Equity-focused / Health Equity Impact Assessment (Ef HIA/HEIA)

Practical tools for building Healthy Public Policy

Workshop for the Vibrant Communities Symposium
April 26, 2012

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Healthy Child Manitoba Office & University of Manitoba

Karen Serwonka, MHSc, Cert HIA
Manitoba Health (Research Team Member); Healthy Child Manitoba (formerly on secondment as EfHIA Pilot Project Manager)
Overview of today’s presentation

- Who is presenting today?
- What is health equity?
- Why does health equity matter?
- History of health impact assessment and impact assessment methodology
- What is equity-focused health impact assessment (EfHIA)?
- Lessons learned from EfHIA Manitoba Pilot
- What is health equity impact assessment (HEIA)?
- Practical group case study – how to use Ontario’s HEIA tool
- How can you apply HEIA or EfHIA in your organisation?
- Future of EfHIA ... in your community? Manitoba? Canada
Who is presenting today?
What is health equity?
Health equity is most often defined by the absence of health inequities or disparities.

*Health inequities or disparities are differences in the health outcomes of specific populations that are “systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.”*

- Margaret Whitehead

Why does health equity matter?
Why Health Equity Matters

• A difference of 16 km between 2 neighbourhoods in Glasgow, Scotland can result in a 28 year drop in life expectancy

• A boy from the Glasgow suburb of Calton could expect to live to 54, while a boy born in nearby affluent Lenzie is likely to reach 82. ¹

Social Factors Key to Ill Health BBC Video ²
This map illustrates a 20 year difference in life expectancy resulting from socio-economic circumstances and poor access to healthcare within Hamilton, the average age at death is 67 years of age in a lower income neighbourhood and as high as 86 in a higher income neighbourhood.
Figure 3.11: Adjusted Lorenz Curve for Potential Years of Life Lost in Rural Areas 1984-1988
Adjusted by (2004-2007) age & sex, residents aged 0-74

Cumulative Percent of Potential Years of Life Lost

Cumulative Percent of the Population

GINI = 0.103 (95% CI 0.069, 0.138)

Source: Manitoba Centre for Health Policy, 2010
Figure 3.12: Adjusted Lorenz Curve for Potential Years of Life Lost in Rural Areas 2004-2007
Adjusted by (2004-2007) age & sex, residents aged 0-74

Cumulative Percent of Potential Years of Life Lost

Cumulative Percent of the Population

GINI = 0.168 (95% CI 0.122, 0.214)

Source: Manitoba Centre for Health Policy, 2010
Figure 4.11: Adjusted Lorenz Curve for High School Completion (Including Band-Operated Schools) Rates in Rural Areas 1996

Adjusted for (2002) sex, percent of Grade 9 students who graduated within six years from time period

Cumulative Percent of High School Completions

Cumulative Percent of the Population

GINI = 0.069  (95% CI 0.044, 0.095)

Source: Manitoba Centre for Health Policy, 2010
Figure 4.12: Adjusted Lorenz Curve for High School Completion (Including Band-Operated Schools) Rates in Rural Areas 2002

Adjusted for (2002) sex, percent of Grade 9 students who graduated within six years from time period

GINI = 0.079 (95% CI 0.057, 0.101)

Source: Manitoba Centre for Health Policy, 2010
HEALTH INEQUITIES IN MANITOBA:
Is the Socioeconomic Gap in Health Widening or Narrowing over Time?

September 2010 (2nd Edition)

University of Manitoba
Faculty of Medicine
Community Health Sciences

Manitoba Centre for Health Policy
Department of Community Health Sciences
Faculty of Medicine, University of Manitoba

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Patricia Costain, PhD
Colleen Magro, BSc (Pharm), PhD
Rob Santos, PhD
Karen Serwinka, MHS

http://mchp-appserv.cpe.umanitoba.ca/deliverableslist.html
Health from a Social Determinants Perspective

Source: Dahlgren and Whitehead, 1991
“Putting right these inequities – the huge and remediable differences in health between and within countries – is a matter of social justice . . . an ethical imperative”

HEIA / Ef HIA : A Tool for Addressing Health Inequities

Among WHO Commission on the Social Determinants of Health’s recommendations for tackling health inequities (2008):

→ health equity needs to be routinely considered in policy-making practice;

→ health equity impact assessment (HEIA / EfHIA) identified as a particularly effective tool;

→ governments build capacity for health equity impact assessment among policy-makers and planners across departments.
2010 Report on the Health Status of Manitobans

Recommendation 3.1:

More comprehensive prevention strategies should be developed, in consultation and collaboration with appropriate stakeholders, to achieve reasonable and specified objectives or targets, based on evidence and the following approaches:

1) **Consider the health and health equity impacts** of major decisions, legislation, policies and actions.

MOHLTC and LHINs have a legal and ethical responsibility to integrate equity considerations into planning and decision making

- In the *Excellent Care for All Act*, 2010 (ECFA) preamble, equity is defined as a critical component of quality health care.

