Checklist

for Analysing Equity in Health Strategies, Programmes and Activities (SPAs)

MINISTERIO
DE SANIDAD

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Pilot process for the tool in November 2019 at a workshop organized by the Directorate-General for Public Health and Participation of the Department of Health and Consumer Affairs of the Autonomous Community of the Balearic Islands.

Drafted: November 2021

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Approved by the Health Promotion Committee on 14 March 2022

Approved by the Public Health Commission on 17 March 2022

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Presentation

The purpose of this checklist is to analyse a health strategy, programme or activity (SPA) focusing on equity and social determinants of health (SDH), in order to identify and create proposals for their improvement that integrate an equity approach into that SPA.

This tool is an updated version of the checklist that forms part of the first phase of the process in the 2012 Methodological Guide to Integrating Equity into Health Strategies, Programmes and Activities **(1)**. The checklist has been updated to create a tool which, in itself, makes it possible to carry out an analysis focusing on equity and SDH, and to define proposals for improvement.

A draft of the checklist was drawn up in November 2019, when a pilot version was tested in a workshop organized by the Directorate-General for Public Health and Participation of the Department of Health and Consumer Affairs of the Autonomous Community of the Balearic Islands, during which the participants applied the checklist to programmes in different areas, such as: hearing loss screening, cancer screening, sexual health, nutrition and physical activity, and health promoting schools. Thanks to this workshop, the checklist was analysed and improvements included in the final version.

To this end, a review was conducted based on prior work since 2010, which constitutes the aforesaid Guide **(1)**, and on the experience acquired until that time in different national and international training processes and other actions integrating equity into specific contexts, mainly:

- Reflection tool on how to integrate equity at the local level as part of the Strategy for Prevention and Health Promotion in Spain's National Health System, created in 2015 **(2)**.
- Screening tool for Health Impact Assessment (HIA) of national policies, designed by the Ministry of Health in 2014 **(3)**.
- Proceso formativo multi-país organizado por la Oficina Regional de la Organización Mundial de la Salud (OMS) para Europa con el apoyo del Ministerio de Sanidad: Multi-country training on reorienting strategies, programmes and activities on MDG 4 and 5 towards greater health equity with an explicit but not exclusive focus on the Roma population[1].
- The Innov8 Approach to examine national health programmes so that no one is left behind, carried out by WHO with the participation of the Ministry of Health, Social Services and Equality in 2016 **(4)**.
- Review of other tools and bibliography **(5, 6, 7)**.

Frameworks and models already developed by different national and international commissions were used to analyse SDH (see **Appendix I**). Within equity in health, gender is analysed as one of the SDH, and therefore the checklist specifically addresses gender issues.

[1] **https://www.euro.who.int/en/health-topics/health-determinants/social-determinants/news/news/2013/03/the-former-yugoslav-republic-of-macedonia-hosts-multi-country-training-on-how-to-achieve-greater-health-equity-for-roma**

Background

Equity in health cannot exist simply as a concept; it must be reflected and mainstreamed into every public health initiative, based on tangible, purposeful and measurable actions.

Health is determined by the circumstances in which people are born, grow, live, work, and age, which includes the health system. These circumstances are known as *social determinants of health*. These SDH are distributed unequally, leading to the appearance of social inequalities in health, which are unjust, systematic and avoidable differences between population groups, defined socially, economically, demographically, or geographically (8).

When a *strategy, programme, or plan* is created, it must be designed with the intention of reaching the entire target population. Analysis using an equity approach, as in the case of this tool, makes it possible to verify who is being reached, and who is not. All with the aim of proposing improvements to advance in terms of SPA effectiveness and equity.

Moreover, these aspects mean that, to analyse equity in health actions, it is important to incorporate an SDH approach, reflected in: intersectoral work to achieve Health in All Policies, including effective participation of the community in designing policies as a form of redistribution of power, and analysing policies and actions to determine whether they are providing a response to different population groups.

This checklist enables the analysis of these aspects, making it a useful tool for improving health SPAs overall.

Purpose of the checklist

To analyse a health SPA with an equity and SDH approach, in order to identify and create proposals for their improvement that integrate equity into that SPA.

Who is the tool's target audience?

Professionals working on health SPAs and decision-makers who want to improve the integration of equity into these SPAs.

How is this tool used?

The tool comprises a series of questions making it possible to verify whether this is an equity and SDH approach and to reflect on this in order to identify proposals for improvement to advance towards equity.

It can be used both while planning an SPA, or during its implementation or evaluation. In the event of applying this analysis before the SPA has been implemented, the questions regarding its implementation, outcome, and evaluation are to be answered according to its planned implementation and evaluation.

For this checklist to be as enriching as possible, it is advisable for different people to participate who have different roles related to the SPA: for instance, people involved in the planning, implementation, and evaluation of different sectors, and also of the SPA's target population.

This tool, in itself, enables a detailed analysis with an equity and SDH approach, and the identification of proposals for improvement. Those interested in conducting a more in-depth analysis may move on to the review and re-design phases set forth in the Methodological Guide **(1)**, which includes the first version of this checklist.

