NO BARRIER

HEALTH EQUITY FOR ALL

Toolkit & Practical Guide
for Health and Community Service Providers

Opportunities for better health
begins where we
live, learn, work, and play.

USE THESE EVIDENCE-INFORMED

TOOLS & RESOURCES

TO HELP YOU:

- Better understand how addressing the social determinants of health and working towards health equity benefits the health and wellness of individuals and our community.
- Identify intended/unintended impacts on health that policies, programs, services, and initiatives may have on specific population groups.
- Engage in planning, development, implementation, and evaluation of programs, services, policies, and initiatives through a health equity lens.
- Effectively communicate key messages using inclusive language.

This toolkit has been developed to assist decision-makers, program planners, service providers, and front-line staff in their work to improve the health and wellness of individuals and communities. Content is laid out to first establish a strong foundation of understanding and comprehension about the concepts of health equity and the social determinants of health. Then, practical tools, resources, and methods are provided to support translating knowledge into evidence-informed action.

It is recommended to review the entire toolkit from beginning to end at least once to strengthen understanding for the factors and contexts that influence the health of individuals and populations. Then, specific sections and resources can be referenced as needed depending on the focus of work.

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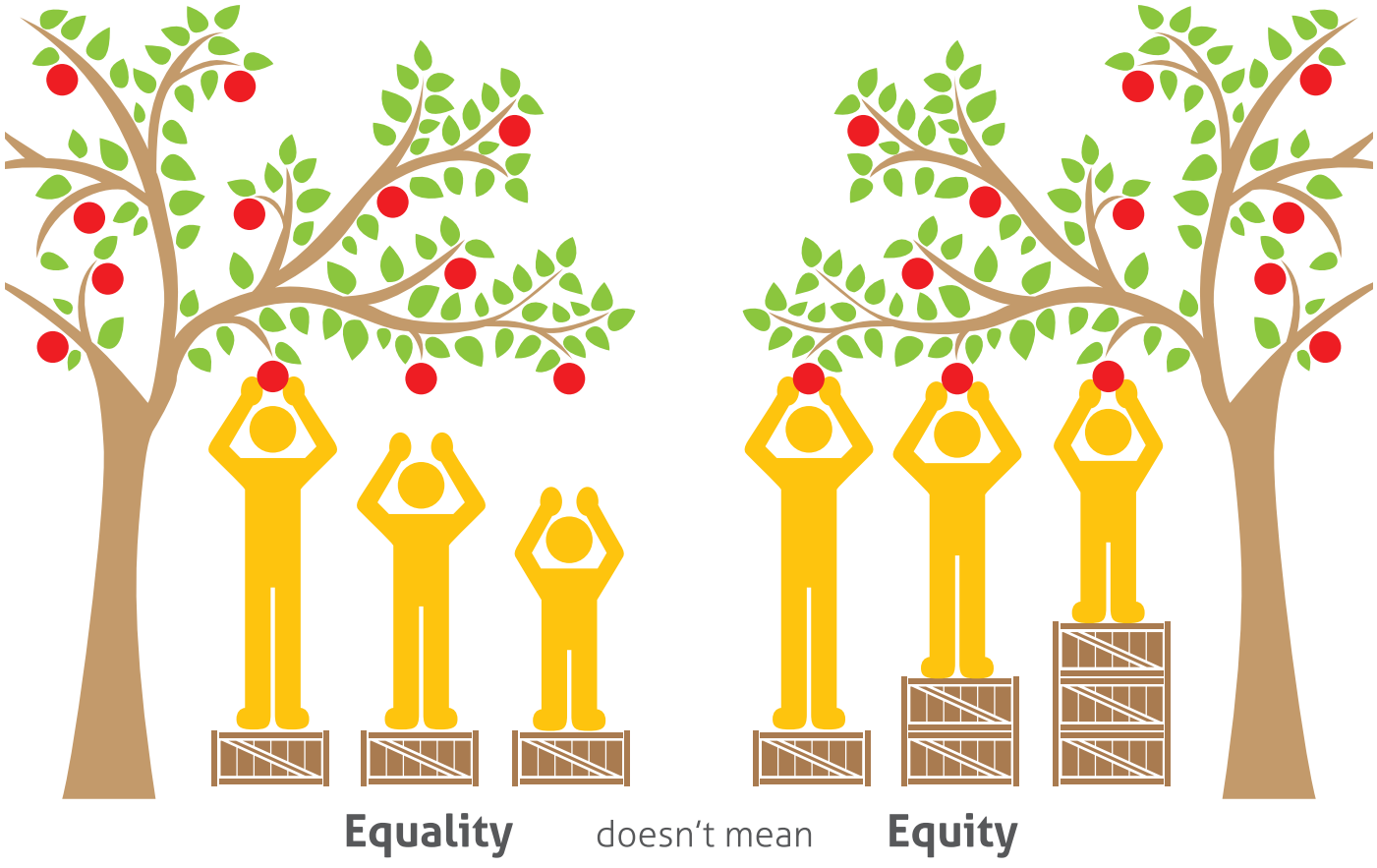
Why Health Equity is Important

Health equity is about attaining the highest level of health for everyone in our community. To promote health equity, efforts need to be made to ensure that everyone has equitable access to opportunities that help them to lead healthy lives. Addressing health equity means seeking ways to remove barriers to achieving good health, and creating opportunities to address the social determinants of health (SDoH) by decreasing health inequities that exist among certain population groups. The premise is that everyone has the right to reach their full health potential and not be disadvantaged because of their social, economic, and environmental circumstances (San Francisco State University Health Equity Institute, 2015; Windsor-Essex County Health Unit, 2013). To better understand the concept of health equity, the infographic below depicts how some individuals in our community benefit from additional supports to achieve the same level of health as compared to others. The infographic further portrays that treating everyone equally doesn't mean that everyone has an equal opportunity to access health.

For more information about Health Equity see the glossary of terms on page 39.



(Reproduced with permission from the Public Health Observatory - Saskatoon Health Region, 2014)

DETERMINANTS OF HEALTH

The health of individuals and communities is significantly influenced by complex interactions between social, economic and political factors, the physical environment, and individual behaviours and conditions. The conditions in which people live and the wider set of forces and systems shaping the conditions of daily life are commonly referred to as the social determinants of health (SDoH). Many of these factors are modifiable at the neighbourhood, community, and societal level. Organizations and decision-makers have the capacity to influence positive changes in the SDoH (e.g., built environments, transportation, language accessibility) through their policies, programs, services, partnerships, and advocacy efforts. Below are some examples of factors that can influence the health of individuals. Please note that this is not an exhaustive list.

FACTORS THAT CAN INFLUENCE HEALTH		
Gender / Gender Identity	Natural and Built Environments	Income / Income Distribution / Income Security
Race / Racialization	Discrimination / Social Exclusion / Social Inclusion / Social Status	Early Life Experiences / Healthy Child Development
Ethnicity / Visible Minority Status	Education Level	Social Support Networks / Social Safety Net
Indigenous Background	Literacy Level	Ability / Disability
Colonization	Health Literacy	Nutrition / Food Security
Biological and Genetic Factors	Language	Housing / Housing Security
Migrant / Refugee Experiences	Employment Status / Job Security	Access to Health Services
Culture	Working Conditions	Lifestyle Choices
Religion	Transportation	Coping Skills

(Adapted from the Ontario Public Health Standards, 2008; Mikkonen & Raphael, 2010; and the National Collaborating Centre for Determinants of Health, 2015)

