Report of an equity-focused health impact assessment of a proposed universal parenting program in Manitoba

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ABSTRACT

OBJECTIVES: To assess potential inequitable impacts of a proposed Teen Triple P Positive Parenting Program (Teen PPP) in Manitoba to achieve equity of access and outcomes for families of diverse backgrounds; recommend (if required) alternative actions to promote greater equity of access and outcomes for families participating in Teen PPP; and evaluate the influence of recommendations on implementation of the proposed program.

INTERVENTION: An equity-focused health impact assessment (EfHIA) of the proposed Teen PPP was conducted, using a standard EfHIA framework. Methods used to assess potential Teen PPP impacts included: a literature review, key informant interviews and 14 community consultations. Evidence was analyzed, summarized and presented to the project Steering Committee (SC), along with draft recommendations for ensuring that equity is considered in Teen PPP planning and rollout.

OUTCOMES: The SC prioritized 12 possible inequitable impacts of Teen PPP with potential to prevent certain parents/caregivers either from accessing the proposed program or benefitting adequately from the program, causing them to drop out prematurely. Recommendations for avoiding these impacts were finalized by the SC and presented to provincial government officials responsible for the proposed program. Follow-up interviews with these individuals indicated that the recommendations were well received and raised equity-related issues that will be considered in future program planning decisions.

CONCLUSION: EfHIA is a proven planning tool for ensuring that health equity is considered in all policies, which is one of the necessary conditions for reducing inequities and closing the health equity gap throughout Canada within a generation.

KEY WORDS: Health impact assessment; health status disparities; vulnerable populations; parenting education

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In 2008, the World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) concluded that eliminating inequities in health is “an ethical imperative” and “a matter of social justice.”¹ Health equity impact assessment – also referred to as *equity-focused health impact assessment (EfHIA)* – was identified as a particularly effective tool for ensuring that attention to issues of health equity is integrated into all public policies and programs, including those that promote healthy childhood environments. The CSDH report recommended that governments build capacity for health equity impact assessment among policy-makers and planners across government departments.

In October 2009, the Strategic Initiatives & Innovations Directorate (SIID) at the Public Health Agency of Canada (PHAC) indicated an interest in supporting and resourcing EfHIA pilot projects in Canada. Members of the research team, based in the province of Manitoba, had recently been made aware of a proposed provincial government parenting program. Our research team, in partnership with the Director of the proposed program, decided that this would be an excellent opportunity to conduct an EfHIA to assess the potential for the program to have equitable outcomes for all parents. We were invited by the SIID to submit a proposal for piloting an EfHIA in Manitoba, which was accepted and funded in 2010.

An EfHIA was conducted on the proposed Teen Triple P – Positive Parenting Program, a program funded by the provincial Healthy

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Conflict of Interest: None to declare.

Child Manitoba Office (HCMO). The EfHIA project was conceptualized in two phases, which took place from the fall of 2010 through the fall of 2011. The first phase involved a comprehensive EfHIA of the proposed Teen Triple P Program. The second phase involved an evaluation of the EfHIA process and exploration of the lessons learned. In this paper, we report primarily on the first phase of the project.

Why conduct an EfHIA of a parenting program?

The Triple P Positive Parenting Program is an evidence-based population health promotion initiative that promotes positive parenting and healthy child development by helping parents to learn effective management strategies for dealing with a variety of childhood developmental and behavioural challenges.² Triple P uses a tiered system of interventions of increasing strength, ranging from media and information-based strategies, to more intensive levels of parenting training and behavioural family intervention targeting parenting skills and other family factors, such as marital conflict and high levels of parenting stress. Triple P programs have been shown to be effective in reducing child behaviour problems, dysfunctional parenting and/or parental stress (as reported by parents) in studies by Triple P researchers across many settings and with diverse groups of parents (e.g., parents of gifted children, Indigenous parents) in various countries (e.g., Australia, Japan, Switzerland).^{3–6} However, a PRISMA systematic review and meta-analysis conducted by independent researchers⁷ concluded that there was no convincing evidence that Triple P interventions work across the whole population or that any benefits are long-term.

The need for a culturally tailored parenting program for Indigenous Australians was expressed in the mid-1990s by Indigenous workers, who were concerned that mainstream parenting programs – including Triple P – were having difficulty recruiting and maintaining the involvement of Indigenous parents.^{8,9} A cultural adaptation of the mainstream group Triple P was developed following extensive community consultations related to program content, resources and delivery format. A randomized control trial⁹ of group Triple P for Australian Indigenous families found that a culturally tailored program for Indigenous parents in Australia, living in low-income urban areas with high rates of unemployment, appeared to break down some of the obstacles that Indigenous families face in accessing mainstream services.

