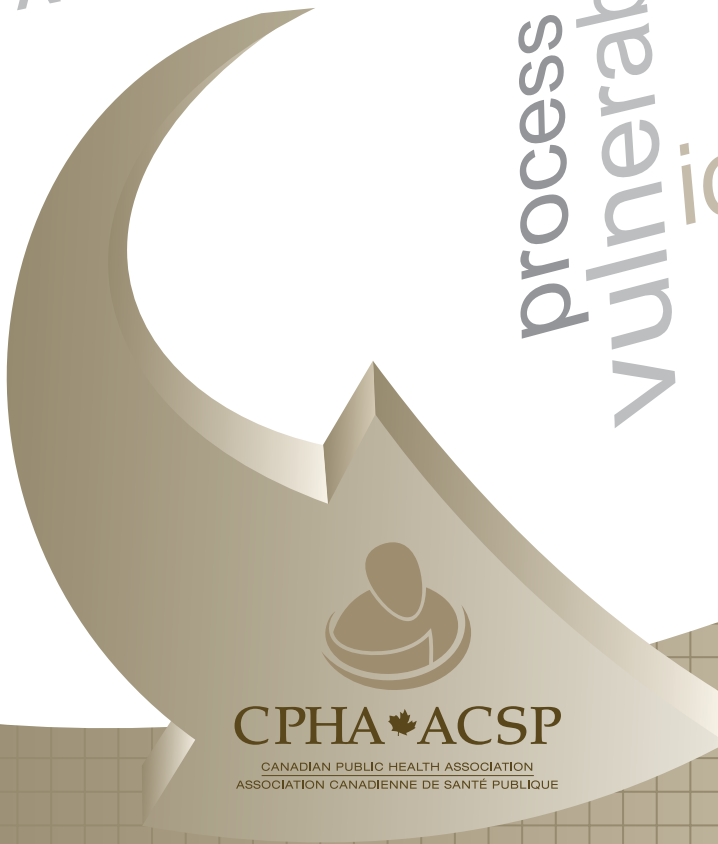


analysis
method
priority
HIV/STBBI
evaluation
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factors that impact
populations
treatment
Health Equity Impact
Assessment (HEIA) Tool
mitigation
positive and negative
probability
knowledge
goal and objectives
dissemination

process
vulnerability
identification



Sexually Transmitted Infections and Other
Blood-Borne Infections, including HIV, (STBBI)
Health Equity Impact Assessment (HEIA) Tool

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Members of the NRG included

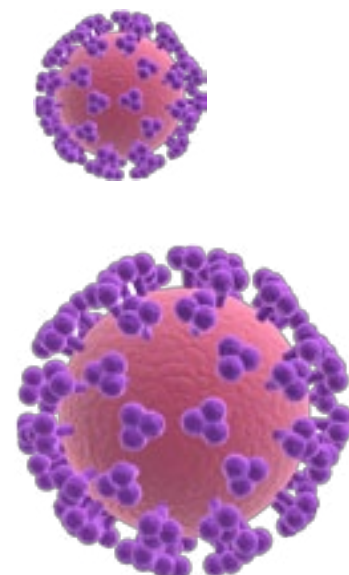
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List of terms and short forms

Not all of these terms are used in this document, but they are all useful in understanding the context of STBBI prevention and sexual health.

Aboriginal peoples: First Nations, Inuit, and Métis people in Canada (for the purpose of this document).

ACB: African, Caribbean, and Black communities; there is a high rate of HIV within groups of people in Canada who have originated from ACB countries.

AIDS: Acquired immune deficiency syndrome; caused by HIV infection and diagnosed according to certain clinical criteria, such as AIDS-defining illnesses and specific blood tests.

ASO: AIDS service organization.

Barrier-less sex: Sexual activity that does not include any type of physical protective barrier; examples of barrier methods include condoms and dental dams.

BBI: Blood-borne infection; transmitted by direct blood contact from one individual to another through injured skin or a mucous membrane; also transmitted through drug use and sexual contact; examples include hepatitis A, B, and C.

Bisexual: An individual who is sexually attracted to both men and women.

CBO: Community-based organization.

Co-infection: More than one infection at a time; HIV and HCV are examples of co-infections.

CPHA: Canadian Public Health Association.

DoH: Determinants of health; health is determined by complex interactions among social and economic conditions, the physical environment, and individual behaviour; in Canada, 12 broad determinants of health have been identified; some examples are gender, income, employment, working conditions, housing, and education; these determinants do not exist in isolation from each other; it is the combined influence of the determinants that results in health status. See also SDH (social determinants of health).

FIV: Factors that impact vulnerability; factors that impact a person's risk of STBBIs and vulnerability to STBBIs.

Front-line service providers: Any individual who is the first point of contact with the patient or client of a public health unit, community-based organization, or AIDS service organization.

Gender identity: A person's self-image or belief about being female or male; does not always correspond to biological sex.

HCV: Hepatitis C virus.

