Methodological Guide to integrate Equity into Health Strategies, Programmes and Activities

SANIDAD 2012
MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

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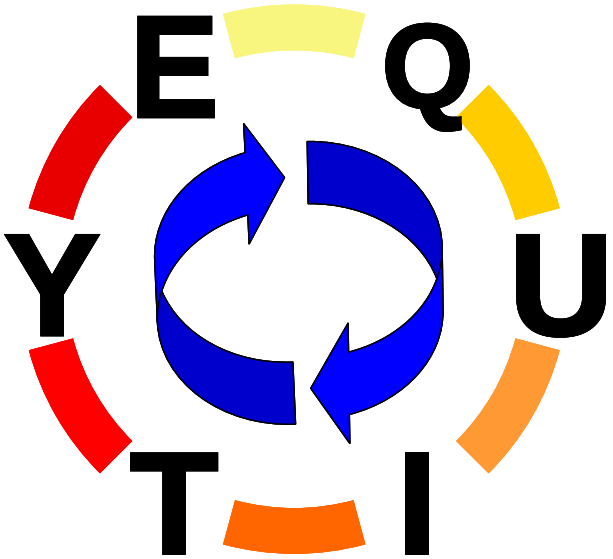

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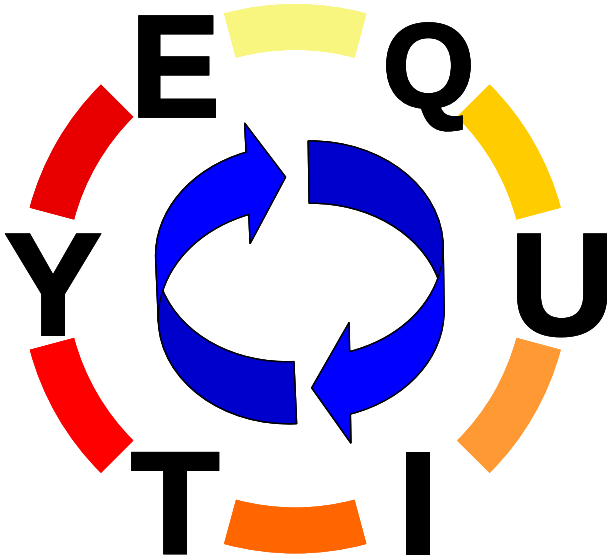

GOBIERNO DE ESPAÑA
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Caminante, no hay camino,
se hace camino al andar.

Wanderer, there is no road,
the road is made by walking.

Antonio Machado

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PREFACE

This guide has been drawn up by the Health Promotion Area of the Sub-Directorate General of Health Promotion and Epidemiology, General Directorate of Public Health, Quality and Innovation of the Spanish Ministry of Health, Social Services and Equality, as a result of the training process for the "Integration of a focus on Social Determinants of Health and equity into Health Strategies, Programmes and Activities" carried out during the period November 2010 to September 2011, and based on the experience and the technical documentation of the Chilean Ministry of Health for the review and redesign of health programmes. The Chilean initiative was developed during 2008-2009 and framed within the Social Determinants and Equity agenda, which was coordinated by the Technical Secretariat of Social Determinants of the Sub-Secretariat of Public Health.

The Spanish training process is framed within the National Strategy on Health Equity, and, moreover, within its aim: "To promote and develop knowledge and tools for intersectoral work, moving towards the concept of Equity and Health in all policies".

The purpose of the guide is to raise awareness of the approach towards health equity and the social determinants of health among professionals in the health sector and among those working in the sectors with the highest impact on the health of the population. It also aims to provide a tool that can facilitate the integration of equity into Health Strategies, Programmes and Activities (SPAs) in a practical way. The ultimate goal is to make health equity a cross-cutting, explicit and practical axis of all public health activities and plans, of health services and of all other policies which have an impact on social determinants of health in order to guarantee equitable health opportunities and results for the whole population.

The examples included in this guide are drawn from the work performed by the professionals who participated in the training process in Spain. This process has been developed with the teaching support and guidance of Dr. Jeannette Vega and Dr. Orielle Solar, both experts in the realm of health equity, who were in charge for the Chilean experience and also members of the WHO Commission on Social Determinants of Health.

The guide has benefited from the contributions of the participants in the training process during the meeting "Integration of Social Determinants approach and Equity into Strategies, Programmes and Activities related to health: Conclusions of the review process and breakthroughs" within the framework of the XXII Public Health School of Menorca 2011; and their subsequent suggestions.

This guide is expected to be a dynamic document, which will undergo constant review and improvements leading to subsequent versions.

AIMS OF THE GUIDE

General aims:

- To raise awareness of the approach of health equity and social determinants of health (SDH) among professionals in the health sector and in those employed in, sectors with the highest impact on the health of the population.
- To provide a tool that eases the integration of equity into health Strategies, programmes and Activities (SPAs).

To whom is the guide addressed?

This guide is addressed to professionals working in health SPAs who are interested in applying a re-orientation process towards equity in one or more selected SPAs.

How to use the guide?

The global process to integrate equity into the SPA comprises three stages that can be followed sequentially or not, depending on the level of depth with which the process is intended to be carried out:

1. *Initial analysis* of equity through the application of a checklist.
2. *Review cycle* through five steps to include equity in the SPA.
3. *Redesign*: Implementation of the changes agreed upon during the review cycle.

It is recommended to start reading chapter 1, where a general vision of the context in which this guide was created is provided. Afterwards, read chapters 2 and 3 carefully to gain a full understanding of the fundamental concepts surrounding health equity and the conceptual framework of the World Health Organization (WHO) Commission on Social Determinants of Health.

Chapter 4 gives a general view of the process and gathers some key suggestions as to how to organise it. Therefore, it is advisable to read it before starting the initial analysis (checklist).

Chapter 5 includes a detailed description of the methodology of the three stages of the process to integrate equity in the SPAs.

To make this integration process easier, in addition to the content of this guide, professionals can complement their knowledge with a list of recommended readings, located on page 120 of this guide.

Professionals working in the Spanish context, have also been offered the following:

- Support materials for the training process, which can be requested using an online form in the section about health equity in the web page of the Spanish Ministry of Health, Social Services and Equality.

- The possibility of being assessed during the process by the Health Promotion Area (promocionsalud@msssi.es) and the professional group that participated in the training process (see participants in the training process in chapter 8).

1. Contextualisation and background of the guide

1. Contextualisation and background of the guide

National Strategy on Health Equity

The past few years have seen health equity gain increasing attention and status within the international agenda. Institutions such as the European Union, the World Health Organisation, the Council of Europe, the Organisation for Economic Co-operation and Development and the United Nations have included equity in their agendas and strategic strands of work.

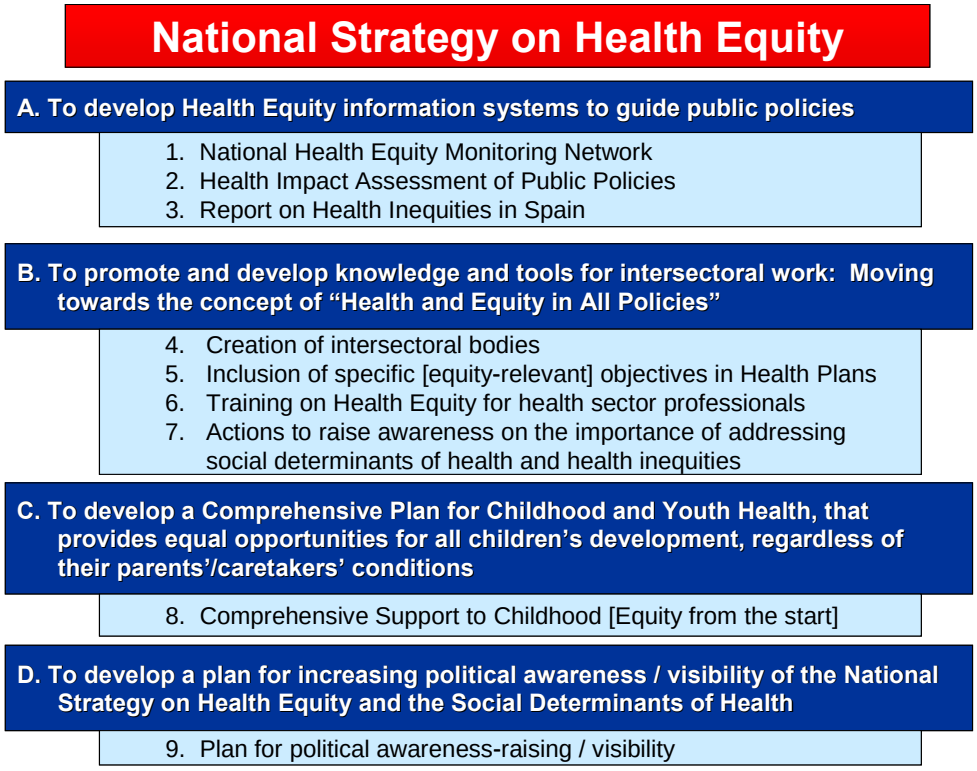
This international development has had a noticeable bearing on the national agenda, which has benefited from important research surrounding the scope and magnitude of inequities in our country. This has in turn contributed to the progressive consideration of the health equity approach in laws and strategic documents, such as the Spanish Act 16/2003 of Cohesion and Quality of the National Health System, and the Plan of Quality of the National Health System, both of which consider equity to be a cross-cutting axis. Recently, the Spanish Act 33/2011 of 4 October, General of Public Health, has provided the basis for the development of the principle of equity and "Health in All Policies" as a mechanism to guarantee the equity that is embedded in our Constitution and that has never been sufficiently developed until now.

In October 2008, the General Directorate of Public Health and Foreign Health set up the National Commission on the Reduction of Social Inequalities in Health in Spain, comprising of national experts, whose expertise in this area is well recognised. Their task was to launch a proposal of recommendations about the strategic policies that should be implemented or fostered by different levels and sectors of the administration in order to reduce health inequities in Spain.

In May 2010, the Commission presented a document with 27 general recommendations and 166 specific ones[1]. Within the recommendations, 20 policies were prioritised whose first target for development was the Public Health services. Out of these recommendations, the Ministry has prioritised 9 measures, which are framed within four strategic strands and represent the starting point for the National Strategy on Health Equity.

[1] http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/Moving_Forward_Equity.pdf

Figure 1. Strategic lines of the National Strategy on Health Equity.



Prioritisation of these 9 measures has been endorsed by the National Working Group on Health Promotion, which took place on 16 September 2010, and by the Committee of Public Health of the Inter-territorial Council of the National Health System of 30 September 2010. The National Working Group on Health Promotion is the group responsible for driving the National Strategy on Health Equity with the support of the Public Health Committee.

The Sub-Directorate General of Health Promotion and Epidemiology is developing actions to move forward within this strategic framework, and is coordinating the prioritising process, consolidation and implementation of these prioritized recommendations in every Autonomous Community.

The training process in order to integrate a focus on Social Determinants of Health and equity into health SPAs which is described and systematised in this guide, is framed in the strategic line N. 2: "To promote and develop knowledge and tools for intersectoral work, moving towards the concept of Equity and Health in all Policies". It is considered an internal process linked to the institutions with implications on the Strategy to raise awareness, to build capabilities and to train professionals in order for them to initiate the process of inclusion of health equity into their activities and institutions.