The core Triple P program is intended for parents of children under 12 years of age. Teen Triple P extends the core program by providing evidence-based family interventions supporting parents of adolescents.^{10–12} It seeks to improve the quality of parent–teenager relationships and provide parents with effective, practical strategies for managing a wide range of common adolescent issues.

In 2005, HCMO began delivering the core Triple P program to support parents and provide them with parenting information, resources and assistance. The program began with a focus on families with children under age six. It was later extended to families with children aged birth to 12 years. In 2009, there were discussions about extending the program to include parents and caregivers of teenagers 12–16 years of age.

A key feature of Triple P is that the program is offered to all parents and caregivers in Manitoba, but participation is voluntary. There is evidence that universal prevention/health promotion programs that focus on education and/or individual behaviour

change can result in increased inequities in outcomes due to differences in access and uptake – the more socially disadvantaged being less likely or slower to access programs.^{13–15} Differences in access or uptake can be related to structural factors such as availability of programs, location, hours, availability of childcare, program content (cultural, literacy level) or perceptual factors such as previous negative experiences with health and social systems, belief that the program is intrusive or irrelevant, or shame about needing help or fear of being labelled or judged.^{16,17} In a preliminary report¹⁸ on implementation of the early-years Triple P program in Manitoba, released in the fall of 2010, factors that kept practitioners from using Triple P with families included literacy levels (17%), language barriers (13%) and racial or cultural concerns (7%). However there are no details about the specific nature of these issues or specific populations concerned.

In Manitoba, as elsewhere, health inequities – related to income inequality, social exclusion, gender, belonging to an Indigenous or racialized group, and/or living in remote areas – persist and in some cases are widening, even in times of economic prosperity.¹⁹ Children and youth who live in socially disadvantaged families often have more health and social difficulties than other children.²⁰ These families often face even greater challenges when it comes to parenting than other families. Psychosocial stresses associated with socially disadvantaged positions may affect the familial system, resulting in disturbed relationships, inter-familial conflicts and reduced familial support, which are important determinants of adolescents' health.²¹ Indigenous families face particular disadvantage due to a colonial legacy of intergenerational trauma associated with residential schooling, extensive loss of language and culture, experiences of racism and social exclusion, and low socio-economic status (and associated food, housing and employment insecurity) that have resulted in social conditions linked with parenting difficulties.^{22,23} Given the substantial health and social inequities that exist among families with children in Manitoba, and the evidence that the early-years Triple P program might not be benefiting all families, an EfHIA of the proposed Teen Triple P program offered a unique opportunity to assess the potential for it to have equitable outcomes for all parents/caregivers.

Objectives of the EfHIA

A comprehensive EfHIA was undertaken to:

1. assess potential inequitable impacts of HCMO's proposed Teen Triple P Positive Parenting Program (TTP) to achieve equity of access to and outcomes of participation in the program for families of diverse backgrounds, including marginalized and socially disadvantaged populations;
2. recommend (if required) alternative actions to promote greater equity of access and outcomes among diverse families participating in TTP; and
3. evaluate the influence of EfHIA recommendations on implementation of the proposed program.

EfHIA methodology, participants, setting

Equity is a core value of Health Impact Assessment (HIA),²⁴ but there is evidence that, in practice, equity issues have not systematically

been included.^{25,26} We decided to use an established equity-focused HIA framework²⁷ to guide the impact assessment process, in order to ensure that equity was considered at every stage. This EfHIA framework consists of several phases: *screening* (determining the suitability of a proposed policy or program); *scoping* (including establishing terms of reference [ToR], clarifying dimensions of equity, and data collection planning); *impact identification and assessment* (literature search, consultation with key stakeholders and target population, weighting and synthesis of evidence, identification of potential inequitable impacts); *recommendations* (to policy/program proponent for mitigating or avoiding inequitable impacts); and *monitoring and evaluation* of uptake of EfHIA recommendations. Since the EfHIA was conducted as part of a larger research project (which included a process evaluation), the screening step and certain aspects of the scoping phase related to data collection were predetermined by funding and ethics processes. The project was approved by the University of Manitoba's Research Ethics Board.

