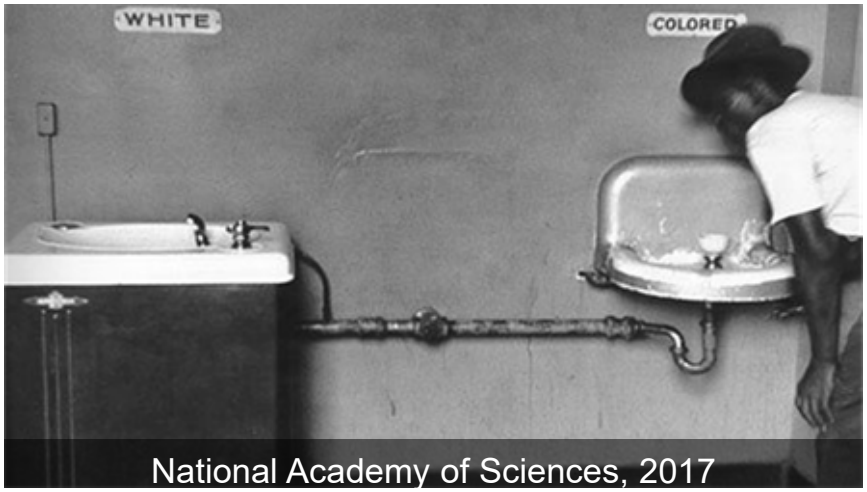
Community Level
- Differential resource allocation
- Racially or class segregated schools

Institutional Level
- Hiring and promotion practices
- Under- or over-valuation of contributions

Interpersonal Level
- Overt discrimination
- Implicit bias

Intrapersonal Level
- Internalized racism
- Stereotype threat
- Embodying inequities

Pathways

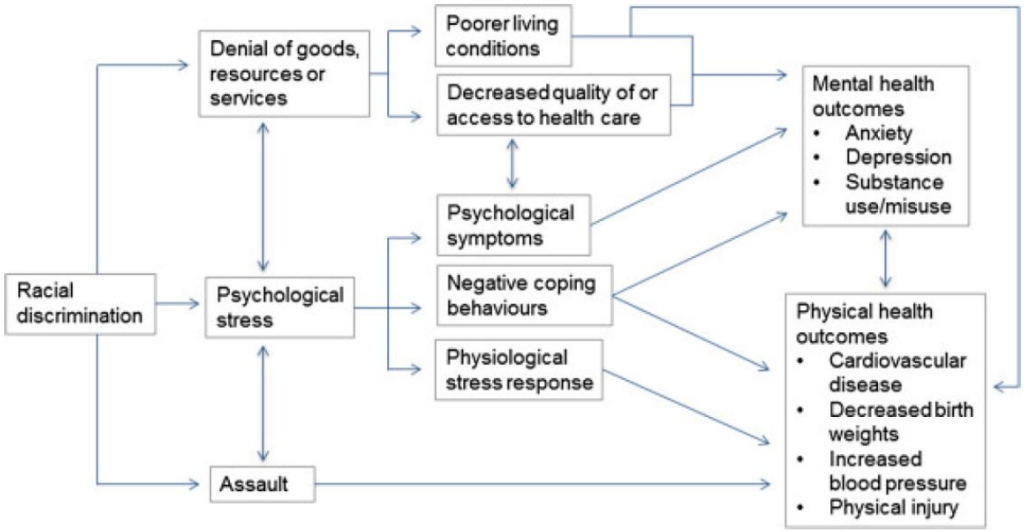


National Academy of Sciences, 2017

Racial discrimination includes 2 components:

- (1) “Differential treatment on the basis of race that disadvantages a racial group” (disparate treatment)
  - “Disparate treatment,” studies have shown that racial discrimination limits people of color’s access to educational and employment opportunities, housing, and other resources, resulting in social and economic consequences
- (2) “treatment on the basis of inadequately justified factors other than race that disadvantages a racial group” (disparate impact).
  - “Disparate impact,” also has implications for creating racial/ethnic disparities (e.g. income inequity).

A conceptual model of the relationship between racism and health



Source: Paradies et al; Systemic Reviews 2013 2:85

- Racial Segregation and Neighborhood Disadvantage
- Education, Income Inequality and Debt
- Discrimination, Trauma, and Stress

Fewer Opportunities, Higher Costs

Racial Segregation

Among middle- and upper-income households, African-Americans are more likely than Hispanics or whites to live in disadvantaged neighborhoods that are surrounded by spatial disadvantage. More than half of middle- and upper-income African-American households 52% live in neighborhoods that are disadvantaged and surrounded by disadvantage, compared to 44% of Hispanic households and 11% of white households.

Only 31% of middle- and upper-income black households live in advantaged tracts that are surrounded by spatial advantage, compared to 39% of Hispanics and 77% of whites

Mapping Life Expectancy (VCU/RWJF, 2015)