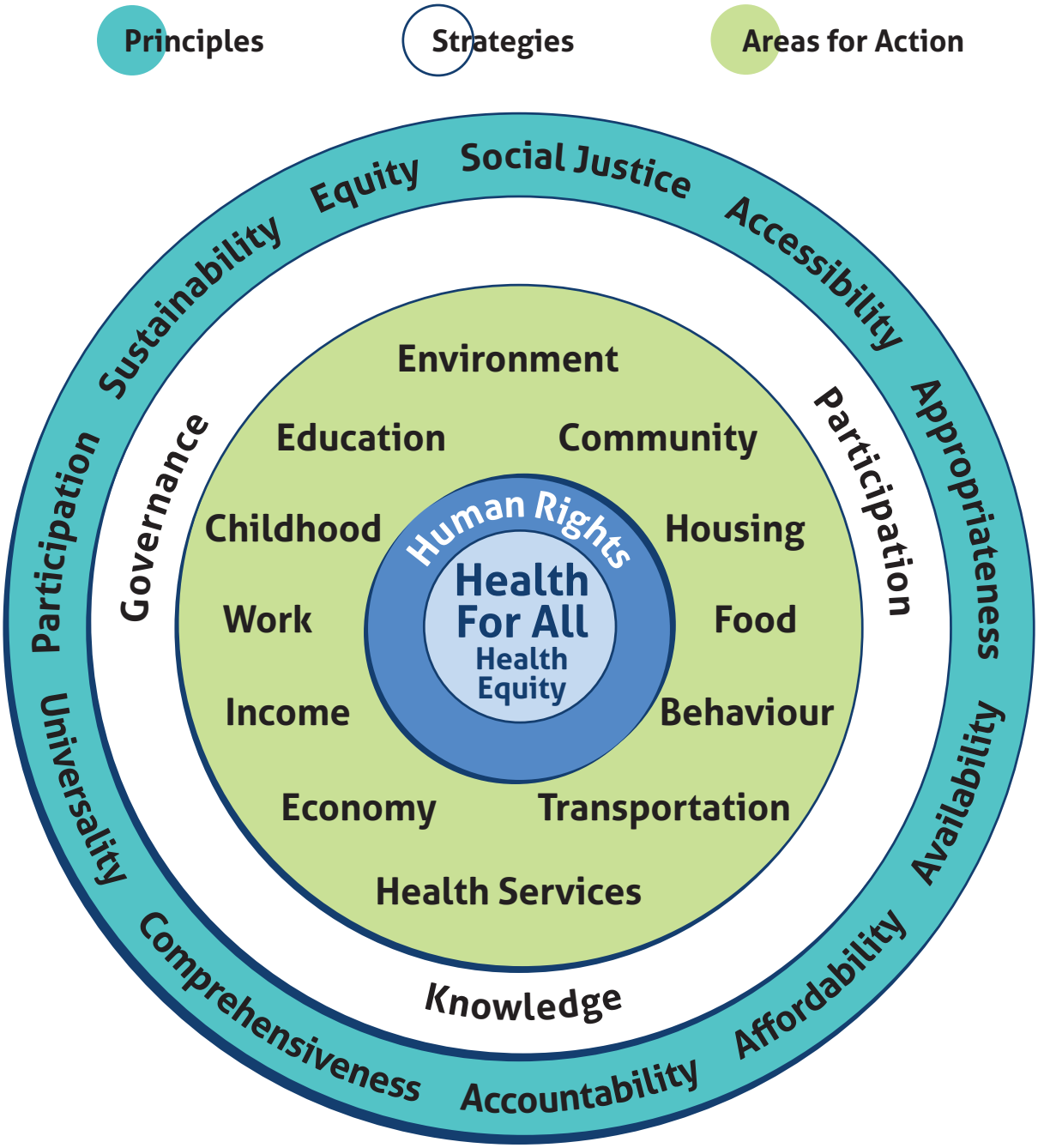
"Canadians are largely unaware that our health is shaped by how income and wealth is distributed, whether or not we are employed, and if so, the working conditions we experience. Furthermore, our well-being is also determined by the health and social services we receive, and our ability to obtain quality education, food and housing, among other factors. And contrary to the assumptions that Canadians have personal control over these factors, in most cases these living conditions are – for better or worse – imposed upon us by the quality of the communities, housing situations, our work settings, health and social service agencies, and educational institutions with which we interact."

(Mikkonen & Raphael, 2010, p.7)

A Framework for Understanding and Addressing Health Equity

To move from awareness to action, it is useful to have a shared vision and focus. The Winnipeg Regional Health Authority has developed a helpful framework that outlines key principles, strategies and areas for action to address health equity.

The framework helps to visualize and communicate the underlying foundational concepts and factors associated with working towards greater health equity in our community.



FRAMEWORK DESCRIPTION

The center of the diagram shows the end goal of a community/system where health and wellness is attainable by all individuals. Directly surrounding this important outcome is a layer recognizing that health, and most of the factors identified within the framework, are internationally recognized **human rights.**

The next outer layer identifies **12 areas for action,** each having potential to improve health equity. Since many of these factors are inter-related and inter-dependent, the greatest impact can be experienced when we work towards addressing multiple factors.

The **3 strategies** are identified as knowledge (e.g., research evidence, indicators/data, lived experience) and tools (e.g., health equity assessment) to inform effective health equity action. Governance recognizes that those with power, authority, and the means to allocate resources are active participants in making system changes. Lastly, participation highlights that relationships, partnerships and citizen engagement are necessary for effective and lasting health equity results.

The outer layer of the framework presents **11 principles** which represent a basic set of intentions to facilitate planning and action to improve health equity.

(Used with permission from the Winnipeg Regional Health Authority, 2013)

Approaches to Tackling Inequity

There are many ways to tackle inequities and work towards creating greater fairness and opportunities for good health across all populations. These efforts can broadly be categorized into three levels of approaches aimed at improving the overall health of our population.

DOWNSTREAM APPROACHES

Interventions that seek to address immediate health and social needs of populations.

Interventions based on this approach are often rooted in biomedical and behavioural practices which focus on individual health status and lifestyle factors causing illness. Strategies aimed downstream concentrate on addressing inequities in accessing health care and improving the quality of care available. These tend to be more short-term in nature and reactionary. To reduce inequities at this level, a focus is needed to ensure that access to and the delivery of health and social services are fair and equitable. Consideration should been given to developing and implementing strategies that will increase access and decrease barriers to programs, services, and health information for people whose life circumstances have made them more vulnerable to poor health.

MIDSTREAM APPROACHES

Interventions that seek to reduce exposure to health risks by either improving physical working /living conditions or through the promotion of healthy environments.

Strategies aimed midstream frequently focus on reducing exposure to hazards in daily life by the creation of supportive community environments where health promoting conditions exist and/or where healthy behaviours are perceived as the easy choice. At this level, there is awareness that individual choice is influenced by political, economic, social, and environmental forces and factors outside of an individual's control. Working through midstream approaches means that individuals and organizations works towards advocating for improved broader community factors that influence health, such as access to safe and affordable housing, improved working and living conditions, and enhanced access to healthy food. To reduce inequities through midstream approaches, efforts focus on advocacy and collaborative partnerships across sectors to affect micro policy changes within organizations, communities and regions.

