Abstract

This paper is a contribution towards achieving health equity and sustainable development in the indigenous context. It reviews some of the recent literature on the structural drivers of the underlying factors of health inequity as well as the devastating burden of some forms of diseases. It also identifies the need to reinforce policy approach towards achieving health equity and sustainable development by thinking more broadly and working across sectors to develop healthy public policy. Some identified policies during secondary research emphasized the right to health and the accessibility of health within the non-indigenous populace. The overarching policy should target indigenous and non-indigenous populations.

This paper focuses on the health inequities faced by indigenous peoples and ethnic minorities coupled with a discourse on policy and intervention approach that can create better momentum for addressing such inequities. The first chapter highlights the issue of definition of the paper, background information and introduction to the paper, while the second chapter examines the thesis statement, theoretical framework (literature review) and key concerns. The third chapter explains the policy argument, the fourth summarizes the findings and the last chapter proposes some policy design so that indigenous communities and ethnic minorities have a better chance to move out of the margins towards health equity and acquiring their right to health.
Chapter One

1. Issue Definition

The legacy of colonization is considered by some scholars to be the major structural driver of health inequity for the indigenous peoples. This paper, “Towards achieving health equity”, describes health disparities experienced by diverse indigenous groups. It examines the possible social, economic, behavioural, environmental, biological & genetic factors, as well as the historical conditions that can influence indigenous inclusive policy interventions. The commitments from all parts of the society, not just the health sector will ensure that the public health goal of health equity is achieved. According to Kass, 2001, an ethics framework for public health states that “public health is what we, as a society do collectively to assure the conditions in which people can be healthy.” What we need now is a collective commitment to view those conditions, through an equity lens.

1.1 Background

Geographical distance is not a barrier to the historical and current similarities among indigenous people around the world as they relate to health inequities. An estimate by the United Nations declares that about 370 million Indigenous peoples are in the world living in at least 70 countries (United Nations, Department of Economic and Social Affairs (DESA), 2009). All these ethnic minorities are connected with the colonial history associated primarily with the British. History tells us that during the European colonization, indigenous peoples were suppressed and exploited, which yielded inequity and until now, this is still reflected in the poor health outcomes for indigenous peoples around the world.

Indigenous peoples across the world have recorded an array of chronic diseases such as diabetes, cardiovascular illnesses, mental illness, tuberculosis, maternal and infant mortality, malnutrition and other infectious diseases such as HIV/AIDS and Hepatitis as against their non-Indigenous counterpart. Life expectancy varies between the indigenous and non-indigenous peoples due to the susceptibility of the indigenous peoples to several aforementioned diseases. Definitely, health inequity is seen as one of the major contributors to the high burden of chronic disease among Indigenous populations across the globe.

1.2 Introduction

“Good health is a major resource for social, economic and personal development and an important dimension of quality of life.” (World Health Organization, 2010). The healthcare system is driven by various local, national and international policies that result in health inequity. Furthermore, health inequity also arises from social and economic inequity, which differ from one community to the other with varying magnitudes. However, the right to health of Indigenous peoples has been internationally recognised by conventions and charters with several declarations from the United Nations protecting indigenous rights to healthcare.
The terminology - ‘indigenous peoples, ethnic and cultural minorities’ - is often used globally because it reflects the fact that health disparities and their origins are often similar across these groups. Nevertheless, the situation of health is not the same across all groups, countries or continents, and even the way health challenges are addressed within this group differs. In Fact, there have been several arguments as to what classifies a group as an indigenous people. In this paper, the concept of the indigenous utilized was given by Jose R. Martinez Cobo (1986/7) the Special Rapporteur of the Sub-Commission on Prevention of Discrimination and Protection of Minorities, in his famous Study on the Problem of Discrimination against Indigenous Populations:

*Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system.* […]

*On an individual basis, an indigenous person is one who belongs to these indigenous populations through self-identification as indigenous (group consciousness) and is recognized and accepted by these populations as one of their members (acceptance by the group).*

Indigenous peoples can be represented by cultural and ethnic minorities because it accounts for the unrecognised indigenous people in a particular country and the excluded from indigenous people. This paper frequently uses the term – “indigenous peoples for simplicity,” but it is important to indicate that ethnic and other cultural minorities experience the same disparities.