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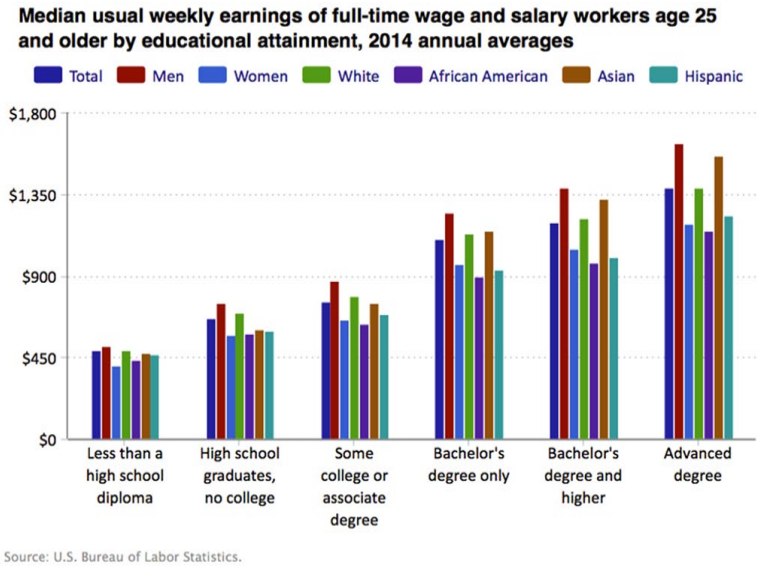
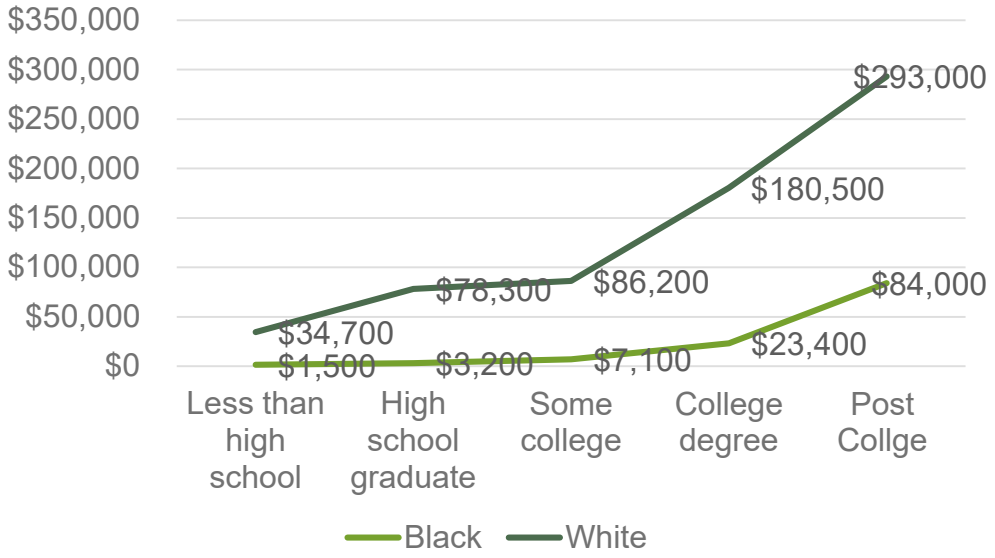
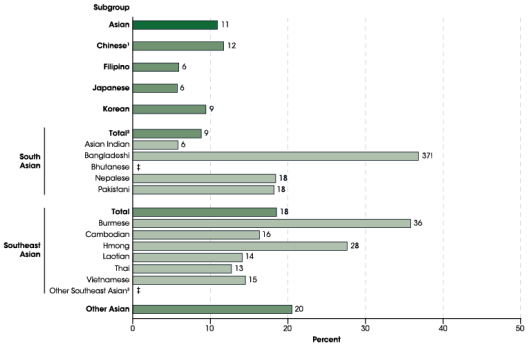
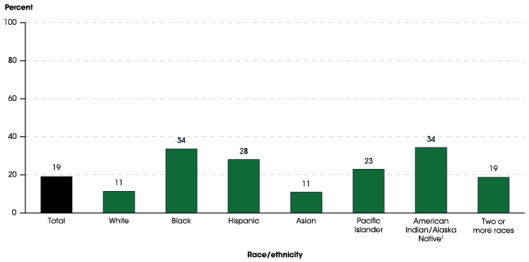
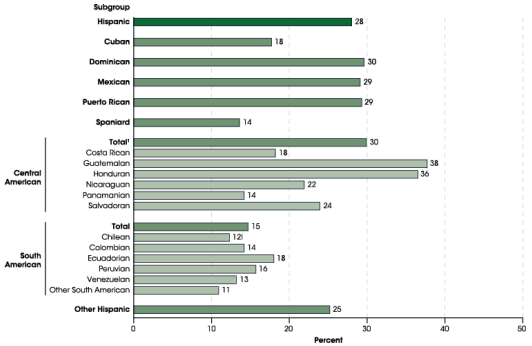
Income Inequality



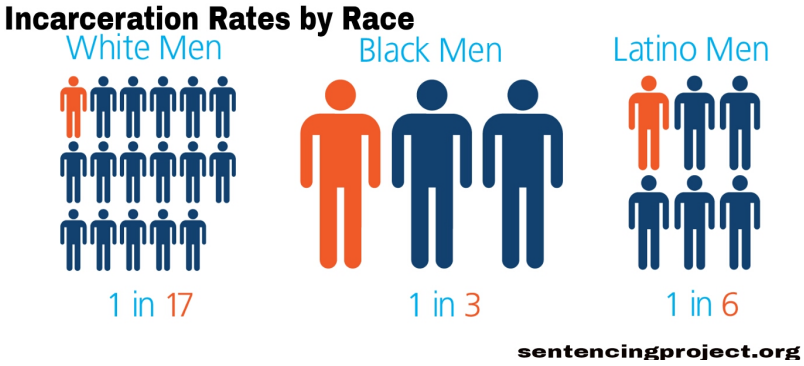


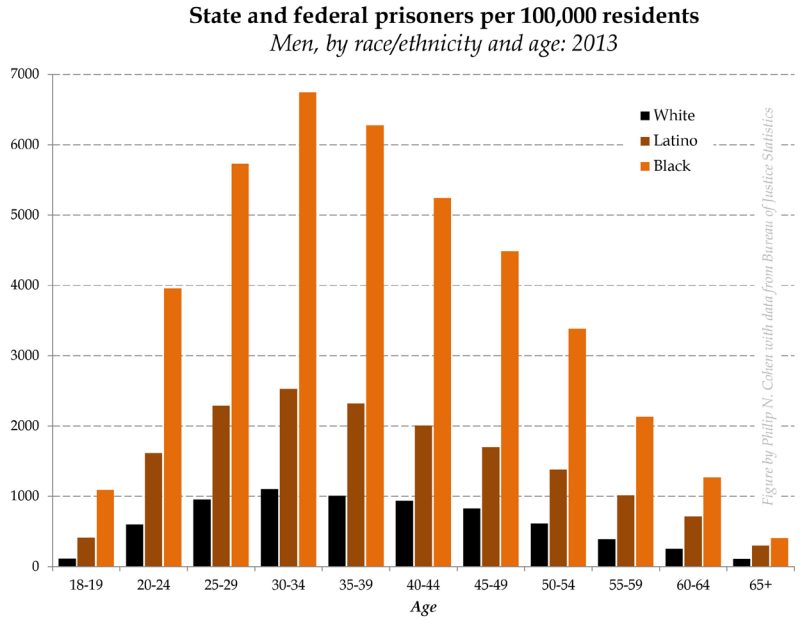






Children Living in Poverty for Racial/Ethnic Subgroups





Incarceration

How do we look at health equity through a nutrition, diet, and obesity lens?