Health equity: The absence of health disparities between groups even though they are differently advantaged according to the social determinants of health; reducing the barriers that result in health disparities leads to health equity.

HEIA tool: A health equity impact assessment tool.

Hepatitis: A viral inflammation of the liver; there are several different forms of the virus, including types A, B, C, D, E, and G; hepatitis C is often associated with intravenous drug use and is a chronic liver disease.

HIV: Human immunodeficiency virus; results in a combination of illnesses that in advanced stages can lead to AIDS.

MSM: Men who have sex with men, regardless of how they identify themselves; this is an epidemiological classification for STBBI transmission.

Perinatal: The period directly before and after birth.

PHAC: Public Health Agency of Canada.

Priority populations: Populations identified by PHAC as most at risk of STBBIs in Canada, based on risk exposure categories and rates of infection collected by PHAC; eight broad categories have been defined; the categories are not mutually exclusive; the overlap and intersection between groups results in complex identities and complex health issues.

Risk gradient: The more prevalent risk factors for STBBIs are in a person's life, the more a person's risk increases over time and the greater the risk a person faces from the various factors; social gradient is similar: the lower a person's socio-economic status, the lower a person's health outcome is likely to be.

SDH: Social determinants of health; specific to the social and economic conditions that shape the health of individuals, communities, and countries; these determinants also influence the extent to which individuals have the physical, social, and personal resources to achieve their goals, satisfy their needs, and cope with their environments.

Sexual orientation: How people think of themselves in terms of sexual desire for another person.

STBBI: Sexually transmitted and other blood-borne infections; examples include chlamydia (sexually transmitted) and hepatitis C (blood-borne).

STBBI HEIA tool: The tool developed as part of the CPHA project Developing Core Competencies for STBBI Prevention.

STI: Sexually transmitted infections; infections caused by sexual activity or exposure. (Note: The term sexually transmitted disease is no longer used.)

Transgender: A person whose gender identity, outward appearance, expression, or anatomy does not fit into conventional expectations of male or female.

Two-spirited: "Native people who are gay, lesbian, bisexual, and transgender individuals who walk carefully between the worlds and genders," as defined by the organization 2-Spirited People of the 1st Nations; this term is not used in all communities.

Part One: The STBBI Health Equity Impact Assessment Tool

I. Introduction

Health inequities are both avoidable and unfair. Health equity is the absence of disparities in the social determinants of health among groups with different levels of social advantage. The determinants include factors such as gender, income, employment, working conditions, housing, and education. Social disadvantage creates barriers that result in disparities in health status. A health equity approach contributes to the health system and its sustainability by reducing the incidence and cost of preventable illnesses.

To address health inequity, we must first understand the barriers to care and the needs of groups who already face many disadvantages. Research has shown that the roots of health disparity lie in broader social and economic inequality and exclusion. There are clear social gradients showing that the lower a person's socio-economic status, the lower a person's health outcome is likely to be. For example, the lower a person's income and education, the poorer their overall health tends to be.

An understanding of the social determinants of health is required in order to understand how to impact and potentially mitigate health disparities. We also need effective and practical tools to apply this understanding to the health initiatives we create, whether they are policies, programs, projects, interventions, or services. One such tool is a Health Equity Impact Assessment (HEIA).

An HEIA identifies vulnerable and priority populations within a community. It is often used as a "first-pass" tool by program planners, decision makers, and policy makers who wish to incorporate equity considerations into the planning of new initiatives. An HEIA can support the achievement of a long-term strategic priority, such as improved access to care for groups that face barriers.

The HEIA tool presented in this document is designed to help you and your front-line organization examine any proposed initiative (e.g., policy, program, project, intervention, or service) to determine if it could unintentionally increase a population's

vulnerability, specifically to sexually transmitted and other blood-borne infections (STBBIs). This STBBI HEIA tool is also designed to uncover any unintended impacts of the new initiative in relation to STBBI prevention and treatment that you may not be aware of.

II. Need for an HEIA that is STBBI-Specific

The STBBI HEIA tool in this document has been adapted from the generic HEIA Tool and Workbook (version 2.0) produced by the government of Ontario. It is designed for use with priority populations as identified by the Public Health Agency of Canada (PHAC) in the context of preventing sexually transmitted and other blood-borne infections, including HIV (STBBIs).

All HEIA tools seek to uncover "hidden" groups within the general population that are at particular risk or more susceptible to STBBIs. PHAC has established eight priority populations for STBBIs based on their risk exposure and higher incidence rates. These priority populations are the foundational categories for this STBBI HEIA tool (hereafter referred to as "the Tool"), which is unique in helping organizations better identify and examine the intersections and resulting identities within these groups and communities.

Intersections among populations

The priority populations are not mutually exclusive. This Tool uses PHAC's populations as a starting point and then seeks to identify how populations intersect and factors overlap between the populations; for example, individuals who are First Nation and MSM (men who have sex with men) and urban-dwelling have complex identities and this Tool can help identify the unique risks of these intersecting identities.