The scoping phase included the formation of a project Steering Committee (SC). The SC's core responsibilities included: establishing the ToR; approving the approach to collecting evidence; discussing progress in gathering evidence; and helping draft and finalize recommendations on program directions to HCMO decision makers. The SC consisted of several research team representatives, the Director of Parenting Initiatives at HCMO (the proponent), the EfHIA project manager, chairpersons of Parent-Child coalitions from the three study regions, a representative from Manitoba Aboriginal & Northern Affairs Department, and (non-voting) representatives from PHAC.

The following methods, approved by the SC, were used to assess potential TTP program impacts:

Literature Review

The Project Team analyzed evidence, gathered via a librarian-assisted literature search, of the health and well-being of teens and the impact of parenting support programs (including the Triple P program). Sources of information included English language literature (e.g., existing systematic reviews and meta-analyses of literature, peer-reviewed journal articles) as well as "grey" literature (e.g., reports from government agencies, unpublished reports from research groups), dating from 2003 to March of 2011. Approximately 142 sources were reviewed and a detailed synthesis of findings was completed.

Community Consultations

The goal of the consultation process was to give key stakeholders, and population groups at greatest risk to be differentially or inequitably impacted by the proposed program, an opportunity to identify a) potential impacts of the proposed TTP program and b) the extent to which parents/caregivers (P/Cs) and community agency managers (CAMs) envisaged differential impacts potentially occurring for different groups.

One or more general (i.e., open to all) consultation meetings with P/Cs were organized in each of the three geographic regions of Manitoba. However, in an attempt to better capture the varied needs of P/Cs from different cultural backgrounds and/or living circumstances, separate consultations were organized for newcomer P/Cs, Indigenous (First Nations, Métis and Inuit)

P/Cs, P/Cs who had youth with special needs, and P/Cs with LGBTIQ* youth. It was determined that sole-support/single P/Cs, and P/Cs living on low incomes or in poverty make up such significant proportions of the population that they were likely to be well represented among the above-mentioned groups. The demographic data we collected for P/C participants (in the form of a brief questionnaire provided prior to the consultations) proved this hypothesis to be true. We recognize that there are additional population groups to consider for focused outreach – e.g., P/Cs living in First Nations communities, foster parents, LGBTIQ P/Cs, P/Cs with disabilities, and visible minorities born in Canada. However, due to limited time and resources and jurisdictional challenges, it was decided to limit our outreach to the population groups listed above.

A variety of methods were used to recruit P/Cs for community consultation meetings, including delivering recruitment posters to community agency staff members for posting and distribution to clients. The eligibility criteria for P/Cs were the ability to speak/understand English and having children aged 12–16 years. For CAMs, any agency that was likely to offer the proposed program received a letter of invitation. A project staff member provided participants with a detailed review of key components found in the consent form at the start of the consultations, and assistance was provided to complete the forms when needed.

Fourteen community consultations were held in three regions of Manitoba (urban, rural and northern): 5 with 14 P/Cs (1 for Indigenous P/Cs in the northern region; 1 for all P/Cs accessing services in the rural region; 1 for P/Cs of youth with special needs in the urban region; 2 for newcomer P/Cs – refugees and provincial nominees/skilled – in the urban region), and 9 with 73 managers from agencies that provide services to parents of teens or teens themselves (1 northern; 1 rural; 7 urban).

In spite of efforts to reach out to P/Cs, only 5 of 10 planned P/C consultations went ahead due to lack of turnout. Our timelines did not allow for rescheduling of a "make-up" focus group/community meeting. All of the consultations with CAMs were completed. The Project Team reflected on reasons for the lower than desired P/C turnout, and identified potential contributing factors, including recognition that compensatory measures (honorarium, bus tickets) offered to offset anticipated barriers to participation might not have been enough to increase the relatively low priority that participation in an EfHIA would have had for many P/Cs.

The consultations were conducted in a structured manner using a focus group interview approach. P/Cs were first asked to share with the group some of the main issues they encountered when parenting their teen(s). They were asked to explore ways in which the TTP program may be able to help (and/or not help) in dealing with some of these issues. They were also queried as to what issues make it difficult for them or other P/Cs to participate in a parenting program, and to put forth recommendations that would make the program more accessible and/or relevant for families of varied backgrounds. Last, we asked P/Cs to consider any potential adverse impacts the program may have on them or other types of families and again put forth recommendations that might help to mitigate these in the future. The meetings with CAMs were structured in a similar way to those with P/Cs. However, unlike P/Cs, CAMs did not

* Lesbian, gay, bisexual, transgender, intersex and questioning.

fill out a demographic questionnaire, nor did they receive an honorarium. Moreover, the consent form, the PowerPoint presentation and the question guide for the CAM meetings differed from those used with P/Cs, not in content, but in terms of literacy and English language level.