Equity vs Disparities: an Epistemology that guides Methodology

With its origins in philosophy, epistemologies of ignorance highlight the role and function of ignorance in the practice and production of knowledge. For example, conventional biomedical, biobehavioral, and psychosocial frameworks and the public health research, interventions, and policies they inform typically conceptualize health primarily as a property of individuals and the result of individual behaviors. In so doing, they obscure the role of social–structural factors (e.g. political, economic, institutional discrimination) that constrain the health of historically marginalized individuals, communities, and societies…

Neglecting the historical legacy of how race (as well as the other marginalized social positions that intersect with race) has structured social inequality for people of color in the United States serves to center the health experiences of White people as normative, "color blinds" White privilege to highlight positive health outcomes among White people as the product of their individual actions, and reifies negative stereotypes about the "irresponsible" health behaviors of people of color.

Bowleg, L. (2017) Towards a Critical Health Equity Research Stance: Why Epistemology and Methodology Matter More Than Qualitative Methods

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What is our Epistemology?

Do we believe:

- Inequity exists across systems, structures, policies, and institutions in the United States, including public health, criminal justice, education, financial, housing, etc.
- Inequity is deeply entrenched and historic.
- Inequities are at the root of differences in childhood obesity outcomes and that these outcomes are avoidable and unjust
- Dominant approaches to systems and behavior change fail to integrate an intentional equity lens into the work including the system of research
- Transformation requires systemic equity-driven, evidence-based interventions and **training** to change thinking, address structural and social determinants of health, and improve outcomes for all populations

4 Steps to Achieve Health Equity (RWJF, 2017)

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Identify important health disparities. Many disparities in health are rooted in inequities in the opportunities and resources needed to be as healthy as possible. The determinants of health include living and working conditions, education, income, neighborhood characteristic, social inclusion, and medical care. An increase in opportunities to be healthier will benefit everyone but more focus should be placed on groups that have been excluded or marginalized in the past.

Change and implement policies, laws, systems, environments, and practices to reduce inequities in the opportunities and resources needed to be as healthy as possible. Eliminate the unfair individual and institutional social conditions that give rise to the inequities.

Evaluate and monitor efforts using short- and long-term measures as it may take decades or generations to reduce some health disparities. In order not to underestimate the size of the gap between advantaged and disadvantaged, disadvantaged groups should not be compared to the general population but to advantaged groups.

Reassess strategies in light of process and outcomes and plan next steps. Actively engage those most affected by disparities in the identification, design, implementation, and evaluation of promising solutions.

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Systems Change with an Equity Lens (Bamdad and Mann, Building a Movement Project)

1. **Grounding in shared humanity**. The systems change effort is aligned around a clear vision for change that recognizes the unique and individual needs of everyone in the system. The effort seeks to repair, restore and lift up relationships and connections across people and communities to support shared stewardship for change.

2. **Reinforcing and resourcing decisions made by communities affected by injustice**. The systems change effort redistributes and rebalances power. Communities are a part of meaning-making and decision-making rather than simply informed. This includes providing communities with the funding, training and information needed to make decisions that serve them.

3. **Shifting the role of power from reinforcing systems of injustice to sparking equitable change**. The approach is grounded in an understanding of how white supremacy and patriarchy have shaped systems and structures to perpetuate inequity. The strategy assesses who/what has power and how we build, redistribute and share power to transform systems and prevent systems from resetting back to the status quo.

4. **Addresses the internal condition of the intervener as well as the system**. Effective systems change requires the intervener to look inward and tend to the inner health of the change effort in order to effectively spur change. The systems change effort seeks to alter the dominant and oppressive narratives we tell ourselves and supports people in being grounded and in touch with their emotions so that they can be in relation with one another

https://www.buildingmovement.org/blog/entry/systems_change_with_an_equity_lens#_ftn1

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BEFORE EQUITY CONSULTATION

1) To help providers follow your state's healthy eating policies, are in-person trainings:

Offered to:

- ❑ Centers?
- ❑ Family day care homes?
- ❑ Other?

Offered:

- ❑ Monthly
- ❑ 6-11 times per year
- ❑ 3-5 times per year
- ❑ 1-2 times per year
- ❑ Less than annually

AFTER EQUITY CONSULTATION

a) Are the trainings offered in multiple locations?

- ❑ Yes
- ❑ No

b) Which languages are trainings offered in?

- ❑ English only
- ❑ Multiple languages

c) Are there culturally-specific trainings? If so, please describe:

d) Are there any fees that child care providers have to pay in order to access the training?

- ❑ Yes
- ❑ No

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BEFORE EQUITY CONSULTATION

(crickets chirping)

AFTER EQUITY CONSULTATION

Are there any specific funds earmarked for providing training, technical assistance, or other supportive resources for helping providers meet standards for nutrition, physical activity, and screen time?

- ❑ Yes:
  - ❑ [If yes] To whom are these funds targeted (check all that apply):
    - ❑ All providers – no specific target OR:
      - ❑ Providers participating in state QRIS
      - ❑ Providers receiving CCDF subsidies
      - ❑ Family child care providers
      - ❑ Center-based providers
      - ❑ Rural providers
      - ❑ Urban providers
- ❑ No

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BEFORE EQUITY CONSULTATION

(crickets chirping)

AFTER EQUITY CONSULTATION

In your view, how much of a priority is providing training or technical assistance on your state's child care regulations for specific providers?