Individuals considered members of priority populations are at greater risk of STBBIs due to a variety of factors. These factors place them in circumstances that have an impact on their health and well-being, including their risk of STBBIs. It is important to acknowledge that health and personal circumstances are not static. Individuals may find themselves on a risk gradient that changes throughout their lives. Addressing the unique circumstances that have an impact on a group's health is central to any effective prevention-based initiative. This Tool helps

organizations to systematically identify groups in their community that are more susceptible to STBBIs. These groups are then deemed priorities in the community.

The social determinants of health and the evolution of the factors that impact vulnerability (FIV) Most HEIAs are based on a generic framework that can be applied to any sector and any context to ascertain if a proposed initiative will increase or decrease inequities for key populations. These HEIAs then look at how best to mitigate any unintended negative effects while trying to maximize the unintended positive effects. Many HEIA tools look at communities through the lens of determinants of health (DoH) and how the determinants affect overall health and well-being. Likewise, many approaches to STBBI prevention are looking through the same lens; while it is useful, this lens does not focus on the risk of STBBIs.

This document gives examples of factors that may have a positive or negative impact on the risk of STBBIs. These factors are based on the larger social determinants, but they manifest themselves differently within STBBI priority populations. We call them factors that impact vulnerability (FIV) and they can be found in Appendix B.

CPHA held consultations, focus groups, and key informant interviews in seven locations across Canada. The FIV were identified and further refined by people who self-identified as members of priority populations in the STBBI context, public health professionals, clinicians, allied health professionals, front-line workers, volunteers, experts, and researchers. The list of FIV is not meant to be definitive. Over time, the FIV will change or new factors will be added as we better understand what impacts peoples' vulnerability to STBBIs. FIV can affect the health and well-being of priority populations differently than the general population. Some factors may be common across all of the priority populations, but they may manifest themselves quite differently in day-to-day life, depending on the factor, the context, and the priority population. Service providers who plan prevention initiatives within the STBBI context must be aware of how their initiatives might positively or negatively impact these factors and populations. The FIV are meant as a companion resource when completing the Tool's template to help uncover unique impacts within

specific populations.

III. The Tool

The STBBI Health Equity Impact Assessment (HEIA) Tool consists of instructions, an adaptable template, and a list of factors that impact vulnerability (FIV). It can be used to assess a prevention-based policy, program, project, intervention, or service that is under development. For simplicity's sake, this document will refer to all of these efforts as "initiatives."

A. Goal and objectives

The Tool's goal is to provide a practical tool that will help service providers as they prepare front-line initiatives to do their utmost to ensure that their initiatives do not increase any existing health inequities for people who are vulnerable to STBBIs.

The Tool's objectives are as follows:

- Support an organization's assessment and decision-making processes during the development of initiatives.
- Identify and address unintended impacts, both positive and negative, on priority populations and other groups that may face challenges in attaining equitable health outcomes.
- Build on an organization's existing prevention work and enhance consistency and transparency in how equity issues are addressed.
- Strengthen work around the factors that may impact vulnerability to STBBIs.
- Catalogue the decision-making process in a systematic way to assist in the development of future initiatives.



Completing the template and “thinking outside the box” will help organizations create strategies to mitigate unintended negative impacts and maximize unintended positive impacts.

If potential negative impacts are discovered, the Tool provides a framework to explore ways of mitigating those impacts. ***The Tool is not intended to determine whether an initiative is right or wrong.***

The Tool is not a substitute for a needs assessment, nor is it an evaluation tool or framework. Rather, it is a means to inform the design and planning of new prevention-based initiatives.

B. Priority populations

This list comprises the eight priority populations as defined by the Public Health Agency of Canada with modifications for use by the STBBI HEIA Tool

1. Aboriginal peoples (First Nations, Inuit, and Métis peoples)
2. Gay, bisexual, two-spirit, and other MSM (men who have sex with men)
3. People who use substances, including injection drugs (modified from people who inject drugs)
4. People who are or have been in prison (modified from people in prison)
5. Youth at risk
6. Women at risk (modified from women)
7. People from African, Caribbean, Black (ACB), and other countries where HIV is endemic, including newcomers (modified from people from countries where HIV is endemic)
8. People who are living with HIV/AIDS
9. Other population groups, such as those without legal status in Canada or without health insurance and people without a family doctor (added as a ninth group)

The Tool uses these priority populations as a baseline for examining a community and its various subpopulations. For example, not all gay men are at risk of STBBIs; however, the subpopulation of gay men engaged in survival sex or street-level sex work may be at risk of STBBIs as well as violence and criminalization. The aim of the exercise is to identify how these populations and subpopulations intersect.

In reality, people often do not fit neatly into one population group. The priority populations listed above are just a starting point, or “first cut,” for front-line service providers to consider as they develop and refine their community profile. Recognizing the intersections and fluidity of the groups is essential to using this Tool.

This is your opportunity to highlight the priority groups, subgroups and individuals in your own community who may be more susceptible to STBBIs. For example, a woman may identify as being First Nation, an intravenous drug user, and a sex trade worker. The intersection of these identities results in a unique and complex set of barriers to her health and well-being and may significantly increase her risk of STBBIs.