Key concepts for using the checklist

- **Equity in health:** This means that people are able to achieve their maximum health potential, regardless of their social position or other circumstances determined by social factors **(1)**.
- **Social inequalities in health:** These are unjust, systematic, and avoidable differences between population groups, defined socially, economically, demographically, or geographically **(1, 8)**.
- **Social determinants of health (SDH):** The circumstances in which people are born, grow, live, and work, and a wider set of factors that mould their living conditions and have an impact on health. There are different models to explain SDH; highlights among them include those developed in 1991 by Dahlgren and Whitehead **(9)**, by the WHO Commission on Social Determinants of Health in 2006 **(10)**, by Spain's Commission to Reduce Health Inequalities in 2010 **(11)**, and by the Pan American Health Organization (PAHO) Commission on Equity and Health Inequalities in the Americas **(12)**. **Appendix I** presents these models in more detail.
- **Gender:** This SDH refers to the norms (beliefs about women and men, boys and girls that are handed down from generation to generation), roles (what is expected of women and of men, and boys and girls, in society), and socially defined relations (based on the norms and gender roles that often create hierarchies that lead to unequal power relationships) between women and men **(5)**. It also refers to gender expressions and identities.
- **Community participation:** A process by which different actors in the community get involved–directly or indirectly–in decision-making and/or in planning, designing, coordinating, implementing or evaluating services, using methods of consultation, collaboration and/or empowerment **(13)**.
- **Intersectionality:** A concept that describes the ways in which systems of inequality -based on gender, race, ethnicity, sexual orientation, gender identity, disability, class, and other forms of discrimination- intersect and reinforce each other to create unique dynamics and effects. Therefore, they must be analysed and addressed simultaneously to prevent one form of inequality from reinforcing another **(14).**
- **Intersectoral action in health:** A recognized relationship between the health sector and other sectors, which has been formed to take action on an issue or to achieve health outcomes in a way that is more effective, efficient, or sustainable than could be achieved by the health sector working on its own **(10).**

Areas addressed by the checklist

The checklist to analyse an SPA has 11 sections:

1) GOALS OF THE SPA
2) JUSTIFICATION FOR CARRYING OUT THE SPA
3) POPULATION NEEDS ASSESSMENT
4) SPA TARGET POPULATION
5) SPA INTERVENTIONS OR ACTIONS
6) IMPLEMENTING SPA INTERVENTIONS OR ACTIONS
7) INTERSECTORAL WORK
8) PARTICIPATION
9) SPA OUTCOMES
10) REFLECTION ON THE SOCIAL DETERMINANTS OF HEALTH
11) EQUITY CHALLENGES

These sections are structured as different questions, which are then answered. A list of these questions is included as **Appendix II**.

Checklist form

Name of the SPA	
Institution responsible for the SPA	
Starting date of the SPA	
Current development phase of the SPA (e.g. planning, implementation, evaluation, or redesign)	Planning
People participating in filling out the checklist (name and relationship to the SPA)	
Date of filling out the checklist	

1. Objectives of the SPA

1.a. List the general and specific objectives of the SPA

GENERAL OBJECTIVES	SPECIFIC OBJECTIVES

1.b. Is there an equity objective? Are there objectives aimed at a specific population group? Which ones?

An equity objective must specifically aim to reduce social inequalities in health which may exist within the framework of the SPA.

Even if a SPA's objectives are universal and in principle do not exclude any population group, this does not mean that they are inclusive/equitable and leave no one behind. This requires using a proportionate universalism approach: the actions must be universal (for the entire population), but implemented proportionally, according to the needs of the different population groups **(15)**.

2. Justification for carrying out the SPA

2.a. What is the justification for carrying out the SPA? What value is provided by the existence of this SPA?

2.b. Has a situation analysis been conducted as part of the SPA's approach framework which considers equity and social determinants of health?

This analysis must take into account such aspects as:

- Which social determinants influence the issue or topic addressed by the SPA, and how.
- The context associated with the subject addressed by the SPA.
- Distribution in the population according to such inequality axes as: territory, social class, gender, age, educational level, disability, ethnic group, employment status.
- Legal framework and other strategies or plans that may influence the SPA.

3. Population needs assessment

To carry out a SPA, it is necessary to conduct a population needs assessment regarding the topic that the SPA addresses. This needs assessment can be carried out in different ways.

It is important for the needs analysis to be qualitative as well as quantitative, and that it involves the target population's participation.

3.a. On what sources of information was the population needs assessment based?

Some examples are: expert opinions, review of official databases (e.g., use of services, epidemiological data, complaints and suggestions), population surveys, use of qualitative methods incorporating population participation, comparison with needs of populations having similar characteristics.

3.b. What are the principal needs detected?

3.c. Have the specific needs of different population groups been analysed?

If so, describe how they were studied, and which population groups were targeted.

3.d. Are all the needs detected expressed as objectives/actions of the SPA? Indicate needs not included.

4. SPA target population

4.a. What is the SPA target population?

Describe its sociodemographic characteristics, location, etc.

4.b. Are there population groups already specifically identified in the SPA within the target population?

It should be analysed whether, within the SPA target population, groups are specifically identified. As a general guide for this purpose, the list of variables measuring social inequalities in health (axes of inequality) in the following table may be used. Not all of these variables have to be applicable to every SPA, nor is this an exhaustive list. Besides those on this list, there may be other population groups to consider, based on the purpose of each SPA.

Lines of inequality	Population group identified in the SPA	Main purpose
Age		
Gender		

Socio-economic level		
Employment status and working conditions		
Sexual orientation		
Gender identity		
Territory[2]		
Ethnic group		
Persons with disabilities		
Country of origin		
Other (describe):		

[2] Also considering the rural/urban variable.

5. SPA interventions or actions

5.a. Type of SPA interventions or actions

List the interventions of the SPA. This refers to an action that enables the achievement of one or more objectives of the SPA. In the case of a Strategy, if there are no explicit interventions, describe its lines of action.