For providers serving predominantly families who are English language learners:

a. Not a priority at all b. Minimal priority c. Same priority
d. More of a priority e. Highest priority

For providers serving predominantly low income families:

a. Not a priority at all b. Minimal priority c. Same priority
d. More of a priority e. Highest priority

For providers serving predominantly families from marginalized racial/ethnic groups:

a. Not a priority at all b. Minimal priority c. Same priority
d. More of a priority e. Highest priority

For providers who are English language learners themselves:

a. Not a priority at all b. Minimal priority c. Same priority
d. More of a priority e. Highest priority

CAREE J. COTWRIGHT, PHD, RDN, LD

UNIVERSITY OF GEORGIA


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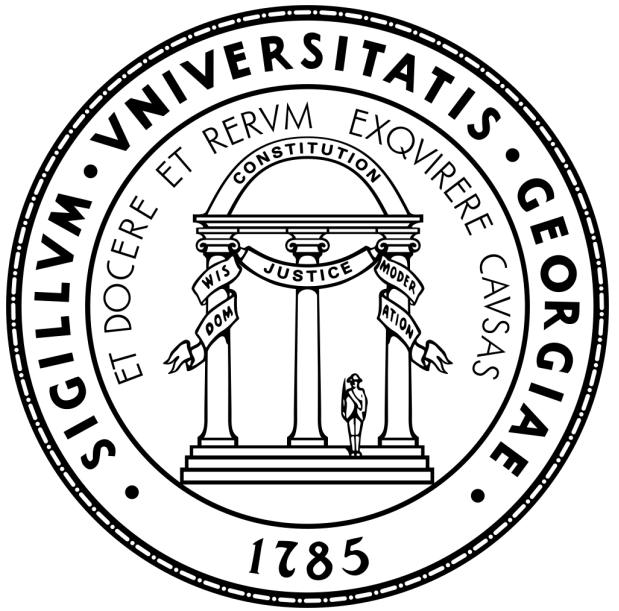
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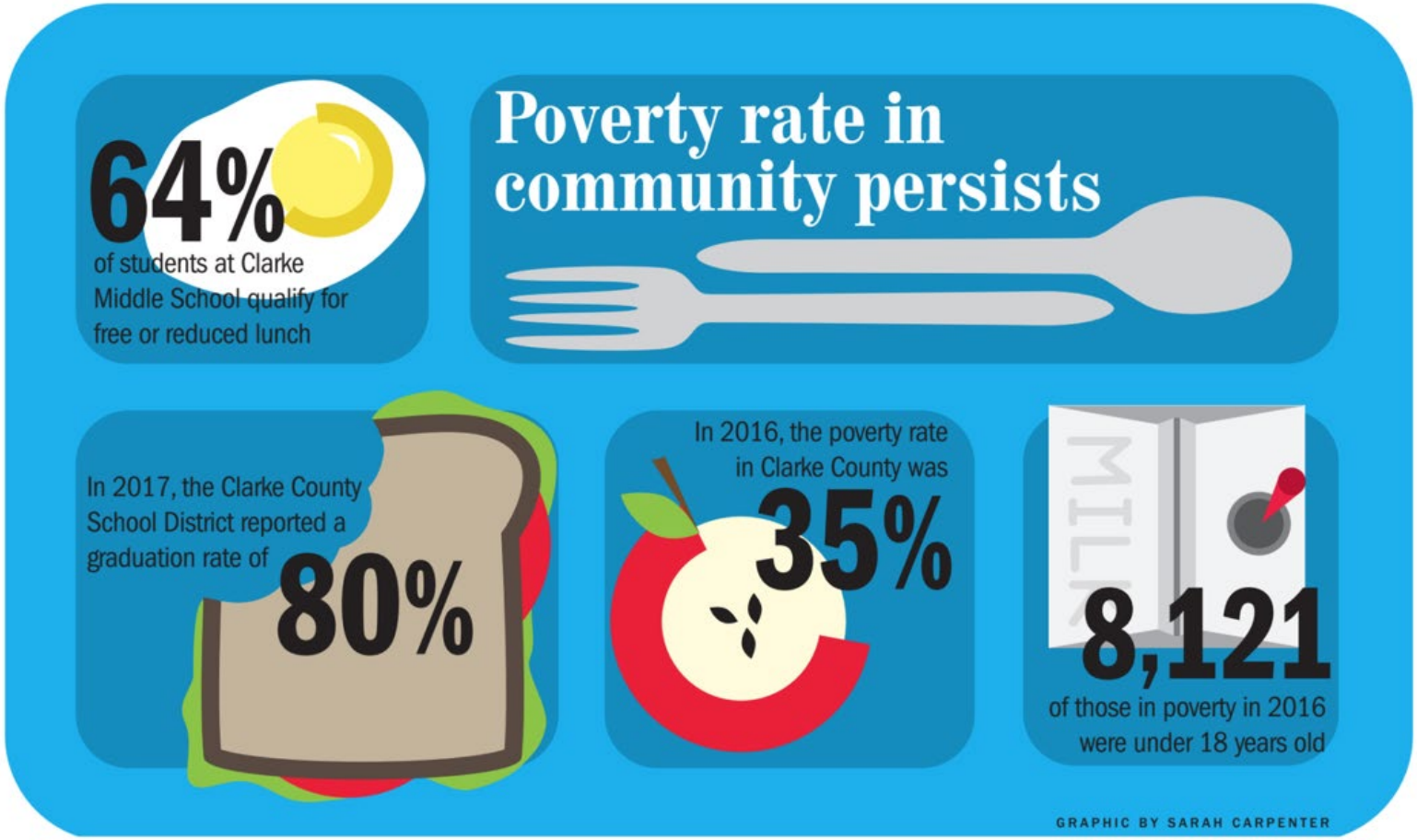
64%
of students at Clarke Middle School qualify for free or reduced lunch
Poverty rate in community persists
In 2017, the Clarke County School District reported a graduation rate of
80%
In 2016, the poverty rate in Clarke County was
35%
MILK
8,121
of those in poverty in 2016 were under 18 years old
GRAPHIC BY SARAH CARPENTER


HUNTER &
HOLMES
UGA's First African
American Students
Georgia
GROUNDBREAKERS
GEORGIA
1785

1961


GEORGIA
1785
MARY FRANCES EARLY
Her Impact and Legacy Continue

1962

2020

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“Instead of rushing to solutions we must rush to understanding.”-Jeremy Everett