Individuals are complex and changing. They are not static beings, nor are the situations in which they live. People may find themselves on a risk gradient over time or even episodically. Identification with risk categories can change over time. For example, the risk for a street-level sex worker who is an active substance user will change if she leaves sex trade work or stops using drugs. At the same time, front-line service providers will find themselves needing to change their prevention approaches according to the individual. For example, a Canadian gay man will not have the same lived experience as a woman from a country where HIV is endemic. They will require different approaches to care for their health and well-being, and need very different STBBI-prevention approaches.

The central challenge in planning an initiative is to reduce a specific group’s risk of STBBIs without increasing the vulnerability and inequities of other groups. While targeted prevention initiatives can be effective it is important that other groups are not inadvertently impacted. People in priority populations may already feel isolated, so it is important not to further alienate them by failing to understand their needs.

A new initiative may not necessarily trigger vulnerabilities within other population groups, but front-line service providers and organizations should be aware of the potential for unintended impacts.

Using this Tool can help identify how the priority populations targeted by a new initiative intersect. The key is to uncover and identify some of the more complex and intersecting identities in the community that may be impacted by the initiative.

As well, front-line organizations could do their best to integrate feedback from community members during the initiative's planning stage to understand how individuals identify themselves and to better serve the uniqueness of each population group. While this may not be easy, the more information collected the more effective and relevant the initiative will be in preventing STBBIs.

C. Factors that impact vulnerability (FIV)

To assess in advance the potential unintended effects of a proposed prevention initiative, you need to know about the factors that impact vulnerability specific to STBBIs. Some FIV are applicable across priority populations in a broad sense while others appear to be population-specific. FIV provide a valuable lens through which you can assess an initiative before its implementation.

The set of sample STBBI-specific FIV in Appendix B was developed through a process combining research from existing sources, focus groups with members of the priority populations, consultations with front-line organizations, and key informant interviews. Within each FIV, there may be more subfactors that can be linked to an increased risk of STBBIs, such as ethnicity, sexual identity/orientation, language, and access to culturally appropriate health services. Some of the impacts are greater or manifest themselves differently in different populations.

How FIV manifest themselves in real life

The factors that impact vulnerability to STBBIs can be very subtle and nuanced. The example below shows how layered levels of impacts and intersections among factors can increase individual vulnerability and risk:

Jane, a middle-class woman in her mid-thirties, enters her community health centre because she has not been feeling well and would like a check-up. The health centre provides integrated and allied services, which include mental health and

addiction supports, a drop-in sexual health clinic, an HIV clinic, and a host of community wellness programs. Jane has been coming to the health centre for a long time as she does not have a family doctor and usually comes in for minor health concerns.

Jane notices a woman entering whom she has not seen in years. The woman has physically deteriorated and appears quite ill. Jane and the woman had been good friends and roommates in university. They had partied together often with various groups of people. She recalls that during that time, they didn't have much money and relied on the men they were seeing to pay for most things. Although some of those relationships were brief, Jane had always felt obligated to have sex with them. During this time, she experimented with drug use to keep awake for exams and deadlines. A few times she used cocaine and other stimulants. Jane continues to use cocaine once in a while with her husband. Her friend comes over to speak with Jane while she finishes registering. They stand next to the counter to chat and catch up. While talking, Jane thinks that the receptionist keeps glancing at the two of them and she starts to feel uncomfortable. Suddenly, she realizes her friend mentioned something that she missed hearing. Jane asks her to repeat it and the woman says quite loudly that she is at the health centre to see the HIV specialist. Jane notices that the receptionist overhears this information and she begins to feel even more uncomfortable. Jane is shocked; she has never known anyone who has HIV and she has never been tested.

Jane thinks that the receptionist must know that her friend is HIV positive and she becomes embarrassed to be seen with her. The doctor arrives at reception and the receptionist pulls him aside. They speak quietly for a few minutes behind the counter. The doctor looks at Jane a few times during the exchange and then puts on latex gloves. The nurse hands him Jane's file and he appears to review it while her friend continues speaking, but Jane has stopped listening. Then,

Jane's name is called. In the examination room, the doctor asks her the reason for her visit. All Jane can think is that

“he must think I have HIV as well!” The doctor asks her to get on the examination table. At this point, Jane says she is feeling much better and that she really doesn’t need to be there. She apologizes for taking up his time and quickly leaves. Once outside, she tells herself she didn’t need to see a doctor anyway, doesn’t really need a family doctor, and can always go to the emergency room if she needs to.

Jane seems to have feared that the receptionist identified her as HIV positive, given the status of her former friend. Whether the receptionist’s actions supported her belief or not, Jane’s fear or expectation of being discriminated against caused her to leave the health centre without accessing the treatment she came to receive. In addition, Jane’s vulnerability to STBBIs has also increased dramatically because she now feels uncomfortable at the health centre, no longer seeing it as neutral territory. She does not want to return for any type of care, choosing instead to access emergency services when necessary. Jane has never been tested for HIV and does not know her status. She continues to use drugs, sharing paraphernalia with her husband, who also has an unknown status. As a result of the fear of stigma, Jane’s risk for acquiring or having an STBBI has grown.