Subsequently, classify the interventions according to whether they target the individual level (e.g. actions at the outpatient services, health education actions or a pharmacological intervention) or they are inventions seeking to act upon determinants at the population level, modifying situations and environments in ways that influence health (e.g. community action, excise taxes on cigarettes or alcohol, legislation to regulate the content of salt or fats in food, environmental legislation, urban planning, changing the social environment).

Interventions / actions	Does the intervention target individuals?	Does the intervention aim to change the situation and environment in which the population lives?
1.		
2.		
3.		
4.		
5.		
6.		
7.		

5.b. How effective are the interventions/actions you have just described?

It is important to reflect here on what justifies each one of the interventions or actions proposed, whether because they have been evaluated and are having positive outcomes that show their effectiveness, or because, based on the available evidence or based on a successful experience elsewhere which, due to it being a similar situation, is considered transferable.

This reflection is important, because it would not be advisable to continue including equity in actions/activities that are ineffective or that are not justified by the evidence or other available experiences.

Interventions / actions	Is it effective?*		
	Yes	No	Don't know**
1.	○	○	○
2.	○	○	○
3.	○	○	○
4.	○	○	○
5.	○	○	○
6.	○	○	○
7.	○	○	○
	○	○	○
	○	○	○
	○	○	○

***Effectiveness should be assessed in terms of the different axes of inequality. Is it equally effective for men and women? According to age?**

****In this case, it is especially important to investigate/study the effectiveness of these actions.**

5.c. How are the interventions/actions adapted or reformulated for different population groups, and how do they complement each other?

In other words, whether different aspects are taken into account —such as the gender perspective, age, educational level, different working conditions and geographical location— when developing the interventions.

5.d. Has a gender perspective[3] been taken into account in designing the SPA actions?

The assessment of the incorporation of a gender perspective does not have to be limited to evaluating whether the SPA targets men and/or women and to presenting disaggregated data; it should also assess approaches and actions intended to reverse gender stereotypes and to show gender sensitivity, respect for diversity, and a rights-based approach.

For example, it should be assessed whether there are interventions aimed at advancing gender equality, the empowerment of women, and/or changes in men towards attitudes more favourable to equality.

5.e. Is there a population group that is or could be left behind by the SPA approach (population that does not have access to or benefit from it)? How can this be remedied?

It is appropriate to conduct this reflection using the approach of Tanahashi's effective coverage model **(16)**. This model identifies different factors that can occur over the course of the SPA implementation that determine the population's access to it, by acting as barriers or facilitators (see **Appendix III** for the types of factors).

Identify the population groups that you consider are being or could be left behind in the SPA approach, and what kind of factors (availability, accessibility, acceptability, acceptability, contact or use of services, see **Appendix III**) do you think could come into play in these cases.

[3] See the concept of gender in the section on **Key Concepts**.

To this end, for each of the SPA interventions and actions, fill in the following table to analyse who is being left behind or could be left behind at each stage, and which factors are acting as barriers (-) or facilitators (+).

Intervention or action	Population group left behind	Availability		Accessibility		Acceptability		Contact with services	
		(-)	(+)	(-)	(+)	(-)	(+)	(-)	(+)
		◯	◯	◯	◯	◯	◯	◯	◯
		◯	◯	◯	◯	◯	◯	◯	◯
		◯	◯	◯	◯	◯	◯	◯	◯
		◯	◯	◯	◯	◯	◯	◯	◯
		◯	◯	◯	◯	◯	◯	◯	◯
		◯	◯	◯	◯	◯	◯	◯	◯
		◯	◯	◯	◯	◯	◯	◯	◯
		◯	◯	◯	◯	◯	◯	◯	◯
		◯	◯	◯	◯	◯	◯	◯	◯
		◯	◯	◯	◯	◯	◯	◯	◯

6. Implementation of the SPA interventions or actions

6.a. Who implements each of the interventions or actions?

Interventions/actions	Who implements them
1.	
2.	
3.	

4.	
5.	
6.	
7.	

6.b. How are these actors coordinated?

6.c. Have the people implementing the SPA been involved in its design? In what way?

6.d. Is there information on the SPA publicly available (online or otherwise)?

6.e. Have the gender perspective, intercultural sensitivity, disability, and the diversity of the target population been considered, with an intersectional approach[4], in disseminating the SPA, drafting its materials, and the messages being conveyed? How has this been done?

For example: inclusive, non-sexist and non-ethnocentric written and visual language; materials accessible to different age groups, persons with disabilities, languages, and patterns of use/access to dissemination channels, seeking common elements among the different social groups and communicating from a standpoint of shared objectives and values, instead of only representing the sum of these identities.

7. Intersectoral work

7.a. What sectors of the public administration are participating in the development of the SPA?

Describe the sectors with which work is being carried out in the framework of the SPA, and what is the aim of their working together, on a case-by-case basis. Below is a non-exhaustive list of sectors. Not all of them are applicable to all SPAs, and there may be sectors involved that are not on this list.

Sectors	Is the topic addressed by the SPA related to this sector?	What actions are being carried out with this sector?*	Why is joint action being carried out with this sector**	Form of coordination ***
Health sector	Don't know			
Education	Don't know			
Social policy	Don't know			
Equality	Don't know			

[4] See definition of Intersectionality.

Urban planning	Don't know			
Housing	Don't know			
Employment	Don't know			
Economy	Don't know			
Agriculture	Don't know			
Environment	Don't know			
Transport	Don't know			
Law enforcement bodies	Don't know			
Other (specify):	Don't know			

*For example: joint work to design, develop or implement a specific action, for assessment, etc.