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Black Researcher Conducting Research in Black Communities

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In the Community

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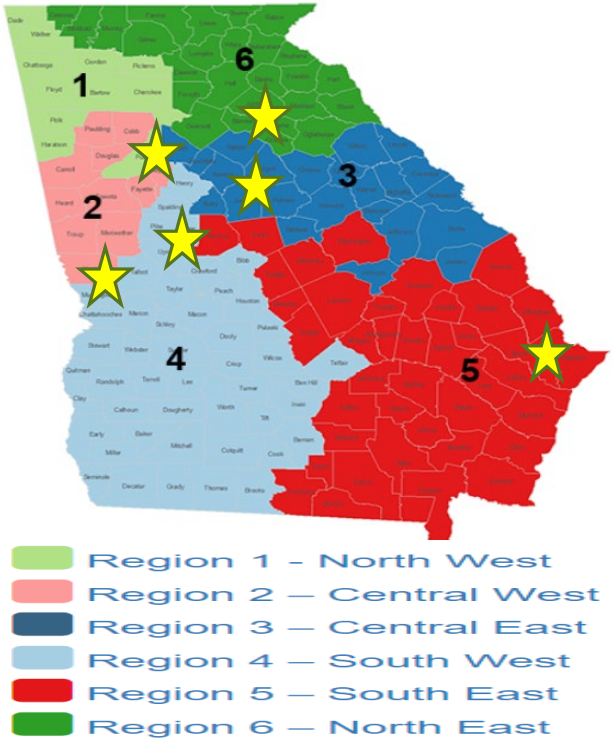
SNAP-ED

RWJF



The Importance of Understanding in Equity

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Griot: The Keeper of Stories
The rush to understanding

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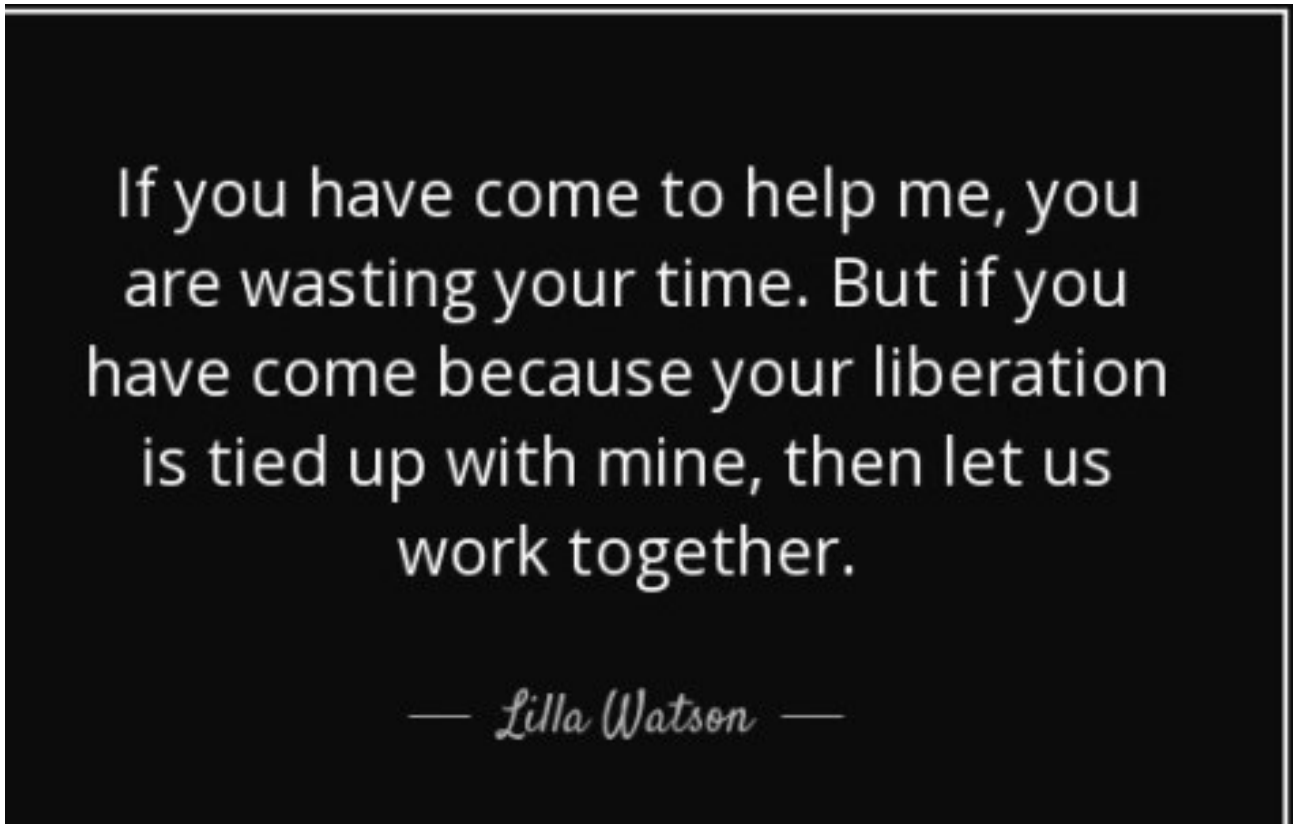

SHIRIKI KUMANYIKA, PHD, MPH

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Getting to Equity in Obesity Prevention

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Getting to Equity in Obesity Prevention

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ANALYTIC ESSAYS

A Framework for Increasing Equity Impact in Obesity Prevention

One of the most pressing unmet challenges for preventing and controlling epidemic obesity is ensuring that socially disadvantaged populations benefit from relevant public health interventions. Obesity levels are disproportionately high in ethnic minority, low-income, and other socially marginalized US population groups. Current policy, systems, and environmental change interventions target obesity-promoting aspects of physical, economic, social, and information environments but do not necessarily account for inequities in environmental contexts and, therefore, may perpetuate disparities.

I propose a framework to guide practitioners and researchers in public health and other fields that contribute to obesity prevention in identifying ways to give greater priority to equity issues when undertaking policy, systems, and environmental change strategies. My core argument is that these approaches to improving options for healthy eating and physical activity should be linked to strategies that account for or directly address social determinants of health.

