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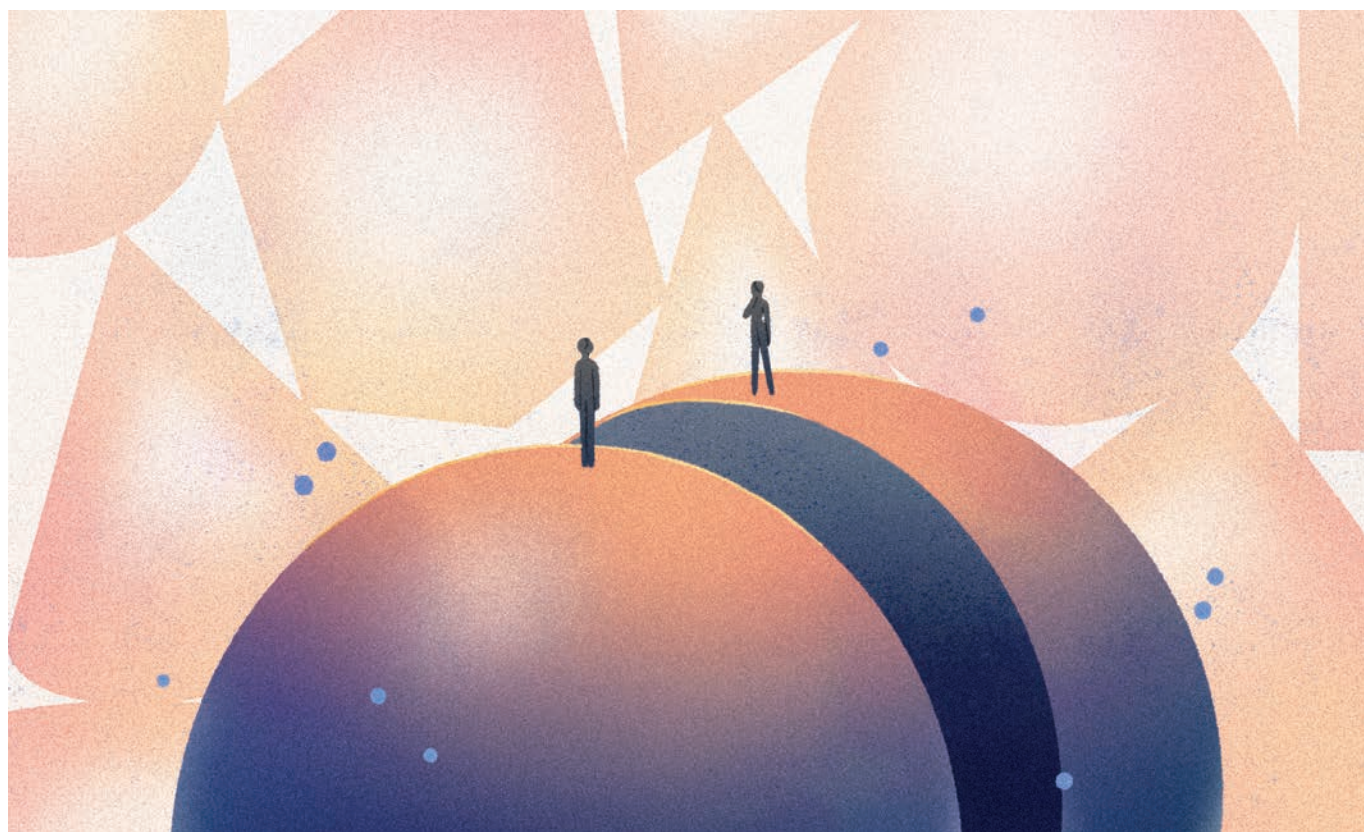
Bringing Equity to Implementation Supplement **Equity in Implementation Science Is Long Overdue**

By Ana A. Baumann & Pamela Denise Long

Stanford Social Innovation Review
Summer 2021

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Stanford Social Innovation Review
www.ssir.org
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Equity in Implementation Science Is Long Overdue

Implementation researchers and practitioners must examine how the field can be truly equitable. A systemic approach offers a path forward.