Key Informant Interviews

Five officials working in the HCMO office were interviewed on an individual basis. These individuals were involved in the early consideration of the TTP program and/or involved in the management of the existing Triple P program for P/Cs with younger children. By speaking with HCMO key informants, the Project Team was able to get a better understanding of the TTP program and the potential for differential impacts from an internal government perspective.

Analysis

Evidence collected during the EfHIA (from the literature review, community consultations and key informant interviews) was analyzed thematically and summarized by the project team using evidence charts. An “All Evidence” Impacts Chart, combining evidence from the literature, the focus groups (P/Cs, as well as CAMs) and key informant interviews with HCMO/Triple P program officials (the proponents) was created. This chart noted for each potential impact of the proposed program: the types of sources (literature, focus groups or key informant interviews); an initial appraisal as to the direction of the impact (overall positive or negative impact expected for one or more populations, or unclear); differential impact (positive or negative) expected for some sectors of the population; impacts deemed to be *differential but not inequitable* (i.e., not related to some form of avoidable social disadvantage); and initial recommendations for maximizing positive impacts or avoiding/minimizing negative impacts.

In total, 46 potential impacts were categorized into three main sections: i) *Content & Core Principles of the Triple P Program* (12 of 16 impacts appraised as differential); ii) *Availability of the Program in Communities Throughout the Province* (four impacts, all of which were appraised as differential); and iii) *Approaches to Delivering/Implementing the Program* (21 of 26 impacts appraised as differential).

This summary of evidence produced by the project team was reviewed by research team members (who provided feedback regarding clarity and organization of the evidence) and presented to the SC, along with draft recommendations for ensuring that equity is considered in TTP planning and rollout. SC members then participated in a prioritization process – using rankings of high, medium or low priority – to determine from among 47 potential impacts and emerging recommendations those which, if addressed in planning and implementation of the proposed program, would hold the most potential to positively influence equity of access to, and equity of outcomes from, the program.

OUTCOMES

Potential inequitable impacts identified

Twelve potential inequitable impacts of the proposed TTP program were identified. Five were identified as having a high priority (i.e., essential to address) in order to achieve better equity of access and outcomes for the proposed program. Specifically, the SC was

concerned about the *potential* for inequitable program impacts regarding:

- lack of cultural appropriateness or safety, especially in relation to Indigenous families (e.g., not acknowledging intergenerational impacts of colonization on Indigenous families/caregivers)
- sporadic or no offerings in some communities if agency uptake is voluntary
- high literacy levels of the program not adequately meeting the needs of all parents/caregivers
- practical factors (child care, transportation, convenient location and physical accessibility, convenient hours, far-reaching advertising and marketing) not being incorporated consistently in program planning
- broader living conditions and circumstances in which parenting takes place not being fully addressed (e.g., income, housing, food security; education level and literacy).

The SC viewed these impacts as having the potential to prevent certain P/Cs – including those with low income or low literacy, and Indigenous P/Cs – from accessing or benefitting adequately from the program, causing them to drop out prematurely (which the literature review revealed is a significant problem with parenting programs).

Recommendations to prevent potential inequitable impacts

All identified potential inequitable impacts were accompanied by recommendations for preventing them. A review of the recommendations will show that some pertain specifically to the program itself, others pertain to issues associated with potential implementation inequities, while the remainder relate to other broader societal and environmental factors. Tables 1–5 list those recommendations that the SC identified as a high priority to address. The following assumptions underlying these recommendations were stated:

- With regard to the parent/caregiver groups for whom potential negative impacts are expected, it is recognized that there is tremendous diversity among any grouping of parents and caregivers.

Table 1. Recommendations related to cultural appropriateness and cultural safety

Conduct an independent, multidisciplinary review of Teen PPP content/curriculum and provider training, including a diversity/equity/anti-oppression review to identify any potential to reinforce privilege or discrimination (via biases or barriers); orientation and screening of program providers to foster a safe environment for parents/caregivers of diverse backgrounds; consideration of benefits and challenges of variations of homogeneous (e.g., distinct groups for single- and two-parent families) or heterogeneous group composition.

Specific to Indigenous families:

- include Indigenous elders and representatives of Indigenous organizations that have established relationships of trust with Indigenous families in the development of supplementary content and training modules focused on the profound social and intergenerational impacts of colonization on these families;
- foster or enhance relationships with agencies providing services to teens and their families on- and off-reserve;
- recruit and sufficiently fund local agencies with established relationships with Indigenous parents and communities to deliver the program.