I describe the framework rationale and elements and provide research and practice examples of its use in the US context. The approach may also apply to other health problems and in countries where similar inequities are observed. (*Am J Public Health*. Published online ahead of print August 15, 2019: e1–e8. doi:10.2105/AJPH.2019.305221)

Shiriki K. Kumanyika, PhD, MPH

Forty percent of US adults and nearly 20% of US youths aged 2 to 19 years have obesity, with increasing trends in adults and stable prevalence in youths.[1] Obesity is epidemic globally, which is untenable because obesity has high health, social, economic, and personal costs.[2] The causal narrative has become familiar: (1) population-wide obesity is linked to eating and physical activity patterns that are abnormal physiologically, yet have become normative; and (2) communities are laden with obesity-promoting influences, which overwhelm individuals' efforts to control weight in a healthy range—a plethora of heavily marketed high-calorie, nutrient-poor foods and beverages combined with daily routines lacking in opportunities to be physically active.[2] Changing these conditions requires comprehensive policy, systems, and environmental (PSE) changes to shift the range and balance of behavioral options toward an obesity-protective direction—no small feat and a long-term proposition.[2-4]

Patterns of obesity prevalence include marked disparities by race/ethnicity. For example, prevalence is significantly higher in non-Hispanic Black (35%) and Hispanic (51%) than non-Hispanic White women (38%), and in Hispanic (43%; but not non-Hispanic Black [37%]), than non-Hispanic White (38%) men.[1] Prevalence in 2- to 19-year-old youths is significantly higher in non-Hispanic Black (22%) and Hispanic (26%) than non-Hispanic White (14%) youths.[1] Socioeconomic status effects are complex and differ by race/ethnicity; lowest risk is not always observed in the highest socioeconomic status strata of income or education.[5]

These disparities are neither surprising nor coincidental. Risks of having obesity and related health problems are conditioned by adverse social circumstances, part of a deeper problem of systemic structural dynamics that curtail opportunities for advancement.[6] Social disadvantage means a greater likelihood of living in poor-quality housing and in neighborhoods with fewer services and limited options for healthy eating and physical activity.[7] Thus, even when progress is observed (e.g., declines in child obesity prevalence in some states and localities), detailed data may reveal widening gaps attributable to greater progress in White and higher-income than in ethnic minority and low-income youths.[8,9]

Assuming that any observed progress can be attributed to PSE initiatives implemented over the past 10 to 15 years, persistent or widening disparities suggest a lack of reach to or effectiveness with those who need them the most. Differences in uptake or benefit from PSE approaches were suggested by findings from a large observational study of childhood obesity prevention policies and programs in 130 US communities.[10] Positive associations were reported for the comprehensiveness and intensity of these policies and programs with children's weight status and diet or physical activity behavior in White, high-income children and communities but not in children from low-income families or Black or Hispanic children.

Ensuring that populations affected disproportionately by obesity benefit from preventive strategies is among the most pressing unmet challenges in policy and practice. Marked racial/ethnic and income disparities were clearly evident in the 1980s, predating recognition of epidemic obesity in the US population at large.[11] However, documenting disparities does not necessarily trigger deliberate or effective action to address them.

I propose an equity-oriented obesity prevention framework to guide practitioners and researchers in public health and other fields that contribute to

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This article was accepted June 4, 2019.

doi: 10.2105/AJPH.2019.305221

Free access at:
https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305221

A Framework for Increasing Equity Impact in Obesity Prevention ("Getting to Equity Framework")

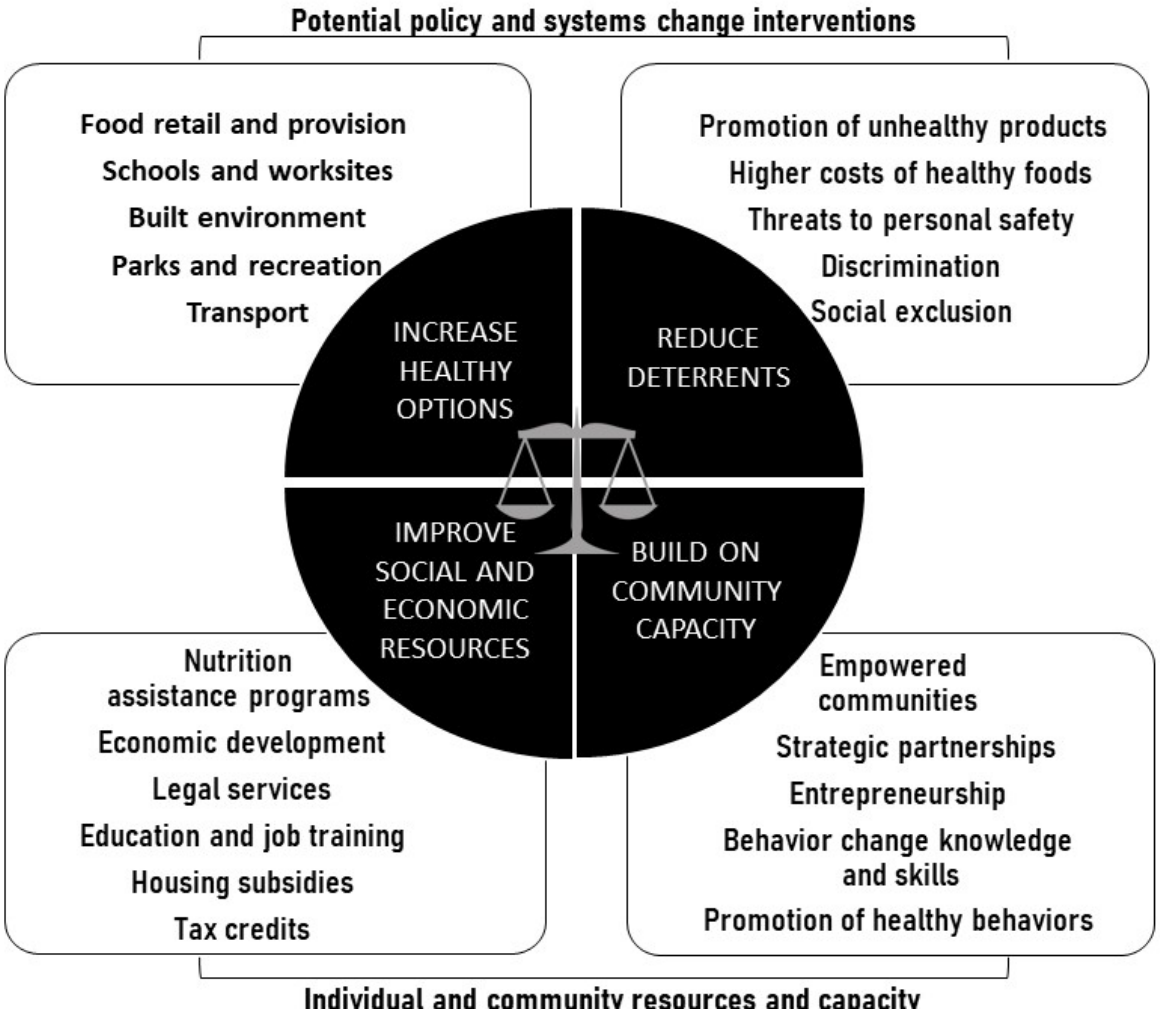
Supplemental file a: **Excerpts from the Centers for Disease Control and Prevention Practitioner's Guide to Advancing Health Equity**