Training process: General description

The training process was carried out in Spain between November 2010 and September 2011, with a mixed methodology of in-person workshops and online work through a virtual platform, hosted by the Virtual Public Health Campus of the Pan American Health Organization (PAHO). The process also had the technical support of WHO-Europe.

The Health Promotion Area led the coordination of the process, with the teaching support and guidance of Dr. Jeanette Vega and Dr. Orielle Solar, both of whom are experts in the realm of health equity and are responsible for the Chilean Ministry of Health process for the review and redesign of health programmes developed during 2008-2009 and framed within the Social Determinants and Equity agenda, which was coordinated by the Technical Secretariat of Social Determinants of the Sub-Secretariat of Public Health.

The participants were technical professionals working in key areas for the reduction of health inequities within the Ministry of Health, Social Services and Equality (MoHSSE), of the Departments of Health of the Autonomous Communities (AACC) and other key institutions for health equity, including town councils. Participants were designated by the General Directorates involved –in the case of the MoHSSE– and by the Public Health General Directorates of every AACC or institution. They were divided into two groups, the first comprising of MoHSSE professionals (called national level group), and the second a group of professionals from the AACC and from other key areas for the public health (called regional and local level group). During the training process, thirteen working teams (called “working teams” instead of “working groups” to emphasise the importance of working jointly as team-players) were created, of which, ten completed the process. To finish the process, consolidate the work and exchange experiences of both groups, a meeting was organised in the XXII School of Public Health of Menorca, where a draft of this guide was presented to receive contributions of the participants in the process.

A more detailed description can be found in Annexe I of this guide.

2.
Basic concepts about Health Equity

2. Basic concepts about Health Equity

What is Health Equity?

Health equity means that all individuals are able to enjoy their highest health potential regardless of their social position or other circumstances determined by social factors.

From the point of view of public policies, health equity means that resources have to be allocated according to people's needs. It also means equity in health outcomes for all social groups.

Health equity is a value linked to concepts such as human rights and social justice. Amartya Sen, member of the WHO Commission on Social Determinants of Health, pointed out that "Health equity cannot be concerned solely with health as an isolated factor. Rather, it must come to grips with the larger issue of fairness and justice in social arrangement, including the economic distribution, paying appropriate attention to the role of health in human life and freedom. It is true that Health Equity is not only about the distribution of health, neither about the distribution of healthcare which is a more restricted aspect. In fact, Health Equity has an enormous scope and importance."[2]

The right to health is not only the right to be healthy; it needs to take into account the Social Determinants in order to meet the citizens' rights and the highest attainable level of health. It must be stressed that health is crucial for our wellbeing and that our freedom and everything we are capable of depends on our achievements in health.

What are the Social Determinants of Health?

Social Determinants of Health (SDH) are understood as being the social conditions in which people live and work and that have an impact on our health.

To experience better or worse health depends on different factors. Social factors are increasingly proved to be the ones with the greatest impact on health in comparison to others such as genetic or biological factors, which, besides having a lesser influence, cannot be modified.

It is known that the social and economic environments– in which people live and work– are responsible for approximately 50% of an individual's level of health, while the health

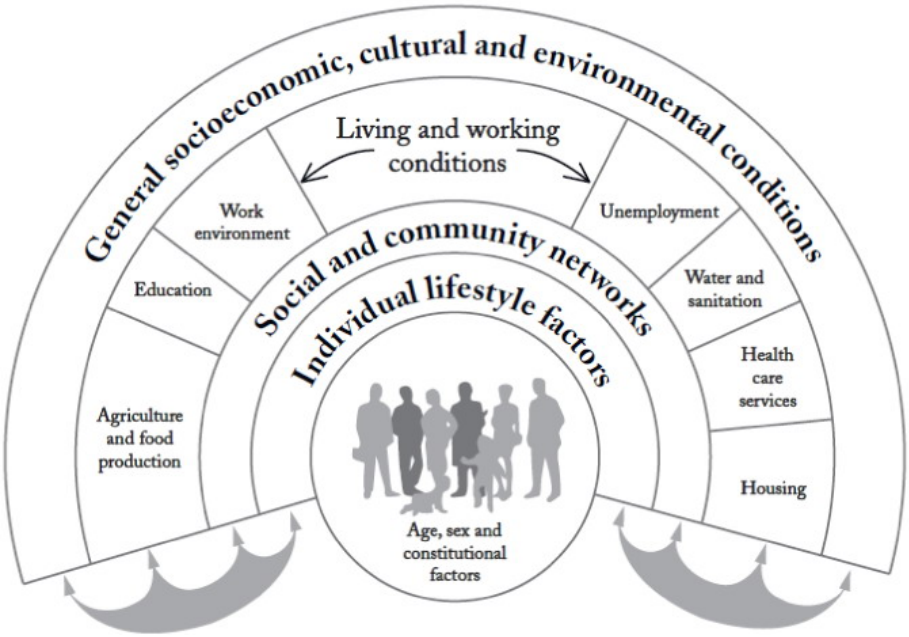
[2] Sen A. ¿Por qué la equidad en salud? [Why equity in health?] Rev Panam Salud Publica. 2002 June; 11 (5-6): 302-309.

system is only responsible for 25%[3]. Therefore, SDH such as where we live, our educational level, our social relationships, the job we do, our income level, our access to services, policies, culture and market economy are much more relevant to our health than the health system itself.

There are different models to explain SDH and to understand how social inequities are created. One of the most widely used has been the Dalghren and Whitehead model (Figure 2), which represents factors influencing health in the shape of an onion with different layers:

- Factors which cannot be modified, like age, sex and other constitutional factors (in the centre).
- Factors linked with individual lifestyles; influenced by social and community networks, and by living and working conditions.
- Finally, the macro-political environment (in the external shape), covers the general socio-economic, cultural and environmental conditions we live in.

Figure 2. Dalghren and Whitehead Framework of Social Determinants of Health (1991).

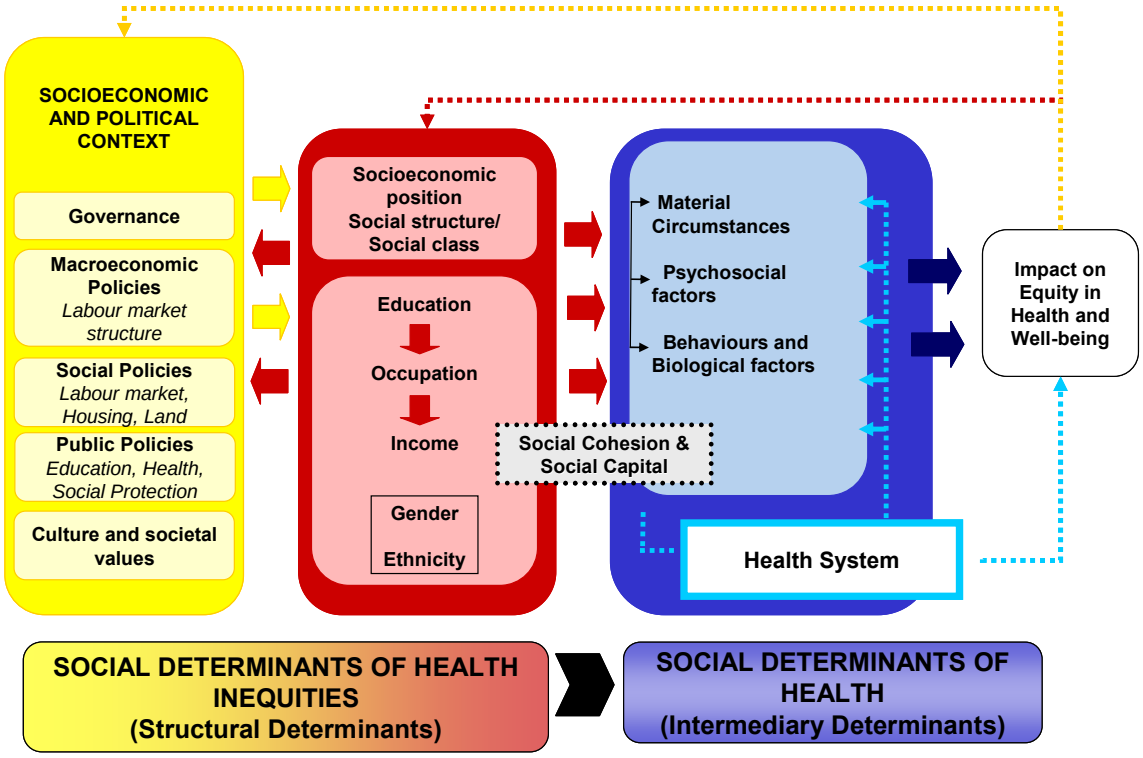


Source: Taken from Whitehead M, Dahlgren G. WHO Regional Office for Europe (2006). Concepts and principles for tackling social inequities in health. Levelling-up (Part 2). Available at: http://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf

The framework developed by the WHO Commission on Social Determinants of Health (CSDH) –which is explained in chapter 3 of this guide– has been employed for the purpose of this training.

[3] O'Hara P. Creating Social and Health Equity: Adopting an Alberta Social Determinants of Health Framework. Discussion Paper. Edmonton Social Planning Council. 2005. Available at: http://edmontonsocialplanning.ca/images/stories/pdf/sdoh_discussion_paper.pdf

Figure 3: Conceptual Framework of Social Determinants of Health. WHO Commission on Social Determinants of Health.



Source: Solar O, Irwin, A. Conceptual Framework of Social Determinants of Health. WHO Commission on Social Determinants of Health. 2006.

What are social inequities in health?

Social inequities in health are the unfair and avoidable health differences that occur in a systematic way among socioeconomic groups of a given population, and are the consequence of an unequal distribution of SDH throughout the social scale.

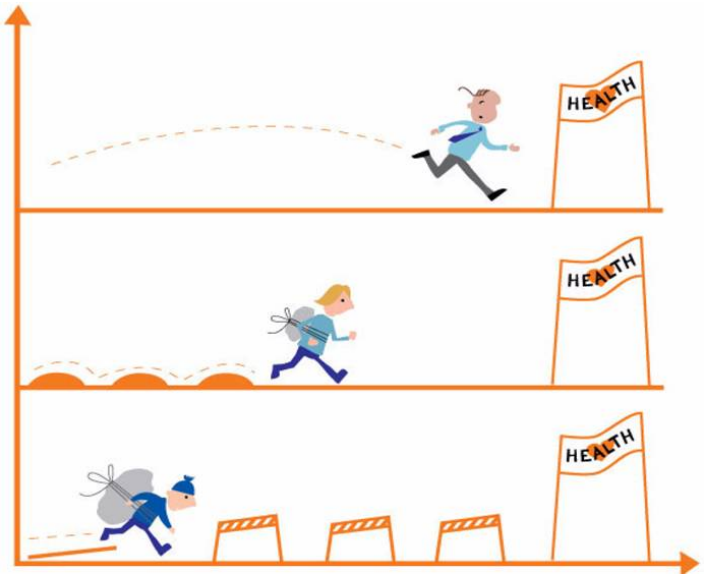
People with higher level of income, higher education level or a superior occupational situation tend to live longer and have fewer health problems. This situation is unfair for those who do not have the same social opportunities and can be prevented by modifying certain policies, especially those affecting the most structural factors.