BY ANA A. BAUMANN & PAMELA DENISE LONG

Implementation science is an evolving field that aims to use evidence and rigorously acquired knowledge to close quality and outcome gaps in health and human services. However, we still have work to do as a field to advance equity, particularly for historically underserved populations.

To advance equity, implementation researchers and practitioners must engage in a consistent process of knowledge development, intervention selection, and use of implementation strategies, all focused squarely on equity. We can achieve equity in implementation science only by integrating the voices and wisdom of historically oppressed communities and reflecting on our own behaviors and values as implementation researchers and practitioners.

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We must also critically assess the gaps between the intentions and the impact of our work. Equitable implementation requires us to engage in social justice inquiry of our work and pursue fair, restorative, and equitable outcomes. In light of such inquiry, we propose that if we are to truly engage in equity work, all interventions and accompanying implementation strategies must address social determinants of health (SDOH)—the broad range of social, economic, political, and psychosocial factors that directly or indirectly shape health outcomes and contribute to health disparities. Health is not just the absence of disease, but also the presence of the resources and supports that people need to thrive.

THE COLLATERAL EFFECTS OF SOCIAL DISTANCING

The public health response to COVID-19 has made social distancing part of everyday language. When coupled with other interventions such as masking and hand-washing, social distancing has proven to be an effective evidence-based intervention for combatting respiratory virus epidemics. However, social distancing as an intervention has also shown us the negative consequences of implementing interventions with a single target (i.e., the prevention of disease) without examining context. For example, school shutdowns have exacerbated preexisting inequities in education, while limiting developmentally necessary social contact for children and taxing household resources.

Educational attainment and social isolation are social determinants of health. Since the initiation of social distancing, data show an increased risk for depression and traumatic stress responses, the mental health effects of which could extend beyond the COVID-19 pandemic. Social distancing is also affecting business, especially small businesses. Social distancing saves lives, yet exacerbates and compounds inequities in all walks of life, particularly for Black communities.

Half a century ago, British physician Julian Tudor Hart developed a concept he dubbed the inverse care law to describe the notion that public health interventions are the most successful with populations that need it the least, and the least successful with those facing the greatest risks. In our example, social distancing works best for populations that are able to work at home and have the resources to support remote learning. Acknowledging and addressing the collateral consequences of intervention-generated inequalities is only part of what is needed to achieve equity in health-care delivery.

The COVID-19 pandemic has disproportionately affected populations in already vulnerable contexts. Scholars call it a syndemic—a term coined by anthropologist Merrill Singer that describes the relationship between endemic and epidemic conditions, influenced and sustained by a broader set of political, economic, and social factors. Here, we use it to refer to two or more health conditions (e.g., COVID-19 and mental health) co-occurring in a particular environment. A practice of equitable implementation could potentially diminish or even prevent syndemics and other negative outcomes of our work in historically underserved populations.

THREE CALLS TO ACTION

We suggest three calls to action for the implementation science field: equity-focused evidence development, intervention selection and outcomes measurement, and implementation strategies. We also provide critical reflection questions about the equity-focused practices of researchers and implementation support practitioners.

Call to Action #1: *Engage with historically underserved community members and collaborate with other disciplines for evidence development with equity at the forefront.*

As the issues around social distancing have shown us, developing more equitable interventions requires us to reflect critically about the unintended and detrimental consequences of our work as implementation scientists. We need to nurture a greater understanding of the social determinants of health and of the political, social, and historical dynamics of the context in which we are implementing our interventions. Implementation researchers and practitioners must account for the deep and prolonged history of white supremacy, systemic racism, and other forms of discrimination that exact broad social consequences for the populations we engage, and the ways present-day organizations are shaped by cultural and historical dynamics.