Supplemental file b: **Potential tool for rating research proposals on sensitivity to health equity issues**

Commentary: Wang, ML. Wang, Relevance and Uses of the Getting to Equity in Obesity Prevention Framework, AJPH; 2019; 109: (10): 1321-1323

Equity-oriented obesity prevention framework

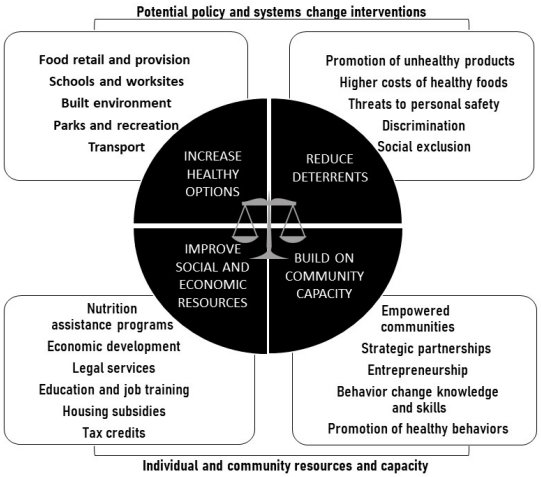
Healthy Eating Research



Kumanyika AJPH 2019

How we can increase the equity impact of research?

Healthy Eating Research



Kumanyika AJPH Oct 2019

Acknowledge historical oppression and structural racism as underlying drivers of inequities.

Identify inequities related to intervention settings.

Identify people's life circumstances, hopes, needs, and realities related to topic of the PSE intervention in these contexts.

Think about intervention elements and how they are assumed to work and examine validity of assumptions.

Consider threats to effectiveness and look for ways to address them by increasing individual and community resources and capacity (HER Tool Appendix).

Combine interventions for synergy within and across policy and people/community domains.

Analysis of Settings and Environments

Healthy Eating Research

Environment size / Environment type	Micro-environment (settings)		Macro-environment (sectors)	
	Food	PA	Food	PA
Physical	What is/isn't available?			
Economic	What are the financial factors?			
Policy	What are the rules?			
Socio-cultural	What are the attitudes, beliefs, perceptions, values and practices?			

Analysis Grid for Linked Environments (ANGELO) Swinburn et al, 1999, with permission

Analysis From "People" Perspective

Healthy Eating Research

Who are the people in these settings?

How might their lives and perspectives differ from those of people in communities where these interventions seem to be working?

What are they trying to accomplish? Would the intervention help?

What resources and assets available in other settings are or are not there?

What non–obesity "co-benefits might this intervention offer?

What liabilities might it pose?

Analysis From Intervention Perspective

Healthy Eating Research

In what ways is the intervention relevant to this population and context?

What is the primary pathway for the intervention effect and what assumptions suggest that this is a valid pathway?

Are these assumptions met in this context? If not, what needs to be changed or added?

What contextual factors or other interventions might adversely influence or enhance the effects of the intervention?

How can resources and capacity be enhanced to improve intervention effectiveness?

Potential Tool for Rating Research Proposals on Sensitivity to Health Equity Issues

Healthy Eating Research

Series of questions that prompt for evaluation of how well equity issues have been considered in terms of the population context, study rationale, intervention design, sample design, data collection and analysis plan, evidence of community engagement, and team composition.

Based on concepts in the Getting to Equity Framework.

Underlying rationale and principles in an Appendix to the tool

Developed for potential use in the RWJF Healthy Eating Research program https://healthyeatingresearch.org/

Supplemental File B, for American Journal of Public Health Article "A Framework for Increasing Equity Impact in Obesity Prevention," by Shiriki Kumanyika (kumanyika@drexel.edu).
DOI: 10.2105/AJPH.2019.305221

Healthy Eating Research

Appendix Content

- **Definitions**
  - Health equity
  - Priority populations
  - Criteria for research impact on health equity
  - Characteristics of research that can impact health equity
- **Potential factors that influence the relative effectiveness of Policy, Systems, and Environmental (PSE) change strategies on health equity**
  - Effectiveness issues
  - Examples
  - Implications

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Potential factors that influence the relative effectiveness of PSE strategies in priority populations (issues, examples, implications) (1)

Different logic– The intervention has a different role or different leverage within the change pathway in the priority compared to the reference population and is, therefore, relatively more or less pivotal in driving the desired population behavior changes in the priority population.

Differential salience - The intervention is more or less relevant to the priority population needs and preferences. Cultural adaptations would be in this category, but contextual adaptations are also important.

Differential reach – Relatively more or fewer people in the priority population are exposed to the intervention.