- The Ontario Public Health Standards (OPHS) 2008, explicitly acknowledges the work of public health in reducing health inequities. Specifically, the OPHS Foundational Standard directs boards of health to plan and deliver focused interventions to meet the needs of priority populations.

- The Local Heath System Integration Act, 2006 (LHSIA) preamble states that the health system should be guided by a commitment to equity and respect for diversity in communities in serving the people of Ontario, specifically referring to Ontario’s French-speaking community and First Nations and Aboriginal peoples.

- The *French Language Services Act*, 1986 (FLSA) defines where individuals are guaranteed to receive service in French.

- There are both ethical and legal obligations to address health equity (*Canada Health Act, Future of Medicare Act, Charter of Rights and Freedoms, Ontario Human Rights Code*).

- Addressing health equity can make a critical contribution to health system sustainability by reducing the incidence of costly and preventable illnesses and related treatments.
HEIA provides a systematic method to embed equity in planning and decision making

• HEIA is a **proven method** to assess initiatives and investments to ensure that potential unintended health impacts on populations are considered/addressed to reduce health disparities across vulnerable/marginalized population groups.

• HEIA leverages existing work and creates greater **consistency** and **transparency** in the way that equity is being considered across the health system.

• *Access and quality barriers sustain or even widen serious health disparities, resulting in increased future cost burden and poor health outcomes for vulnerable populations.*
What is health impact assessment?
An popular definition

‘a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population and the distribution of those effects within the population’.


A practitioner’s perspective …

‘I believe HIA is a really useful way to highlight the strong linkages between health outcomes and social, economic, cultural and environmental factors. It also has the strength of using both evidence and community participation to assist in designing policies.’

Margaret Earle
Ministry of Health
HIA Support Unit
New Zealand

Assessment of Impacts

- overall positive
- overall negative
- differential (but not inequitable)
- inequitable
- unclear
Origins of Health Impact Assessment
2 main streams of influence

Stream A

Environmental Impact Assessment

Social IA

Human Rights IA

Health IA

Stream B

The New Public Health (Revitalization)

Ottawa Charter for Health Promotion
(1 of 5 action areas: Healthy Public Policy)
HIA as tool to advance HPP

Human IA

Equity-focused HIA

Community-driven HIA

Mental Well-being IA
What is equity focused health impact assessment (EfHIA)?
Equity-focused HIA (EfHIA)

- uses established HIA methodology to create a structured and transparent process of determining the potential differential of a policy or program on the health of the population, and how impacts are distributed among population groups.

- seeks to ensure that policies/programs do not disproportionately disadvantage some groups compared to others.

- may indicate how a policy/program can redress existing inequities through recommendations to decision-makers and, thereby, contribute to narrowing the health equity gap.

- identifies potential unintentional consequences (and pre-empting them) and opportunities for advancing positive health impacts and minimizing negative impacts through the improvement of the policy/program before its implementation.

- ideally, EfHIA is conducted prospectively - prior to the implementation of a policy/program - in order to influence equity considerations in the future implementation of the policy/program.

(Harris-Roxas, Simpson, & Harris, 2004; Mahoney, Simpson, & Harris, 2004; Simpson, Mahoney, Harris, Aldrich, & Stewart-Williams, 2005)
(Ef)HIA place within the Policy/Program Planning Cycle

Needs/Assets Assessment

Planning of Intervention(s) to address needs (policy, program, project, initiative, strategy, legislation, etc.)

Draft Program Proposal

Screening

Impact Assessment

EfHIA Recommendations (revised proposal)

Decision-makers review recommendations & make decision re: degree to which they will adopt Recs

Program Implementation

Monitoring

Evaluation

Adapted from Harris et al. (2007)
(Ef) HIA Steps

Screening

Scoping

Impact Identification

Impact Assessment

Recommendations to Decision-makers

Implementation of Intervention

Monitoring & Evaluation
Depth of HEIAs

- Desktop
- Rapid (in between)
- Comprehensive

Whether HEIA is mandated (set) or voluntary (leeway)

- Time available in the policy/program development cycle
- Resources available to conduct an impact assessment
- Evidence gathered
- Extent of public & stakeholder consultation (testimony)
Overview of the Influence of the pilot Manitoba / Canada EfHIA & the Program that was assessed
Research Team launches EfHIA Pilot / Study

University of Manitoba

Research Lead: Dr. Benita Cohen
Faculty of Nursing & Dept. of Community Health Sciences

Other Research Team Members:

Dr. Marcia Anderson DeCoteau
Dept. of Community Health Sciences
(also works with Manitoba Health)

Dr. Christine Ateah
Faculty of Nursing

Dr. Mariette Chartier
Dept. of Community Health Sciences
(also worked with Healthy Child Manitoba Office)

Dr. Steven Feldgaier
Clinical Health Psychology
Also works with Healthy Child Manitoba Office
Government of Manitoba