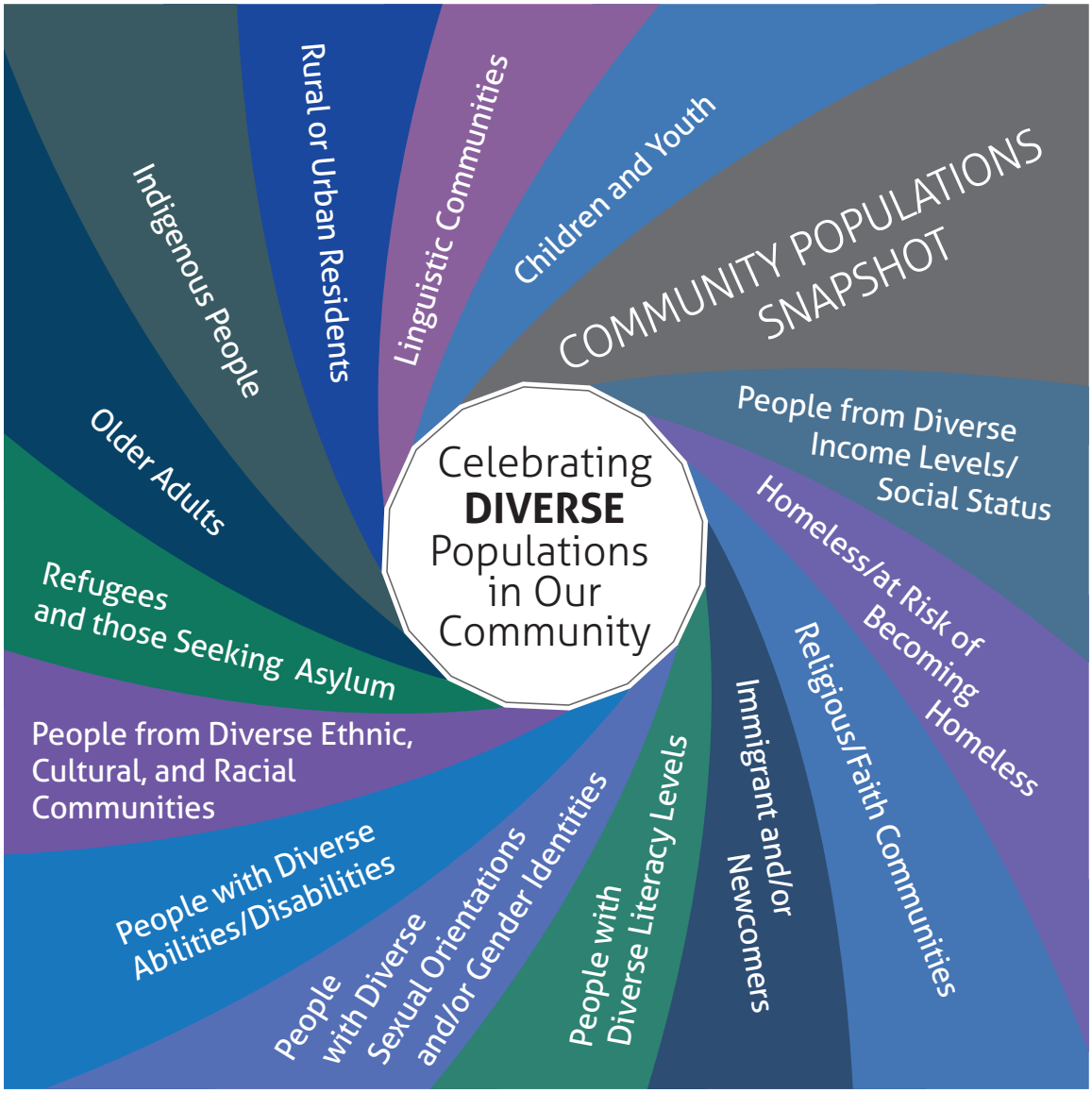
UPSTREAM APPROACHES

Interventions that seek to reform the fundamental social and economic structures that distribute wealth, power, opportunities, and decision-making.

At this level there is recognition that the health of individuals and communities is largely influenced by broad socio-environmental, cultural, and political structures. Macro policies and practices of higher levels of government and transnational organizations as well as deep-rooted socio-cultural values and beliefs impact income distribution, social status, and prejudices. Strategies and interventions at this level aim to address the foundational inequities in our society that are avoidable, unfair and unjust affecting people's access to the determinants of health. These may be related to economic policies (e.g., increasing national minimum wage standards to align with living wage costings), environmental policies (e.g., investments in alternative energy sources) and/or socio-cultural policies (e.g., broad federal healthcare coverage for refugees new to Canada). Working through upstream approaches means actively examining the underlying systems, policies, and values affecting resource allocation and advocating for changes that will improve the health of our population in the long-term.

The stream analogy suggests that efforts can eventually reveal and address the root causes of poor health by focusing on initiatives that address political, social, economic and environmental factors affecting how health and health resources are distributed. It is beneficial for program planners, decision-makers, and health-related organizations to think upstream at the settings and conditions in which their program and services are offered. Advocating upstream creates enhanced opportunities for midstream and downstream approaches to have maximum impact.

Community Populations Snapshot



Use this diagram as a starting point for discussion and reflection concerning groups that may be experiencing health inequities in our community.

Please recognize that the groups shown above are by no means representative of all population groups. Instead, this snapshot is meant to stimulate discussion and build awareness of the diversity in our community as programs, services, initiatives, projects, and policies are being developed, implemented, and evaluated. In addition, know that groups are not mutually-exclusive. Individuals may self-identify as belonging to many groups (e.g., a person who has just immigrated to Canada and who is living on a low income). Lastly, please be aware that the terminology used here to identify population groups may or may not represent the preferred terminology of a given group. Please defer to how individuals or groups self-identify.

Environmental Influences on Values & Priorities

Our social, cultural, and economic foundations

Research shows that the environment in which individuals are raised significantly affects the way they view the world, how they make decisions, and what they value (Payne, DeVol, & Dreussi-Smith, 2009). Those deprived economically, and those living in disadvantaged and under-resourced environments face a variety of chronic stressors in daily living. They struggle to make ends meet; have few opportunities to achieve positive goals; experience more negative life events, such as unemployment, marital disruption, and financial loss; and must deal with discrimination, marginality, isolation, and powerlessness (Baum et al., 1999; Lantz et al., 2005; McEwen, 1998). These stressors can trigger a host of compulsive behaviours that lead to negative health outcomes such as overeating, drinking, and smoking (Björntorp, 2001; Marmot, 2004). For example, studies shed light on this by showing higher smoking rates among persons experiencing high levels of anxiety, including unemployed workers (Fagan et al. 2007), poor single women with child-rearing duties (Graham, 1995; Marsh & Mackay, 1994), those from disadvantaged backgrounds (Lynch et al. 1997), and residents of deprived neighbourhoods (Duncan et al. 1999).

Population health data shows that the people most negatively affected by the SDoH and those who experience the most health disparity are often those living in low income situations (WECHU SDoH Report, 2014; CIHI, 2013). The correlation between poverty and ill health is well established; however it is important to recognize that although income is a significant factor, there are many other influences that contribute to an environment that limits health potential. Therefore, it is important to be mindful that individuals who grew up in under-resourced environments—and who may still be living in them—could feel limited in the choices available to them. The term "under-resourced" refers to factors such as access to financial stability/assets, access to supports that help develop mental/cognitive skills such as reading, writing, and critical thinking, and access to positive role models/relationships that foster strong social support systems (Payne et. al., 2014). For further information on this, please see Bridges to Health and Healthcare (2014). As was outlined in previous sections of this toolkit, it is crucial to recognize that all these factors are influenced by greater socio-economic, environmental and political policies and practices affecting communities and consequently the conditions in which people live. Under-resourced environments tend to produce obstacles and stigmas that may in turn create barriers for people to take action to access available opportunities.

While advocating for policy change, what is also needed is an approach that allows more power to move those in under-resourced environments to the decision-making table. Communities and organizations that use collaborative models and frameworks, such as the Bridges Out of Poverty model (Payne, DeVol, & Dreussi-Smith, 2009), see the value of implementing a community level non-judgmental approach that allows the powerful to work with the less powerful to overcome problems and work toward sustainability.

> "We can't help people make healthy lifestyle choices without also improving the social determinants of health like education and housing that create barriers to healthy choices."
>
> (National Collaborating Centre for the Determinants of Health, 2014, pg.3)

Ensuring that there is representation and input from individuals and populations that face additional barriers to health, is critical to affecting sustainable changes.