### 1.3 Inequality and inequity in health issues

This paper is centred on health inequity, which justifies the frequent use of inequity rather than inequality. Inequity encompasses inequality because it describes the unfairness of inequality that stems from social injustice. On the other hand, inequality denotes disparities in outcomes between groups, individuals or men versus women.
Chapter Two

2. Thesis statement

Health inequity challenges the development space and its impact is worrisome both from the public health and the human rights perspectives. It has its origin from discrimination dating back to the colonial era. Indigenous peoples and ethnic minorities have a long history of discrimination as a result of the colonization and this resulted in health inequity between the indigenous and non-indigenous peoples. These centuries of prejudices deserve inclusive policy-driven approach to produce positive health outcome totally free of inequity. Policy-makers often perceive indigenous peoples and ethnic minorities as being laid back and therefore blame their health problems on their backwardness, their culture and perhaps their bad habits. Contrary, to the policy-makers’ opinion, the aftermath of the Spanish and Portuguese invasions in Latin America about five hundred years ago was disease epidemic that decimated millions of the indigenous peoples. The historical connection between the majority ethnic groups and the indigenous or minority ethnic groups in Africa, Asia and Middle East is the genesis of their present situation. To an extent, the national policy support received by Indigenous peoples is proportional to their population. Bolivia is an example of a country with indigenous-policy governance because indigenous peoples constitute the majority population, coupled with the fact that their president is Indigenous as well. However, the opposite is the case for most countries of the world where indigenous peoples are the minorities with diverse cultural practices in relation to traditional healthcare and health system.

Predominantly, health policies in different regions and countries of the world neglect indigenous health issues, which prevent Indigenous peoples from equal health outcomes when compared to the non-indigenous population. As a matter of fact, some countries have poor documentation of the health situation of their minority and indigenous people. According to scientific and government reports, few countries such as Australia, North America and New Zealand with about 1.1 percent of the world’s indigenous population possess indigenous health data. The developing regions of Latin America, South Asia and Africa have insufficient policy and scientific attention to combat indigenous health issues.

2.1 Literature Review

2.1.1 Sustainable development and the health sector

The Rio+20 development document identified the health sector as an important component of the three dimensions of sustainable development. Notably, economic, social and environmental sustainability can only be achieved in a complete state of physical, emotional and social well-being. Apprehensions about sustainable development in the health sector beyond 2015 reveals three clear implications for health urgencies; Most importantly, sustainable development is unachievable in an environment with high incidence of transmittable and non-transmittable diseases. Successively, determinants of health should be targeted, particularly the social and environmental determinants to establish inclusive and healthy societies. This
includes policy approach confronting the escalating threat and negative action of social determinants as well as climate change impacts contributing to health inequity. Evidently, the acknowledgement of the right-based approach to health is central to achieving sustainable development.

2.1.2 Major structural factors at the root of inequity across indigenous populations

Multiple and overlapping factors create health inequity between the indigenous and non-indigenous peoples globally. The risk factors that contribute to health disparities otherwise called the “determinants of health” are interrelated elements with a combining power that affects individuals across their lifespan, from inception to the end of life. These factors cannot be far fetched. They include social, behavioural, economic, environmental, historical, biological and genetic, and political factors, to mention but a few, are at the root of health inequity globally. The interaction of the above-mentioned factors influences the health and well-being of individuals and communities for good or ill. The determinants of health can be grouped under four broadly accepted categories:

- Social determinants of health include: culture, gender, socioeconomic status, employment status, educational attainment, food security status, and availability of housing and transportation, colonization and health system access and quality. Remarkably, culture is the leading social determinant, and establishes other social determinants.

- Behavioural determinants of health include: patterns of overweight and obesity; exercise norms and the use of illicit drugs, tobacco, or alcohol.

- Environmental determinants of health include workplace safety factors, unsafe or polluted living conditions and climate change impacts.