Table 2. Recommendations related to sporadic or non-existent program delivery

Adequately resource/fund agencies such that they are able to deliver and systematically and rigorously evaluate the process and outcomes (impacts) of the Teen PPP – including indicators related to equity and the social determinants of health.
Prioritize funding for training and accrediting program providers serving First Nations communities and Indigenous families living off-reserve where they have indicated a need for and an interest in offering the program.

Table 3. Recommendations related to high literacy level of the program

Identify (for Triple P International) concerns re the high literacy level of assessment forms to enter the program and of the core program materials (e.g., parent workbooks and tip sheets). Request Triple P International to thoroughly assess this within the Canadian context and address this issue in upcoming publications.
Special consideration should be given to training program providers to adequately support persons with literacy challenges.

Table 4. Recommendations related to addressing broader living conditions and circumstances of parents/caregivers

That HCMO, in discussion with potential agency partners, assess the agencies' mechanisms for and competencies in broader needs identification and appropriate referral mechanisms, so that families' needs – beyond what Teen PPP meets – are adequately addressed (e.g., income, housing and food security; education and literacy; social inclusion).
That training for program providers include an orientation to available resources for specific groups of parents/caregivers (Indigenous, newcomers, low-income, special needs, etc.).
That, ideally, Teen PPP be offered in venues co-located with other agencies offering a broad range of health and social services and programs, to facilitate referral and access to families with multiple/complex needs.

Table 5. Recommendations related to practical factors in program planning and implementation

That agencies provided to the Teen PPP be sufficiently resourced/funded that they can provide adequate childcare transportation and food to address potential barriers to participation. HCMO should develop parameters related to this funding and assume a coordinating role to help resolve these practical program implementation issues.

- With regard to the recommendations made, it is assumed that HCMO will engage relevant community stakeholders in meaningful dialogue at all appropriate stages of needs identification, program planning, delivery and evaluation.
- It is recognized that all of the HCMO's programs and policies are part of an integrated whole-of-government strategy. This approach recognizes that any program or policy does not exist within a vacuum but is part of a broader planning context. Therefore, there are inherent limitations for any one program or policy to meet all unmet needs, and there is potential for other programs or policies to meet needs unmet by the program or policy in question.

Influence of the EfHIA recommendations

The recommendations were finalized by the SC and presented to the HCMO Management Team in June 2011. Follow-up interviews with HCMO officials during the fall of 2011 indicated that the recommendations were well received and raised equity-related issues that will be considered in future program planning decisions, both in relation to proposed TTP and other programs. At the writing of this paper, HCMO is undertaking a small TTP pilot project to further explore a number of the proposed recommendations of the EfHIA study with the goal of using the findings (and the associated EfHIA recommendations) to guide future TTP program planning.

DISCUSSION

To the best of our knowledge, this was the first EfHIA conducted on a proposed parenting support initiative, and the first comprehensive EfHIA conducted on a provincial government program in Canada. Rapid HIAs are commonly undertaken when time and/or resources are limited.²⁷ We were fortunate to have the time and resources to explore the EfHIA process in more breadth and depth. This comprehensive approach allowed us to i) develop a robust steering committee with a shared understanding of and commitment to an equity focus by all parties²⁸; ii) gather a wide range of evidence and iii) make a concerted effort to engage and draw upon the insight of a wide range of people involved in, or affected by, the proposed program. Engagement of program decision makers from early on in the process is considered ideal.²⁹ We were fortunate to have from the outset a high level of engagement from HCMO officials, who were committed to equity and willing to put themselves and one of their programs under the microscope for this project.

Participatory approaches are widely regarded as an essential mechanism for consideration of equity within HIA, as they offer an opportunity for those most likely to be impacted to have a voice and input into the HIA's recommendations.²⁵ In spite of our efforts to minimize barriers to participation in our community consultations, the P/C turnout was low. While this meant that we were unable to capture the views of some P/Cs who might be most at risk for inequitable impacts from the proposed program, we believe this limitation was offset to a certain extent by important insights gained through perspectives of CAMs who work with P/Cs of teens from marginalized populations.

Among those attending consultations, only a small percentage had direct knowledge or experience with Triple P (either as a trained practitioner or as a P/C having participated in a Triple P intervention). We believe this limitation was offset to a certain extent by the quality of information about the proposed program that was provided to participants before the consultation began.