There are social inequities in heath between countries as well as within countries and regions themselves. Data reveal that, in general, the lower the socioeconomic situation of a person is, the worse health this person has. The relationship between socioeconomic level and health shows a gradient along the entire social scale. It means that even if there is a wider gap between those at the top and bottom of the social scale, there are differences among all social groups.

Figure 4 clearly illustrates this concept of social gradient in health and how social groups have to face different barriers to achieve a good level of health: some people are born with more opportunities and it is easier for them to achieve a good health, "for them the race is already won" whilst others are born with additional responsibilities or

disadvantages and must spend their whole life “jumping hurdles”, whilst progressively accumulating disadvantages.

Figure 4. Diagram explaining social inequities in health.



Source: Norwegian Ministry of Health and Care Services (2006). National Strategy to Reduce Social Inequalities in Health. Report No. 20 (2006–2007) to the Storting.

When talking about social inequities in health, it is necessary to emphasise that these differences in health are not the result of biological factors or individual choices, they depend on factors that come together in people according to the socioeconomic group they belong to; these social inequities in health can be modified through effective public policies to tackle SDH.

INEQUALITIES OR INEQUITIES?

In the European Union, the term "inequalities" is commonly employed while in other countries, especially in Latin America, and in international bodies including the WHO, the term “inequities” is used. It is important to clarify that the concept both terms refer to in this field of work is the same: unfair, systematic and preventable differences.

While the use of any of these two terms would be appropriate, in this guide it has been decided to use “inequities”, since it has been considered a more comprehensive term. However, we have continued to use the term “inequalities” in certain official names of Commissions or reports where this specific term was employed.

WHO ARE AFFECTED BY THESE INEQUITIES?

Social inequities in health affect all people in all countries but they have a more severe impact in those who have fewer resources.

SDH are not equally distributed among the population. As previously stated, they follow a social gradient: the lower the social class of the individual, the more impact they

have. Consequently, the highest social inequities appear in the lowest levels of the social scale.

There are also especially vulnerable populations to consider. These include people with low income, unemployed people, women, people with mental disorders, people with disabilities, some migrants and ethnic minorities such as the Roma people.

Why take action to reduce social inequities in health?

A poorer level of health for the population as a whole and the existence of health inequities are detrimental factors for all society, both for the social and economic development of a country or a region.

The less equitable societies translate into societies with a worse performance in every sense:

- Less social cohesion and sustainability.
- Poorer welfare, economic development and health indicators.

Moreover, health forecasting related to the current economic crisis suggests that health inequities will tend to increase if no action is taken to prevent it.

Some data illustrating the impact of health inequities are shown below:

- In the United Kingdom, the social group with the lowest death rate is represented by people with university degrees. If all people over 30 had the same mortality rate as those who have university degrees, 202,000 premature deaths would be prevented each year[4].
- Health contributes to economic development. A study conducted by the University of Harvard[5] estimates that for each year that the life expectancy of a population increases, its per capita income increases by an average of 4%.
- Cardiovascular diseases and psychiatric disorders, both of which are closely linked to SDH, have an estimated annual economic cost of 1%[6] and 3-4%[7] of GDP, respectively.

[4] Fair Society, Healthy Lives. The Marmot Review 2010.
[5] Bloom, David E., David Canning, and J. Sevilla, 2004, "The Effect of Health on Economic Growth: A Production Function Approach," World Development, Vol. 32 (January), pp. 1–13.
[6] M. Suhrcke, M. McKee, R. Sauto Arce, S. Tsolova y J. Mortensen: The contribution of health to the economy in the EU, Brussels, 2005.
[7] Gabriel, P. and Liimatainen, M. R. Mental Health in the Workplace. International Labour Organization, Geneva, 2000.

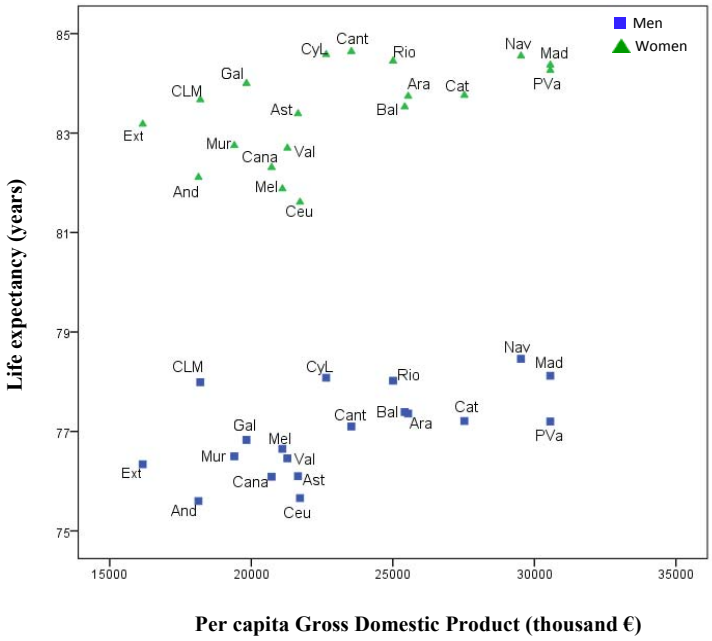
Which is the situation in Spain?

The Spanish population lives, on average, longer and healthier than previous generations thanks to enhanced living conditions and better access to goods and services. However, the study of health inequities has proved how socioeconomic position, gender, ethnic group or demographic area serve as inequity axes which strongly impact the population's health. In this regard, we present some data illustrating how inequities impact health in Spain.

- There is a difference in life expectancy of 3 years between the richest and the poorest Autonomous Communities (Figure 5). This difference can be even greater when comparing different districts of one city[8].
- Social inequities between men and women, and between the most and the least favoured social classes become huge inequities in terms of mortality and health status. For example, only 55% of women of social class V (unskilled manual jobs) state a good health status while this statement can be found in 85% of men of social class I (managers and professionals) (Figure 6).
- Moreover, social inequities related to certain diseases and risk factors are not decreasing but increasing over time. For example, inequities concerning obesity (Figure 7) have risen during the latest years, especially to the disadvantage of women.

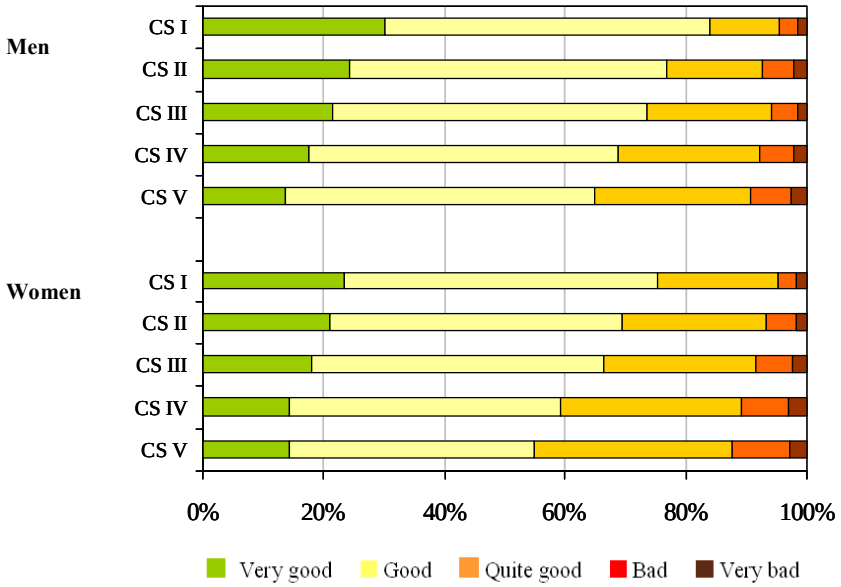
[8] MEDEA Project. http://www.proyectomedea.org/

Figure 5. Life expectancy at birth for men and women according to per capita Gross Domestic Product in the Autonomous Communities. Spain, 2007.



Source: Created with data from the Spanish National Statistics Institute. In: Commission on the Reduction of Social Inequalities in Health in Spain. Moving Forward Equity: a proposal of policies and interventions to reduce social inequalities in health in Spain. Madrid, Ministry of Health, Social Policy and Equality, 2011. Available at: http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/Moving_Forward_Equity.pdf

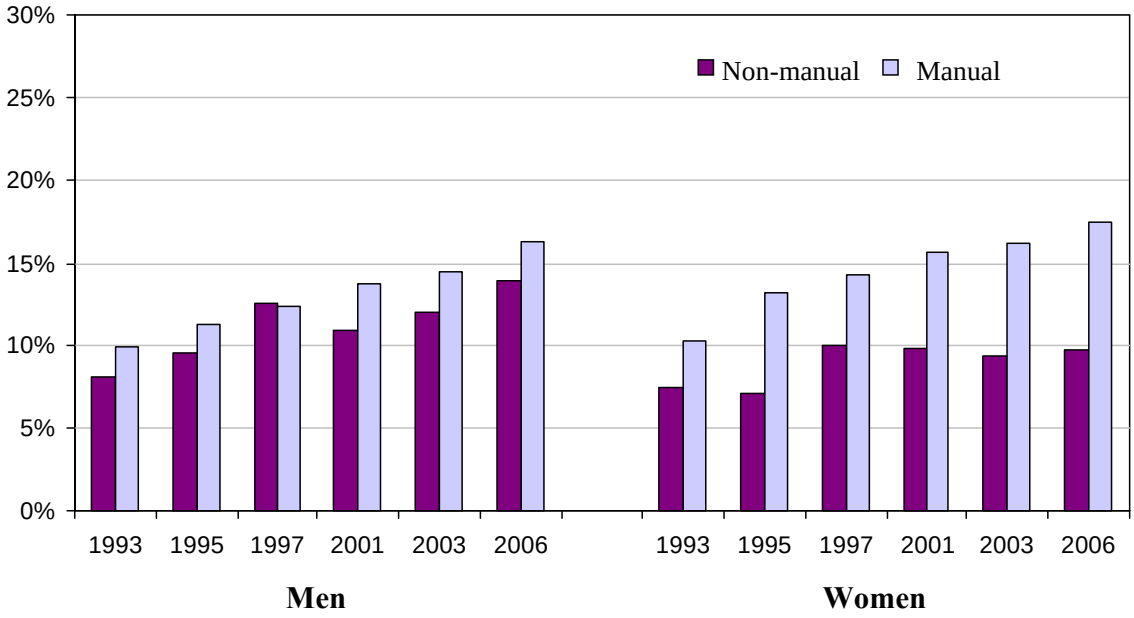
Figure 6. Distribution of perceived health status according to social class among men and women. Spain 2006. Age-standardised percentages.



CS: Social class based on occupation, the most advantaged being I (managers and professionals) and the less advantaged being V (unskilled manual jobs).