- Biological and genetic determinants of health include family history of diseases and inherited conditions such as haemophilia and cystic fibrosis (Mikkonen & Dennis 2010)

2.1.3 Social determinants of health

Social determinants have the highest effect on health among other determinants of health and they contribute about 80% of the causes of health inequity. Psychosocial and societal factors such as employment opportunities, healthcare accessibility, hopefulness, and freedom from racism are at the core of social determinants. The combined action of the determinants of health through their indirect relationship or through their influence on health promoting-behaviour has a long lasting effect on individuals and communities at large. Policy approach and interventions influence the availability and distribution of social determinants to various social groups, including those defined by socioeconomic status, race/ethnicity, sexual orientation, sex, disability status, and geographic location. To an extent, inequitable distribution of social
determinants is a contributing factor to health disparities and health inequity. Certainly the path towards health equity is an escalation of how societal conditions, health behaviour and access to health care can affect health outcomes. Remedial actions on the unbalanced distribution and availability of social determinants of health can result from an understanding of the complexity of factors that contribute to these social determinants. (Commission on Social Determinants of Health, 2008)

2.1.4 Health inequities experienced by indigenous populations around the world: A bird’s Eye view.

Several reports on health inequities experienced by indigenous peoples show a consistent pattern across different population groups. Health inequity is not randomly distributed, but is systematic in nature because the fundamental causes arise from a complex combination of the determinants of health spanning over a lifetime and sustained across multiple generations. Indigenous peoples face direct and indirect discrimination as well as disparity to realizing the right to health. They encounter limited access to healthcare that translates to increased susceptibility to diseases, illnesses and greater mortality compared to their non-indigenous counterparts. Besides, marginalization is at its peak considering the insufficient policy-attention received by the minority population, and the consequences include less education, poor standard of living, infant mortality, increased suicide rate and poor health system relative to the majority population.

Discrimination occurs in the health services and outcomes that significantly contribute to health inequity experienced by the indigenous and ethnic minorities. It is perceived in the availability of healthcare, access to health facilities and unbalanced provision of the underlying social determinants of health such as access to safe water, sanitation, adequate housing and nutrition, increase rate of illiteracy, and availability of hazardous type of employment. Direct discrimination encountered by indigenous populations is noticeable by longer waiting times for medical treatment in hospitals, inadequate diagnosis, the provision of less quality medication, patient segregation, or neglect in patient hygiene or nutrition displayed by medical personnel. Indirect discrimination is suggestive when western ways of knowing take precedence over indigenous knowledge. Likewise, access to health information and preventive practice is provided in ambiguous terminologies and only in dominant languages or in accordance with dominant cultural practices. Similarly, fee-based health services are forms of discrimination that capitalize on the poverty level of the Indigenous people who are poorer than their non-indigenous counterparts and thus unable to afford such services. Discrimination rate in health services is increasing rather than decreasing and this is suggestive from an example in India where only 1% of disabled persons receive help from the government for education and out of this 1%, the percentage of the minority population of Dalitis and Schedules Tribes is about half of the dominant caste (The United Nations Inter-Agency support Group (IASG) 2014).

Another factor that contributes to health inequity is poverty and social exclusion that is experienced differently by various ethnic minorities and indigenous populations. These groups inevitably take up jobs with higher occupational health risk owing to underemployment and high
poverty rate that exist within the minority population. Moreover, the minority group experience high rates of food insecurity and inadequate housing attributable to their poverty situation. The above-mentioned low standard of living explains the increasing incidence of communicable and non-communicable diseases within the indigenous and minority groups. An example reported by UNICEF is the minority Pashtun population with the highest polio rate of about 77% of polo cases in Pakistan. Similarly in Alaska, the non-communicable report alliance documented high mortality rate from rheumatic heart disease in indigenous Alaskans relative to non-indigenous Alaskans (The United Nations Inter-Agency support Group (IASG) 2014).