To apply a social justice lens to the field of implementation science, we need to recognize that research is inherently entangled with the power relations, perspectives, and identities of academics and the institutions that govern their behavior. We urge implementation researchers and practitioners to routinely examine their evidence—how it was collected, measured, and/or analyzed, by whom, and under what conditions. Without intentional equity-focused evidence development, researchers can perpetuate the erroneous notion that an inquiry can be objective and/or divorced from historical context.

If we are to develop interventions that produce desired outcomes for communities, we need to formulate research questions and topics together with historically underserved populations, so that those with a stake in implementation share in the decision-making. Other researchers, including the authors of this supplement, have written about how to engage and collaborate with communities who face barriers to services and about the need to examine who recruits par-

ticipants for trials, how recruitment is done, and what value the study has for those populations. By cocreating research, with the assumption that health inequities affect us all, we can better understand and examine the contexts in which we are conducting our studies. The field of implementation science could learn a lot by conducting trials in churches, barbershops, and other gathering places where people feel safe. Accordingly, researchers and practitioners should ask themselves: What processes do you use to include community insights in developing research questions? Who is absent in these conversations and why? Where are you conducting your trials and how does the setting affect the participants who are present—and absent—in your research?

As we engage historically underserved communities to create equitable knowledge development, we also advise implementation scientists to resist the temptation of developing a new and separate jargon for well-known concepts. Scholars in community-based participatory research (CBPR), community-engaged research (CEnR), and Critical Race Theory (CRT) have been exploring these issues for decades. We must expand existing equity-supporting frameworks of analysis in our research and avoid creating an even larger communication gap between our field and others. Consider: Have you reached out to scholars who do equity work? What are your assumptions around equity and which literatures are you reading? Before you modify or create a new framework, design, or measures, have you looked at the wealth of resources put forth by equity and anti-racism scholars?

Call to Action #2: *Pay attention to intervention selection and outcomes measurement by examining their relationship to social determinants of health.*

Evidence development informs intervention selection. Intervention selection and its implementation strategies must be informed by the context and the people who will receive the intervention. Researchers and practitioners increasingly realize that the structural conditions in which people are born, live, and work are powerful determinants of health disparities.

Evaluations of interventions usually track their effects on applicable markers of health, such as a decrease in the spread of COVID-19. Sometimes researchers also track implementation outcomes during the development of treatment (e.g., how feasible and how acceptable is the intervention). While developing an intervention for a specific outcome is valuable in itself, researchers should think beyond proximal outcomes (e.g., the rate of viral infection and death) and measure potential effects on social determinants of health (e.g., the impact of social distancing on small businesses). For instance, an intervention aimed at reducing substance abuse could have other benefits; sobriety could show decreases in rates of incarceration or probation. A study of an evidence-based intervention for parents from GenerationPMTO shows that improving parenting practices not only yields better outcomes for children and improves parent mental health, but also improves household income.

Interventions can also target social determinants of health. For example, studies have shown that housing mobility improves physical and mental health, including obesity and depression; that economic strengthening has positive association with HIV testing and care; that parent interventions coupled with interventions around food security are associated with reduced violence against children. Interventions that target SDOH are perhaps more effective at promoting equity in the long term than interventions addressing only one outcome.

Consider: What type of SDOH outcomes could you also measure as you implement your interventions? How might you prioritize selecting interventions that affect more than just proximal outcomes? And how might you examine the impact of the interventions beyond the main target outcomes?

Call to Action #3: *Develop equitable implementation strategies.*

Just as we advocate for implementation researchers and practitioners to consider SDOH outcomes in the development and measurement of their interventions, we also urge them to adopt implementation strategies that are focused on systems. Implementing systems-level strategies is not a simple task, because identifying and measuring contextual factors is challenging. Context too often tends to be an afterthought of our work, but it drives differences in our studies and sustains inequities. To enhance equity, implementation researchers and practitioners must address the *structural* determinants of health—the socioeconomic, historical, and political contexts—that contribute to the socioeconomic position of those being served. Equity-focused implementation strategies ensure that people from underserved communities are not blamed or deemed to have character deficits. They address the historical mistrust, anger, and fear that these communities rightfully have with traditional systems of care. The previous two calls to action asked implementation science stakeholders to embrace their place as advocates for justice. Justice, in turn, requires implementation researchers and practitioners to address the context that the individual faces.