IV. Conducting the STBBI Health Equity Impact Assessment

Ensuring vulnerabilities and inequities are not increased This Tool helps front-line organizations to examine any proposed initiative (e.g., policy, program, project, intervention, or service) to determine if it could unintentionally impact a population’s vulnerability to STBBIs. It also helps to uncover both unintended positive and negative aspects of the initiative, and if potential negative impacts are discovered, it provides a framework to explore ways to mitigate those impacts and maximize the positive unintended impacts.

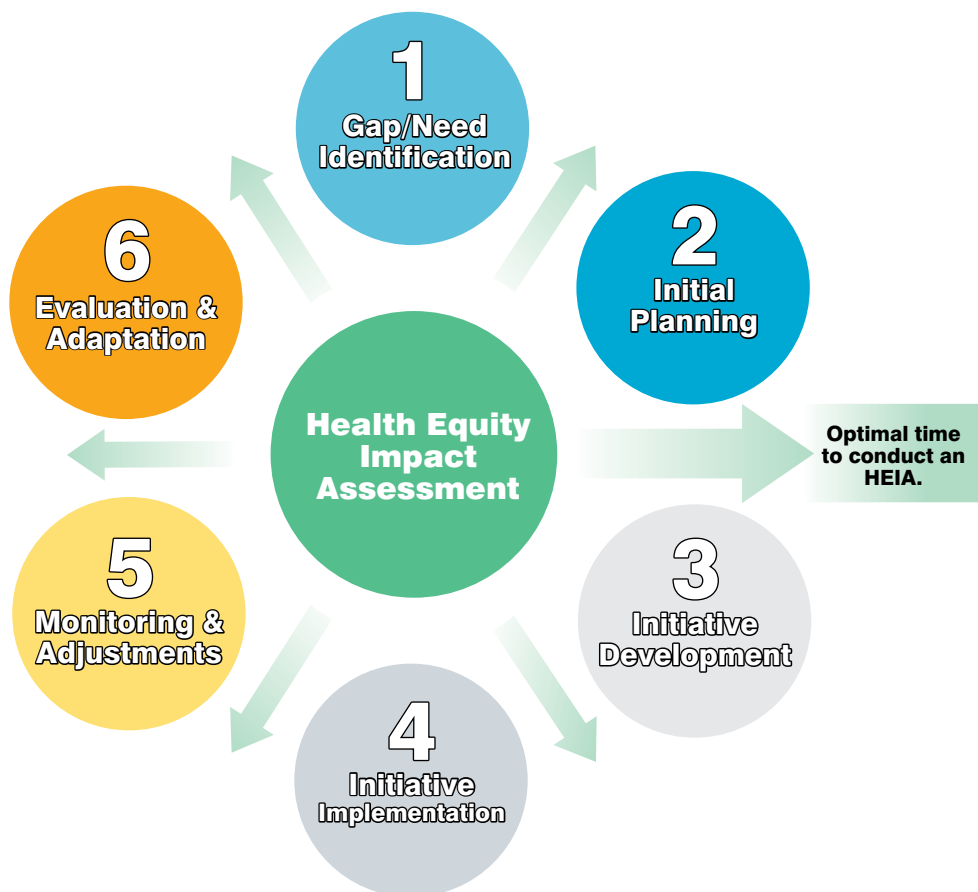
The Tool is not intended

to determine whether an initiative is right or wrong. Conducting an STBBI HEIA should not be considered a substitute for a needs assessment, or be seen as an evaluation tool or framework. Rather, it is a means to inform the design and planning of new, prevention-based initiatives.

A. When to conduct the STBBI HEIA

An STBBI HEIA should be conducted as early as possible in the planning or initiative development stages of the initiative cycle (see illustration below). This enables organizations to make adjustments to their initiatives before opportunities for change might become limited.

While early assessment is ideal, an HEIA can still be introduced at later points within the planning or development cycle. For example, an assessment might take place during reviews or evaluations related to program growth, realignment, or closure. However, at these later dates, any recommendations coming from an HEIA may be constrained by factors such as earlier decisions, investments already made, remaining resources, and time commitments.



B. Levels of assessment

All HEIAs provide an evidence-based, systematic approach to ensuring that equity is addressed in an initiative's planning and decision-making processes. The assessment is typically conducted by an internal staff team, not an external consultant.

There are three levels, or approaches, to conducting the assessment:

- The rapid, or desk-top, HEIA gathers information from existing literature reviews, service user interactions/ interviews, and usage statistics. It does not usually involve extensive community participation, nor does it require original research. The assessment can be completed in a few hours or days.
- The standard HEIA is more detailed and involves greater outreach and sourcing of information through literature reviews and community participation. New research designed to answer specific questions related to the initiative may be incorporated. This type of assessment is used for projects that may have wide impacts within the community. The assessment can be completed in a few days or a few weeks.
- The comprehensive HEIA brings together all of the elements mentioned above around participation, data sources and new research. It involves more extensive research, such as engaging communities and different sectors through consultations. Typically, this HEIA approach is used for large-scale, complex projects that will have major impacts within the community. The assessment can be completed in a few weeks or a few months.