Detrimental situation and lack of respect for the rights to health and life of indigenous women and youth have been reported by demographic and health surveys. Numerous health issues, sexual and reproductive health (SRH) issues, and maternal issues have been identified with indigenous women around the world. Notable gaps exist between the indigenous and non-indigenous women globally in terms of access to family planning services, delivery care for pregnant women as well as immunization coverage and the prevalence of illnesses associated with higher mortality rates for their children. The recognized gaps are health inequity that should be combated to achieve positive health outcomes in the post-2015 era. Sexual health is another area of prevalence in which there is health inequity between indigenous and non-indigenous adolescent. In fact, (UNFPA 2010) asserted that; “A special mention needs to be made with respect to indigenous adolescents, given the higher proportion of adolescent maternity that reveals ethnic related unequal access to reproductive rights.” Health inequity in relation to sexual health is connected to factors such as less education for girls compared to boys, inadequate culturally appropriate health services and restricted access to health care in rural residence. For instance, some countries in Latin America record large numbers of adolescent mothers in the indigenous population in comparison to the non-indigenous population. These countries include: Brazil (27% versus 12%), Costa Rica (30% versus 12%), Panama (37% versus 15 %), and Paraguay (45% versus 11%), respectively. Furthermore, social norms and attitudes towards sexual protection and family planning have also contributed to higher rates of pregnancies for adolescent women in indigenous communities and this is inextricably linked to prevalence of sexually transmitted infections and HIV/AIDS because the precaution against such infections is forgone.
3. Policy options

Literature analysis explained that the worst health experiences and the many issues seen among the indigenous people of the world could be traced to their history of colonization and the factors of social determinants. A wide gap exists between the health outcomes of the indigenous people and non-indigenous counterparts, and this gap remains inexcusable. For instance, indigenous peoples worldwide living with diabetes remain undiagnosed, and untreated. Thus, they eventually get caught with life threatening complications—such as heart attack, kidney failure or retinopathy that could be otherwise prevented with medicine, essential know-hows and self-management. The actions to reduce health inequities have specifically focused on vulnerable and marginalized groups worldwide. Internationally, all nations are required to “ensure the incorporation of indigenous peoples into the attainment of national health policies; develop, together with WHO, strategic alliances with indigenous peoples and other stakeholders to further advance the health of the indigenous peoples. Policies and programmes that address health inequity in the post-colonial era allows scholars to target not only conditions of extreme poverty and exclusion but also social conditions that affect everyone. This way, several policies and programs will have greater potential towards achieving health equity and consequently improving the health outcomes of the indigenous population. However, this can only be achieved when the indigenous people are made the target population of the policies and programs aimed at improving health equity (The Winnipeg Regional Health Authority 2013).

Perhaps, it is pertinent at this junction to examine the possible policies currently being used to alleviate health inequity.

3.1. Option 1: Rights-based approach to achieving indigenous health equity:

Good health is everyone’s right. It isn’t paid for neither is it given nor acquired from somebody else. Everyone has the right to gain and fight for good health individually or by seeking the assistance of others. This policy approach to health equity has empowered the minorities and indigenous peoples, who have long experienced the negative effects of inequity. Article 24 of the UN Declaration on the Rights of Indigenous Peoples (2007) states that:

*Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.*

Right-based approach to achieving indigenous health equity targets direct and indirect discrimination. This approach pioneers the act of leaving lives of dignity and fairness resulting in equal citizenship that enables meaningful choices on health related issues while facilitating significant development strategies in the post 2015 era. It is a policy option that strengthens
advocacy in health-related programs and the social determinants of health. According to the General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights, which oversees the core treaty that recognizes the right to health, this right:

“is the right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health…. [The right includes both] timely and appropriate health care … [and] the underlying determinants of health, including access to safe and potable water, and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.’