For those who self-identify as living in more vulnerable conditions, the prospect of adopting new lifestyle behaviours or changing current routines can be very daunting. As program planners, decision makers, policy developers and front-line staff, it is important to be mindful of the lived experience of an individual or population. Consider that if a person's basic needs are not currently being met or their situation becomes destabilized, priorities will likely shift to survival and away from those of the providers' intended program or service. By being aware and taking into account the competing demands facing individuals and groups in under-resourced environments, decision-makers and front-line staff can act, plan activities, and advocate based on the realities of their clients and communities.

It is very important to recognize that at all income and societal levels, lifestyle choices are informed and influenced by social, economic, environmental, and political factors. It is not enough to tell individuals and specific groups that they need to change their behaviours (e.g., eat more vegetables and fruit). Instead, it is more effective to work towards addressing the root causes that limit opportunities to make healthier choices for themselves and their families. For additional resources and to learn more, visit www.ahaprocess.com

Here are a few examples of **common competing demands** experienced by those living in under-resourced environment *or* in unstable circumstances:

- Living paycheque to paycheque or on low government aid.
- Constant worry and fear associated with unstable housing situations, precarious working conditions, availability and affordability of food, and/or access to reliable transportation.
- Availability of reliable and affordable childcare.
- Concerns over personal safety and protecting family and friends from harm.
- Pressures (e.g., societal or peer) and expectations associated with how people act, where they live, and how they spend their time.

Those in under-resourced environments are also more susceptible to the adverse effects of emergent problems such as unexpected car repairs, unforeseen decreases in hours of work, illness, or injury. Compared with individuals living in stable or abundantly-resourced situations, those living in under-resourced environments often lack the social or economic safety nets to cope with these types of additional life stressors. Existing competing demands, coupled with acute life challenges, can result in a snowball effect of negative outcomes. When working with individuals who self-identify as living in more susceptible conditions, it is even more important to be patient, compassionate, and emotionally supportive. For example, if a client misses an appointment, it is critical to work with them to identify why they were unable to make it. Did they forget? Did their babysitter cancel at the last minute? Did the bus break down? Reserve judgment and try to adopt a problem-solving and supportive approach to assist with overcoming or mitigating barriers. Attitudes and actions that convey understanding and acceptance can go a long way in making individuals feel more secure and more likely to seek out assistance.

The work of Dr. Ruby K. Payne (2005), and many others has been influential in shedding light on the different attitudes and outlooks of individuals from varying resourced backgrounds. How individuals perceive the world directly influences the decisions they make and also what resources they believe are available to them. Thus understanding the foundational values, beliefs, and priorities of those facing economic, social, or other significant barriers, as well as recognizing how they may differ from the views of others; is critical for decision-makers, program planners, service providers, and front-line staff to consider in their daily work. It is important to be mindful of the fact that many of the policies, procedures, practices, and systems in existence today are based on stably-resourced mindsets, values, and priorities (Payne, DeVol, & Dreussi-Smith, 2009). Stably-resourced thinking prioritizes planning, achievement, and personal choice. Awareness of possible challenges, barriers, strengths, and priorities of those living in differently resourced environments can help to more effectively tailor messages, develop interventions, offer meaningful opportunities, and improve engagement with target populations.

The following table is adapted from the work of Payne, DeVol, & Dreussi-Smith (2009), with additions and input provided by Jennifer Johnston. It outlines generalized resources and priorities available to those in differently resourced environments. This knowledge will assist in better understanding the underlying assumptions and values of clients and communities. Please note that this framework is founded on the well-established understanding that income is one of the most influential determinants of health. Evidence shows that the lower an individual or group's socioeconomic position, the worse their health outcomes (World Health Organization, 2013). There are certainly many other factors that affect the health of populations (see page 2 on the determinants of health), however viewing situations through the lens of income inequality is intended to build an appreciation for barriers and challenges facing some individuals and groups. The overall intention is to foster more supportive environments for addressing health inequity. Furthermore, it is important to understand that the "hidden rules" describes the priorities, motivations, and day-to-day experiences of individuals and groups living in under-resourced, stably-resourced, and abundantly-resourced settings. Individuals always have a choice as to which hidden rules they use. It is possible to be living in one environment and use the hidden rules of a different one. Each environment has its strengths and weaknesses.

EXCERPTS OF THE HIDDEN RULES AND PRIORITIES OF DIVERSE ECONOMIC ENVIRONMENTS

PRIORITY	UNDER-RESOURCED ENVIRONMENT	STABLY-RESOURCED ENVIRONMENT	ABUNDANTLY-RESOURCED ENVIRONMENT
DRIVING FORCES	**Survival, relationships, and entertainment.** Vulnerability requires immediate and concrete reactions. Relationships are a resource for solving problems and to feel a sense of belonging. Entertainment is for socialization and distraction from life stressors.	**Work and achievement.** Economic stability affords the opportunity to focus on the future. Much time is dedicated to understanding and effectively navigating systems (e.g., academic system or corporate system).	**Financial, political, and social connections.** The environment is so stable that instead of living in the present or foreseeable future, those born into wealth often focus on developing and sustaining their legacy. Power and influence are cultivated and maintained through social connections.
FOOD	**Quantity most important.** Key question: Did you have enough?	**Quality most important.** Key question: Did you like it?	**Presentation most important.** Key question: Was it ethically sourced?

PRIORITY	UNDER-RESOURCED ENVIRONMENT	STABLY-RESOURCED ENVIRONMENT	ABUNDANTLY-RESOURCED ENVIRONMENT
TRANSPORTATION	**Dependability.** Personal vehicles may not be dependable and may require constant repair; breakdowns can result in lost jobs, missed appointments, and stress. Insufficient public transportation further limits mobility.	**Quality.** Often owns more than one dependable car in good repair. Sees the value of investing in maintenance.	**Prestige.** Travelling in luxury and style serves to enhance prestige and affords opportunities to strengthen connections.
HOUSING	**Necessity.** Houses are often in isolated rural areas or unsafe urban and suburban neighbourhoods. Houses can be crowded, there may not be a private place for children to do homework, rooms may be used for many purposes, people sleep on the couch, repairs can't be made, landlords can be difficult, and people may have to move frequently.	**Investment.** Economic stability often affords the choice of neighbourhoods. Key considerations are location and proximity to quality community amenities and conveniences.	**Exclusivity.** Often own multiple dwellings. May include international properties which afford the opportunity to travel, seek out new connections, and build influence.
Power and Hierarchy	**Linked to personal respect.** Power is associated with those that have the ability to fight.	**Linked to self-sufficiency.** Power is associated with those that have self-governance. Power is linked to information and institutions.	**Linked to expertise, connections, and stability.** Power is associated with those who influence policy and provide leadership.

(Adapted from *A Framework for Understanding Poverty: A Cognitive Approach, 2013, and Bridges Out of Poverty: Strategies for Professionals and Communities*, 2009). For more information visit www.ahaprocess.com)

Effective Communication

Conveying the importance of addressing the SDoH and health equity is a definite art and skill. Our ability to effectively communicate messages, influences how individuals, key decision-makers, and the public think about health, the SDoH and health equity. We must always keep in mind that people understand the world through their own set of values, beliefs, political views, and personal experiences. Recognizing how to tailor language and messaging for specific audiences based on their foundational values and beliefs, can go a long way in increasing awareness, gaining support, and influencing how your information is received. This section will provide you with evidence-informed suggestions for effectively communicating the importance of the determinants of health and health equity.

INCLUSIVE LANGUAGE

The words we choose to use when speaking and writing are powerful tools for communicating personal and organizational values and beliefs. Inclusive language means communicating in ways that demonstrate respect for all people while expressing an appreciation for human differences (Region of Waterloo, 2014a). It avoids terminology that reinforces stereotypes, excludes certain groups, labels people, or strengthens power imbalance. The goal of using inclusive language is to create a non-judgemental environment that promotes equality, objectivity, and a sense of belonging. Using inclusive language involves actively choosing words and phrases that are free from sexist, racist or other discriminatory words or phrases (McGill University Student Services, 2010). Although beyond the scope of this resource, there is considerable literature and extensive guidelines available that provide in-depth information on this topic. We encourage you to explore additional resources.