**Such as, for example: achieving greater coverage, consultation to define a policy or regulation, conducting a campaign, resolving a specific topic, joint planning to achieve common objectives.

***For example in a permanent working group, a committee, or occasional contact.

7.b. What challenges or difficulties exist in carrying out intersectoral work? How can they be overcome?

7.c. How is coordination established with other related plans/SPAs?

8. Participation

8.a. Which population groups or social organizations are participating in this SPA, and how are they participating?

Population groups / organizations*	Participating in**			Degree of participation***
	Design	Implementation	Evaluation	
	Don't know	Don't know	Don't know	
	Don't know	Don't know	Don't know	
	Don't know	Don't know	Don't know	
	Don't know	Don't know	Don't know	
	Don't know	Don't know	Don't know	
	Don't know	Don't know	Don't know	

*Include a description of the population group/organization, if necessary.

**It is also important to address the following questions: Have the objectives been agreed upon in a participatory manner? Has there been participation in needs detection? Has there been social participation in identifying the SPA target population?

***For example, if they have been informed about the SPA, they have been consulted, they have participated actively, and there has been shared leadership.

8.b. Are all population groups of interest involved? Which ones?

Are there relevant population groups that are not participating in the SPA?

Have men and women participated equally (parity is considered achieved when the participation falls between 40% and 60%)? Have other groups participated according to axes of inequality? Have work-life balance measures been introduced to enable participation?

8.c. What challenges or difficulties are there for the participation of the population within the framework of the SPA? How can they be overcome?

For example: times when meetings are scheduled, deadlines, choice of venues, workload that participation involves, and how these elements are connected.

9. Outcome of the SPA

9.a. What do you hope to achieve by implementing the SPA?

9.b. What indicators are considered most important for the SPA?

Both process indicators (measuring aspects related to the activities' implementation) and outcome indicators (measuring the achievement of objectives) may be identified.

9.c. How is the SPA assessment being carried out, and who is participating?

9.d. What outcomes has the SPA achieved so far?

9.e. What equity indicators are being measured as part of the SPA?

These are indicators that enable analysis disaggregated by socio-economic variables, e.g. sex, age, social class, and educational level, and by small geographic areas or situations of vulnerability. There can also be process indicators that measure the participation of other sectors in the SPA, or the participation of the population.

9.f. Have the outcomes achieved been the same for all population groups? Please provide details.

10. Reflection on the social determinants of health

10.a. Considering the framework of social determinants of health [5], mark those which you consider to have an influence on the SPA, and explain how they influence it and at what level:

Structural determinants		Does it have an influence on the SPA?
Socio-economic and political context	Government and political tradition	Don't know
	Macroeconomic policies	Don't know
	Labour policies	Don't know
	Social policies	Don't know
	Health policies	Don't know
	Education policies	Don't know
	Environmental policies	Don't know
	Climate change	Don't know
	Culture and social values	Don't know
Socio-economic position / axes of inequality	Education	Don't know
	Job	Don't know
	Income	Don't know
	Territory	Don't know
	Gender	Don't know
	Ethnicity	Don't know
	Other	Don't know
Social cohesion		Don't know

[5] Table based on the framework of the WHO Commission on the Social Determinants of Health, of the Commission for Reducing Health Inequalities in Spain, and on the model of the PAHO Commission on Equity and Health Inequalities in the Americas (see Appendix I).

	Intermediary determinants	Does it have an influence on the SPA?
Material resources	Housing and material situation	Don't know
	Neighbourhood conditions	Don't know
	Environmental conditions (green areas, water quality, energy, air quality, noise)	Don't know
	Affordability of basic goods	Don't know
	Public transport	Don't know
	Working conditions	Don't know
	Domestic and care work	Don't know
Psychosocial factors	Psychosocial stress	Don't know
	Public safety and security	Don't know
	Social support and networks	Don't know
	Work-life balance	Don't know
Lifestyles	Food	Don't know
	Physical activity	Don't know
	Tobacco use	Don't know
	Alcohol use	Don't know
	Use of other drugs or other addictions	Don't know
	Sexual practices	Don't know
Health system	Availability of health system services	Don't know
	Accessibility of health system services	Don't know
	Acceptability of health system services	Don't know

10.b. After assessing which social determinants influence the SPA, and how, do you see an intersection of several determinants in any group which may multiply disadvantages and which need to be taken into special consideration[6]?

11. Challenges and proposals for improving equity

11.a. Considering your experience, and after the analysis conducted in each section of this checklist to be filled in, which do you believe to be the major equity challenges that the SPA should address, and what improvements would you suggest to better integrate equity?

To advance towards equity in health, it is important to analyse each one of the sections and to identify proposals for improvement in response to the opportunities and challenges that have been detected and analysed. Addressing these will enable integration of equity into the SPA.

1) Objectives of the SPA	
2) Justification for conducting the SPA	
3) Population needs assessment	
4) SPA target population	
5) SPA interventions or actions	

[6] See definition of Intersectionality.

6) Implementation of the SPA interventions or actions	
7) Intersectoral work	
8) Participation	
9) SPA results	
10) Reflection on the social determinants of health	

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Appendix I[7]

There are several conceptual models that help us understand the interrelationship between social determinants of health and social inequalities in health. These models share a common approach, which is to establish a hierarchy among the social determinants of health.

One of the most widely used models is **Dahlgren and Whitehead's 1991 model (9)**, which considered social and community networks and socio-economic, cultural and environmental conditions as the genesis of individuals' health, in an ecological conceptual framework where individual determinants are integrated with collective ones (figure 1).

