



# **How do I Address Health Inequities in my Program Development?**

Using "First Steps to Equity" in  
Population Health Assessment,  
Program Planning, and Evaluation

OPHA Access, Equity and Social Justice Work Group



# Our Goal

To assist Public Health practitioners in learning to use an equity lens in developing programs that acknowledge and respond to health inequities

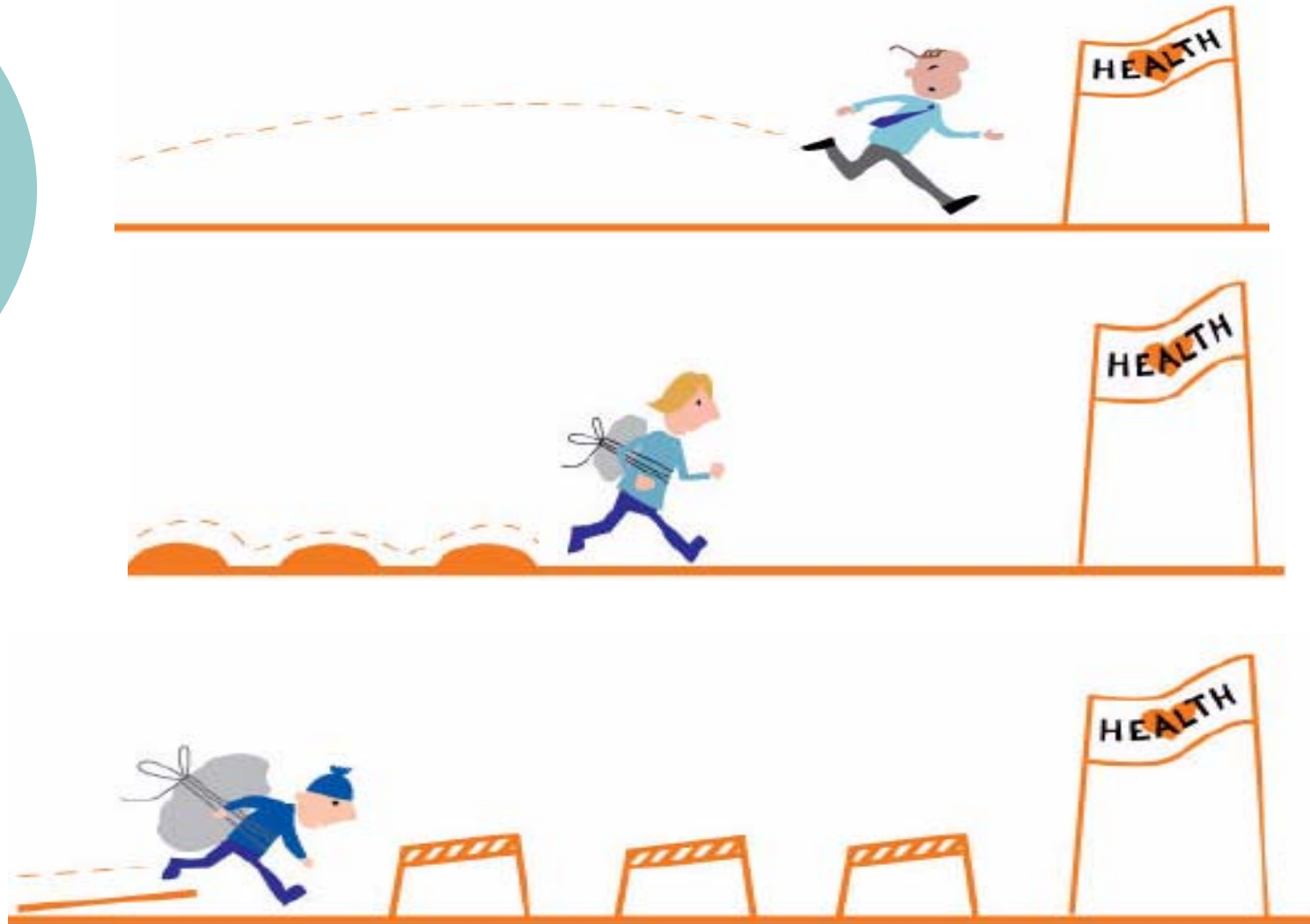
- We will:
  - Briefly present the main messages from the tool
  - Examine two case studies that reflect “real life” issues in addressing health inequities
  - Obtain feedback from the participants and build upon messages in the document
  - Ask participants to provide ideas for next steps that we could collectively take



# First Steps to Equity

- First Steps to Equity is an initial, brief guide
  - Presented at the launch of the OPHS Foundational Standard
- Invites a multi-disciplinary approach to integrating evidence in identifying and addressing health inequities
- Explains:
  - why it is critical that we look at health inequities and priority populations,
  - how that meets our population health goals, and
  - key steps and questions to ask when doing population health assessment, research, program evaluation, and program planning activities.

# Health Burden & Access Barriers (Hurdles) Widen Equity Gap



*People figures from Norway's National Strategy to Reduce Social Inequalities in Health (2007)*



# Ontario Public Health Standards "The Impact"

Boards of Health need to consider the following:

- "What are the barriers to achieving maximum health potential for individuals, groups, and communities and narrowing inequities in health?"



# Ontario Public Health Standards

## The Impact

- "Public Health interventions shall acknowledge and aim to **reduce existing health inequities**.
- Furthermore, boards of health shall not only examine the accessibility of their program and services to address barriers (physical, social, geographic, cultural and economic), but also assess, plan, deliver, manage and evaluate programs to **reduce inequities** in health while at the same time maximizing the health gain for the whole populations."