Here are some basic guidelines to follow based on recommendations from the Region of Waterloo (2014b) and McGill University Student Services (2010):

Guidelines	*Rationale*
Use person-first language. Example: Instead of labeling a person as "a diabetic", alternatively use, "a person living with diabetes".	This emphasizes the value of a person ahead of any personal characteristics.
Avoid gender-specific terms such as him/her or he/she if they are not necessary to convey meaning. This can often be accomplished by re-organizing a sentence or making a phrase plural. Example: Instead of specifying a gender, a more inclusive phrase would be, "a client should try to arrive 10 minutes before their appointment to fill out paperwork".	This recognizes that gender (a term that refers to a sense of oneself that is socially constructed - as opposed to biological status) is not binary, but is instead a continuum.
Avoid stereotyping descriptors such as those that generalize or label individuals or groups of people.	Using language that reinforces stereotypes demonstrates bias and discrimination.
Be aware of how language can rank and prioritize people. Example: Instead of referring to a neighbourhood as, "low income", try using, "under-resourced".	Ranking focuses on differences rather than similarities. Avoiding terms that rank people is based on the belief that all people have inherent value and therefore have something to contribute.

KEY GUIDELINES FOR EFFECTIVE COMMUNICATION

What to Do	*What to Avoid*
Use clear, plain language.	Technical language or jargon.
Make issues tangible with examples and stories.	Abstract concepts or terms.
Break down and round numbers; place numbers in context.	Complex numbers or large numbers without any context.
Challenge conventional wisdom with one unexpected fact.	Exhaustive documentation.
Use inclusive language (we, our, us).	Creating distance between groups (them, they).
Identify people by shared experiences.	Labeling people by group membership.
Prime your audience with a fact, image or story they are likely to believe, based on their values, interests and needs.	Facts, images or stories that audiences may find too contentious or extreme to be believable (even if they are true).
Leave the audience with a memorable story or fact that can be easily repeated.	Being forgettable.
Use a conversational and familiar tone.	A clinical or academic tone.
Take the time to understand your audience.This includes customizing your message by selecting appropriate tools, approaches and information.	Assuming the same message will work for all audiences.
Prepare your message content and presentation.	Speaking off the cuff.
Focus on communicating one thing at a time.	Trying to do too many things at once.

(Adapted from the Canadian Council on Social Determinants of Health, 2013)

It is also important to be aware that language and terminology are highly context dependent, and as such, are greatly influenced by political, cultural, and historical conditions. The meaning and acceptability of terms changes over time. Conveying abstract concepts like the determinants of health and health equity can be difficult. Using appropriate language will reduce the likelihood of offending or alienating audiences and can serve to empower, show respect and convey empathy. When in doubt, consider consulting with representatives of diverse population groups to ensure that you are using appropriate language and terminology. The following table gives examples of alternative ways to describe health equity-related terms.

SUGGESTIONS FOR ALTERNATIVE WAYS TO DESCRIBE HEALTH EQUITY-RELATED TERMS

When Talking About Abstract Concepts or Groups...	*Try Using Simple, Values-Driven, and Emotionally Compelling Statements*
Social Determinants of Health	• Our opportunities for better health begin where we live, learn, work, and play. • Where we live, learn, work, and play can have a greater impact on how long and how well we live than medical care. • All people should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their income, education, or ethnic background. • The opportunity for health begins in our families, neighbourhoods, schools, and jobs.
Addressing Health Inequity	• Giving everyone a fair chance to live a healthy life. • Everyone has the right to reach their full health potential and not be disadvantaged because of their social, economic, and environmental circumstances.
Vulnerable Groups/Priority Populations	• People who don't have the same opportunities to be as healthy as others. • People whose circumstances have made them vulnerable to poor health. • People who face significant barriers to better health.
Poverty	• Families who can't afford the basics in life. • Individuals living in low income. • People who struggle financially. • People struggling to get by.
Low-Income Workers/ Working Poor	• People who work for a living and still can't cover basic costs.

(Adapted from the Canadian Council on Social Determinants of Health, 2013 and the Robert Wood Johnson Foundation, 2010)

UNDERSTANDING YOUR AUDIENCE

Understanding your audience is another key factor in communicating effectively. The audience may be more receptive, if the message corresponds with their current beliefs, values, and personal experiences. The Canadian Council on Social Determinants of Health has developed an excellent resource entitled, "Communicating the Social Determinants of Health: Guidelines for Common Messaging" (2013). See pages 10-14 of this resource for specific examples of how to develop effective messaging for different target audiences. For example:

TARGETING MEDIA

KNOWLEDGE of the Social Determinants of Health	HOOKS *facts or circumstances based on the audiences' knowledge and beliefs*	PRIMES *ideas that may help to increase audience receptivity to messaging*	OTHER CONSIDERATIONS
Low to moderate. Primary focus tends to be medical care, stories about individual health.	Economic costs of ill health and health inequality, the cost of inaction.	Connection between individual health and the circumstances that create (or undermine) it.	Timeliness is critical. Stories need to be 'newsworthy'.

TARGETING PRIVATE SECTOR LEADERS

KNOWLEDGE of the Social Determinants of Health	HOOKS *facts or circumstances based on the audiences' knowledge and beliefs*	PRIMES *ideas that may help to increase audience receptivity to messaging*	OTHER CONSIDERATIONS
Low. Primary focus tends to be health investments via benefit plans, sick leave, etc.	Ill health has a business cost. It results in workplace absences and diminished productivity. Health is a good investment. Ill health is costly: economically, socially and personally. Possible links to corporate social responsibility agendas.	Investment in the health of employees. It's important that investment covers all aspects of health. Preventing illness keeps employees at work. Employment and occupation can influence health.	Illustrate the costs of inaction, e.g., human capital development, cost of treating instead of preventing illness. Potential for long-term benefits in workforce health, absenteeism, and productivity.

Conclusion

Over the past few decades, there has been a groundswell of evidence showing the foundational link between the social determinants of health and health outcomes. It is now widely acknowledged that health inequities experienced in our society threaten the sustainability and long term viability of our publicly-funded health system. At a time of limited financial and human resources, decision-makers and program planners have the responsibility to make evidence-informed choices about where resources are allocated.

The movement away from directing resources to individual lifestyle and behaviour modification, to instead looking upstream at the underlying social, political, economical and environmental conditions in which people live; is gaining significant momentum. Now is the time to take a look at our current practices and evaluate whether they are helping to reduce inequities or inadvertently creating additional barriers to health. One evidence-based way to do this is to work through a Health Equity Impact Assessment (HEIA). Use the Guide to Applying a Health Equity Impact Assessment Tool and accompanying resources in Appendix A as a road map to start your journey.

Furthermore, it must be acknowledged that addressing the root causes of health inequity is complex and can be very daunting. However, the results of our work will undoubtably be very valuable if we want to improve the overall health of our community. The next big challenge moving forward is establishing consistent measures and evaluation methods for the work being done. Discussions and research are already underway to establish outcome measures, targets, goals, and overall accountabilities and these will certainly serve to strengthen and reinforce this important work.

We acknowledge that the materials presented within this toolkit are just a starting point. We encourage you to share and discuss these resources with colleagues and contacts, as well as explore specific examples that can be found in the literature for how organizations and programs are working to address the SDoH and health equity. Make an effort to routinely consider the underlying conditions and situations in which individuals make decisions. Take the knowledge and awareness acquired through this toolkit & practical guide, and apply it to your everyday practice. Lastly, advocate and work towards upstream approaches that can influence the choices, opportunities, and barriers that individuals, families, and communities ultimately experience. Together, we can work towards no barriers and achieving health equity for all.