Ms. Karen Serwonka, MHSc Cert HIA
Policy Advisor, Public Health, Manitoba Health
Recruited to manage EfHIA pilot project with
Healthy Child Manitoba Office,
Government of Manitoba

Research Proposal received approval from Research Ethics Board (Nursing & Education), University of Manitoba

With support from experienced EfHIA practitioners

Ms. Elizabeth Harris, MA and Mr. Ben Harris-Roxas, MPH
University of New South Wales (Australia), Centre for Health Equity Training, Research & Evaluation (CHETRE)

With support from experienced HIA practitioner, for some consultation on process and technical questions

Mr. Andy Pennington, MPlan, University of Liverpool (UK),
International Health Impact Assessment Consortium (IMPACT),
Division of Public Health

Other University of Manitoba colleagues involved in early stages of research proposal development:

Dr. Javier Mignone, Faculty of Human Ecology

Dr. Lawrence Dean, Faculty of Social Work

Dr. Marni Brownell, Dept. of Community Health Sciences

Funded and Supported by the Public Health Agency of Canada’s Strategic Initiatives & Innovations Directorate

Oversight from a Steering Committee (see upcoming slide)

Staff support from Project Assistants: Ms. Lucia Madariaga-Vignudo, Tara Prakash, and Farzana Quddus; and Thompson Outreach Worker: A. Heather Murray
First Phase

conducting a pilot EfHIA of the proposed Teen Triple Program

Second Phase

examining the influence of the EfHIA on the implementation of the program, broader ripple effects and lessons learned
EfHIA Pilot Project Objectives

1) To assess the potential for Manitoba’s proposed Teen Triple P program to achieve equity of access and outcomes for families of diverse backgrounds, including marginalized and socially disadvantaged populations, using an established EfHIA methodology/process;

2) If required, to recommend alternative actions that could promote greater equity of access and outcomes among diverse families participating in Teen Triple P;

3) To evaluate the influence of the EfHIA process regarding the integration of equity-oriented recommendations related to the implementation of the proposed Teen Triple P program; and

4) To identify key lessons from the pilot test process, tools and outcomes, in the Manitoba context, as well as recommendations for improvement, that could be utilized to facilitate and inform the application of EfHIA throughout Canada.
Key Feature of Ef HIA: Participatory Process

Manitoba/Canada Pilot EfHIA included oversight from a Steering Committee, composed of:

**Members:**

Research Team representatives:
- Research Lead (Co-Chair): Benita Cohen
- Program Proponent (Co-Chair): Steven Feldgaier
- Experienced Ef/HIA practitioner: Ben Harris-Roxas, Uni of NSW

Chairpersons of Parent-Child Coalitions from four geographic regions:
- Catherine McFarlane, Together in Elmwood, A Parent Child Coalition (TIE), Winnipeg
- Dorothy Braun, Healthy Child Coalition, Central Region, Altona
- Peggy Martin, Burntwood Parent-Child Centred Coalition, Thompson
- Linda Archer, St. James-Assiniboia Parent-Child Coalition

Representative from Manitoba Aboriginal & Northern Affairs Dept.:
- Kim McPherson, Senior Policy Analyst

Representatives from the Public Health Agency of Canada, Strategic Initiatives & Innovations Directorate (funder & supporter):
- Beth Jackson, Manager, Research and Knowledge Development
- Charlene Cook, Senior Policy Analyst / Heather Louise Greenwood (Graduate Student then Policy Analyst)

**Observers:**

National Collaborating Centre for Healthy Public Policy (NCCHPP) / Centre de collaboration nationale sur les politiques publiques et la santé (CCNPPS):
- Anika Mendell, Research Officer / Agence de recherche

Public Health Agency of Canada, Manitoba / Saskatchewan Regional Office:
- Cate Herrington, Regional Manager
### Research Team (RT) & Project Staff (PS)

- RT established in 2007 to pilot an EfHIA on a proposed policy or program in Manitoba
- RT approached HCMO to be the proponent (put forward a policy/program to be assessed)
- RT secured funding to conduct pilot use of EfHIA
- RT conducted screening of the proposed program (atypical)
- RT hired project staff (PS)
- RT & PS identified appropriate stakeholders for Steering Committee
- RT/PS developed draft Terms of Reference to serve as collaboration agreement for conducting and overseeing the EfHIA process
- RT & PS developed data collection strategy and identified representative communities. Developed Ethics Proposal and submitted to University Research Ethics Board.
- Research Lead (RL) supervised PS: conduct literature review for evidence on proposed program and its expected impacts and the affected populations; conduct community and agency consultations; critically analyze the data/evidence gathered. RT reviewed summary of evidence; suggested draft action-oriented equity recommendations.
- RL & PS: prepared summary report (charts) of evidence of impacts and draft equity recommendations (destined for program decision-makers).
- RL presented summary of the evidence on priority impacts and equity recommendations to HCMO Executive Management Team.
- RL & PS: conduct process and impact evaluation. Set up monitoring of the influence of the EfHIA recommendation on the program as it is being implemented.
- RL & PS: prepared final report and presentation deck for the funder.