Source: Spanish National Health Survey 2006. In: Commission on the Reduction of Social Inequalities in Health in Spain. Moving Forward Equity: a proposal of policies and interventions to reduce social inequalities in health in Spain. Madrid, Ministry of Health, Social Policy and Equality, 2011. Available at: http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/Moving_Forward_Equity.pdf

Figure 7. Evolution of the prevalence of obesity (body mass index >=30) according to social class among men and women. Spain 1993-2006. Age-standardised percentages.



Social class based on occupation, grouped into 'non-manual' (classes I-III) and 'manual' (classes IV-V). Body mass index is obtained from weight and size reported by respondents.

Source: Spanish National Survey. In: Commission on the Reduction of Social Inequalities in Health in Spain. Moving Forward Equity: a proposal of policies and interventions to reduce social inequalities in health in Spain. Madrid, Ministry of Health, Social Policy and Equality, 2011. Available at: http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/Moving_Forward_Equity.pdf

What actions can be implemented to reduce social inequities in health?

Social inequities in health have a structural nature. It means that they affect the whole social gradient of the population but especially those who are in a worse position at the social scale. As a consequence, actions aimed at reducing health inequities need to be comprehensive and to have a double approach:

- Population-based strategies (universal measures) must be carried out, and not only strategies aimed at those groups considered at risk or more vulnerable (selective measures).
- Measures have to be directed towards the entire causal chain. These include measures aimed at modifying the context or the social stratification (upstream); measures to modify living conditions and lifestyles (midstream) and measures to diminish the consequences of health inequities (downstream)☞.

☞ See definitions of type of interventions in the Glossary.

Figure 8: Social Inequities in Health: Underlying casual chain.

Source: Torgersen TP, Ø. Giæver and Stigen OT. Developing an Intersectoral National Strategy to Reduce Social Inequalities in Health-The Norwegian Case. Oslo, 2007.

PRIORITY AREAS FOR THE REDUCTION OF HEALTH INEQUITIES IN SPAIN

In accordance to the National Strategy on Health Equity, we advise taking the following actions as a matter of priority:

- **Information for action**

  In order to act effectively, we need appropriate information about health inequities as well as to understand their causes.

  Data disaggregated by SDH are required in order to know the extent and the distribution of health inequities and also to manage appropriately the interventions for reducing them. Furthermore, availability of data can foster the visibility of social inequities in health and help to develop social and political awareness of the problem.

  On the other hand, public policies, whether related to health or to other sectors, need to identify the impact of their results on the health and welfare of the population –assessing their health impact– not just in terms of effectiveness (how they are working) but also in terms of equity (for whom are they working) in order to design, evaluate, re-define and re-orient the interventions.

- **Health in all policies**

  Nowadays, the concept of health and the resulting health system model are focused on illness, being the health system primarily responsible for the health of the population. Nevertheless, the majority of health problems and the main causes of premature death depend on other SDH, which don't affect the population on an equal basis and which go beyond the health sector.

In order to achieve effective health equity it is therefore necessary to involve other sectors that develop policies with a high impact on health, such as education, social policy, environment, employment, migration, urban planning, transport and active mobility, economics and finance. The role of the health sector is not to act directly for the transformation of SDH, but to take a shared leading role for tackling health issues from an intersectoral point of view. It has to advocate and raise awareness among these other sectors in order to act together and to make the changes that will lead to the reduction of health inequities. Intersectoral action must be promoted, based on what sectors jointly decide on what should be done and how the work is going to be shared amongst all. To achieve this, it is essential that mechanisms of intersectoral cooperation are developed at all territorial levels and especially at the local level (see section on intersectoral action in chapter 3).

- **Re-orientation of the health system towards health promotion and disease prevention**

  Since the 1970's, when the Lalonde report[9], was launched, we have known that lifestyles and environmental conditions have a greater influence in the promotion and maintenance of health than the healthcare services citizens frequent when they are ill. However, in the health sector, economic resources are mainly employed for healthcare assistance, especially for specialist healthcare, while investment in health promotion and disease prevention remains anecdotal. In Spain, according to data from 2007[10,] 54% of the public health expenses were allocated to hospital and specialist services; 19.8% to the pharmaceutical provision; 15.7% to primary healthcare and 1.4% to public health services. In order to reduce social inequities in health, it is essential that investments in health promotion and disease prevention are viewed as a matter of priority.

- **Visibility, awareness and training**

  One of the main priorities is the existence of political commitment to equity, where institutions assume responsibility for guaranteeing this principle. Both policy-makers and civil society need to be aware of the existence of unfair and preventable differences in health that are socially determined. Visibility must be enhanced at all levels and we must advocate for the reduction of inequities through specific actions aimed at achieving equity from a social justice and human rights perspective

  On the other hand –and going beyond raising awareness– the training of professionals from the health field as well as from other sectors is an essential step on the path towards achieving equity, and towards guaranteeing the

[9] Lalonde M. Minister of National Health and Welfare. Government of Canada. A new perspective on the health of Canadians. 1974. Available at: http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/1974-lalonde/lalonde-eng.pdf

[10] National Health System of Spain, 2010 [Internet monograph]. Madrid. Ministry of Health and Social Policy. Health Information Institute. Available at: http://www.msps.es/organizacion/sns/docs/sns2010/Main.pdf

whole population the right to health. The SDH and the equity approach must be included in the curricula of undergraduate, graduate and postgraduate degrees, fostering a comprehensive approach towards the issue of health and taking into account that it is socially determined. The training process described in this guide sticks to this strand of action.

- **Prioritising equity in childhood**

Reduction of inequities in child health is a key issue in fostering health equity. There is substantial evidence that the first years of life are very important for the reduction of social inequities in health. Health inequities during child development will lead to inequities in the adult life, and, as a consequence, disadvantages will pass repeatedly from one generation to the next.

Nowadays, studies reveal that many of the problems that adult population have to face, such as mental health problems, obesity or cardiac diseases, are rooted in early childhood. Actions taken in the first years of life lead to a lifelong health gains; and societies investing in early childhood and their families enjoy higher levels of education, better health status and fewer health inequities[11].

As such, at all government levels it is essential to prioritise the implementation of comprehensive actions and policies, which are capable of ensuring a good start in life and promoting equal opportunities for a child's development

- **Participation**

The Ottawa Charter for Health Promotion (1986)[12] has already stated the importance of communities taking concrete and effective actions to establish health priorities, decision-making processes and the planning and implementation of strategies in order to improve health.

Community participation is a necessary resource and an instrument for improving the health of the population and for increasing the capacity for intervention in the SDH. Participation in health cannot be focused exclusively on health services but needs also to address other sectors and social conditions directly linked with the health status and living conditions of the population.

It is not possible to build a better governance without a new culture of participation that is able to ensure responsibility for health and health equity. To facilitate the participation of communities and civil society in the design of public policies and in the follow-up to their implementation and evaluation it is crucial to reinforce the sustainability of interventions and to make sure they meet the actual needs of the population.

[11] Irwin LG, Siddiqi A, Hertzman C. Early Child Development: A powerful equalizer. Final Report for the WHO Commission on Social Determinants of Health. 2007. Available in: http://whqlibdoc.who.int/hq/2007/a91213.pdf

[12] http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

In order to follow this path it is essential to start by informing the population and to continue until the transference of power in the decision-making process is achieved (consult section on Social Participation in Chapter 3).

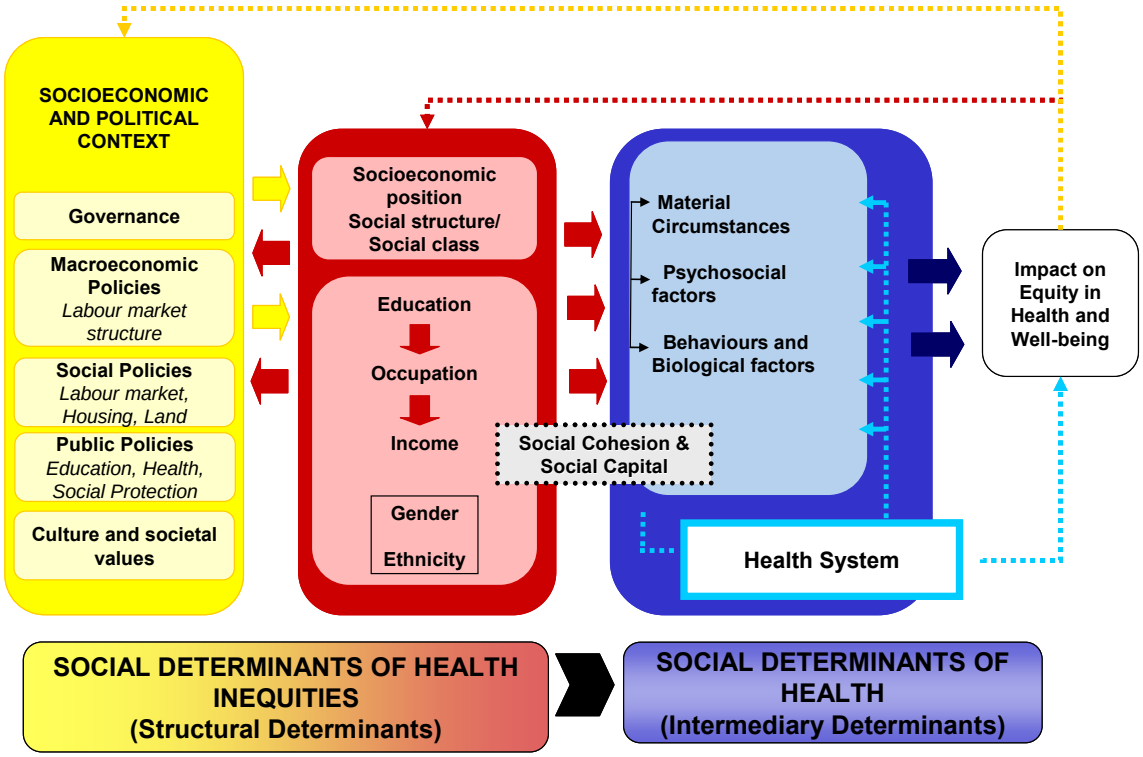
3.
Conceptual framework of the WHO Commission on Social Determinants of Health

3. Conceptual framework of the WHO Commission on Social Determinants of Health

In this chapter, the SDH Conceptual framework of the WHO Commission on Social Determinants of Health, and the role of intersectoral action and social participation will be analysed.

In Figure 9, the diagram of this framework can be observed. It will be described in the coming sections. For further information about this chapter, consult the paper of the WHO Commission on Social Determinants of Health[13], which greatly underpins this chapter.

Figure 9: Conceptual Framework of Social Determinants of Health. WHO Commission on Social Determinants of Health.



Source: Solar O, Irwin, A. Conceptual Framework of Social Determinants of Health. WHO Commission on Social Determinants of Health. 2006.

[13] WHO Commission on Social Determinants of Health. A Conceptual Framework for Action on the Social Determinants of Health. Discussion paper for the Commission on Social Determinants of Health. DRAFT April 2007. Available at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

SOCIAL DETERMINANTS OF HEALTH

The framework of the WHO Commission on Social Determinants of Health includes two main categories of social determinants:

1. Intermediary health determinants (blue box):

Intermediary determinants are factors that have a direct influence on health, through health-related behaviours, and biological and psychosocial factors (blue box in Figure 9). They include:

- Material circumstances. These refer to determinants linked to physical environments, such as housing (relating to the dwelling itself, its location and type of neighbourhood); potential consumption (i.e. the financial means to buy healthy food, warm clothing, etc.); the working conditions and the physical characteristics of the neighbourhood. Depending on their quality, these circumstances could provide positive resources for health or become a health risk.