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APPENDIX A

Guide to Applying a Health Equity Impact Assessment (HEIA) Tool

APPENDIX B

Guide to Applying a Health Equity Impact Assessment (HEIA) Tool

Adapted from the Ministry of Health and Long-Term Care (MOHLTC) Health Equity Impact Assessment Workbook and Template, 2012

Introduction

As a practical assessment tool with broad application, the HEIA helps users to identify potential unintended positive or negative health impacts of a *program, service, policy, initiative, or project on specific populations who face significant barriers to better health. Beyond this, there are many benefits to incorporating a HEIA into decision making, planning, implementation, and evaluation activities.

A HEIA can:

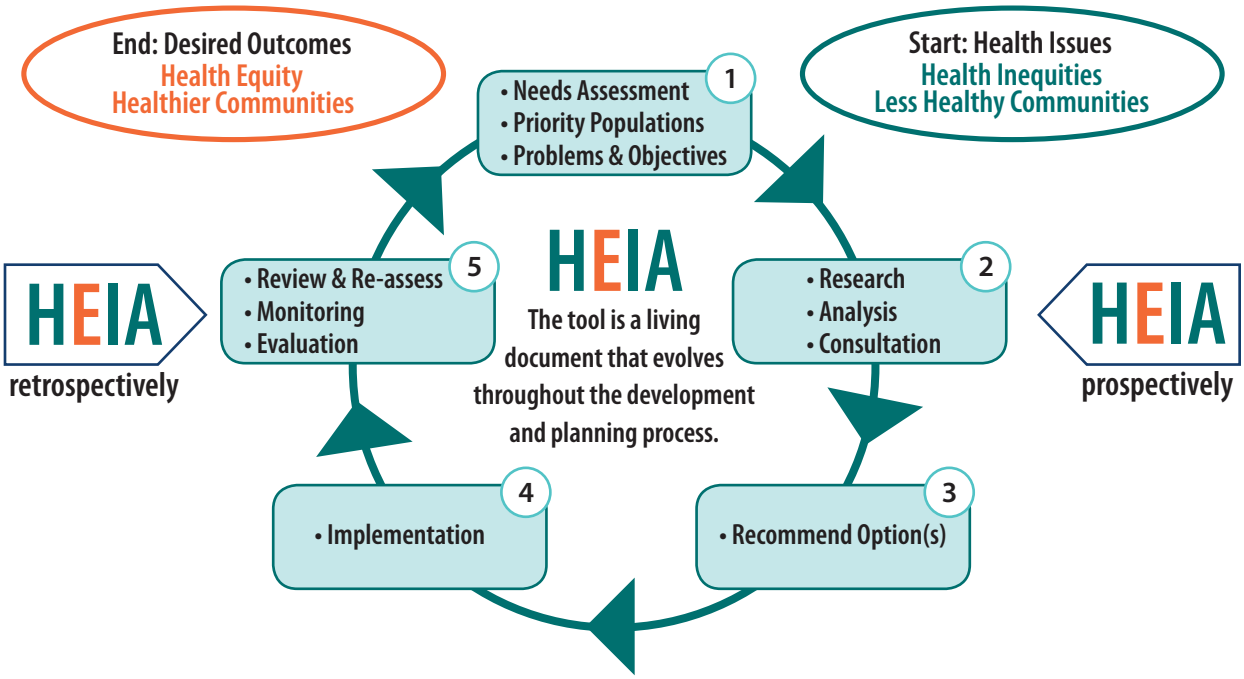
- Assist with identifying opportunities for enhanced engagement with target audiences and stakeholders.
- Prompt users to consider possible challenges and needs of specific populations or groups.
- Help to identify mitigation strategies to decrease barriers to access.
- Motivate users to consider available resources and potential partnerships.
- Stimulate reflection and discussion focused through a health equity lens.
- Provide decision-makers and program managers with an objective means of ensuring that health equity and the determinants of health are considered.
- Help achieve greater health equity consistency and transparency across an organization.

Please note that throughout this document the word **program will be used to represent programs, services, initiatives, policies, projects, and policies.*

The HEIA is a living document. It should be started as early as possible in the planning and development stages (prospectively) so implementation of the program can begin with recommended strategies. However, a HEIA can also be used in the evaluation stage (retrospectively) when reviewing an existing program.

There is a copy of the WECHU's adapted HEIA cover page and template on pages 37 and 38 of this toolkit. In addition, a separate word document of this template has been created so users can directly input and edit information.

Below is a helpful diagram developed by the MOHLTC (2012) from their HEIA Workbook that explains when a HEIA can be used.



Gathering Information

When completing a HEIA, users will need specific information to develop the program, identify target populations, potential health impacts, and mitigating strategies to decrease health disparities. Users may already have some data and information available. However, consider the additional strategies and sources of information below:

- Look at the database list on the Middlesex-London Health Unit Library website at www.healthunit.com/evidence-informed-public-health
- Conduct a community needs assessment or situational assessment.
- Consult with colleagues familiar with your program and content experts through key informant interviews, focus groups, or surveys.
- Visit the Erie St. Clair Local Health Integration Network (ESC LHIN) at www.eriestclairlhin.on.ca

- Peruse the HEIA Workbook on the Ontario Ministry of Health and Long-Term Care website at www.health.gov.on.ca/en/pro/programs/heia/tool.aspx
- Refer to local reports and statistics such as those found on the Windsor-Essex County Health Unit (WECHU) website at www.wechu.org/about-us/reports-and-statistics/reports#533
- Check out the Resource Library on the National Collaborating Centre for Determinants of Health (NCCDH) website at www.nccdh.ca/resources/library and the NCCDH Resources at www.nccdh.ca/resources/nccdh
- Review grey literature. Grey literature "can be government publications, non-governmental organization white papers, technical standards, policy briefs, or university theses among many other things. Information in the grey literature is often of high quality and reflective of current thinking not only from policy makers but of front line workers and the general public" (Middlesex-London Health Unit Library, 2015).
- Go to Statistics Canada at www.statcan.gc.ca/start-debut-eng.html
- Talk to those with lived experience and who are using existing programs (key informant interviews, focus groups, surveys) or link with organizations (advocacy groups, agencies working with your population) doing similar work.
- Use existing information, data, and resources. For example, look at municipal websites or review reports from community organizations.

Time Available to Collect Information for the HEIA

The level and intensity involved in working on a HEIA depends on the users, the scope and nature of the program, as well as available time and resources. There are 3 main categories of HEIA:

1. Desktop

The HEIA information is gathered from existing data and resources and is usually accomplished in a few days.

2. Rapid

This involves a more detailed HEIA with more outreach and information gathering and is usually accomplished over a few weeks.

3. Comprehensive

This category is usually used with large, complex projects, involves extensive research (e.g., needs assessments, consultations) and can take months.

A typical HEIA falls between the desktop and rapid categories.

(HEIA categories originally described in the US National Research Council Committee on Health Impact Assessment, 2011 & the European Policy Health Impact Assessment, 2004.)

Decision-Making Tool

When to Complete a Health Equity Impact Assessment

The results of this table will help to objectively determine if a HEIA is advisable. If you answer Yes/Don't know to any of the answers, completing a HEIA is recommended.

To your knowledge:	*Conduct a HEIA*	*No Need to Conduct a HEIA at this Time*
Is there potential for negative health impacts as a result of the policy, program, service or initiative? *(Although the intention of the program is to affect positive outcomes, consider that it could inadvertently create health inequities for other groups.)*	Yes/Don't know	No
Are the potential negative health impacts likely to affect a large number of people? *(Include consideration of future and intergenerational impacts.)*	Yes/Don't know	No
Are the potential negative health impacts likely to be disproportionately greater for disadvantaged or vulnerable groups in the population? *(Think about which groups in the population could be affected.)*	Yes/Don't know	No
Is there uncertainty about what the potential health impacts might be?	Yes/Don't know	No
Are there public or community concerns about potential health impacts?	Yes/Don't know	No
Is there public support or a call-to-action being driven by the community or a community partner?	Yes/Don't know	No
Is there enough staff/resource capacity within the organization to carry out a HEIA? *(If not, the evidence gathered can be used to advocate fo additional resources/ support at a later date.)*	Yes/Don't know	No

(Adapted from Public Health Advisory Committee, 2005)

"Even though research has proven the importance of SDoH (social determinants of health), public knowledge and understanding about them remains limited. Canadians are more likely to believe their health is shaped by the individual decisions they make about smoking or diet and physical activity, rather than societal factors such as their level of income or education. This belief is often reinforced by media coverage that focused on individual health and health care issues, medically-oriented messages and public awareness campaigns that emphasize personal health behaviours."