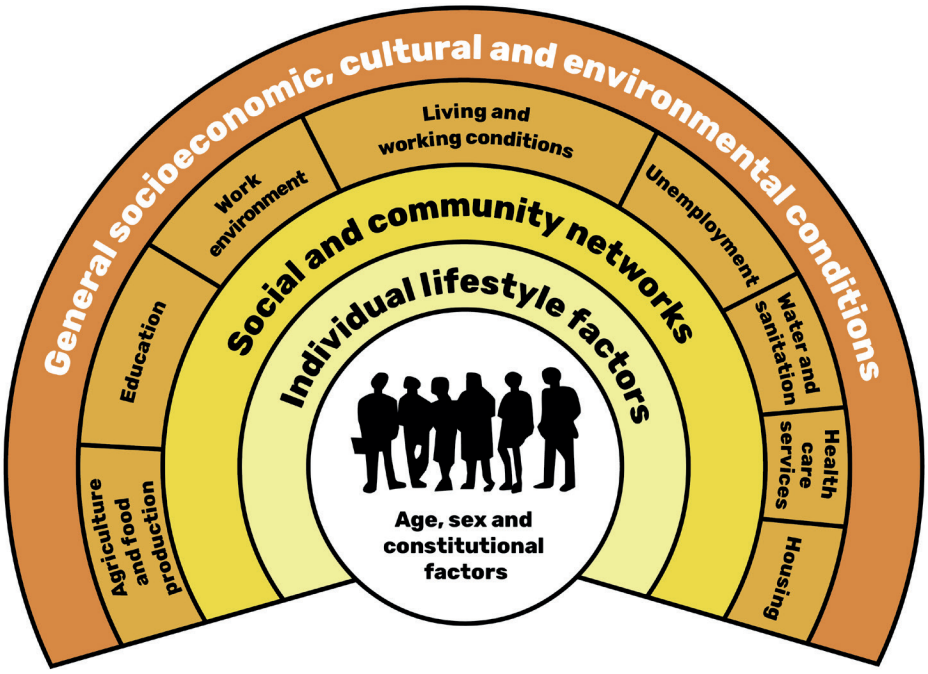

Figure 1. Dahlgren and Whitehead's model (1991)

In 2008, the **WHO Commission on Social Determinants of Health's Conceptual Framework of Social Determinants of Health (SDH)** was created (figure 2) **(10)**. This framework classified the determinants of health inequalities into two types: structural and intermediary. Structural SDHs are those that shape the socioeconomic and political environment where people live, and include the public policies present in a given context, as well as intangibles such as culture and prevailing values. This context predetermines the unequal distribution of power and resources in society, according to axes or systems of social categorization, which in this model are: social class, gender, age, ethnicity and territory. Inequalities along these axes translate into an unequal distribution of intermediary determinants, such as different access to material resources, employment and housing conditions, as well as different exposure to psychosocial factors (stress, isolation, exclusion, etc.) and behavioural and biological factors, such as smoking or alcohol use. Health systems also fall within these intermediary determinants, as access to or quality of services provided may vary according to the social position of individuals.

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[7] Excerpt of **(17)** Ministry of Health. Documento Técnico del Grupo de Trabajo de Vigilancia de Equidad y Determinantes Sociales de la Salud [Technical Report of the Working Group on Equity and Social Determinants of Health Surveillance] 2021. Available at: https://www.sanidad.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/DocTecnico_GTVigilanciaEquidadyDeterminantesSocialesSalud_2021.pdf