### Steering Committee (SC)

- Reviewed draft Terms of Reference, revised and approved.
- Reviewed draft data collection strategy, Terms of Reference, revised and approved.
- Kept a written journal documenting their reflections re: what worked, what didn't; what could have been done better; and how their understanding evolved over the pilot.
- Reviewed and prioritized impacts; further developed and approved recommendations.
- Contributed to the evaluation of the EfHIA process as ‘evaluatees’

### Comparing Roles & Responsibilities

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Program assessed during the EfHIA Pilot: The Triple P – Positive Parenting Program in Manitoba

• In March 2005, Manitoba’s Healthy Child Committee of Cabinet announced the allocation of $1.4 million annually to support parents and provide them with parenting information, resources, and assistance through the implementation of the Triple P – Positive Parenting Program.

• In Manitoba, the program began with primary focus on families with children under age 6. It was later extended to families with children aged birth to 12 years.

• It is currently looking to extend it even further to accommodate families with teenagers 12-16 years of age (i.e. Teen Triple P).
What is the Triple P – Positive Parenting Program?

- developed by Matthew Sanders, a Professor of Psychology, at the University of Queensland in Australia

- a prevention / early intervention program designed to help parents learn and develop effective parenting strategies for strengthening positive relationships with their children/teenagers and for dealing with a variety of behavioural, emotional, or developmental issues.

- Firmly embedded within a comprehensive public health model of intervention

- *Central to the Triple P system is the goal of empowering parents to become independent and autonomous problem solvers and decision makers who decide on the goals and values for their family*

- Practitioners trained in Triple P build upon the strengths of each parent and provide support and guidance to the “minimally sufficient” degree needed
Phase I of EfHIA: Methodology

- Key Informant (KI) Interviews with Provincial HCMO Officials (n = 5)

- Community meetings in the form of Focus Group Interviews (Winnipeg, Portage la Prairie, Thompson):
  - Agency Managers at community agencies that provide services to parents/caregivers of teenagers, 12-16 years (n = 9 groups)
  - Parents & Caregivers (n = 5 groups)

- Literature Review

- Profile of Families with Children 12-16 years (demographic, health, well-being)

- Journal-Keeping among SC Members
# Focus Groups (FGs) for EfHIA of Proposed Teen Triple P Parenting Program

<table>
<thead>
<tr>
<th>FGs with Parents of Teens</th>
<th>FGs with Agencies Serving Parents of Teens</th>
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<tr>
<td><strong>FGs beyond Winnipeg</strong></td>
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<tr>
<td>Thompson ~ Parents, general (P5) ☑</td>
<td>Agencies serving Thompson CAMs (A8) ☑</td>
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<tr>
<td>Thompson ~ Parents of First Nations, Métis &amp; Inuit ancestry (P6) ☑</td>
<td>Portage La Prairie CAMs (A9) ☑</td>
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<td>Parents accessing services in Portage La Prairie (P9) ☑</td>
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<tr>
<td><strong>FGs within Winnipeg</strong></td>
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<tr>
<td>Elmwood Parents  (P3) ☑</td>
<td>Elmwood neighbourhood  CAMs (A2) ☑</td>
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<tr>
<td>St. James-Assiniboia Parents (P7) ☑</td>
<td>St. James-Assiniboia neighbourhood  CAMs (A5) ☑</td>
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<tr>
<td>Parents of Teens of FN, Métis, Inuit Ancestry (P10)</td>
<td>Agencies serving Aboriginal families with teens (FN, Métis &amp; Inuit Ancestry) (A7) ☑</td>
</tr>
<tr>
<td>Parents of LGBTIQ teens  (P4) ☑</td>
<td>Agencies serving LGBTIQ teens &amp; their parents (A3) ☑</td>
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<tr>
<td>Newcomer Parents ~ who came to Canada as Provincial Nominees / Skilled Immigrants (P1) ☑</td>
<td>Agencies serving newcomers  (A1) ☑</td>
</tr>
<tr>
<td>Newcomer Parents ~ who came to Canada as refugees  (P2) ☑</td>
<td>Agencies serving teens with special needs &amp; their families (A4) ☑</td>
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<tr>
<td>Parents of Teens with special needs  (P8) ☑</td>
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<td></td>
<td>Wpg: Agencies with a city-wide mandate to serve parents of teens (A6) ☑</td>
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The Nutcracker Effect: top down and bottom up action for health equity

How did we review the evidence and develop recommendations for program decision makers?
Considerations:

- size / magnitude of the impact: severity and population reach (large, medium, small)

- likelihood of impact occurring (definite, probable, speculative, unlikely)

- modifiability / actionable
### Potential Differential Impacts of proposed program for Parents/Caregivers ~ example of Chart designed to originally present evidence combined from all sources to Steering Committee for review & prioritization May/11