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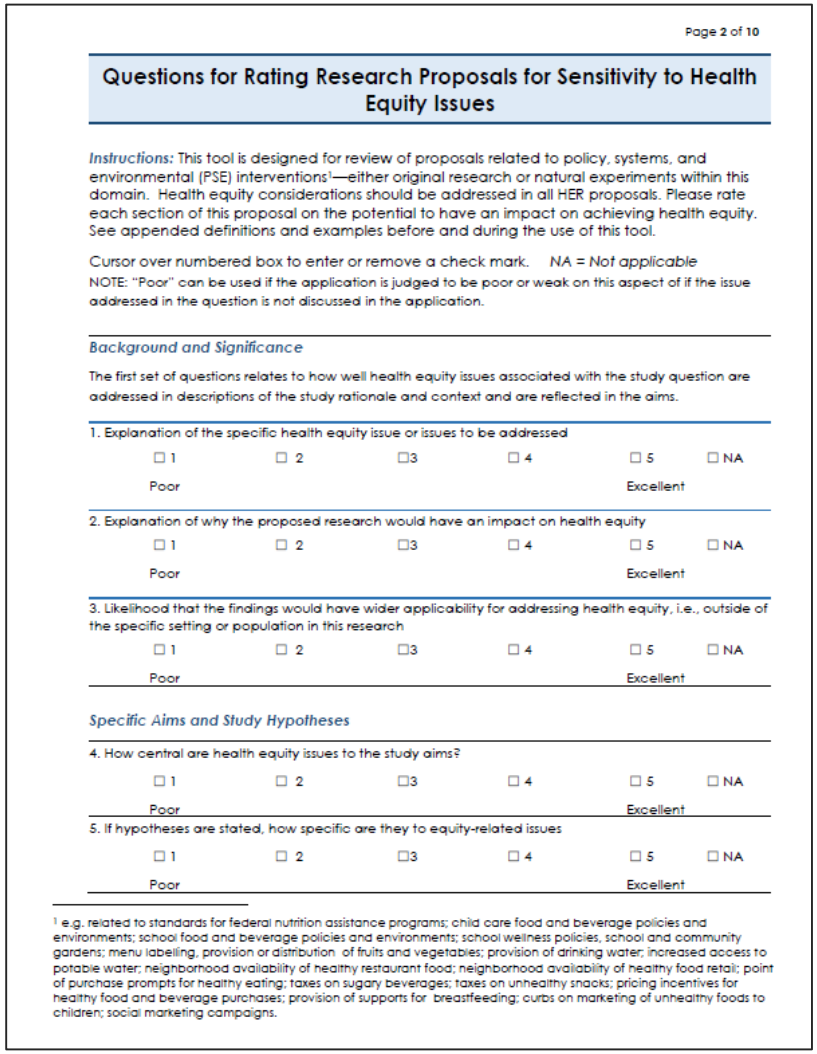
Potential factors that influence the relative effectiveness of PSE strategies in priority populations (issues, examples, implications) (2)

Differential intensity – A single intervention may not be strong enough to overcome competition from other, related but opposing features of the social or economic environment.

Differential feasibility – Uptake of the intervention is limited or sporadic because of feasibility issues.

Side effects – Access to or net benefit of the intervention is altered because of side-effects of the intervention, particularly unfavorable side effects.

TOOL



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Questions for Rating Research Proposals for Sensitivity to Health Equity Issues

Instructions: This tool is designed for review of proposals related to policy, systems, and environmental (PSE) interventions[1]—either original research or natural experiments within this domain. Health equity considerations should be addressed in all HER proposals. Please rate each section of this proposal on the potential to have an impact on achieving health equity. See appended definitions and examples before and during the use of this tool.

Cursor over numbered box to enter or remove a check mark. *NA = Not applicable*

NOTE: "Poor" can be used if the application is judged to be poor or weak on this aspect of if the issue addressed in the question is not discussed in the application.

Background and Significance

The first set of questions relates to how well health equity issues associated with the study question are addressed in descriptions of the study rationale and context and are reflected in the aims.

1. Explanation of the specific health equity issue or issues to be addressed

☐ 1 ☐ 2 ☐3 ☐ 4 ☐ 5 ☐ NA

Poor Excellent

2. Explanation of why the proposed research would have an impact on health equity

☐ 1 ☐ 2 ☐3 ☐ 4 ☐ 5 ☐ NA

Poor Excellent

3. Likelihood that the findings would have wider applicability for addressing health equity, i.e., outside of the specific setting or population in this research

☐ 1 ☐ 2 ☐3 ☐ 4 ☐ 5 ☐ NA

Poor Excellent

Specific Aims and Study Hypotheses

4. How central are health equity issues to the study aims?

☐ 1 ☐ 2 ☐3 ☐ 4 ☐ 5 ☐ NA

Poor Excellent

5. If hypotheses are stated, how specific are they to equity-related issues

☐ 1 ☐ 2 ☐3 ☐ 4 ☐ 5 ☐ NA

Poor Excellent

[1] e.g. related to standards for federal nutrition assistance programs; child care food and beverage policies and environments; school food and beverage policies and environments; school wellness policies, school and community gardens; menu labelling, provision or distribution of fruits and vegetables; provision of drinking water; increased access to potable water; neighborhood availability of healthy restaurant food; neighborhood availability of healthy food retail; point of purchase prompts for healthy eating; taxes on sugary beverages; taxes on unhealthy snacks; pricing incentives for healthy food and beverage purchases; provision of supports for breastfeeding; curbs on marketing of unhealthy foods to children; social marketing campaigns.

- ✓ Background and Significance
- ✓ Specific Aims and Study Hypothesis
- ✓ Research Design and Methods
  - Study Design
  - Populations and settings
  - Theoretical framework/conceptual model
  - Research methods and measures
  - Data analysis
- ✓ Potential limitations and challenges
- ✓ Deliverables and communications plan
- ✓ Project Team

See Kumanyika, AJPH , supp file b
Commissioned by HER

Thank you!

Questions?

Thank you!

- The webinar slides and recording will be available at http://healthyeatingresearch.org/
- Stay up to date on our work and future webinar opportunities at https://healthyeatingresearch.org/email-signup/