- Psychosocial circumstances. These comprise psychosocial stressors (for example, negative life events and stressful living circumstances) or, on the contrary, positive psychosocial effects like social support and networking, among others. Different social groups are exposed to different experiences and life situations that explain the long-term psychosocial patterns, which are related to health inequities.

- Health-related behavioural factors, such as diet, alcohol consumption, smoking and level of physical activity. According to the level of exposure and vulnerability, these factors can be either health protecting and enhancing (like physical activity) or health damaging (like cigarette smoking or unhealthy diet). It is noticeable that behaviours and "lifestyles" result from the material conditions in which people are born, live and work; social groups turn these material living circumstances into behavioural patterns

- The health system☞ can have a direct impact on the differences of exposure and vulnerability through the issue of equitable access to the health system and the promotion of intersectoral action to improve health status. Moreover, the health system is capable of ensuring that health problems do not lead to further deterioration of an individual's social status whilst also facilitating the social reintegration of those who are sick or disabled; acting as a buffer against the consequences of a disease or disability. Thus, the health system could potentially help in reducing the consequences of social inequities in health, especially in a universal health system. However, it must be emphasised that the health system is just one determinant and, therefore, even if it has an important role, it cannot fully account on its own for the reduction of social inequities in health.

☞ See definition of health system in the glossary.

- Social cohesion and social capital. The concept of social cohesion takes into account, on the one hand, the set of mechanisms of integration within a society and, on the other, society's perception of the functioning of these mechanisms. In a parallel way, these perceptions determine the sense of belonging to a community. It can be stated that discrimination is a determinant of social cohesion that justifies the intervention of the government to combat it. There are different definitions for social capital. Nevertheless, beyond the variety of definitions, there is certain consensus: it is considered an intangible and dynamic resource in the social group and it covers aspects such as trust, participation, reciprocity and a sense of belonging to a community.

2. Structural determinants

Structural determinants influence health through intermediary determinants, being the "causes of the causes" of health inequities. They include:

- Socioeconomic position (SEP, red box in Figures 9 and 10). It refers to the social and economic factors that influence the position individuals or groups have in the structure of a society. SEP is considered as an aggregate concept that includes both resource-based and prestige-based measures, as linked to social class (Marx; Weber; Krieger, Williams y Moss). We normally talk about two measures particularly linked to SEP:

  a) Resources-based measures refer to material and social resources and assets, including income and salary. Terms used to describe inadequate or insufficient resources include "poverty" and "deprivation".

  b) Prestige-based measures refer to individuals' rank or status in the social hierarchy, typically evaluated with reference to people's quality of access to and consumption of foods, services and knowledge. The prestige to be measured comes from the recognition of social networking and it is linked to occupation, income and educational level, and also to the advantages of enjoying that status.

  For the analysis of the SEP, there are proxies that serve as an instrument for measuring the social stratification, such as income, education or occupation:

  - Income: it is the SEP indicator that most directly measures the material resources component. It has an accumulative effect over the course of an individual's life and it is the SEP indicator that is most subject to change on a short term basis. Income can affect health through: (1) access to better material resources, (2) access to services that improve health directly (such as health services) or indirectly (such as education), (2) provision of external material characteristics relevant to social

participation, (4), health selection[☞], given that an individual's income level can be affected by his or her health status.

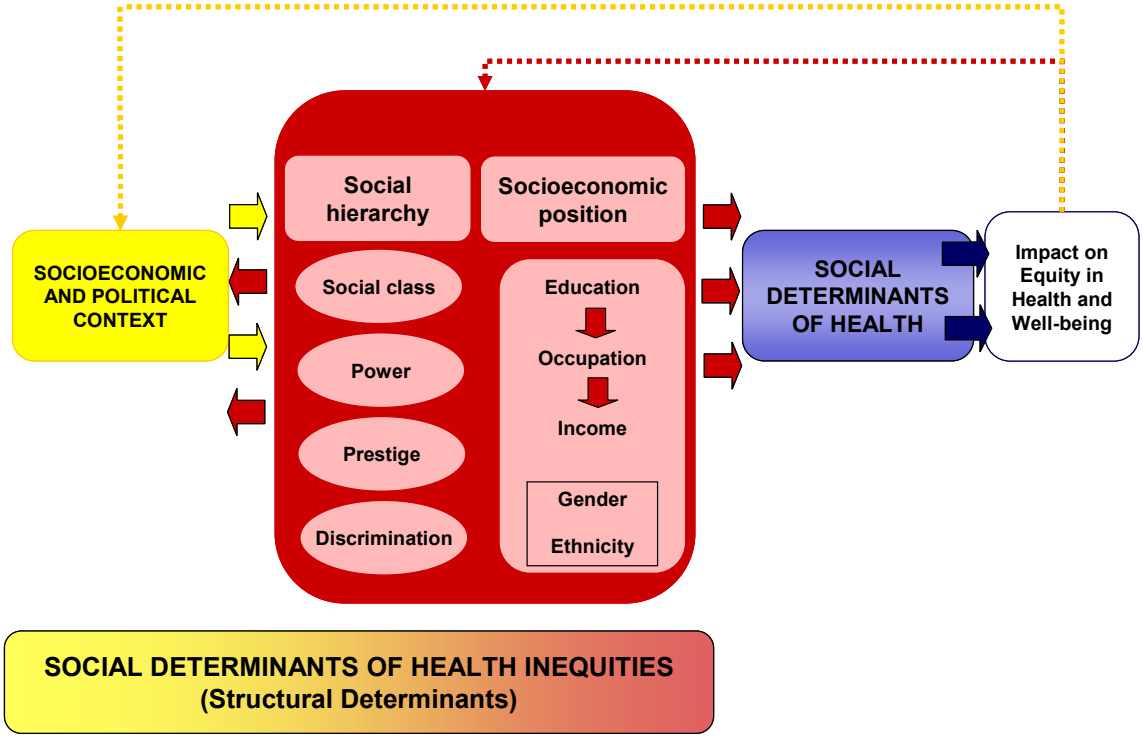
- Education: it is a frequently used indicator. It can be measured as a continuous variable (years of completed education) or as a categorical variable (by assessing educational milestones). Education captures the transition from parents' SEP (received) to adulthood SEP (own) and it is also a strong determinant of future employment and income. Moreover, the knowledge and skills attained through education may affect a person's cognitive functioning and make them more receptive to health education messages, or more able to communicate with health services. By contrast, ill health in childhood could limit educational attendance and/or attainment.

- Occupation: Occupation-based indicators of SEP are also widely used. Occupation determines an individual's place in the social hierarchy and can be related to health outcomes due to the specific privileges of those of higher standing. Moreover, it is related to income level; therefore, health and material resources can be directly linked. Occupation is also related to social networks, work based stress, control and autonomy and may thereby affect health through these psychosocial processes and also through physical and environmental work conditions.

Within this framework, **gender** and **ethnicity** play an important role in the fields of prestige and discrimination.

[☞] For further information about the concept of health selection, consult Ki, M. Health selection and Health Inequalities. Doctoral thesis, UCL (University College London). 2009. Available at: http://discovery.ucl.ac.uk/18913/

Figure 10: Conceptual Framework of Social Determinants of Health. WHO Commission on Social Determinants of Health. Structural determinants: social hierarchy and socioeconomic position.



Source: Solar O, Irwin, A. Conceptual Framework of Social Determinants of Health. WHO Commission on Social Determinants of Health. 2006.

- Socioeconomic and political context (yellow box in Figure 9).

  Socioeconomic and political context refers to the different realities in which a society is immersed, and to the framework in which this society develops.

  Socioeconomic position is defined and modelled by the socio-political and economic context. These situations shape the social conditions which result from social stratification and/or exclusion.

  The context includes:

  - Governance: in a broad sense, it embraces discrimination patterns, participation of civil society and transparency in the public administration.
  - Macroeconomic policies: including financial and monetary balances, tax liability and balance of payments, policies and treaties relating to the labour market, etc.
  - Social policies: they influence factors such as employment, property and distribution of land and housing. They also affect the environmental conditions in which people live as well as their quality of life.
  - Public Policies: in areas such as education, social welfare, health and urban planning.

- Culture and values, which are present and predominant in a society.

To summarise, economical, political and social context (including labour market, educational system, political institutions and socio-cultural values) creates and maintains a social hierarchy allowing groups and individuals a different socioeconomic position. This yields certain groups different levels of access and exposure to material conditions, psychosocial factors and health-related behaviours and habits. These differences also lead to differences in terms of social and individual vulnerability and also to different social, economic and health-related consequences in the face of a specific negative event that will have different health consequences according to an individual's position in the social scale.

INTERSECTORAL ACTION

As shown in the model, structural determinants of health inequities call for action deriving from policies that go beyond the health sector. If the goal is to tackle rooted causes of health inequities then an intersectoral approach is needed.

Most of the factors that create inequities come from outside the health sector. Thus, the work of the health sector is to provide visibility of health inequities related to the actions of other sectors in order for them to gain awareness and to take action within the SDH approach.

Those sectors requiring strategic work must be prioritised. We also need to establish the kind of relation or implication that exists among them and the possible specific actions in order to build intersectoral action between these sectors.

In order to work with other sectors, there has to be the evidence of the impossibility for one sector to reach a solution alone. In addition, the benefits of the coordination and cooperation must be perceived as being greater than the costs. When applied to the planning of policies and programmes, intersectoral action calls for ad hoc institutional agreements, which establish changes in the structure or management of institutions. It is important to note that coordination brings about a loss of organisational autonomy, which may generate resistance.

There are different working models with other sectors or types of intersectoral action[14] (see figure 11):

[14] Solar O, Valentine N, Albrech D, Rice M (2009) Moving forward to Equity in Health: what kind of intersectoral action is needed? An approach to an intersectoral typology. In: 7th Global Conference For Health Promotion, Nairobi, Kenya.

- **Information:** Presentation of the results of the analysis or problem to other sectors. One-way relationship normally associated to recommendations from the health sector to the other sectors. It can be considered an initial approach for the construction of a common language and understanding of each sector's way of thinking and priorities, so that key points and common ground can be identified for the development of a joint working process.

- **Cooperation:** Interaction between sectors to reach a better efficiency of actions undertaken by each sector with regard to a subject that implies interest and benefits for other sectors. Its goal is to optimise the resources of the different sectors and to establish a certain formality in the working relationship, resulting in a loss of autonomy for each sector. It is fundamentally present in the implementation and execution of policies but not in their formulation.

- **Coordination:** Joint working method that implies the adaptation of policies of each sector in order to achieve a greater efficiency and effectiveness. It is oriented towards networking and horizontal work. Usually, there is a common source of funding, which is very important since it creates synergies within the public administration (or at the very least avoids negative influences), it is necessary to have a wider perspective of the issues or problems to be tackled from which a logical inclusive framework can be developed. This will lead to greater dependency between sectors and ultimately a loss of autonomy for each.

