

The 5 Building Blocks for Equity in Collective Impact

Health equity is the absence of avoidable and unjust differences in health among population groups. Because many determinants of health lie outside of the health system, it is necessary to coordinate work across sectors when attempting to address inequities. Health equity does not emerge intrinsically from well-intended multisectoral partnerships, but rather must be systematically prioritized throughout collaborative work. As part of our five year CIHR funded research program, [Equity Lens in Public Health \(ELPH\)](#), we identified that Scott's Five Building Blocks for Equity-Focused Work¹ provides a useful framework to ensure health equity is integrated into Collective Impact efforts. Our interpretation of Scott's Five Building Blocks, based on other readings^{2,3}, is detailed below.

What is Collective Impact?

In 2011, Kania and Kramer coined the term Collective Impact (CI) to describe a structured approach to aligning actions across sectors for solutions to complex social problems⁴. CI is a unique approach characterized by five specific collaborative conditions to achieve social change⁴:

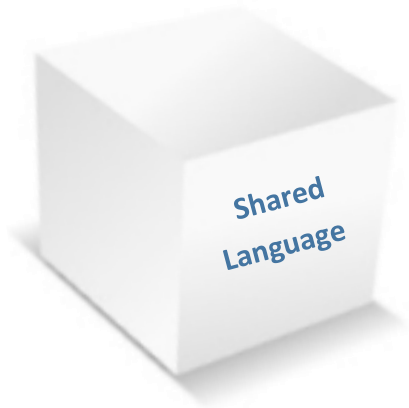
- 1) Common Agenda
- 2) Shared Measurements
- 3) Mutually Reinforcing Activities
- 4) Continuous Communication
- 5) Backbone Support

Although the initial CI approach did not highlight the importance of equity, it was soon recognized that without careful integration of an equity lens, "efforts to align and coordinate resources can inadvertently reinforce institutional patterns that promote disparities and constrain progress for our most vulnerable community members"⁵. Scott's Building Blocks, some of which directly correspond to the above CI conditions, provide a framework for integrating equity into CI efforts.

Power as the Foundation of the Building Blocks

Power is the mortar that binds the Five Building Blocks and the lens which we use to frame our interpretation of each of the Building Blocks. In a CI initiative, all partners must investigate and reflect on how power operates to create health disparities and how power can create participation disparities between groups. It is important to ask the following questions: How is power in CI shared between 'official' experts and community experts? Whose voices are included or excluded at the table? Who needs to step back or step up to ensure equity is as integral to the process as it is to the goals of CI? The Five Building Blocks offer an effective framework for integrating health equity into CI efforts, and can be considered groundwork for structured intersectoral action for systems change.



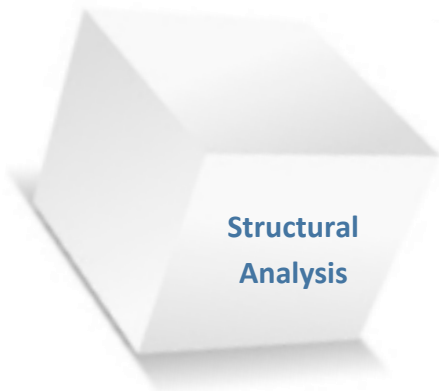


Equity Building Block 1: Shared Language

Establishing a common agenda for social change is the first of the five conditions for CI. In parallel, the first building block emphasizes how CI partners need a common understanding and discourse about inequities, as well as shared meanings of health equity and inequity. Partners require a shared understanding of how power, political structures and social processes play a role in the production of health inequities. In this building block, it is critical that those affected by health inequities are supported to provide leadership and given the opportunity to share their insight about the common agenda.

Equity Building Block 2: Disaggregated Data

A shared measurement system is the second condition for CI which coincides with the equity building block of disaggregated data. This building block asserts that the ability to tackle health inequities hinges on access to data divided by geographic, demographic or social group. Understanding differences in health outcomes among groups allows identification of populations that may be disadvantaged by social conditions and provides insight into what may support these populations despite structural adversities. Relevant funding and services can be provided to appropriate communities based on accurate and pertinent disaggregated data.



Equity Building Block 3: Structural Analysis

The purpose of structural analysis is to uncover both root causes and possible intervention points for change. The aim is to explore both present and historical sources of inequities, with a goal to challenge worldviews, policies and structures that perpetuate inequities. Structural analysis is necessary for developing effective upstream action and avoiding the trap of band-aid solutions. This process is best led or co-led by communities or groups affected by the inequities in question. Otherwise, the most insightful voices will be missing from the table.

Equity Building Block 4: Systematic Application

Systemic application concerns 'walking the talk' of equity at every level and stage of CI work. The aim of this block is to ensure all decision points are an opportunity to foster equity through intentional and appropriate (re)distribution of power and resources. Substantial long-term financial and organizational commitment to ensure efforts to systemically imbed equity into engagement processes should ultimately be established and sustained.





Effective Communication

Equity Building Block 5: Effective Communication

This building block relates to the fourth CI condition, Continuous Communication. Equity in communication means sharing both the successes and failures of equity work to continue to foster collaboration, learning and change. CI partners who implement this block adapt their engagement strategies to ensure continued meaningful participation and communication with people or groups who experience barriers to involvement. It also means examining and re-examining who has power over lines of communication and how participation of disadvantaged or historically marginalized groups may be impacted by this. This allows the stories of those experiencing and impacted by health inequities to be shared and embraced.



Building Health Equity

In exploring the concepts of the Five Building Blocks, we see that health equity is only possible if those affected by inequities are included and engaged as community experts and decision-making partners at the CI table. If attention to health equity is not explicitly integrated into a CI initiative from the outset, there is a greater risk of perpetuating rather than eliminating health inequities.

Acknowledgements

This resource was developed as part of an Equity Lens in Public Health (ELPH) student internship. Samantha Magnus collaborated with the Northern Health Authority's Population Health Programs team and was tasked with exploring how to integrate a health equity lens using a CI approach in the development of a health promotion initiative for children and youth (Every Child and Coach a Winner or ECCW). We gratefully acknowledge this contribution to ELPH.

*Please cite this document as follows: MacDonald, M., Magnus, S., Strosher, H.W., van Roode, T., Shahram, S.Z., & Pauly, B. (2017). *The Five Building Blocks for Equity in Collective Impact*. Victoria, BC: The Equity Lens in Public Health (ELPH) Research Project.*

References

1. Scott JS. Maximizing Impact: Building Blocks for Equity Focused Work. Presented at Champions for Change: Leading a Backbone Organization for Collective Impact 2015 Mar 25; Washington, D.C.
2. Schmitz, P. Vu Le is Right* About Equity and Collective Impact. *Collective Impact Forum*, 2015 Dec 14. <https://collectiveimpactforum.org/blogs/38876/vu-le-right-about-equity-and-collective-impact>
3. Witt, S. Pitfalls to Avoid When Pursuing Equity. *Collective Impact Forum*, 2015 Oct 23. <http://collectiveimpactforum.org/blogs/87516/pitfalls-avoid-when-pursuing-equity>
4. Kania J, Kramer M. Collective impact. *Stanford Social Innovation Review* 2011, (Winter Issue) pp35-50.
5. Kania J, Kramer M. The equity imperative in collective impact. *Stanford Social Innovation Review* 2015, Oct 6. http://ssir.org/articles/entry/the_equity_imperative_in_collective_impact

Find our other

ELPH KTE Resources [here](#)

Web: <https://www.uvic.ca/elph/>

Email: elph@uvic.ca



CIHR IRSC