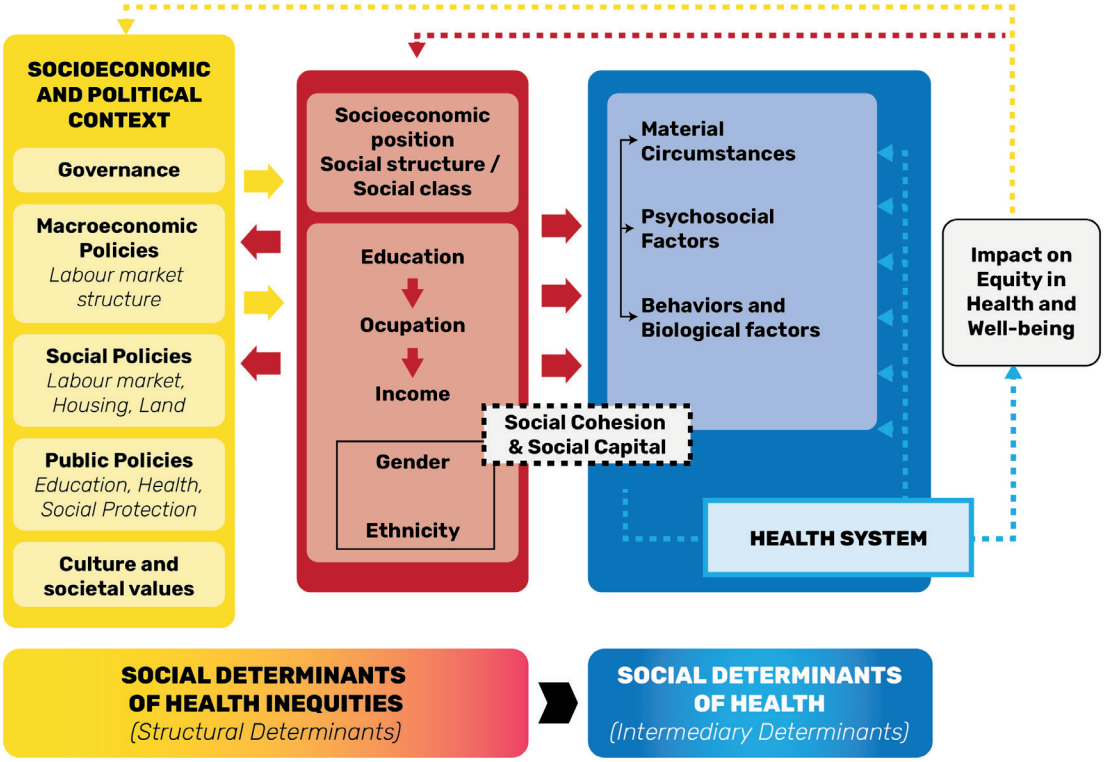

Figure 2. Conceptual framework of the Social Determinants of Health. WHO Commission on Social Determinants of Health

In 2010, this WHO framework was adapted in Spain by the National Commission for Health Inequalities **(11)**, giving more weight to aspects related to gender, domestic work and care or the residential environment (figure 3).

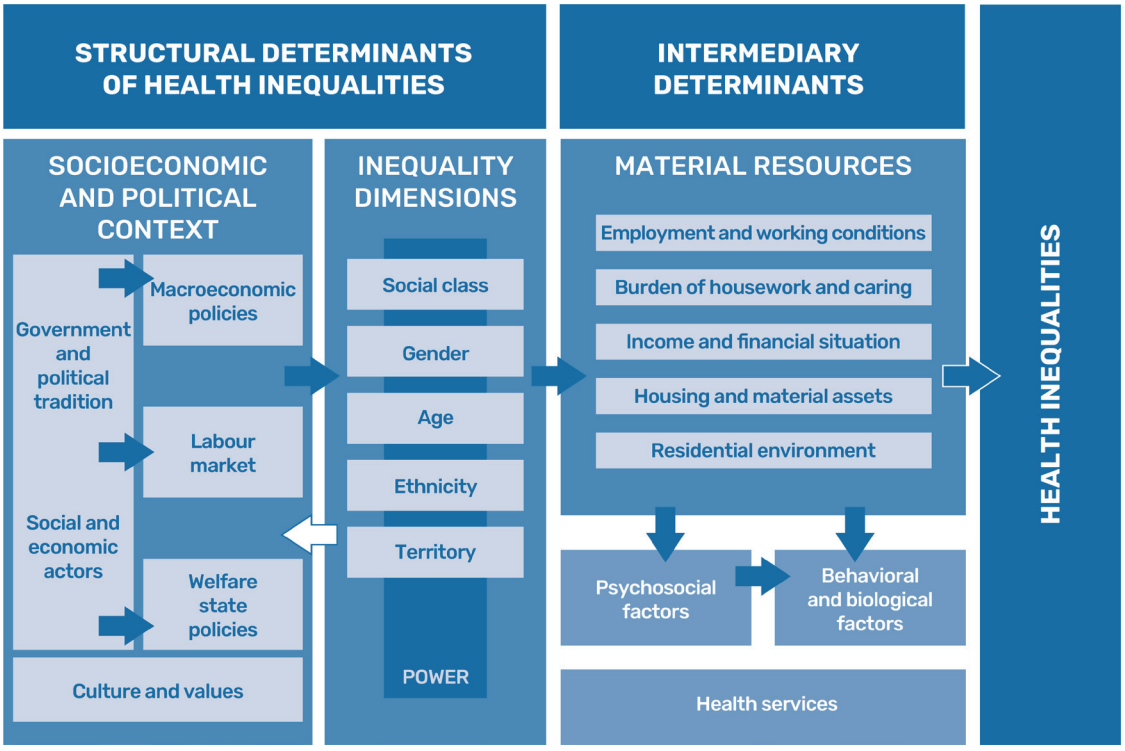

Figure 3. Model of the Commission for Reducing Health Inequalities in Spain (2010).

The model of the **Pan American Health Organization** (12) incorporates as structural factors, compared with previous models, those related to the natural environment, land and climate, as well as historical determinants, such as persistent colonialism. It also places more emphasis on the impact of structural racism, and adds other axes of inequality such as sexuality, migration and disability, and gives greater visibility to the critical stages of the life cycle, such as the first years of life and old age (figure 4) and to the human rights approach.