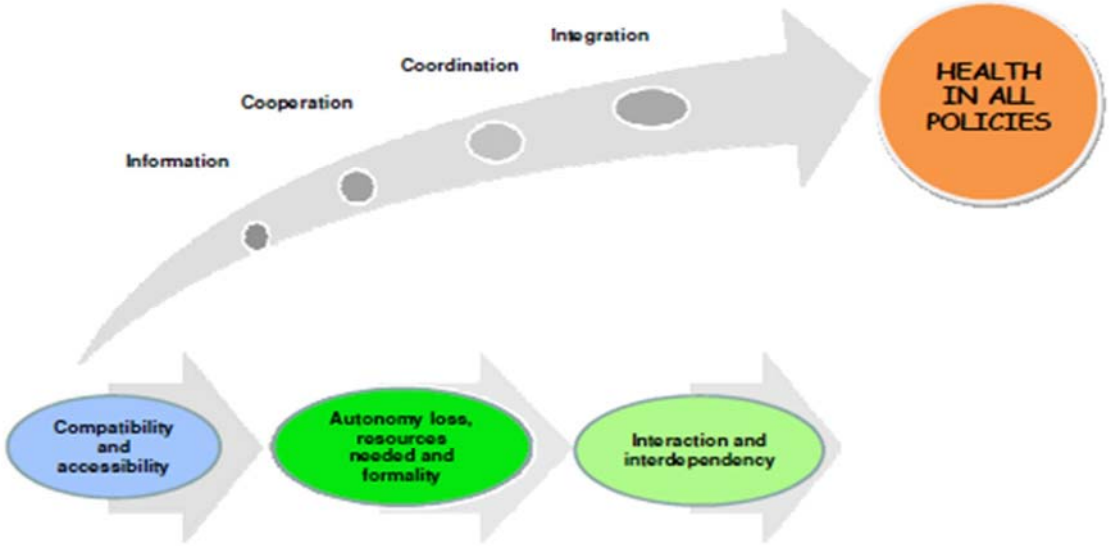
- **Integration:** Integrated work where a policy or programme involving more than one sector needs to be jointly defined. Along with the integration of policies, the sectors involved can be autonomous as their formulation, design and funding are agreed on and adapted according to a common social goal and not according to the specific requirements of the sectors. Intersectoral work usually calls for cross-cutting management.

- **Health in All Policies:** Government strategy seeking to improve health through structures, mechanisms and actions planned and managed mainly by sectors other than health. This strategy is based on the SDH approach as a bridge between policies and health results and where reduction of social inequities in health is one of the core and principal elements[15]. It is an additional or complementary step to integration. In this regard, the Adelaide Statement on Health in All Policies [16] maintains that this approach works best in conjunction with the following provisos: a clear mandate, which establishes joined-up government; systematic processes taking account of interactions across sectors; mediation occurs between interests; the presence of accountability, transparency and participatory processes; engagement from stakeholders outside of government, and practical cross-sector initiatives, which build partnerships and trust.

[15] Adapted from Ståhl et al. Ministry of Social Affairs and Health. Health in All Policies. Prospects and potentials. Finland 2006. Available at: http://ec.europa.eu/health/archive/ph_information/documents/health_in_all_policies.pdf

[16] Adelaide Statement on Health in all Policies, WHO, Government of South Australia, Adelaide 2010.

Figure 11: Working models with other sectors or types of intersectoral action.



Source: Solar O., Valentine N., Netherland Adapted from Policy Integration. E. Mejiers[17].

It is important to highlight that different types of relationship between sectors coexist over time, both regarding relationships with a certain sector and relationships among different levels of organisation and government (national, regional, local and community level). These relationships don't necessarily present progressive stages of development. Windows of opportunities and political conditions leading to integration or to the inclusion of Health in All Policies may appear. These may result from a previous relationship or coordination between sectors, for example.

The kind of intersectoral practice that is carried out in one country or region is related to the vision of health of the specific society and the focus of Public health interventions linked to this vision. In the next table, a diagram of the three main current trends on Public health is shown: a) interventions focused on disease, b) prevention of risk factors and promotion of healthy lifestyles, (especially through individual strategies) and c) social production of health, bearing in mind the SDH; linking these three trends with the prevailing relationship patterns that the health sector establishes with other sectors.

[17] Meijers E., Stead D. (2004). Policy integration: what does it mean and how can it be achieved? A multi-disciplinary review. Berlin Conference on the Human Dimensions of Global Environmental Change: Greening of Policies – Interlinkages and Policy Integration.

Focus of Interventions	Disease	Prevention and Promotion of healthy lifestyles	SDH: Social production of health approach*
Prevailing relationship patterns with other sectors	Information-Cooperation	Cooperation-Coordination	Integration - Health in All Policies
Results of intersectoral action	Joint actions in response to a specific problem or illness, i.e. informative campaign	Interventions for the control or eradication of risk factors and for the promotion of healthy lifestyles, e.g. tobacco regulations	Joint plans with shared funding, i.e. structural interventions

Source: Adapted from Solar O, Valentine N, Albrech D, Rice M (2009) Moving forward to Equity in Health: what kind of intersectoral action is needed?. An approach to an intersectoral typology.

* Health promotion activities should always gather this third approach, which was already included in the Ottawa Charter for Health promotion[18] as one of the five recommended strategies for promoting health "Building healthy public policies". On the other hand, health equity has always been a core issue in Health promotion activities but a true approach has not always been achieved in practice. The existence of the Health in All Policies approach does not guarantee the equitable distribution of health gain among the population. For that reason, re-orientation methods and practices towards Health Equity are essential in order to develop the most effective course of action.

SOCIAL PARTICIPATION

If the origin of inequities is in the unequal distribution of power, then, full-scale participation is one of the mechanisms for the re-distribution of power; hence, it can help to modify inequities as it broadens opportunities for action and intervention in the social hierarchy, both globally and at the SPA level. This brings to light the importance of social participation. The participation of civil society in the decision-making processes is crucial for ensuring that individuals have power and control in the development of policies.

There are different mechanisms and modalities of participation:

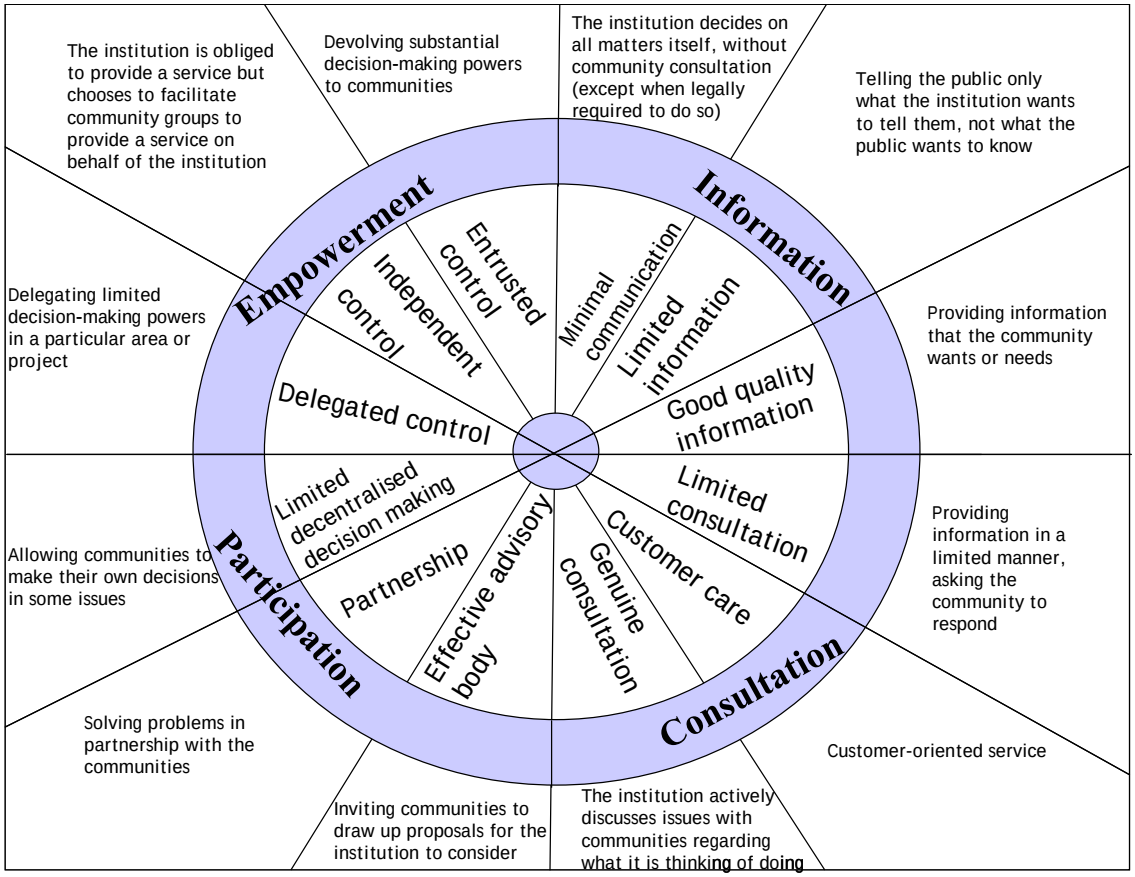
- **Information:** Offering balanced and objective information to people to help them to understand the problems, alternatives, opportunities and/or solutions.
- **Consultation:** Getting feedback from the communities which stand to be affected by the analysis, alternatives and/or decisions.

[18] WHO. Ottawa Charter for Health Promotion. Geneva, 1986.

- **Participation:** Working directly with the communities during the process to make sure public concerns and aspirations are well understood and taken into account.
- **Collaboration:** Working together with the communities involved in every aspect of the decision-making process, including the development of alternatives and the identification of the preferred solution.
- **Empowerment**: In order to guarantee that communities have the "last word" and, ultimately, the control over the key decisions that affect their welfare.

Social participation needs to be planned in order to guarantee its effectiveness. In this regard, South Lanarkshire Council has developed a wheel of participation that shows how different participation techniques allow for different objectives being achieved (Figure 12)[19].

Figure 12. Wheel of Participation



Source: Davidson, S. Spinning the wheel of empowerment. Planning, 1998; 1262: 14–15.

[19] Davidson, S. Spinning the wheel of empowerment. *Planning*, 1998; 1262: 14–15.

4.
Overview of the Process to integrate Equity into Health Strategies, Programmes and Activities (SPAs)

4. Overview of the Process to integrate Equity into Health Strategies, Programmes and Activities

The global process of integrating equity into health SPAs is comprised of three stages which can be completed in a sequential manner or not, depending on the degree of depth with which the process is carried out.

Figure 13. Global diagram of the process of integration of equity into health SPAs.

1. *Initial analysis* of equity through the application of a checklist.
2. *Review cycle* through five steps to include equity in the SPA.
3. *Redesign:* implementation of the changes agreed upon during the review cycle.

1. INITIAL ANALYSIS: CHECKLIST

The first stage of the process consists of a checklist that will encourage an initial discussion on equity and the SDH approach.