<table>
<thead>
<tr>
<th>Program Dimension 1: Content &amp; Core Principles of the Triple P Program</th>
<th>Notes for Prioritizing</th>
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</thead>
<tbody>
<tr>
<td>If this happens (in these circumstances, under these conditions) ...</td>
<td></td>
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<tr>
<td>... the potential exists to impact parents and caregivers (P/Cs) of teens in Manitoba in the following way(s) (potential impacts, consequences, outcomes)</td>
<td></td>
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<tr>
<td><strong>Sources of Evidence</strong></td>
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<td><strong>D</strong></td>
<td></td>
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<tr>
<td><strong>Groups, Sub-Populations, Communities bearing Differential Impacts</strong></td>
<td></td>
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<tr>
<td><strong>Parents &amp; Caregivers:</strong></td>
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<tr>
<td>Important notes: initial suggestions from the data analysis on ways to maximize + impacts or to avoid/minimize – impacts; and draft recommendations from Research Team for Steering Committee consideration</td>
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<tr>
<td>NB: If they suggested a remedy / solution, this would imply that it is avoidable</td>
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**Notes for Prioritizing**

- Size / Population Reach: Large / Med
- Likehood of & Define, Prioritize, Unlikely
- Note Prioritization

<table>
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<tr>
<th>Program Dimension 2: Availability of the Program in communities throughout the Province (where it is made available first)</th>
<th>Notes for Prioritizing</th>
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<tbody>
<tr>
<td>2c) If uptake of this program by agencies is voluntary ...</td>
<td></td>
</tr>
<tr>
<td>... the potential exists for program delivery to be occasional or sporadic in some communities and non-existent in others. Sometimes leading to long waiting lists to access the program, resulting in some families not getting help when they need it most. ... it is a waste of resources and a missed opportunity.</td>
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<tr>
<td><strong>KII</strong></td>
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<tr>
<td><strong>D</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Agencies serving “high needs” communities</strong> e.g. families with multiple/complex needs, families living in poverty, inner city communities, remote communities etc. Especially families in crisis, P/Cs mandated to take the program by CPS or the court</td>
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<tr>
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<tr>
<th>Program Dimension 3: Approaches to Delivering / Implementing the Program (once program is rolled out, how it is delivered)</th>
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<tbody>
<tr>
<td>3b) If, however, the perception is that Teen Triple P is for P/Cs who have somehow failed in their parenting or for teens with serious behavioural problems is not addressed in the messaging (advertising, promotion) of the program ...</td>
<td></td>
</tr>
<tr>
<td>With the increasing trend for parents involved with Child &amp; Family Services or with the courts, to be mandated to take some form of the Triple P program ...</td>
<td></td>
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<tr>
<td>... the potential exists for P/Cs to be reluctant to participate in the program, for fear of being judged (by family, friends, neighbours, workmates, agency staff etc.).</td>
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<td><strong>D</strong></td>
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<tr>
<td><strong>Lit</strong></td>
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<tr>
<td>* mandated to take Triple P who are not interested in / committed to it and other interested P/Cs in a group setting with them, on social assistance, new-comers of teens with special needs involved with the child welfare system.</td>
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**Suggestions:** to deal with the issue of stigma is mass public advertising campaign (currently under way), in order to normalize.

| KII | FGs |                       |

**Notes for Prioritizing**

- Note Prioritization
- Size / Population Reach: Large / Med
- Likehood of & Define, Prioritize, Unlikely
### Potential inequitable impacts

The potential exists for the proposed program to not fully address the broader living conditions and circumstances, in which parenting takes place, which can make parenting all the more challenging; nor address the material and social resources that support/enable effective parenting. This, in turn, may result in:

- needs not being fully met
- not completing the program
- and may contribute to the low enrolment and high attrition typical of services targeted at families with teens.

**Evidence:** Focus Groups, Key Informant Interviews, Literature

**Impacts:** 1, 3l, 3mi, 3mii, 1l, 3t, 3e

### Recommendations

**Ranking:** 6 of 7 (High / Essential)

- ensure skills in broader needs identification and mechanisms for appropriate referral, so that families’ needs are adequately identified, referred and addressed by the proposed program and additional programs, services and policies.

- training for program providers includes an orientation to available resources for specific groups of parents/caregivers (e.g. Indigenous, newcomers, low-income, special needs, etc.)

- program venues ideally located in agencies offering a broad range of health and social services and programs, to facilitate referral and access for families with multiple/complex needs.

- explore potential for Healthy Child Manitoba Office (HCMO,) given its broad mandate, to play a substantial role in facilitating linkages with other programs and services and government bodies and co-ordinating service, program and policy responses to meet families’ needs. {Beyond Triple P}
### Potential inequitable impacts

The potential exists for the proposed program....