(Canadian Council on Social Determinants of Health, 2013, p.1)

Getting Started

TO BEGIN, COMPLETE THE HEIA COVER SHEET
Identify the lead person(s) and their contact information.
Broad overview and program summary: - provide context (i.e., big picture considerations) - program purpose - available resources (e.g., people, data, funding) - who should be involved (e.g., staff, stakeholders, specific populations)
Objectives for completing the HEIA.

The next few pages describe each section of the HEIA tool. There is a list of questions in each section (adopted with permission from the MOHLTC), to guide users through the HEIA process and assist in making decisions about the program (Note: there may be other appropriate questions to consider, this list is not exhaustive).

Although the HEIA template is laid out in a step-wise fashion, it is flexible enough to begin in any section and move between sections, adding details as they become available. See an example of WECHU's adapted HEIA cover page and template on pages 37 and 38.

The rest of this guide will assist with identifying:

- populations facing additional barriers
- potential health impacts
- mitigation strategies
- monitoring and evaluating outcomes
- ways to share results

Population(s) Identification

[HEIA Template Section 1]

Identifying specific populations within the general population, ensures that consideration is given to those who experience significant barriers. For example, some groups may experience inequities because of social determinants of health, the prevalence of chronic diseases, high risk behaviours, the distribution of health resources, and/or access to and utilization of programs.

This process for identifying what are commonly referred to as "priority populations", is important but challenging work. At this time, there is no pre-determined, common understanding or definition for the term, either in the literature or in practice (Ontario Agency for Health Protection and Promotion, 2015). Organizations are strongly encouraged to discuss and establish a consistent and clear definition for what constitutes a priority population (i.e., what characteristics or criteria are used to judge/decide) so that decision-makers, program planners and staff can do this in a standardized way across the entire organization. For more information about this critical process, please see the technical report entitled Priority Populations Project: Understanding and Identifying Priority Populations for Public Health in Ontario (2015).

It is advisable to focus on a small number of specific populations for the initial HEIA (i.e., one to three). This will help keep the scope manageable and promote achieving meaningful outcomes.

Use evidence such as research and experiential knowledge to identify which population group(s) may experience inequities and unintended health impacts (positive or negative) as a result of the proposed program. For ideas, consider reviewing the Community Populations Snapshot on page 7.

In addition, consider the following questions:

- How will the program effect the health of identified population(s)?
- Will the program have different impacts on some clients?
- Will some clients have different health outcomes than others?
- Are there any other populations, other than the ones initially identified, that may experience unintended impacts from the program?

Note: Populations experiencing health inequities may be affected by multiple SDoH factors at the same time, (e.g., female newcomers to our community who speak English as their second language.)

Potential Health Impacts

[HEIA Template Section 2]

This part of the HEIA focuses on identifying potential unintended positive or negative health impacts of the program and assists users in recognizing when more information is needed to make informed decisions.

Potential health impacts are identified throughout the process of program design, assessment, planning, implementation, and evaluation. Keep in mind that positive impacts enhance health equity while negative impacts contribute to or maintain health inequities.

To complete this section of the HEIA, consider the following questions:

- Are there unintended positive health impacts on the population(s) which enhance health equity?
- Are there unintended negative impacts on the population(s) which contribute to, maintain, or strengthen health disparities?
- How likely is it that the unintended negative health impact will occur?
- Will the negative impact be immediate or will it occur over time?
- What is the severity and scale of the negative impact?
- Will some people benefit more than others? Why?
- Are there some groups who are underserved by the program?
- Will some clients have difficulty accessing the program?
- Will providing or improving access to this program help to narrow the health differences between those who are the least healthy and those who are most healthy?

In some instances, more information may be needed (e.g., additional research, outreach, or consultation) in order to accurately identify the unintended potential health impacts on specific populations.

Mitigation Strategies

[HEIA Template Section 3]

This section of the HEIA focuses on the development of strategies and possible program changes to minimize or eliminate negative health impacts. For example, if transportation is identified as a significant barrier to attending a program, it would be advisable to consider alternative locations accessible by public transportation or look for ways to subsidize client/participant transportation costs. In addition, this section of the HEIA encourages users to reflect on strategies to amplify positive impacts of the program.

To complete section three, consider the needs of the population(s) the program is working to support:

- How will the program work to address identified SDoH factors and/or health disparities?
- How will barriers to access be identified? How will they be addressed?
- Is the location accessible (e.g., for families, people with disabilities, older adults, etc.)?
- Is the location reachable by multiple modes of transportation (e.g., bus, walking or bicycle)?
- Should alternate locations be considered (e.g., urban and rural)?
- To decrease negative health impacts, what specific changes need to be made to the program?
- How can anticipated/actual positive impacts be preserved and magnified?
- How can representatives from the identified population(s) be included in the program planning, development, implementation and evaluation process?
- Who else could be consulted and collaborated with (e.g., organizations/agencies that serve or advocate for diverse groups)?
- What strategies can be used to better reach diverse groups?

Monitoring & Evaluating Outcomes

[HEIA Template Section 4]

This section focuses on evaluating the outcomes of each mitigating strategy identified in the previous section. The results of section four should be integrated into the overall monitoring and evaluation plan and will assist in identifying indicators to measure progress and success.

When completing section four consider the following questions:

- How will progress and success be measured?
- Did the mitigating strategies in section three make a difference?
- Did the identified mitigating strategies have the intended effects?
- What outcomes were observed? Were they the outcomes anticipated?
- Were the identified changes actually made to the program?

At this point, don't forget to complete the "Conclusions" section of the HEIA cover page.

Sharing Results
(HEIA Template Section 5)

After the program has been implemented and evaluated, it is important to share the results with others (e.g., summary report that includes a copy of the HEIA) so they may take advantage of lessons learned.

It is beneficial to share details of the development process such as literature reviews, any resources developed, outcomes of the program and any recommendations, adding to the growing body of health equity knowledge.

Consider the following questions:

- Which stakeholders (within or outside of my organization/group) would benefit from hearing about the results and recommendations?
- When should the information be shared and how?
- How should the language and method of information sharing be tailored to the audience?

For a more in-depth and detailed description of completing a HEIA including many examples, please see the Ministry of Health and Long-Term Care's Health Equity Impact Assessment (HEIA) Workbook (2012): www.health.gov.on.ca/en/pro/programs/heia/docs/workbook.pdf

HEIA – Cover Page

Health Equity Impact Assessment

HEIA is a flexible and practical assessment tool that can be used to identify and address potential unintended health impacts (positive or negative) of a policy, program or initiative on specific population groups.

Date:	
Organization:	
Name and contact information for the individual(s) or team completing the HEIA:	
***Program name:**	

Broad overview and program summary:
(e.g., context, purpose, resources, who should be involved?)

Objective for completing the HEIA:
(e.g., to determine where to best invest resources in a new policy, program, or initiative?)

Note: This section to be filled in after completing the following HEIA template.

Conclusions:
(e.g., what decisions were made following completion of the HEIA tool?)