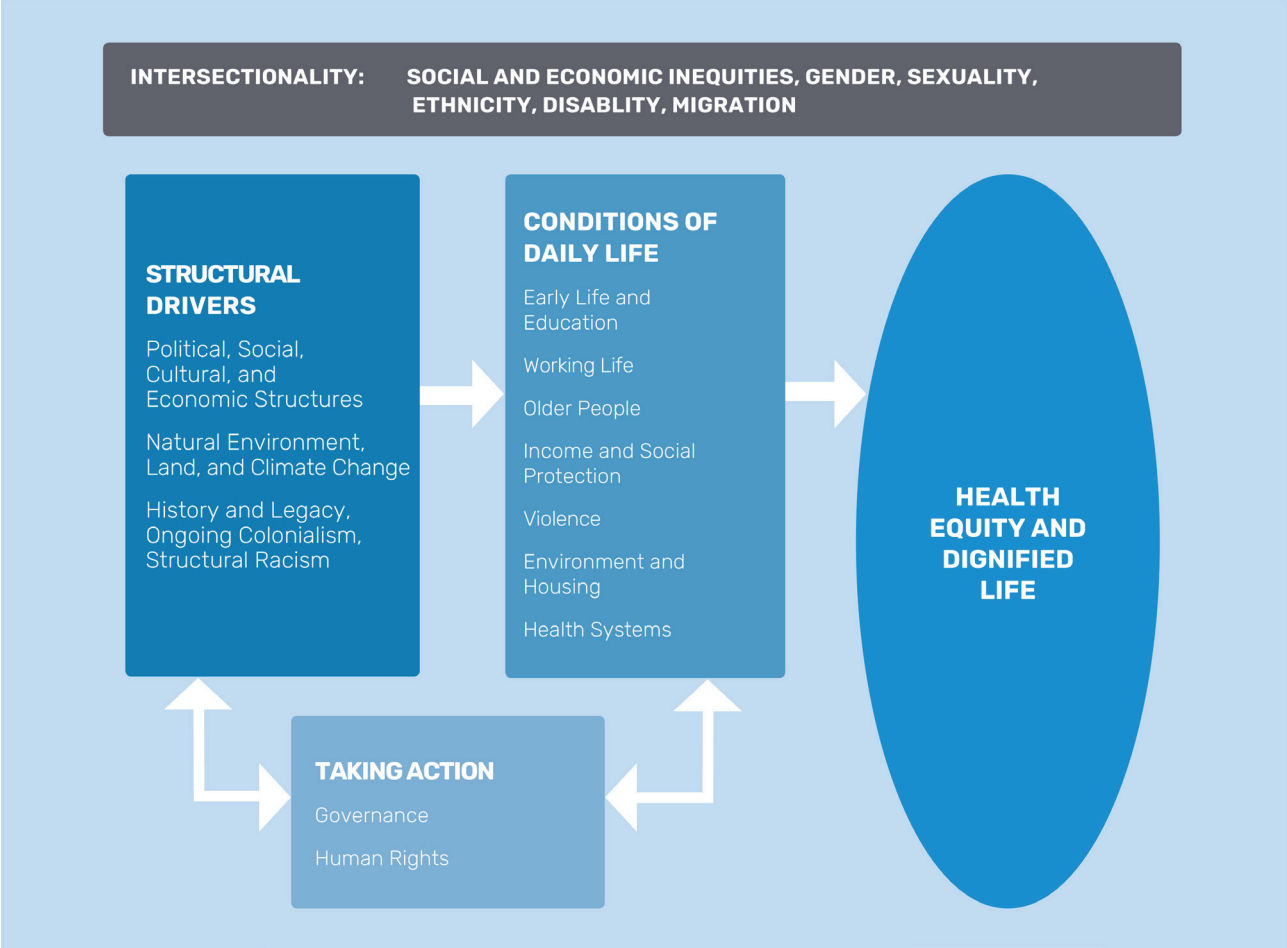

Figure 4. Model of the Pan American Health Organization Commission on Equity and Inequalities in Health in the Americas (2018).

Appendix II

1) OBJECTIVES OF THE SPA

1.a. List the general and specific objectives of the SPA.

1.b. Is there an equity objective? Are there objectives aimed at a specific population groups? Which ones?

2) JUSTIFICATION FOR CARRYING OUT THE SPA

2.a. What is the justification for carrying out the SPA? What value is provided by the existence of this SPA?

2.b. Has a situation analysis been conducted as part of the SPA's approach framework which considers equity and social determinants of health?

3) POPULATION NEEDS ASSESSMENT

3.a. On what sources of information was the population needs assessment based?

3.b. What are the principal needs detected?

3.c. Have the specific needs of different population groups been analysed?

3.d. Are all the needs detected expressed as objectives/actions of the SPA? Indicate needs not included.

4) SPA TARGET POPULATION

4.a. What is the SPA target population?

4.b. Are there population groups already specifically identified in the SPA within the target population?

5) SPA INTERVENTIONS OR ACTIONS

5.a. Type of SPA interventions or actions

5.b. How effective are the interventions/actions you have just described?

5.c. How are the interventions/actions adapted or reformulated for different population groups, and how do they complement each other?

5.d. Has a gender perspective been taken into account in designing the SPA actions?

5.e. Is there a population that is or could be left behind by the SPA approach (population that does not have access to or benefit from it)? How can this be remedied?

6) IMPLEMENTATION OF THE SPA INTERVENTIONS OR ACTIONS

6.a. Who implements each of the interventions or actions?

6.b. How are these actors coordinated?

6.c. Have the people implementing the SPA been involved in its design? In what way?

6.d. Is there information on the SPA publicly available (online or otherwise)?

6.e. Have the gender perspective, intercultural sensitivity, disability, and the diversity of the target population been considered, with an intersectional approach, in disseminating the SPA, drafting its materials, and the messages being conveyed? How has this been done?

7) INTERSECTORAL WORK

7.a. Which sectors of the public administration are participating in the development of the SPA?

7.b. What challenges or difficulties exist in carrying out intersectoral work? How can they be overcome?

7.c. How is coordination established with other related plans/SPAs?

8) PARTICIPATION

8.a. Which population groups or social organizations are participating in the SPA, and how are they participating?

8.b. Are all population groups of interest involved? Which ones?

8.c. What challenges or difficulties are there for the participation of the population within the framework of the SPA? How can they be overcome?

9) OUTCOME OF THE SPA

9.a. What do you hope to achieve by implementing the SPA?

9.b. What indicators are considered most important for the SPA?

9.c. How is the SPA assessment being carried out, and who is participating?

9.d. What outcomes has the SPA achieved so far?