Some other areas of potential inequitable impacts may include:

- intergenerational impacts of colonization
- familiarity with child welfare system; rights and responsibilities of parents and children
- service delivery and implementation
- literacy levels
- cultural appropriateness

### Recommendations

For each identified area of potential inequitable impact, recommendations were developed to address concerns and mitigate potential negative impacts and maximize potential positive impacts.
The EfHIA has identified a number of potential inequitable impacts and equity issues that will need to be considered.

Recommendations will need to be reviewed with consideration given to their potential implementation. Additional factors will need to be examined in developing the overall implementation plan for the program, including:

- Timeliness
- Feasibility
- Role of government
- Etc.
Objectives were to examine influence of EfHIA in terms of:

- **direct outcome** on policy decisions related to Teen Triple P program (e.g., consideration of potential equity impact recommendations by HCMO decision-makers; their adoption and implementation);

- **indirect outcome** of the EfHIA (e.g., changes in understanding of health equity and the social determinants of health inequities, particularly as they relate to parenting and healthy youth development; use of information to inform other decision-making and planning within organization; ‘ripple effects’ on other departments, sectors or jurisdictions); and

- **perspectives of** key HCMO stakeholders and SC members regarding the **EfHIA process**, including identification of enablers and challenges.
Value added by conducting an EfH-IIA during the planning phase of program development

Challenges encountered

Things we would do differently next time around
Health Equity Impact Assessment (HEIA)

Introduction to Ontario’s Health Equity Impact Assessment (HEIA) Tool
The MOHLTC HEIA tool is an evidence-based decision support tool that facilitates improved targeting of health care investments at the Ministry, Local Health Integration Network, Public Health Unit and health service provider level to improve health equity.

- HEIA has four key objectives:
  - Help identify \textit{unintended} potential health equity impacts of decision-making (positive and negative)
  - Support equity-based improvements in strategy/policy/planning/program/or service design
  - Embed equity across an organization’s existing and prospective decision-making models
  - Raise awareness about health equity throughout the organization

- HEIA has been successfully integrated in a number of international jurisdictions including England, Wales, New Zealand, and Australia, and is used and endorsed by the World Health Organization (WHO).
Ontario is a leader: MOHLTC’s Health Equity Impact Assessment (HEIA) Tool is number one on Google.

- HEIA is endorsed by the World Health Organization (WHO)
- Ontario is a national leader in health equity and HEIA implementation
In this simplified example, those with the most need get the lowest level of service: the undesirable “inverse care law”

Source: Health Equity Audit: A Guide for the NHS, UK Department of Health
The HEIA tool includes a template and a workbook, which provides step-by-step instructions on how to complete the HEIA template.

### Template & Workbook – core components of HEIA

Health Equity Impact Assessment (HEIA)

**Workbook: How to conduct HEIA**

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<table>
<thead>
<tr>
<th>Health Equity Impact Assessment (HEIA) Template</th>
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**Step 1: Scoping**

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<tbody>
<tr>
<td>b) Population</td>
<td>1. Unintended positive impacts</td>
<td>1. Mitigation strategy to address positive impacts</td>
<td>1. Monitoring of strategy effectiveness</td>
</tr>
<tr>
<td>c) Social Determinants of Health</td>
<td>2. Unintended negative impacts</td>
<td>2. Mitigation strategy to address negative impacts</td>
<td>2. Monitoring of strategy effectiveness</td>
</tr>
<tr>
<td>e) Other</td>
<td>4. Information needed</td>
<td>4. Mitigation strategy to address other factors</td>
<td>4. Monitoring of strategy effectiveness</td>
</tr>
</tbody>
</table>

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**Note:** The workbook may only be performed by members of the scoping team and there will be some recommendations provided by an independent consultant.
Additional resources that complement the tool include the French Language Supplement and the HEIA website.
Forthcoming resources for the tool – a Public Health Supplement, Evidence Summaries, and additional web-based resources.
HEIA implementation has been staged, with continued active collaboration across the healthy system.

- The HEIA Tool was launched on March 25, 2011, and training was completed for each of the 14 LHINs in August 2011. Ministry-wide HEIA trainings began in September 2011 and training is also being provided to interested agencies.

- LHINs and some stakeholders committed to applying HEIA in 2011/12. Many LHINs are promoting HEIA, applying it to selected initiatives and provide training to Health Service Providers (HSPs).

- Further resources for HEIA users are being developed that will be made available on the HEIA website
  - For example, development of evidence summaries to assist users to complete the tool

- The ministry is planning a large Health Equity Forum May 28 2012, invitations to be released shortly.

- Collaboration with Public Health Ontario (PHO) led to the development of “HEIA 2.0” which includes an added ‘step’ to HEIA and a Resource Guide for Public Health Unit users.
How to conduct an HEIA
Getting started…

• HEIA is typically conducted by the planning, policy or program team or staff person (*not an external/third-party*)

• HEIA should be conducted **as early as possible** in all planning or policy development to enable adjustments to the initiative before opportunities for change become more limited.