Please note that throughout this document the word* ***program* *will be used to represent programs, services, initiatives, policies, projects, and policies.*

HEIA Template

Population(s) Identification [Section 1]		**Potential Health Impacts** [Section 2]			**Mitigation Strategies** [Section 3]	**Monitoring & Evaluating Outcomes** [Section 4]	**Sharing Results** [Section 5]
Using research evidence and other knowledge, identify population groups that may experience unintended (positive or negative) health impacts as a result of the program.	Identify potential social determinants of health factors and health inequities that may affect the identified population groups.	Unintended Positive Impacts.	Unintended Negative Impacts.	More Information Needed.	Identify ways to reduce potential negative impacts and amplify positive impacts.	Identify ways to measure success for each mitigation strategy.	Identify ways to share results, lessons learned, and recommendations to address health equity.

Adapted with permission from the Ministry of Health and Long-Term Care (2012)

HEALTH DISPARITY

Health disparities are differences in health status that occur among population groups defined by specific characteristics. They mostly result from inequalities in the distribution of the underlying determinants of health across populations. Socio-economic status (SES), Aboriginal identity, gender, and geographic location are the important factors associated with health disparities in Canada. These factors are interdependent (Public Health Agency of Canada, 2004).

HEALTH EQUITY

Health equity means that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance (National Collaborating Centre for Determinants of Health, 2013).

Health equity "involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill" (World Health Organization, 2006, p. 5). While striving to improve health outcomes for all population groups, the pursuit of health equity seeks to reduce the excess burden of ill health among socially and economically disadvantaged populations (National Collaborating Centre for Determinants of Health, 2013).

HEALTH EQUITY IMPACT ASSESSMENT

Health Equity Impact Assessment (HEIA) is an evidence-based tool that has a broad application for use by organizations across the Ontario health care system, such as the Ministry of Health and Long-Term Care (MOHLTC), Local Health Integration Networks (LHINs), Public Health Units (PHUs), and health service providers; but also by organizations outside the health care system whose work can have an impact on health outcomes. Examples include other Ontario social policy ministries such as the Ministry of Education, Ministry of Transportation, and Ministry of Children and Youth Services, and various non-profit organizations and community service providers. The HEIA tool also has the intention of being a bridging tool across relevant sectors to encourage creative thinking, collaboration, and practical, actionable solutions on current policies, programs, or initiatives impacting health outcomes (Ministry of Health and Long-Term Care, 2012).

HEALTH INEQUALITY

Health inequality is a generic term used to designate differences, variations, and disparities in the health achievements and risk factors of individuals and groups. (Bowen, S., Botting I., Roy J., 2011).

HEALTH INEQUITY

Health inequities are health differences between population groups–defined in social, economic, demographic or geographic terms–that are unfair and avoidable (National Collaborating Centre for Determinants of Health, 2013).

Three distinguishing features, when combined, turn mere variations or differences in health into a social inequity in health. They are systematic, socially produced (and therefore modifiable) and unfair (World Health Organization, 2006).

LEVELING-UP

Leveling-up is the way to narrow the health gap in an equitable way. It brings up the level of health of the groups of people who are worse off to that of the groups who are better off (World Health Organization, 2006).

POPULATION HEALTH APPROACH

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations. A population health approach aims to improve the health of the entire population and to reduce health inequities among population groups (Public Health Agency of Canada, 2001).

PRIORITY POPULATION

There are many ways to understand and/or define the term priority population. There is no common and consistent definition currently identified in the literature (Ontario Agency for Health Protection and Promotion, 2015), however presented here are two examples. Priority Populations are those population groups at risk of socially produced health inequities and are identified using epidemiology and inequity/social factors (Sudbury & District Health Unit, 2010). Priority populations are identified by surveillance, epidemiological, or other research studies and are those populations that are at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level (Ministry of Health and Long-Term Care, 2008). Organizations are advised to discuss and establish how priority populations are defined (i.e., what criteria are used).

PROPORTIONATE UNIVERSALISM

With the knowledge and understanding that there is a social gradient in health, Proportionate Universalism is a concept where interventions such as program, services, and policies are implemented based on a scale and intensity comparable to the level of need (Marmot et al., 2012). This idea effectively incorporates the concepts of universal and targeted approaches, since it advocates for interventions that provide supports and resources to all populations (universal), while promoting that those identified with higher needs receive proportionally more benefits and services (targeted) across a spectrum. Therefore, adopting a proportionate universal approach ensures that a range of responses for different barriers and levels of disadvantage are available. This is in contrast to concentrating resources merely on the most disadvantaged groups (Ontario Agency for Health Protection and Promotion, 2015).

SOCIAL GRADIENT OF HEALTH

The poorest of the poor, around the world, have the worst health. Within countries, the evidence shows that the lower an individual's socioeconomic position, the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. This is a global phenomenon seen in low, middle and high income countries. The social gradient in health means that health inequities affect everyone (World Health Organization, 2013).

TARGET GROUP

The Sudbury & District Health Unit (2010) defines target group as the population group to which public health actions are directed. It can also be understood as audience. Furthermore, they clearly distinguished between target group and priority population. Many activities have a target group or audience to whom the activity is directed, but having a target group does not necessarily mean that the activity addresses priority populations. Target groups can have priority populations within them. For example, men may be a target group for a particular activity. However, there may be priority populations within that target group, such as men with low incomes, who may experience socially produced inequities in health.

TARGETED APPROACH

A Targeted Approach applies to a priority sub-group within the broader, defined population. Eligibility and access to services are determined by selection criteria, such as income, health status, employment status or neighbourhood. Targeted approaches are based on a belief that social constructs (for example, classism, sexism, racism and colonization) are barriers to equitable access to the determinants of health, and that interventions directed to disadvantaged members of society are needed to close the health gap (National Collaborating Centre for Determinants of Health, 2013).

TARGETING WITHIN UNIVERSALISM

Targeting within universal programming can be focused on priority populations within a universal strategy. For example, universal interventions can be adjusted to increase accessibility for certain groups, or specific strategies can be developed to address inequalities in the social determinants of health. This fine tuning of programs increases the likelihood that those who are at greater risk of adverse health receive the greatest benefit. As a result, the health of the entire population improves, but the health of priority populations improves faster—reducing health inequities (Sudbury & District Health Unit, 2012).

UNIVERSAL APPROACH

A Universal Approach applies to an entire population. Eligibility and access are based simply on being part of a defined population such as all women, all children under age six, or all people living in a particular geographic area, without any further qualifiers such as income, education, class, race, place of origin, or employment status. The approach is based on the belief that each member of society should have equal access to basic services such as education or health care (National Collaborating Centre for Determinants of Health, 2013).

UPSTREAM INVESTMENT

Efforts and investments in a population health approach are directed at root causes to increase potential benefits for health outcomes. The identification and definition of health issues and the investment decisions within a population health approach are guided by parameters based on evidence about what makes and keeps people healthy. A population health approach directs investments to those areas that have the greatest potential to influence population health status positively. A population health approach is grounded in the notion that the earlier in the causal stream action is taken the greater the potential for population health gains (Public Health Agency of Canada, 2001).

Authors:

Jennifer Johnston, *Public Health Nurse*
Windsor-Essex County Health Unit

Thelma Maxwell, *Public Health Nurse*
Windsor-Essex County Health Unit

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- *Bridges to Health and Healthcare: New solutions for improving access and services* by Ruby K. Payne, PhD, Terie Dreussi-Smith, Lucy Shaw & Jan Young, PhD
- Ministry of Health and Long-Term Care
  Health Equity Impact Assessment Template and Workbook
- Niagara Region Public Health
  SDoH Menu of Tools
- New Zealand Public Health Advisory Committee
  A Guide to Health Impact Assessment: A Policy Tool for New Zealand
- Saskatoon Health Region's
  Public Health Observatory
- Winnipeg Regional Health Authority
  Health for All: Building Winnipeg's Health Equity Action Plan

Links provided throughout this document reflect the sources of information at the time of publishing.

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Windsor-Essex County Health Unit
519-258-2146
www.wechu.org