National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

PART OF THE
LEARNING FROM PRACTICE
SERIES

EQUITY IN INFLUENZA PREVENTION IN MANITOBA

PRIORITIZING POPULATIONS FOR INFLUENZA PREVENTION AT MANITOBA HEALTH, HEALTHY LIVING AND SENIORS

This story describes how Manitoba Health, Healthy Living and Seniors (MHHLS) prioritized Aboriginal communities in its response to the 2009-10 *H1N1 influenza pandemic (pH1N1)*, and used this experience to further develop influenza prevention and immunization equity measures.

Public Health planners and practitioners at the front lines are acutely aware that disadvantaged communities experience greater risks and poorer health outcomes during influenza outbreaks. They also know the challenges, during an influenza emergency, of reaching out to low income families, Aboriginal peoples, newcomers to Canada, street-involved and homeless youth, and people living with addictions and mental illness. During the 2009 H1N1 influenza pandemic, the need for an equity approach came sharply into focus for MHHLS. With the support of its Health Equity Unit, Manitoba's response was unique among Canadian provinces in identifying Aboriginal peoples as a distinct equity group related to H1N1 exposure.

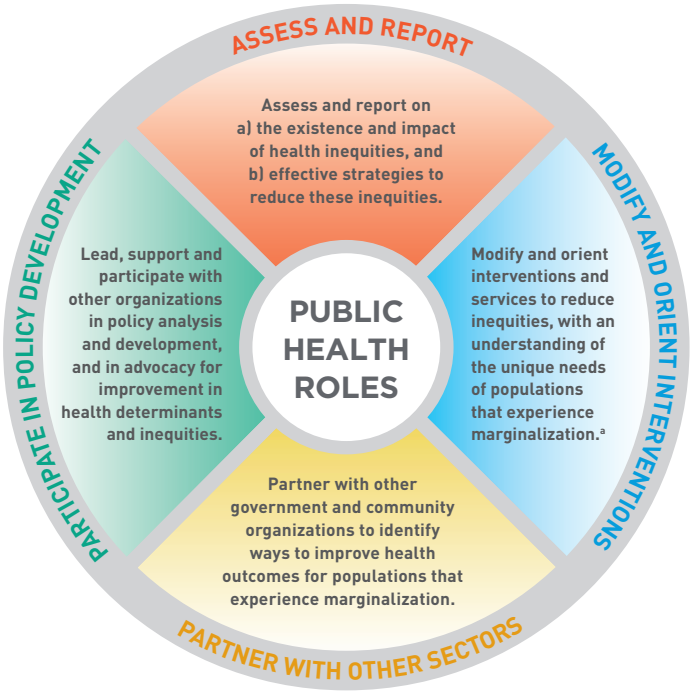
We hope this story about equity-focused influenza prevention at MHHLS will help guide other public health units in finding ways to reach people who experience barriers to adopting influenza prevention practices and to immunization services.

BACKGROUND TO THE STORY

Manitoba Health, Healthy Living and Seniors funds and oversees public health programs and services for 1.25 million Manitobans. MHHLS has been moving toward a greater health equity focus in all its work for almost a decade. One of six priorities identified in the department's overarching strategic plan is to improve health status and reduce health disparities amongst Manitobans. (3) In 2013, the Office of the Chief Provincial Public Health Officer with its Health Equity Unit was integrated into the Public Health Branch. Today, the Population Health and Health Equity Unit is responsible for equity aspects of education, surveillance and policy and program tools. (4)

FRAMING THE STORY

We have organized this story under the *four roles in the NCCDH's framework for action to reduce health inequities*. The roles framework, which is used by public health groups across the country, is described in the short document, *Let's talk... public health roles for improving health equity.* (2) The roles are: 1) assess and report on health inequities and effective strategies; 2) modify and orient interventions; 3) partner with other sectors; and 4) participate in policy development.



ROLE #1 ASSESS AND REPORT ON HEALTH INEQUITIES AND EFFECTIVE STRATEGIES

Manitoba Health, Healthy Living and Seniors considers effective disease surveillance to be a cornerstone of its approach, and the gathering and analysis of data on the occurrence of seasonal diseases is the foundation of the department's equity approach to influenza. It uses a variety of data sources, notably the Integrated *Public Health Information System (iPHIS)* and the *Manitoba Immunization Monitoring System (MIMS).* This data describes the geographic spread and intensity of activity in seasonal diseases, characteristics of those infected, as well as severity and trends, along with immunization rates across the province. It is used to guide prevention and control recommendations. Panorama, an integrated electronic public health record that enables real time surveillance of outbreaks, as well as population immunization levels, will soon replace iPHIS and MIMS, and is expected to help identify individual and group health needs, which is especially important for responding effectively with vulnerable populations.