Most assessments typically fall between the rapid/desk-top level and the standard level. Your organization will need to determine which level of assessment you need, based on the breadth and depth of the initiative, the resources available, and your level of engagement with other organizations in the community.

Part Two: Completing the STBBI HEIA Template

The template (see Appendix A) is designed to help

you organize your stages of assessment—the key is to systematically follow the identified steps. You can adapt the template or create your own reporting system to best suit your organization. As you work through the steps, be as creative as the people taking part in the process.

At the top of the template, fill in the following information about your initiative:

- name of initiative
- primary target population(s)
- intended outcomes

Step 1: Scoping

Column 1(a): Other populations that may be impacted by the initiative

Although your organization may deliver programs specific to one population, this step will help you to start thinking about other members of your community that may be affected by your initiative as well. This is not to say that your organization needs to deliver programs to all populations; that may not be realistic or feasible. Rather, this step is designed to help you gain a broader picture and sense of the community you operate within.

Begin with the priority populations. Then you can further refine your search to identify populations that may be vulnerable to STBBIs in your community. Always examine the possibility of intersection and how your initiative might impact people who belong to more than one group or subgroup. Some people may not identify themselves as belonging to more than one group, while others may feel strongly that their identities are reflected in more than one group. On a first review, the impact on other populations may not be clear.

Remember, these are populations that are hidden, but they are identified in your community as priority, so it will be helpful to conduct as thorough a scan as possible. For example, staff can conduct key informant interviews with people from other organizations that do not work specifically in STBBI prevention but nevertheless provide services and programs to clients who may be at risk (e.g., housing providers, mental health and addiction services, regional correctional services, and law enforcement). Interviews, surveys, or focus groups with current clients are useful to determine if other mem-

bers of priority populations have been overlooked in the past or have been affected by past initiatives.

In Column 1(a), identify all of the groups within your community that you think may be affected by your proposed initiative and that may be most susceptible to STBBIs. Use the template to focus on those who may be inadvertently impacted. Think about the complex nature of identities and who may live in your community.

Discuss with one another if there are some populations you were not focused on that may be affected by your new initiative. Remember that priority populations exist on a gradient. Risk will vary over time and is not static.

Column 1(b): Factors that impact vulnerability (FIV)

For each population you have identified in Column 1(a), list the relevant factors that impact vulnerability to STBBIs (from Appendix B). Start thinking about how these factors relate to your initiative. The template provides limited space, so use whatever format you need.

Ask yourself the following questions:

- Are some populations affected more than others?
- Are some FIV stronger than others?
- Are there other FIV that may have an impact on any of the population groups you identified?

Step 2: Unintended Potential Impacts on Populations

Column 2(a) and 2(b): Unintended positive and negative impacts

Unintended impacts can be negative, positive, or even neutral. For each population you have identified in Column 1(a), list the unintended impacts that are positive or neutral in Column 2(a) and list the unintended impacts that are negative in Column 2(b).

At this point, take time to discuss how the initiative may impact the intended population groups. Examine how it might impact other populations as well. Note that population groups are fluid. Individuals identify in many ways. You will need to explore the

generic FIV and the FIV specific to your community's own priority populations. The questions below are intended to foster brainstorming and creative thinking. Keep track of all possible impacts, both positive and negative, for each of the FIV that you have identified.

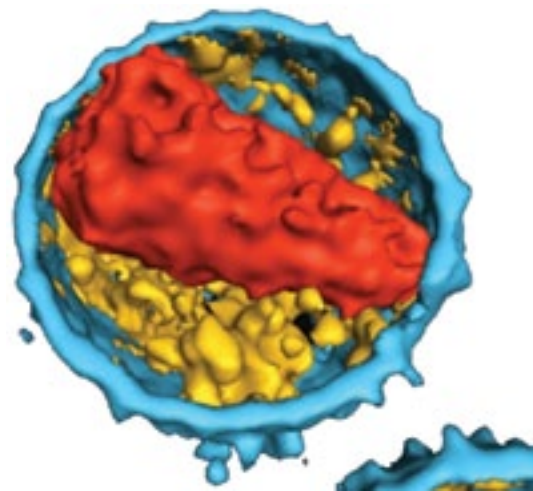
- Will social supports be impacted?
- Will STBBI-related services be impacted?
- Will overall health services be impacted?
- Which population will be impacted the most?
- What is the probability of the impact?
- What is the severity and scale of the impact?
- Will the impact be immediate or long term?

Column 2(c): More information needed

Typically in a rapid/desk-top HEIA, you are assessing an initiative with only the information you have on hand. This might include your team's experience with other initiatives, a quick environmental scan, a review of existing literature, or a quick search for articles using key words from your initiative.