This can be considered as a first analysis of the SPA and the first exploratory step in assessing the need and the capacity to go on with the review cycle of the SPA to include equity and the SDH approach.

The development of the checklist is explained in section 5.1 of chapter 5 of the guide.

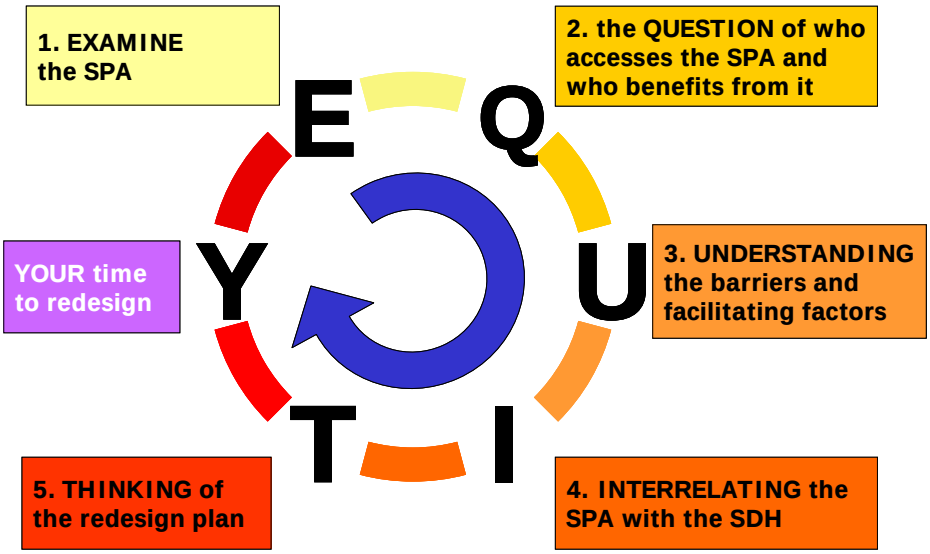
2. REVIEW CYCLE

After an initial analysis guided by the checklist, the review cycle can begin. This cycle is aimed at analysing how the SPA (or part of it) works for one or several priority sub-groups of the target population. Furthermore, it tries to analyse the reasons why

differences in access and health results affect these groups with regard to the results expected within the SPA.

The acronym EQUITY stands for the five steps of the cycle, and it ends with the redesign stage:

Figure 14. Review Cycle Steps.



The following table provides a synthetic view of the different steps of the review cycle and their objectives.

Step	Title	AIMS
E	**EXAMINE the SPA**	Analyse the general characteristics of the SPA, identifying interventions and key stages. Understand the SPA theory and assess whether it includes an equity and SDH approach. Identify and select the scope of the review.
Q	**The QUESTION of who accesses the SPA and who benefits from it**	Analyse which groups are able to access the SPA and benefit from it in each key stage. Identify and prioritise which groups are affected by inequity.
U	**UNDERSTANDING barriers and facilitating factors in each key stage**	Identify barriers that hinder access and benefits in each key stage of the SPA. Identify factors that facilitate the access and benefits in each key stage of the SPA.
I	**INTERRELATING the SPA with the SDH**	Associate the analysis of the SPA made in the previous steps (E-Q-U) to SDH. Analyse intersectoral action and social participation in the development of the SPA and its role when tackling the barriers identified.
T	**THINKING of the redesign plan**	Identify the priorities and goals of the redesign. Integrate intersectoral action and social participation in the redesign of the SPA.

In section 5.2 of chapter 5 of this guide, the development and activities of each cycle step are explained.

3. SPA'S REDESIGN

The redesigning phase is the final stage of the process of integration of an equity and SDH approach. At this time, the plan for the redesign agreed upon in the review cycle is implemented through incorporating the necessary changes to achieve greater equity.

Paso	Título	Objetivo
Y	**YOUR time to Redesign**	Implementing and developing the SPA's redesign.

Section 5.3 of chapter 5 of this guide explains this section.

CRITERIA FOR ORGANISING THE WORK

Before starting the process of integration of equity into the SPA, it is necessary to form a working team and, subsequently, to select the SPA that is going to be analysed. In order to accomplish the previous steps, some aspects to take into account are presented below, drawn from the lessons learnt by the working teams during the training process.

Formation of a Working Team

We recommend the formation of a working team in order to analyse a SPA according to the equity and SDH approach and integrate it within the SPA. Drawing on the experience of the training process, here are some aspects to bear in mind when forming the working team:

- First of all, the working team has to be operative. It is therefore very important to take into consideration practical aspects such as the number of individuals that are going to take part, their availability of time as well as the logistical factors required for the organisation of meetings among the members.
- In relation to the selection of the members of the working team, the experience gathered throughout the training process suggests that it is advisable to involve professionals with experience in the SPA that is going to be analysed and professionals with the ability to exert control over the SPA. It is also recommended to include a facilitator in the team or to share leadership among the members of the working team by shifts.
- As we have previously seen, intersectoral action and social participation are key elements for working on SDH. Consequently, another aspect to bear in mind is the possibility of having individuals coming from other sectors — separate from health but with an impact in the SPA—as members or consultants.

- In the event of not being able to establish a working team for the process, this could be carried out individually. Nevertheless, if this was the case, it would be important to have the assessment, review and comments of other professionals, as well as to make the consultations needed, especially regarding those aspects found more difficult to develop by the person in charge of the analysis process.

Selection of the SPA to be analysed:

The experience of the different teams during the training process shed some light about critical aspects to make the election easier in the case of doubts arising with regard to which SPA to choose in order to apply the process of equity integration:

- Selecting a SPA that has already been implemented instead of selecting "young" SPAs at a design stage. Information about the selected SPA should be available in order to understand how it works and how it is being implemented.

- Selecting a SPA over which control may be exerted in order to guarantee a greater capacity of implementation at the redesign stage.

- Selecting a Programme or Activity: it is easier to apply this process methodology in Programmes or Activities (which have a more concrete and operative level of planning) than in Strategies.

In addition, in order to facilitate the selection, a brief abstract of the main criteria employed by different methodologies of prioritisation in Public Health has been provided in Annexe III.

5.
Process to integrate Equity into Health SPAs

5. Process stages to integrate equity into Health SPAs

According to the last chapter, the whole process consists of three phases, as we will detail below:

1. **Checklist** for the initial equity analysis of the SPA.

2. **Review cycle**: **E-Q-U-I-T-Y** steps.

3. **Redesign stage: Y**. Recommendations for the implementation, monitoring and evaluation of the SPA redesign.

5.1. Checklist for the initial equity analysis of the SPA

In the first step of the process, an initial comprehensive debate on the SPA is fostered in order to check if it includes the equity and SDH approach.

For this purpose, once the working team has been formed and the SPA selected, the team will begin the reflection and analysis of the different elements of the checklist. In general terms, the checklist analyses the following SPA areas:

1. Aims of the SPA.
2. SPA's target population.
3. Evaluation of people's needs.
4. Analysis of the SPA's interventions.
5. Implementation of interventions.
6. Intersectoral action.
7. Participation.
8. Expected SPA's results.
9. Equity challenges.

WHAT NEEDS TO BE DONE?

- The working team must fill in the checklist for the selected SPA.

CHECKLIST FOR THE INITIAL ANALYSIS OF THE SPA'S EQUITY

NAME OF THE SELECTED SPA **(Specify if it is a Strategy, Programme or Activity)**	
PARTICIPANTS IN THE DISCUSION AND COMPLETION OF THE CHECKLIST	**1** **2** **3** **4** **5**

1. What are the aims of the SPA?

List the aims of the SPA.

Is there any explicit aim relating to equity?

2. What is the target population?

Describe the socio-demographic, geographic, economic characteristics and other of the target population.

In your experience, which are the different social groups that need to be identified within the SPA in order to move forward in terms of health equity?

Answer the questions and complete the table.

Target population	No	Yes	Which one(s)?
Are there social groups not taken into account in the SPA's definition?			
Does the SPA consider taking additional actions for some specific social groups?			
Regarding the SPA's formulation, are there any social groups benefiting more than others?			
Regarding the SPA's results, are there any social groups benefiting more than others? For example: are there groups with earlier access to new programmes or actions?			
Do the SPA's interventions negatively affect any social group? For example, an excluded group or an action that will increase inequities.			

3. Evaluation of the health needs of individuals

Does the SPA regularly analyse the health needs of the target population? Explain your answer.

There are several definitions of health needs. **Which of the definitions of needs is more similar to the one employed by the SPA? Give a mark from 1 to 5 for each definition, (1 = very similar and 5 = very different).**

Typology of needs by Bradshaw	1	2	3	4	5
***Normative need*:** An expert defines the need through the definition of the norms, criteria or standards that are to be achieved.					
***Felt need*:** Individuals are questioned in order to know their needs which are translated into problems or expectations by the specific group or community.					
***Expressed need*:** Based upon the information about the use of preventive, curative or promotion services. It is equivalent to the demand for health services, how do people use the services or turn the need into action.					
Comparative need: This applies to a population that has the same characteristics as another one and is receiving a specific service or coverage. When normative criteria are not used for defining the need, it is common to compare the health status of different areas or environments to establish which ones have more gaps (needs).					

If the SPA does not analyse the needs, what evidence is supporting its formulation and evaluation?

4. Analysis of interventions

List all the SPA's interventions. In the case of a strategy, if there are not explicit interventions, detail the actions that are carried out in its development:

→ **Intervention 1:**_____
→ **Intervention 2:**_____
→ **….** _____

In the case of detailing interventions, indicate which ones come from individual approaches and which ones correspond to population approaches. In case of not detailing interventions, indicate what the global SPA's orientation is, in other words, indicate whether it is and individual or population strategy:

Intervention	Individual	Population
Intervention 1	Yes/No	Yes/No
Intervention 2	Yes/No	Yes/No

5. Implementation of interventions

Describe the players that implement interventions within the SPA analysed.

Intervention	Players

What are the difficulties identified during the SPA's implementation?

What kind of supervision or coordination exists between the SPA and the players implementing the interventions?

What type of participation do these actors have in the formulation of the SPA?

6. Intersectoral action

Answer the questions according to your experience with the SPA (in its formulation or implementation) up to now.

SPA	No	Yes	Which one/ones? Explain
Does the SPA include any intersectoral action? With what sectors?			
If intersectoral action is included, what are the existing coordination mechanisms between the SPA and other sectors (permanent working group, joint scheduling, only joint evaluation or sporadic contact)?			
Is there a specific budget and plan in place for intersectoral action?			

If intersectoral actions were carried out, what was the main motivation behind the health sector to develop them? Tick the corresponding options.

	Tick when appropriate
To reach a wider coverage	
To consult on the definition of policies or regulations	
To launch a campaign	
To solve a particular matter	
To undertake joint planning in order to achieve shared goals	
Other	

In your opinion, what are the main reason/s for the other sectors (excluding the health sector) to develop intersectoral actions?

In your experience, what are the main obstacles to carrying out intersectoral work?

Do intersectoral actions respond to people's needs?