Non-discrimination and equity is the outcome of the right-related approach and it lays the foundation for conscious participation by both the health providers and the health beneficiary. Chandler and Lalonde (1998) explained that self-determination is responsible for low suicidal rate in communities and the greater control such communities possess of social and cultural institutions within their communities. Obviously, not only will this approach proffer participation and transparency, it will strengthen indigenous self-determination and empower the right-holders to identify their right to health and in turn ensures that health-care givers meet their obligations. A right-based approach to health draws attention to inequity in the health care system, ensures that the marginalized enjoy the same health care benefits and endows both the indigenous and non-indigenous with an equal opportunity for enhanced health care. Human rights standards and principles in health care programming intensify health availability, accessibility, acceptability and quality through the strength and efficacies of the key elements like participation, accountability, non-discrimination, empowerment, linkage to rights and sustainability. (Lennox, Corinne, & Carolyn) The proficiency of this approach is the integration of legal services into health care to boost access to justice and to provide holistic care. Rights-based approach to health has been successful in some indigenous health programs across the globe, which includes the following;

- Justice for Roma women coercively sterilized in Central Europe
- Promoting the rights of Roma patients in the Macedonian healthcare system
- Ending discrimination in access to nationality for children of Nubian descent in Kenya
- Roma health mediators in Romania
- Campaign for indigenous health equality in Australia
  (Havard School of Public Health 2013)

3.2. Option 2: Health literacy and action on social determinants

Health literacy approach to health equity tackles the understanding of the health care system from the angle of the health care provider and the health care beneficiary. This approach curbs poorer health outcomes and higher health care cost in the populace seeking health treatment. In fact, it is a knowledge enhancer for patients, caregivers and the public. However, systemic factors impede health literacy within the society, particularly within the indigenous diversity. The systemic factors may include: culture, medical terminologies and communication skills,
knowledge of medical professions, health care and health system expectations as well as the contextual situation of the patient. The UN Declaration on the rights of indigenous peoples (2007) affirmed that: “Indigenous peoples and individuals have the right not to be subjected to forced assimilation or destruction of their culture.”

Amongst the barriers to health equity, culture is the foremost social determinant that is addressed in health literacy approach to equity. This is basically because both the patients and the health-care systems have their principal cultures. Therefore, ill health cannot be treated in isolation of both cultures. Thus patient-centered care should be culture-inclusive because cultural neglect between patients and health-care institutions could result in a negative medical outcome. Moreover, the non-compliance or unwillingness of patients to visit the hospital could result in alienation for those seeking treatments while the hospital itself becomes destabilized following the conflict of interests. It suffices to say that cultural and linguistic competence is a must in order to enshrine health equity, such that health practitioners recognize the cultural beliefs, values, attitudes, traditions, language preferences, and health practices of diverse populations more particularly the indigenous peoples, and apply that knowledge to produce a positive health outcome. Competency entails communicating in plain language that is linguistically and culturally appropriate. In this regard, literacy strategy strengthens language simplification by breaking down health terminologies and information into understandable chunks while medical expressions are presented in layman’s language. Using the literacy policy sustains preventive medicine and alleviates low literacy in the health-care system that originates from higher rates of hospitalization and less frequent use of preventive services. The essentiality of the approach lies in its preventive strength rather than its corrective potency within the most vulnerable ethnic minorities. This policy is prominent in Canada as a tool to improve the health literacy of the indigenous people, thereby reducing the health disparity within the country (Anderson and Olson 2013).

3.3 Option 3: The two eyed-seeing approach

This policy option embraces the indigenous and non-indigenous worldview towards achieving health equity. A balanced consideration of indigenous and western knowing accentuates the policy, such that both knowledge resources can be used to address the burning questions of health inequity centred around Indigenous peoples and ethnic minorities. Although a critique of positivism and colonization previously emasculated and/or disallowed Indigenous ways of knowing as they claimed its “half-baked” but the two eyed-seeing approach allows Western and Indigenous understanding to health matters. Indeed, it ensures equal consideration of both indigenous and non-indigenous worldviews such that parity is achieved. It depicts how a balanced consideration of the contributions from different worldviews yields positive outcomes. This is a workable tactic towards achieving health equity that reshapes the nature of questions in the domain of Indigenous health research. The two eyed-seeing approach instigated by Elder Albert Marshall of the Eskasoni Mi'kmaw First Nation, in Cape Breton, Nova Scotia is apt to address health inequity faced by indigenous peoples and ethnic minorities. (Schroth, McNally and Harrison 2015)
A better adaptive strategy of the approach involves weaving indigenous ways of knowing into western ways of knowing so that none is superior to the other, but both eyes are at par in resolving the inequity in health issues. This approach has given the indigenous people a voice with particular reference to increasing the number of culturally aware clinicians, health promoters, health service program managers and decision-makers, and academics.