For a more in-depth and detailed assessment, key informant interviews and focus groups are two examples of how to gather more information. Your organization will have to determine if gathering more data will better inform the initiative and how best to collect the data, if you have the capacity to do so.

For example, if a front-line organization wanted to develop an STBBI awareness program for new immigrants from countries where HIV is endemic, is there an opportunity to speak with members of this population? If not, how will this affect the development of the initiative? If you can't get that information within the timeline of the exercise, note how and when you are going to get it in Column 2(c).



Step 3: Mitigation

Once impacts of the initiative have been identified in Columns 2(a) and 2(b), the next step is to address the unintended negative impacts. Here are some examples of mitigation strategies:

- Reduce or eliminate barriers to access, such as translation, transportation, and child care.
- Ensure that communications are at an appropriate reading and comprehension level.
- Ensure cultural appropriateness of communications and service delivery.
- Increase priority group participation in the planning and initiative development process.
- Align more closely with complementary projects or partners, both inside and outside the health sector.
- Offer education, training, and professional development opportunities to staff.

This step involves brainstorming potential mitigation strategies for each of the FIV you have identified and then developing a plan to implement the strategies.

Be creative yet practical in proceeding with this step. Consider what can be mitigated now and what can be dealt with later. Although you may have identified many negative impacts, that does not necessarily mean the initiative should be shelved. It may just require a more concerted strategy to counter those negative impacts, especially if the positive impacts continue to outweigh the negative ones.

For each of the unintended negative and positive impacts identified in Step 2, outline your recommended adjustments to the initiative in order to

- minimize unintended negative impacts on the populations identified and
- maximize unintended positive impacts on the populations identified.

Also, given that the FIV include the physical, social, mental, and spiritual health of individuals, organizations are encouraged to build collaborations with different sectors. The information you gather for the assessment from those most affected can lead to creative and innovative ideas.

Here are some examples of questions to ask as you brainstorm your strategies and your implementation plan:

- What changes are needed so that the initiative meets the needs of each member in the priority populations? If that is not possible, how can the initiative be adapted to decrease risks and vulnerabilities for most populations being served?
- Can the population be engaged in designing and planning the needed changes?
- Can the key stakeholders be consulted? What is the most appropriate and culturally safe manner to do so?
- How will the initiative address systemic barriers to equitable access to care created by the health care and other systems? Can the initiative alleviate any of those barriers?
- Is there the opportunity to expand work to other affected populations? If not, is there the capacity to provide linkages to the other front-line organizations that meet the needs of other affected populations?
- Are there organizations typically not involved with STBBI prevention that can become engaged (e.g., local housing providers, mental health service providers, addiction workers)?

Once you have done this exercise, briefly consider any possible unintended consequences of the adjustments themselves. If a strategy increases vulnerability for a population, the initial proposal should be re-examined. If the initiative has too many impacts and a realistic mitigation strategy is not possible, then alternative initiatives could be considered.

Step 4: Monitoring

In this step, you begin to identify ways to measure success for each mitigation strategy. Describe how you will monitor the initiative to determine its impacts within the priority populations you analyzed in Steps 1 and 2.

If your organization has tools already in place, such as formal program evaluations, you may choose to stay within those parameters. Once you have finalized the monitoring method, integrate it into the overall evaluation or performance measurement plan for the initiative.

Articulate the indicators of success or progress. Treat this Tool as a living document. Go back to it and compare your results to the original HEIA

objectives. The resulting data will enhance the evidence base and will inform your planning and initiative development process.

Here are some examples of tools you can use to monitor the initiative:

- Client surveys or questionnaires for members of priority populations
- Feedback from community partners
- Program evaluation that tracks measures of program success in the priority populations, such as STBBI rates
- Process evaluation to ensure that front-line service providers, developers, planners, and decision makers are integrating equity and the FIV into their processes and client interactions
- Focus groups with affected populations to see if their vulnerability has increased or decreased since the implementation of the initiative

Here are some examples of questions to ask in the monitoring process:

- Was the mitigation strategy implemented?
- Was the mitigation strategy effective, with no identified increases in risk? How do you know?
- What are some indicators that the organization can use to illustrate equity impacts?

Step 5: Dissemination

This step involves identifying ways to share results and recommendations of your STBBI HEIA. It is also important to share any lessons learned and any recommendations for addressing inequities and refining the FIV. Knowledge exchange allows other organizations to benefit from what you have learned and acts as a capacity builder for others to conduct their own STBBI-specific assessments.

Document any policies you revise or decision-making processes you change as a result of the assessment. This is useful for organizational memory and for reviewing any future initiative and its impact on populations. Document any suggested follow-up assessments or longer-term plans, such as a program redesign.

Remember to share your results and recommendations with stakeholders from non-health sectors, such as housing, transportation, social services, legal services, and other allied health professionals. Their initiatives and policies can have a substantial

impact on FIV. Raise awareness about the challenges and barriers facing many individuals at risk of STBBIs. This will foster the building of intersectoral interventions to decrease vulnerabilities and increase equity.