# The four key roles for public health

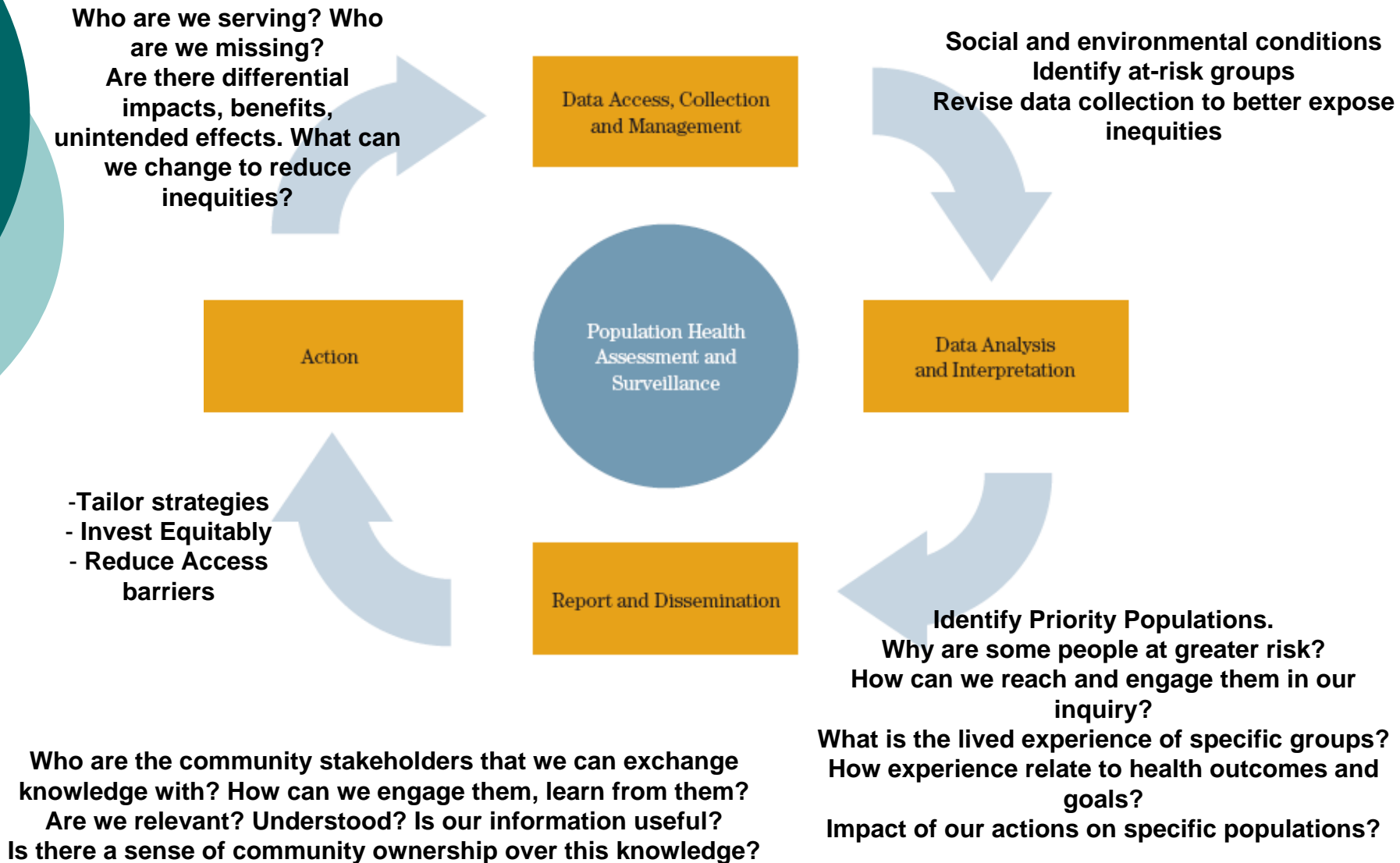
- Identify and describe evidence of health status and health inequities
- Modify public health interventions to meet the unique needs and capacities of priority populations
- Engage in community and multi-sectoral collaboration in addressing the socio-economic needs of these populations
- Support community and other stakeholders in policy advocacy for improvements in socio-economic determinants of health



# Why is Equity-based Assessment and Planning Important

- There is no “general population”.
- Universal interventions often widen the gaps
- Population health goals can be achieved by focusing on priority populations and a balanced resource allocation
- Our actions, tools, and methods, whether in protection, promotion, or prevention, need to be accessible, meaningful, diversity-competent, and innovative.

# Integrating Equity into Population Health Assessment and Surveillance Cycle





# Key Equity Questions

## Program Evaluation

Who is accessing/ benefiting from our programs? Who is not?  
What are the barriers, differential impacts?  
What can we do to change that?

## Knowledge Exchange

Who are the community stakeholders that we can exchange knowledge with? How can we engage them, learn from them?  
Are we relevant? Understood? Is our information useful?  
Is there a sense of community ownership over this knowledge?

## Research

Why are some people at greater risk?  
Where are the people we need to learn more about? How can we reach and engage them in our inquiry?  
What is the lived experience of specific groups?  
How does that experience relate to health outcomes and our goals?  
How are our actions relevant to specific populations?

## Assessment & Surveillance

What are the unique social and environmental conditions of this community?  
Who is at risk?  
How can we design data collection to learn more about relationships between SDOH and health outcomes, behaviours, and knowledge?  
How can we improve our surveillance systems and build ones that collect data we need?