• It should be a living document, with health equity impacts identified as the design of the initiative evolves.

• HEIA can also be introduced retrospectively as a valuable evaluation tool to examine whether individual initiatives are capitalizing on available opportunities to improve equity or whether they may potentially result in widening health disparities.
Begin by describing the initiative or decision that the HEIA is being applied to:
Process for completing the HEIA Template: The columns correspond to the 5 steps of HEIA. The user fills in the tool by moving Left to Right.

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<tr>
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<tbody>
<tr>
<td>a) Populations:</td>
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<td>Identify any relevant Social Determinants of Health that should be considered alongside the populations you identify.</td>
<td>Identify the best ways to reduce the potential negative impacts and amplify the positive impacts.</td>
<td>Identify how success could be measured for each mitigation strategy identified.</td>
<td>Sharing Results and Recommendations for Addressing Equity</td>
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<td>Aboriginal, e.g. First Nations, Métis, Inuit peoples</td>
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<tr>
<td>Other</td>
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</table>

For example, the Step 1 column is highlighted in red.
What is HEIA? HEIA 2.0 involves 5 key steps:

To help you get started:
• Ensure you have a clear description/understanding of the policy, program or decision that will be run through the tool.
• Also, ensure that you have identified and gathered required evidence to inform your analysis.

Step 1. Scoping
• Consider and identify affected populations (this includes intersecting populations and relevant social determinants of health)

Step 2. Impact Assessment
• Identify and record the potential unintended (negative/positive) impacts of the planned policy, program, decision

Step 3. Mitigation
• Identify and record the best ways to reduce the potential negative impacts and amplify the (unintended) positive impacts

Step 4. Monitoring
• Articulate how success could be measured for each mitigation strategy you have identified.

Step 5. Dissemination (NEW)
• Identify and record how results and recommendations for addressing equity will be shared.
### Step 5. Dissemination (NEW)

Identify and record how results and recommendations for addressing equity will be shared.

---

**Health Equity Impact Assessment (HEIA) Template**

The numbered steps in this template correspond with sections in the HEIA Workbook. Consult the workbook for step-by-step instructions.

|------------|----------------------|------------------------|--------------|------------------|
| a) Populations: Based on the evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative. For public health units, consider specific bio-hazard and prevention risks to these populations. Link to Public Health Ontario Supplement for specific public health considerations on website. 

**NOTE:** This terminology may or may not be preferred by members of the communities in question and there may be other populations you wish to add. Also consider intersecting populations (e.g. Aboriginal women). 

Aboriginal, e.g. First Nations, Inuit, Inuit peoples

Age-related groups, e.g., children, youth, seniors

Disability, e.g., physical, deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use

Ethno-racial, e.g., racialized or racialized or cultural minorities, some immigrants and refugees

Francophone populations, including new immigrant francophone, deaf communities using LSQ/LSF, etc.

Homeless, marginally or under-housed people

Linguistic communities, e.g., people not comfortable receiving care in English or French or whose literacy affects communication

Low income, underemployed, or unemployed people

Religious/multi-faith communities

Rural/remote, inner-urban populations, e.g., geographic isolation, social isolation, underserved areas

Sex/gender, e.g., women, men, trans, transgender, two-spirit

Sexual orientation, e.g., lesbian, gay, bisexual

Other |
| b) Social Determinants of Health: Identify any relevant Social Determinants of Health that should be considered alongside the populations you identify |

<table>
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<tr>
<th>Unintended Positive Impacts</th>
<th>Unintended Negative Impacts</th>
<th>More information needed</th>
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</table>

Identify the best ways to reduce the potential negative impacts and amplify the positive impacts. Identify how success could be measured for each mitigation strategy identified. |

Sharing Results and Recommendations for Addressing Equity |

**Addition of Step 5 – explicitly encouraging dissemination and sharing of results**

---

[Ontario Logo]
Questions?
Group case study
Project summary:

**Background of Fictitious Case Study:**

The provincial / territorial (P/T) government of Xanadu is contemplating a new income support program to address the high rates of poverty in their region. The goal is to implement a preventative policy now, with the long-term goal of a healthier population.
Proposed Fictitious Decision and criteria for who would be eligible for new programme:

A guaranteed annual income for all families living in the province / territory with children aged 0 to 18 years

- Income rates would be standard across the province – once income bracket for all
- The income would be assessed based on the number of ‘core’ members of the nuclear family resident full-time in that home
- To be eligible, all family members would need to have been residents of Xanadu for 2 full years (with the exception of children < 1 year of age) prior to accessing income support from this program

Families must meet the following criteria to be eligible for the new Guaranteed Annual Income for a Healthy Living Assistance Program:

- Have received within the last year Income Assistance from a municipality; and/or
- Have received Employment Insurance benefits (including parental leave) from the federal government
- Have worked part or full-time at jobs whose wages are so low as to put them below the unofficial poverty line (as per after tax Low-Income Cut-off / LICO rates)
- To maintain eligibility for the program, families would be required to provide proof of enrolment in an educational or training program, or proof of employment seeking activities
- Families availing of this program would be ineligible for other income assistance programs from the P/T, the federal government, Band Council, etc., and similar funding programmes
First glance – who could be affected by this decision?