Research on the indigenous people has been checked by this approach and it has become inclusive-research preventing the former concept of researchers dashing into the communities, collecting data and exiting without dissemination. It demands that research endeavours have to result in evidence based decision making and indigenous community empowerment.

Remarkable successes have been achieved with two-eyed seeing approach such that health care delivery and research experience sensitive equity. A good example is the Association of American Indian Physicians that have over four decades experienced and held cross-cultural medicine workshops that bring the indigenous healers from around United States to conduct a dialogue about indigenous health practices with students, clinicians and other interested community. Furthermore, the Mayo clinic “spirit of Eagles” program empowers indigenous researchers, scientists and medical students who are involved in cancer control activities in indigenous communities. Additionally, tremendous partnership is promoted by the National American Research Centres for health support between tribes and tribally based Organisations for research on indigenous health issues. (Anderson and Olson 2013)
Chapter Four

Conclusion

This paper “Towards achieving health equity” explores existing policies, strategies or interventions on the path to addressing the health inequity experienced by indigenous peoples. The MDGs addressed some part of the health inequity, but none of the eight Millennium Development Goals aimed at the issue of health inequity. For the post-2015 framework, policies towards achieving health equity should approach health as a cross-cutting issue that shapes and is shaped by multi-policies mechanism. This approach will be of mutual benefit to other sectors because health policy contributes to poverty reduction through the financial protection inherent in universal coverage.

Holistic policy approach inclusive of indigenous peoples and ethnic minorities should be embraced to combat issues of inequity towards achieving sustainable development beyond 2015. Tackling the social, political, economic and environmental determinants of health is important for everyone to enjoy the highest attainable standard of health and health equity. This can be achieved when the causes of ill-health have been addressed by policies which address the determinants of health. Then each determinant of health would be tackled towards achieving health equity. This way those economic and political structures, which sustain poverty and discrimination can be confronted.

Health inequity experienced by the minorities and indigenous peoples illustrates how underlying determinants of health significantly contribute to the disparity in health and other development sectors. Holistic Indigenous knowledge of health and well-being held by many minorities and indigenous communities can also inform the mainstream approach to health care. Furthermore, allowing the weave of indigenous and western knowledge move us all beyond narrow biomedical prescriptions. Indigenous advocacy, self determination and autonomy are strategies for building the capacity of minorities and indigenous peoples to claim their right to health, and for governments to respect, protect and fulfil this right. Certainly right-based approaches to health rooted in non-discrimination, participation and accountability are needed.

Since data alone are not sufficient for policy formulation, compelling successes in each of the three-policy approaches could convince the policy makers to fuse the three described policies into one unique policy addressing issues of health equity.
Chapter 5

Recommendations

This paper assessed the historical context and expressions of health inequities of indigenous peoples, cultural and ethnic minorities. Available literature has shown that on most accounts, these groups suffer from hugely disparate health outcomes in comparison to non-indigenous or majority societies. The fundamental cause of health inequity is the violation of human rights of minorities and indigenous peoples, and lack of indigenous inclusive-policy to reflect their perceptions of development.

To achieve sustainable health equity, all hands must be on deck, the society needs to be a health literate society that comprises health literate public, health literate health professionals and health literate politicians and policy makers. In order to achieve better equity in health outcomes, the culture and identity of the indigenous people must be embraced and considered in policy development and service delivery for the different priorities and perceptions of health held by the minorities and indigenous peoples.

The policy on shaping core actions for a coordinated national response should be revised because it doesn’t target the health inequity between indigenous and non-indigenous peoples; rather it focuses on health inequalities between the majority population. The goals of the policy should be structured to address the determinants of health.

Finally, the three existing policies should be fused into one single effective policy that will impact a positive change and accomplish a lasting impact towards achieving health equity in the indigenous context.
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