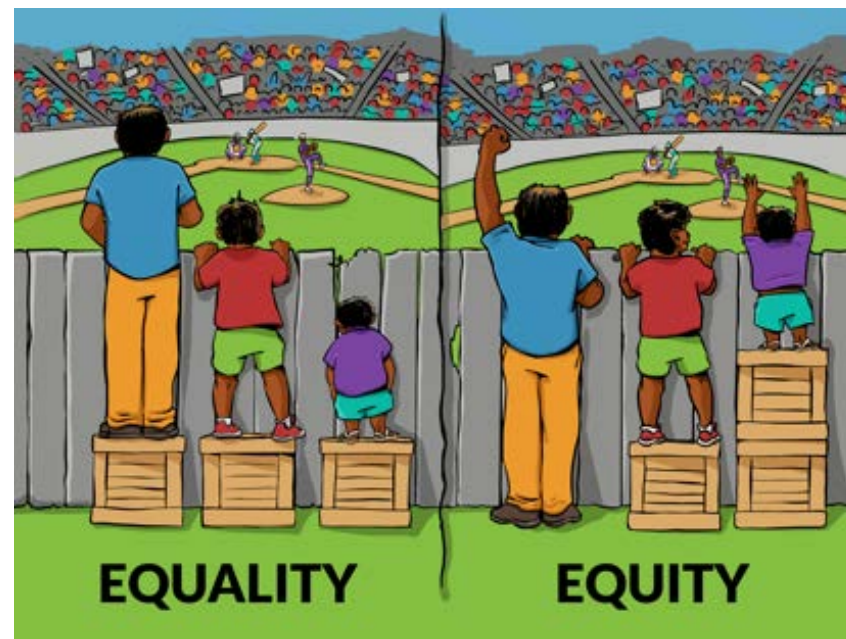


SPER is encouraging all presenters to consider how their research either could or does *impact* or *incorporate* health equity and to include this in your oral and poster presentations



<https://www.impacttulsa.org/impacttulsa-equity-in-education-defining-equity/equality-vs-equity/>

What does this mean?

- The next 3 slides give some background and examples
- Feel free to incorporate any or all concepts in this document throughout your presentation/poster OR as a specific segment/slide

Consideration 1: Could our findings regarding a clinical, policy, or public health advance inadvertently exacerbate inequities if implemented?

- Why? Persons with more advantage in terms of resources, social networks, education, power, etc. are better able to take advantage of clinical and public health advances, whereas persons/groups with fewer advantages are often 'left behind'.^{1,2}
- Example:
 - Neonatal intensive care surfactant therapy: Population-level interventions to improve care of premature and low birthweight infants in Brazil resulted in widening socioeconomic inequities because they initially only reached well-off families³

¹Link BG, Phelan J. Social conditions as fundamental causes of disease. 1995

²Frohlich KL, Potvin L. Transcending the known in public health practice: the inequality paradox: the population approach and vulnerable populations. 2008.

³Victora CG, Barros FC, Vaughan JP. The impact of health interventions on inequalities: infant and child health in Brazil. 2001.

Consideration 2: How can we frame our research to acknowledge health inequities and avoid inadvertently placing 'blame' on those who experience health risks or poor outcomes?

- Research questions and presentation of findings frequently puts the burden of blame or responsibility on affected individuals
- Examples:
 - Stating a certain race or ethnicity is associated with an adverse health outcome without any context about racism and other structural causes
 - Framing a research question around obesity in pregnancy entirely on individual decision-making and not using people-first language (<https://odr.dc.gov/page/people-first-language>)

Consideration 3: Do our data or methods prevent us from giving full attention to health equity? How could we change this in future studies?

- Examples:

- Our single-institution cohort is not racially and ethnically diverse
- Socioeconomic measures are missing or poorly measured in our dataset
- Race/ethnicity is not collected in our dataset; are we in a position to request or advocate for collection of race/ethnicity in future?
- We have included social constructs such as race, gender, or socioeconomic status in our regression model, but have not clarified their meaning
- We have not considered whether our exposure-outcome relationship differs by social factors such as race, gender, or socioeconomic status (i.e., effect modification)