In 2009, early surveillance of the H1N1 influenza outbreak indicated that First Nations communities were being particularly affected in Manitoba; from the beginning of the pandemic, First Nations communities showed a high incidence and rapid spread of the disease. At the same time, Public Health was aware that residents of Northern and remote communities face particular barriers to timely delivery of vaccines and anti-viral medication, and that disease prevention is hampered by overcrowded housing and lack of access to clean water and sanitation. Due to this understanding and to the ready availability of epidemiological data, the Incident Command Team was able to immediately implement measures to address inequities.

ROLE #2 MODIFY AND ORIENT INTERVENTIONS

Based on epidemiological evidence, MHHLS prioritized First Nations, Northern and isolated communities for early distribution of the H1N1 vaccine, post-exposure anti-viral medication and infection prevention and control supplies such as hand sanitizer. During the pandemic, the province added "Aboriginal descent" as a characteristic linked with increased risk of influenza, enabling First Nations, Inuit and Métis to be prioritized in influenza vaccine distribution. This policy change remains in place for annual influenza immunization, and applies to First Nations, Inuit and Métis living anywhere in the province. (5)

Much of the H1N1 awareness campaign conducted in First Nations communities was "grassroots." Community members, First Nations leaders, and stakeholder organizations were engaged, and citizens were informed of the campaign through local radio and newspapers. H1N1 prevention education materials were modified for Northern regions; more visual elements were added to respond to English not being a first language for many Aboriginal Peoples, as well as their often lower education levels.

During the H1N1 pandemic, the Health Equity Unit began adapting a *Health Equity Assessment Tool (HEAT)* that had been developed to address inequities among Maori Peoples in New Zealand. (6) They used three equity questions from the tool in all H1N1 response planning, which embedded equity in policy and program decisions related to influenza throughout the province. The questions were:

- What inequalities exist in relation to the health issue under consideration?
- What are the mechanisms by which the inequalities were created, maintained or increased?
- How could the proposed intervention affect inequalities?

ROLE #3 PARTNER WITH OTHER SECTORS

Manitoba Health, Healthy Living and Seniors credits much of its success in responding to Aboriginal health inequities—both during and after the H1N1 pandemic—to their strong multi-level partnerships. In serving First Nations and Métis communities, close collaboration was required among federal authorities, the provincial government, and Aboriginal organizations.

Partners were engaged at three levels: governance, policy and technical. Early in the pandemic, a high-level H1N1 Influenza Tri-Partite Table was formed, with members from federal and provincial government departments, the Assembly of Manitoba Chiefs, the Manitoba Métis Federation, and representatives of regional health authorities. This Table established important government-to-government relationships among federal, provincial and Aboriginal organizations and helped partners communicate about and resolve issues that arose during the crisis. The group found common ground and reached consensus on many issues. An indication of its effectiveness is that in response to a resurgence of H1N1 cases in 2013-14, the Assembly of Manitoba Chiefs recommended re-convening the Tri-Partite Table.

Parallel to the Tri-Partite Table, a policy-level Equity and Ethics Table was formed to advise the government on how best to reach vulnerable populations with prevention and treatment messages. First Nations, Métis, disabilities, immigrant and refugee organizations were members of this Table, which helped stakeholders and experts apply an "equity lens" to rapidly developing pH1N1 policies and initiatives.

Partnerships and linkages were also facilitated through the appointment of a First Nations physician and University of Manitoba School of Medicine faculty member as the Aboriginal Health Advisor on pH1N1 issues. Her role was to work with First Nations communities, leadership organizations and the federal government to further strengthen communications and coordination of the pH1N1 response.