To achieve equity, we must develop strategies that support communities to be safe, heard, and empowered in traditional service interactions. With justice in mind, we should develop implementation strategies that not only meet immediate needs but also rectify the consequences of inequitable systems. Implementation researchers and practitioners must move beyond programs and practices to institutional and social policy. Only this way can we counteract the relational ruptures and compound inequities of the SDOH with historically underserved populations. We could also benefit from learning the harmful effects of legislation on these populations, including their access to protections and quality service. Laws can reinforce discrimination, protect those with power, and increase the disadvantage of those without social capital. Alternatively, they can create systems for equitable outcomes.

To dismantle racism and enhance equity, we need a seismic shift in the current academic model. We will not be able to make a significant difference with piecemeal studies under current funding mechanisms. We must build a stronger collaborative practice, with thoughtful sharing of resources and deliberate capacity building. The field of implementation science needs to infuse social justice concepts in its work and deliver ongoing anti-bias and anti-racism training to its researchers and practitioners. Implementation scientists can benefit from learning how to examine issues of power (e.g., how our social position affects our research questions and engagement with historically underserved communities), and how to develop and support allyship and collaborative science.

It is time for implementation researchers and practitioners to explore how the field might hold itself accountable regarding equity. We pose the following questions: How do policies impact the reach, implementation, and recruitment of underserved populations in your studies? How could you partner with advocacy groups and policy makers to further equity in your work? How might you develop imple-

mentation strategies that affect the contextual issues that contribute to disparities in outcomes? How could you ensure accountability and self-reflection in learning about the historical contexts of underserved communities? How might you embed anti-bias and anti-racism training in your implementation science trainings and strategies?

MINDING THE GAPS

Our current model of evidence-based interventions that target the behavior of individuals in traditional settings has failed so many people. The implementation science field must quickly catch up by developing equity-focused knowledge, intervention selection, and implementation strategies, lest we fall even further behind the burgeoning social consciousness and social justice movements.

With a more mature understanding of the social determinants of health, we must respond to immediate needs while also advocating for and proffering longer-term strategies that address the ways systems have marginalized people. Correcting the impact of historical oppression and systems-level root causes is the only equitable path forward. ●

Listening to Black Parents

Black children experience racial discrimination in academic environments that actively deplete their self-worth. By accessing the cultural knowledge of Black parents, Village of Wisdom co-designed a liberatory approach to education.

BY WILLIAM JACKSON & KRISTINE ANDREWS

"Oppressed people, whatever their level of formal education, have the ability to understand and interpret the world around them, to see the world for what it is, and move to transform it," said civil rights and human rights activist Ella Baker. She may not be viewed as a pioneer of equitable implementation, but her outsize impact on the civil rights movement was grounded in her ability to listen and support the leadership and wisdom of people most affected by racism.

My name is William Jackson and I'm the founder and a team member of Village of Wisdom, an organization leveraging the collective wisdom of Black families to support advocacy and organizing for racially just schools. Baker's approach was unknown to our team when we founded Village of Wisdom (VOW) in 2014, but the spirit of her approach informs everything we do. Indeed, it wasn't hard to convince us, as the children of Black parents ourselves, that Black parents—a Black child's first teachers—might know best how to facilitate learning for Black children.

VOW's solution was simple at its core: Leverage the cultural wisdom of Black parents to affirm their children's Blackness as an antidote to a world that actively depletes their self-worth through systemic racism and

WILLIAM JACKSON is the founder and chief dreamer of Village of Wisdom (VOW). He leads an amazing team of colleagues whose daily mission is to translate the wisdom of Black parents into strategies that will create more culturally affirming learning environments for Black folk.

KRISTINE ANDREWS is the director of youth development at Child Trends and a leader in racial equity. She has expertise in equitable implementation and evaluation.