This was the first time that Canadian collaborating partners had conducted an impact assessment, so the EfHIA pilot took longer than a typical or subsequent comprehensive EfHIA would be expected to take. A key learning was that, in the real world, conducting an EfHIA is not the neat linear process outlined in guidebooks. It is a complex process that requires iterative planning, incorporating learnings into EfHIA implementation and sometimes revisiting previous steps, based on learnings revealed throughout the process.

As with all impact assessments, the EfHIA findings are context-specific and not intended to be generalized beyond the particular setting and proposed program being assessed. However, we note that the high-priority potential inequitable impacts of the proposed program are not dissimilar to limitations previously noted in the literature about parenting programs in general – specifically, that socially disadvantaged or marginalized P/Cs are less likely to access or benefit from these programs, often due to factors such as program availability, location, hours, availability of childcare, and inappropriate program content. The concern about potential inequitable access and uptake of the proposed program by Indigenous P/Cs fits with the experience in Australia, where the Triple P program was modified in order to meet the needs of Aboriginal and Torres Strait Islander people.

CONCLUSION

The purpose of the EfHIA was to determine whether the proposed TTP program had the potential for inequitable impacts among parents and caregivers in Manitoba. The EfHIA confirmed the importance of taking an equity focus based on different kinds of evidence and shed some light on areas that will improve implementation of TTP and ensure that the most vulnerable populations access and benefit from the program. In particular, it raised awareness regarding limitations of parenting programs that may not adequately reflect kinship networks and Indigenous models of raising children and youth, and approaches that assume cultural universalism which might miss critical factors for success among Indigenous families. Key learnings were that a comprehensive approach to EfHIA takes time and resources to build skills, and that use of traditional consulting mechanisms may not work with marginal communities. To reach these groups would involve high levels of trust that is hard for researchers to build in their time frames, and needs to happen through engaging local civil society groups to act as brokers.

EfHIA is a proven planning tool for ensuring that health equity is considered in all policies, which is a necessary condition for closing the health equity gap throughout Canada within a generation. We suggest developing a plan to strengthen capacity for conducting EfHIAs that recognizes the other ingredients that will need to be in place – such as moving a whole-of-government approach to addressing social determinants of health inequities up the policy agenda, along with mechanisms to institutionalize a) health equity in all policies and b) meaningful civil society engagement in developing public programs and policy.

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RÉSUMÉ

OBJECTIFS : Évaluer les effets potentiellement inéquitables d'un projet de programme de pratiques parentales positives (Triple P) pour les parents d'adolescents au Manitoba afin d'offrir un accès et des résultats équitables aux familles de divers milieux; de recommander (au besoin) des mesures de rechange pour promouvoir plus d'équité dans l'accès et les résultats des familles participant à *Teen Triple P*; et d'évaluer l'influence des recommandations sur la mise en œuvre du programme proposé.

INTERVENTION : Nous avons mené une évaluation d'impact sur la santé axée sur l'équité (ÉISAÉ) du programme *Teen Triple P* proposé, à l'aide d'un cadre d'ÉISAÉ type. Les méthodes suivantes ont servi à évaluer les

effets potentiels de *Teen Triple P* : une revue de la littérature spécialisée, des entretiens avec des informateurs et 14 consultations communautaires. Les données probantes ont été analysées, résumées et présentées au comité directeur (CD) du projet, accompagnées de recommandations préliminaires pour que l'équité soit prise en compte dans la planification et le déploiement de *Teen Triple P*.

RÉSULTATS : Le CD a priorisé 12 effets inéquitables possibles de *Teen Triple P* qui risqueraient d'empêcher certains parents ou aidants d'accéder au programme proposé ou d'en bénéficier convenablement, ce qui les ferait abandonner prématurément le programme. Les recommandations pour éviter ces effets ont été parachevées par le CD et présentées aux fonctionnaires provinciaux responsables du programme proposé. Des entretiens de suivi auprès de ces personnes ont indiqué que les recommandations ont été bien accueillies et qu'elles ont soulevé des questions d'équité qui seront prises en compte dans les futures décisions de planification du programme.

CONCLUSION : L'ÉISAÉ est un outil de planification éprouvé pour que l'équité en santé soit prise en compte dans toutes les politiques, ce qui est l'une des conditions nécessaires pour réduire les iniquités et combler le fossé de l'équité en santé partout au Canada en une génération.

MOTS CLÉS : évaluation d'impact sur la santé; disparités d'état sanitaire; populations vulnérables; information aux parents