ROLE #4 PARTICIPATE IN POLICY DEVELOPMENT

A number of significant policy changes grew out of Manitoba's pH1N1 experience. Most remarkably, the Health Equity Assessment Tool (HEAT) that was adapted during pH1N1 is now used in the design of *all* new MHHLS initiatives to ensure that health inequities are understood and addressed. (7) The Population Health and Health Equity Unit works with stakeholders—from inside and outside health—to promote equity-based policy development, and is developing health equity indicators and providing training on the use of health equity assessment tools within government. (8)

Equity considerations have been integrated into the evaluation of each new vaccine. Staff are required to use the vaccine evaluation template to consider issues of equal access for "First Nations on/off reserve, Métis, low income people, homeless individuals, low literacy level individuals, those with disabilities, new immigrants, etc." (9 p2). If a negative effect on health equity is predicted, staff must undertake a full health equity assessment before approval.

A heath equity statement has also been included in the province's Novel Influenza Plan that addresses new viruses and pandemics. One of the plan's principles is "all Manitobans, regardless of race, ethnicity, gender, socio-economic status, education level or geography should have equal access to all available pandemic influenza resources. Planning should ensure that disadvantaged groups are accounted for and accommodations are provided as necessary to ensure equal access to services" (10 p4)

The Public Health Branch is now finalizing the Manitoba Immunization Strategy 2015-2020, which identifies priorities and strategies for vaccine-preventable diseases among children and adults, including influenza. Stakeholder groups and the regional health authorities were involved in the development of the strategy and will be central to its future implementation. Its first guiding principle is equity. Socio-demographic factors—including socio-economic status, access to credible and accurate information and timely access to services, especially for rural, Northern, remote and isolated communities—are identified as barriers to immunization. (11)

CROSS-CUTTING PUBLIC HEALTH FUNCTIONS: LEADERSHIP AND CAPACITY BUILDING

Leadership and capacity building are important competencies in carrying out all four public health roles to address health inequities. MHHLS's focus on health inequities among Aboriginal peoples during pH1N1 evolved into broad health equity measures imbedded in other provincial public health frameworks and policies. It has also influenced national public health initiatives, and has contributed to revisions to the Canadian Pandemic Influenza Plan, specifically around understanding of First Nations and Métis inequities. And the department's efforts made Aboriginal ancestry a high-risk category for seasonal influenza prevention.

According to staff at MHHLS, while public health is a natural leader in the area of social and economic inequities, we can't assume that other parts of the health system and other sectors share this understanding and commitment. Leading and educating others is an ongoing responsibility. Staff notes, however, that there is a much better understanding of health inequities now compared to a decade ago.

LESSONS LEARNED

Manitoba Health, Healthy Living and Seniors' commitment to addressing health inequities is firmly entrenched, while implementation is "a work in progress," according to staff. Here are some lessons they are learning along the way.

Accurate data if fundamental: "Accurate data is fundamental to designing, implementing and evaluating an equity-focused program."

Educating others on the necessity of an equity focus is essential, ongoing work: MHHLS divides its health equity mandate into three domains: 1) access to health care including prevention, 2) access to the conditions that support health, beyond health care, and 3) access to public participation to influence policies, programs and services. Effectively addressing inequities in all three domains can be a challenge within and outside the health sector. "You need to cultivate 'buy-in' and commitment from all the stakeholders on the importance of a health equity lens if we are to narrow the gaps in access to health."

Take the time to involve partners in substantial ways: "Involve partners early and often. Not that it is always easy! But you will pay the price later if stakeholders are not fully engaged."

Success comes from tenacity and commitment: Prioritizing Aboriginal peoples for prevention initiatives resulted in high levels of vaccine coverage in this population. MHHLS was able to overcome significant logistical challenges in distributing vaccines and antiviral drugs to remote Northern communities; however, the approach was not always supported by decision-makers and required tenacity and commitment among public health leaders.

The hardest job is sustaining partnerships post-crisis: While staff noted the challenges of working closely with stakeholders during a pandemic, crises bring a helpful urgency to the partnership process. This energy can be difficult to sustain after the crisis is over.

Lessons learned during a crisis can be applied to non-crisis equity work: Manitoba's equity-focused, influenza prevention work evolved into policies and strategies for the province's annual influenza vaccination campaigns, for novel influenza outbreaks, and for an overarching approach to immunization.

For more information about this story and the health equity tools developed by MHHLS, contact Tiffany Heindl @ Tiffany.Heindl@gov.mb.ca.

This is one of two stories published by the National Collaborating Centre for Determinants of Health (NCCDH) as part of a National Collaborating Centre for Public Health (NCCPH) collaboration to improve the prevention and control of influenza in Canada (1). The two stories were developed in collaboration with staff from **MHHLS** or the **Saskatoon Health Region**.

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