Here are some examples of ways to disseminate your lessons learned:

- Present a case study at a conference, in a webinar or through another media vehicle.
- Do a literature review or evidence summary.
- Summarize your results for other front-line organizations in your community.
- Lead a workshop or other professional development activity based on your experience within the organization and with community partners.
- Post the results of your STBBI HEIA on your website.

Here are some examples of questions to ask as you plan your dissemination activities:

- Where would be a logical place in the organization to document the results of the HEIA?
- What would be a good forum or strategy to disseminate the results?
- Who could the organization share the information with that previously has not been identified? For example, could the organization share the information with local housing providers, food co-ops, mental health services, or addiction and recovery services?
- What are some of the lessons learned by front-line service providers about completing an HEIA? For example, did you identify missing information or data that highlighted a need for more research about a particular population?
- What are some of the positive aspects of your HEIA?
- What are some of the challenges your organization faced throughout the process?
- What was the result of the process in its entirety?

Filling out the STBBI HEIA template using an initiative example

A community health centre is planning an initiative to increase its STBBI testing to include two evenings per week. It also wants to develop an ambitious poster awareness campaign to highlight the risks of barrier-less sexual activity in the community.

Background on the initiative

Some targeted messaging and awareness campaigns about sexual health and the risks of STBBIs have taken place in the last six months and some front-line service providers have noticed a trend that concerns them. Some of their clients (both men and women) have disclosed for the first time that they are not monogamous with their long-time partners and often do not follow safer sex practices when they are with other partners, who are often of the same sex. Most of the encounters are anonymous and arranged online. Clients are reporting that these websites guarantee confidentiality and have a large client base.

Clients are requesting more and more STBBI testing and it is putting pressure on workload at the clinic. While the tests have increased, no one has yet tested positive for HIV. A few positive STBBI results have been recorded but none that are required to be reported. Staff at the centre have had a few informal discussions and are concerned about both the increase in workload and how to best address the risks that clients may be taking.

A few of the nurse managers in the clinic have now decided to offer testing in the evening instead of during the day in an attempt to make people feel more comfortable and to be more culturally sensitive to the needs of their clients. As part of the strategy to address the risks that clients are taking, the clinic has also decided to embark on an ambitious awareness campaign about the risks of barrier-less sexual activity. The campaign will consist of posters in local restaurants, organizations, and agencies as well as one full-length bus advertisement. The posters will be modeled on community members in an effort to make the campaign more relevant and appealing. The campaign will launch in two weeks.

At the last staff meeting, staff expressed some concern that not everyone had the opportunity to provide input into the decision. To rectify this, all staff will take part in an STBBI Health Equity Impact Assessment to fully assess the proposed initiative.

Community profile

The community is an urban centre with a population of 100,000 and one core industry. Resource extraction provides a median yearly income of \$52,500 to most residents in this primarily blue-collar economy.

The most frequently spoken language at home is English, but there is a large population of families with European, Indian, and Asian backgrounds. There is also a large population of First Nation and Métis people.

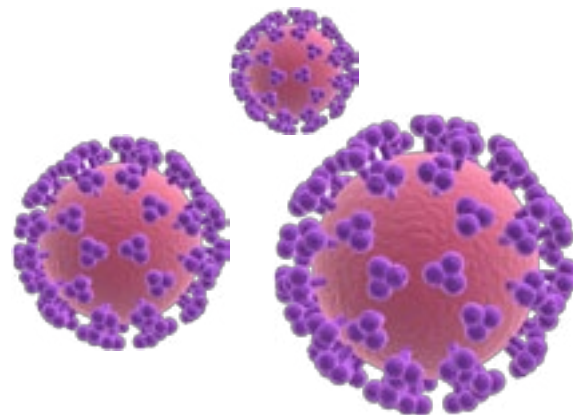
In the most recent national Canadian AIDS survey “Thoughts, Attitudes and Beliefs,” the community was identified as one that offered a number of sexual health services through the public health unit and community health centre, was home to an AIDS service organization (ASO), and had relatively low rates of reported HIV and reportable public health STBBIs. HIV tests (nominal, non-nominal, and rapid tests) are available and provided through the public health unit and the local ASO.

The ASO is not technically population-specific, but typically serves gay men and people living with HIV. Many of the clients are self-described past drug users and have had experience with violence, mental health issues, homelessness, and perceived discrimination in the mainstream health system. Much of the ASO’s programming is delivered by peers and volunteers who have first-hand experience of HIV and drug use, and often act as mentors.

There are some prevention programs, but resources are scarce. With advances in treatment, awareness of the risks of HIV and other sexually transmitted infections has decreased in the community. As a result, the community health centre and public health unit have become the primary prevention agents in the community.

 [Filling out the STBBI HEIA template using an initiative example \(view table\)](#)

 [Appendix A: STBBI HEIA Template \(view table\)](#)



Appendix B: [Link to Factors that Impact Vulnerability to STBBIs](#)