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<th>Social Determinants of Health:</th>
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<td>Identify any relevant Social Determinants of Health that should be considered alongside the populations you identify (e.g., Income/Social Status; Social Support Networks; Employment; Physical Environments etc.). For more information on SDOH refer to Step 2 of the Workbook.</td>
</tr>
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Brainstorming & Discussion

What future uses do you see for HEIA / EfHIA ...

... in your community?
... in Manitoba?
... in Canada?
HEIA Website and Contact Information

HEIA webpage provide public access to the HEIA Tool and associated resources.

English:

French:
http://www.health.gov.on.ca/fr/pro/programs/heia/
For further assistance, advice, and questions, or if you have feedback or comments, please contact:

HEIA@ontario.ca

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Manitoba / Canada EfHIA Pilot Project / Study

Contact Info:

Karen Serwonka, Research Team Member
Policy Advisor, Health Equity Unit, Manitoba Health; formerly on secondment to Healthy Child Manitoba, as EfHIA Pilot Project Manager)
Ph: 204-788-6703 e-mail: Karen.Serwonka@gov.mb.ca

Dr. Steven Feldgaier, PhD, C. Psych.
Research Team Member &
Director, Parenting Initiatives (Program Proponent)
Healthy Child Manitoba Office & University of Manitoba
Tel: 204-945-3084 e-mail: Steven.Feldgaier@gov.mb.ca
Appendices
“Health inequities refer to a subset of health disparities or inequalities that are systematically associated with underlying social disadvantage (e.g., by virtue of being poor and/or a member of a disenfranchised or marginalized group). They reflect unequal opportunities to be healthy, and thus, are considered avoidable and unfair.”

(Braveman & Gruskin, 2003)
Policy Levels for Tackling Inequities in Health

Source: Prof. Margaret Whitehead, Univ. of Liverpool. Presentation “Reflections on a rainbow”, Apr. 2005 Cardiff Conference “Dahlgren & Whitehead & beyond”
HIA as a tool to advance Healthy Public Policy / Health in All Policies

1st Int'l Health Promotion Conf. 1986
Ottawa Charter for HP

2nd Int'l Health Promotion Conf. 1988
Adelaide Recommendations for Healthy Public Policy

1978 Int'l Conference on Primary Health Care
Alma-Ata, Declaration

6th Global Conf. on Health Promotion (HP) 2005
Bangkok Charter for HP in a Globalized World

5 Action Areas

1. Building healthy public policy (HPP)
2. Creating supportive environments
3. Strengthening community action
4. Developing personal skills
5. Re-orientating health care services toward prevention of illness & promotion of health

HPP is characterized by:
- An explicit concern for health & equity in all areas of policy; and an accountability for health impact
- All government sectors Ministries / Depts):
  a) taking into account health as an essential factor when formulating policy, paying as much attention to health as to economic considerations
  b) being accountable for the health consequences of their policy decisions

4 Key Commitments to make the promotion of health
- central to the global dev’t agenda
- a core responsibility for all of government (cross-dept’l)
- a key focus of communities & civil society
- a requirement for good corporate practice

HPP → HiAP
Health in All Policies
Factors influencing choice to:

**Conduct an EfHIA:**
- Health equity impacts are not known (but suspected) for this type of intervention
- Health equity has not been thoroughly considered in the planning of this intervention

**Determine depth of EfHIA or forgo conducting an EfHIA:**
- Health equity impacts are already well known,
- Have been thoroughly considered in the planning of the intervention, and
- Will be evaluated.
2. From what you now know about this program, in what way (or ways) might it help parents?

3. Thinking about all of the ways that Teen Triple P would be able to help parents (that you have just told us about), what types of families might be helped less by the program? And why?

☐ Do you think this [insert differential impact] is very likely, not likely at all, or something in between?

☐ Do you think this [impact] is a little problem, a big problem, or something in between?

☐ Do you think this [impact] is fair?

☐ Do you think this [impact] can be fixed somehow? Please explain

☐ Is there anything else you can think of that can be done to make things better for these families?

4. Are there any negative impacts on parents that are possible from this program? For example, is there anything that would make it difficult (or hard) for parents like yourselves to go to (or to participate in) a parenting program such as Teen Triple P?

5. … Now if we switch it around … what are some things that might help make it easier for parents like yourselves to go to (or to participate in) a parenting program?

{Probe: For example, have you been involved in other programs that have mad it easy for you to participate and benefit? If so, what things helped?}

6. What other supports (or things) do you need as a parent to help you and the well-being of your family?
References


Other Resources:

Gothenburg Consensus Paper, European Centre for Health Policy, 1999