9.e. What equity indicators are being measured as part of the SPA?

9.f. Have the outcomes achieved been the same for all population groups? Please provide details.

10) REFLECTION ON THE SOCIAL DETERMINANTS OF HEALTH

10.a. Considering the framework of social determinants of health, mark those which you consider to have an influence on the SPA and explain how they influence it and at what level.

10.b. After assessing which social determinants influence the SPA, and how, do you see an intersection of several determinants in any group which may multiply disadvantages and which need to be taken into special consideration?

11) EQUITY CHALLENGES

11.a. Considering your experience, and after the analysis conducted in each section of this checklist to be filled in, which do you believe to be the major equity challenges that the SPA should address, and what improvements would you suggest to better integrate equity?

Appendix III[8]

The Tanahashi effective coverage model (see figure 5) **(16)**, can be helpful in identifying, why some groups are able to access and benefit from the SPA and others aren't, in each key stage of the programme. Using this model, for each key phase of the SPA it should be considered whether the problem of a population group's not having access to or benefiting from the SPA is related to the presence or not of barriers and facilitators, and their relative weight.

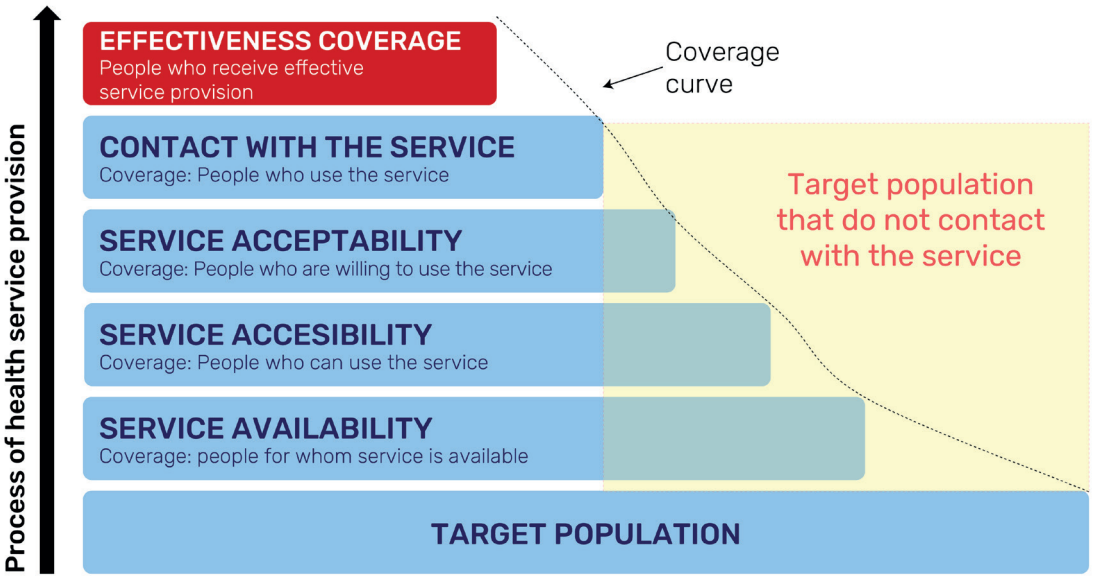

Figure 5: Health service coverage model.
Source: Adapted from Tanahashi T, 1978.

Barriers are those factors that are obstacles for the target population (or a segment thereof) to make appropriate use of the health programme or service being offered. They diminish the effective theoretical coverage of the service, or mean that its outcome is only a reality for some groups. Consequently, the programme's impact on the population is lower than expected, and these barriers generate and perpetuate situations of inequality.

Facilitators are those factors that help a target population to make appropriate use of the programme, including those that make it possible to overcome access barriers and achieve effective use.

For those **SPAs providing services** to people, these barriers and facilitators can be defined and ranked as follows:

[8] Ministry of Health, Social Services and Equality. Methodological Guide to Mainstreaming Equity into Health Strategies, Programmes and Activitie]. Version 1. Madrid, 2012.

Type of barrier or facilitator	Definition	Linked factors
Availability	Relationship between the volume and type of existing resources in the SPA and those needed by the target population to achieve the SPA's aims.	Absence of services or lack of human resources, equipment, supplies, infrastructure. Adequate resources must be generated in order to reach the SPA's objectives.
Accessibility	Factors hindering or facilitating target individuals or populations in getting in contact with the SPA's services. They can be categorised by physical, financial, organisational or administrative accessibility.	**Physical**: distance, transport availability, actual transport time, connections. **Financial**: Transport cost, direct and indirect costs, loss of earnings (i.e. a lost workday). **Organisational/Administrative**: Office hours or access schedules, administrative requirements for getting access, assistance, modality of access.
Acceptability	Factors hindering or facilitating the target population or specific social groups in accepting the SPA's services, raising or decreasing the probability of them using these services. Frequently, in order to know these, the population itself must be consulted.	Linked to social, cultural, historical and religious factors, social networks, beliefs, norms and actual values. Quality of attention. For example, teenagers demand privacy, anonymity and autonomy to the sexual health services.
Contact or utilisation of service	Factors determining whether the SPA's aims have been achieved, adherence or abandonment. They are directly related to the "contact" the individual or group has with the service or programme. The way this contact occurs greatly determines the SPA's adherence or abandonment.	Implies the analysis of the process by which the service is delivered, i.e. quality, effectiveness, waiting time, etc.
Effective coverage	The proportion of target population getting the service provision established in the standards defined in the SPA's aims.	

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