7. Participation

As seen in the section about Social Participation in chapter 3, there are different types or mechanisms of participation (Wheel of Participation). Answer the following questions with reference to this section:

Questions	No	Yes	Which one/ones?
Does the SPA include mechanisms of participation?			
Is there a specific budget and plan in place for participation?			
What groups and/or organisations are taken into account in the participation?			
How do they participate? Mechanisms and types of participation: – Information – Consultation – Participation – Collaboration – Empowerment			
For what purposes do they participate?			
According to your experience, what are the main obstacles to participation?			

8. What are the expected results of the SPA?

Explain what the expected results of the SPA are.

Explain the main achievements of the SPA.

What issues or aspects of the SPA do you think are still pending and are relevant? (What remains to be done?)

What indicators are relevant to the SPA?

What indicators☞ are relevant to the SPA?	List
Process indicators	
Results indicators	
Equity indicators	

Which was the most recent evaluation of the SPA?

Evaluation date	
Type of evaluation: aims and methods	
Who carried out the evaluation?	
Conclusions	
Date of next evaluation (aims and methods)	

☞ Consult definitions of indicators in the Glossary.

Answer the following questions relating to the SPA's results:

Can you demonstrate that the SPA has contributed to improving the health of the target population?

Has the improvement been equitable for all social groups?

Has the SPA enabled better access to healthcare assistance and to actions for prevention or health promotion as defined in the SPA?

Has the improvement in access been equitable for all social groups?

9. Equity Challenges

Drawing on your experience and knowledge, what are the core equity challenges that need to be addressed by the SPA?

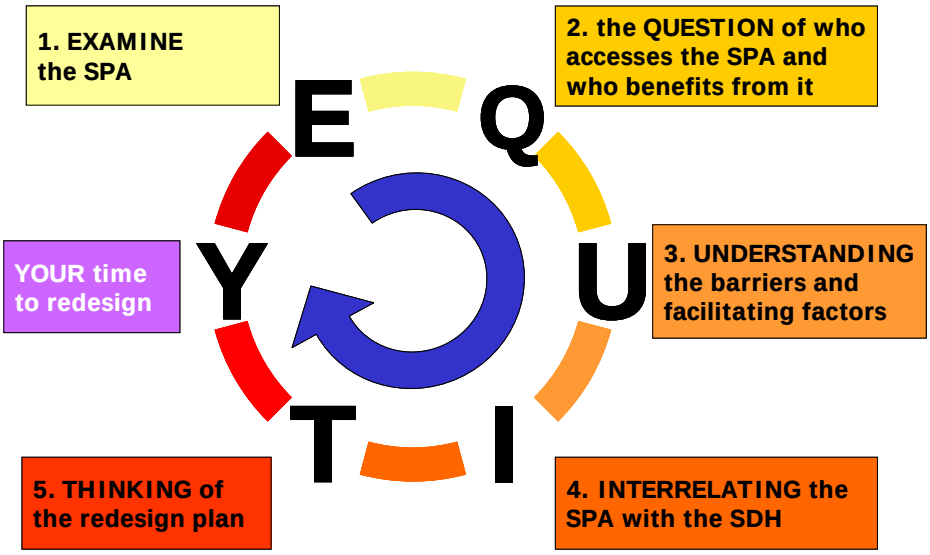
Taking into consideration the framework of the WHO Commission on Social Determinants of Health (chapter 3), think about which Determinants (intermediary and structural) may be linked to your SPA.

5.2 Review cycle: E-Q-U-I-T-Y

After an initial analysis guided by the checklist, the review cycle can begin. This cycle is aimed at analysing how the SPA (or part of it) works for one or more priority sub-groups of the target population. Furthermore, it intends to analyse the reasons why differences in access and health results affect these groups in comparison to what was expected within the SPA.

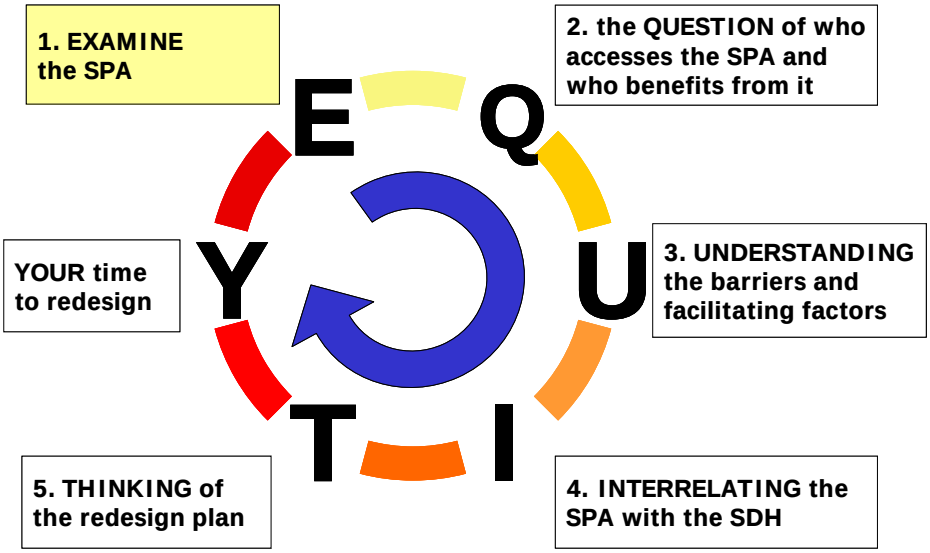
It is a five-step cycle forming the acronym: EQUIT(Y); the final "Y" refers to the redesign phase (chapter 5.3 of this guide).

Figure 15 Steps of the Review cycle.



Now we are going to analyse each of these five steps. The general structure of each step is formed of different activities. At the end of the explanation of each activity, the tasks required for their completion are summarised in a blue box. Examples of different activities are provided. These are drawn from the work accomplished by the working teams during the "Training process to integrate a focus on social determinants of health and equity into health strategies, programmes and activities." In order to make the examples easier to understand, basic information about the SPA analysed by each working team is provided in Annexe II.

5.2.1. Step E: EXAMINE the SPA



Aims

1. To analyse the general characteristics of the SPA, identifying its interventions and key stages.
2. To understand the SPA theory and to assess whether it includes an equity and SDH approach.
3. To identify and select the scope of the review.

Development

In this Table, the development of **step E**, divided into six activities, is summarised:

Step	Activity
Step E: **EXAMINE the SPA**	**Activity 1:** Analysing the goal of the SPA
	Activity 2: Identifying and classifying the interventions or actions included in the SPA
	Activity 3: Identifying and drawing a diagram of the SPA's key stages
	Activity 4: Defining the SPA's theory
	Activity 5: Assessing whether the SPA's theory includes an equity and SDH approach
	Activity 6: Framing the review, if needed

Activity 1: Analysing the goal of the SPA

To start the review cycle, firstly, it is necessary to undertake a general analysis so as to understand what the SPA wants to achieve and the original context of its initial development. That is to say, the SPA's "why" and "what for".

Reviewing the objective of the SPA helps to specify the conceptualization of the problem or issue that it tackles. In many cases, a SPA comprises several objectives, what makes the review of the SPA a complex process.

Reviewing the aims section of the previously made checklist will assist in this process.

WHAT NEEDS TO BE DONE?

A summary offering answers to the following questions must be made:

- What is the problem or issue tackled by the SPA?
- What is the SPA's general objective?
- Justification of the SPA's importance, in other words: why the existence of the SPA makes a difference?
- In what context does the SPA appear and is developed?
- Describe your SPA in brief (what its structure is, to whom is it addressed (final and intermediate recipients), its different levels of implementation, etc.).
- What are the -human, economic, material, etc. - resources available?
- Who participates in its design?
- Who participates in its implementation?
- Who participates in its evaluation?

Example 1: Step E activity 1

Analysis of certain aspects of the SPA, carried out by the working team that analysed the Municipal Plan for Prevention and Assistance in Drug Dependency.

What is the problem tackled by the SPA?

The Municipal Plan for Prevention and Assistance in Drug Dependency tries to address the health problems of the population consuming toxic substances in a specialised and comprehensive manner. Furthermore, the Plan is aimed at reducing drug use or delaying the start of drug consumption among young people and children and in the community level.

What does the SPA do?

- Informs –teaches, raises awareness and counsels about drug dependency and its prevention; it develops health education programmes in schools.
- Evaluates the health impact of drug consumption in users from a biopsychosocial perspective.
- Develops a therapeutic proposal and/or referral to other resources.
- Treats and assesses therapeutic treatments.

How does the SPA achieve this?

- By making proposals for educational and informative interventions in schools.
- By developing interventions for health education with students, parents and teachers.
- By developing interventions for health education at the community level (training of youth mediators).
- By delivering clinical outpatient interventions (therapies) in the CAID, in collaboration with the therapeutic team.
- By monitoring abstinence with the support of drug testing.
- By prescribing drugs and opiate substitutes.
- By making proposals for referral to other resources.
- By writing clinical reports for the Court and other judicial bodies.

CAID: Spanish acronym for Centre for Comprehensive Assistance to Drug Dependants.

Activity 2: Identifying and classifying the interventions or actions included in the SPA

First of all, it is necessary to identify the interventions included within the SPA by considering the following question: What does the SPA do or recommend to be done to tackle the problem identified? (Describe the actions and interventions included in the SPA).

Once all interventions are identified, they will be classified as shown in the table. This will enable a more comprehensive view of the SPA.

Type of Intervention/ Coverage [☞]	Universal	Focused or selective	Combined
Interventions for accessing curative and secondary prevention care ***(Downstream)***			
Interventions for changing behaviours and lifestyles (***Midstream***)			
Interventions dealing with living and working conditions ***(Midstream)***			
Interventions for modifying the context and/or social stratification ***(Upstream)***			

WHAT NEEDS TO BE DONE?

- Make a list with all the SPA's interventions.
- Classify the interventions according to the table.

[☞] See definitions about types of interventions and coverage in the Glossary.

Example 2: Step E activity 2

Types of interventions identified by the working team that analysed the Programme of Information on Smoking in the Region of Murcia:

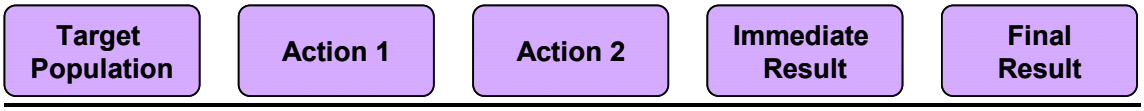
Type of intervention/Coverage	Universal	Focused or selective	Combined
Downstream (Interventions for accessing curative and secondary prevention care)		8. Capacity-building of healthcare professionals in smoking prevention.	
Midstream (Interventions for changing behaviours and lifestyles)	2. Providing resources for smokers in order to quit smoking. 3. Delivering interventions in the media for raising awareness about smoking among the population.		1. Making and distributing informative and educational materials aimed at different groups. 5. Spreading scientific evidence in the media and among social and healthcare professionals.
Midstream (Interventions on living and working conditions)	3. Delivering interventions in the media for raising awareness about smoking among the population.		
Upstream (Interventions for modifying the context and/or the social stratification)		4. Involving social leaders of the Region of Murcia in the prevention of smoking. 6. Health advocating interventions aimed at seeking partnerships for smoking prevention among several social sectors. 7. Fostering active participation of different sectors of the population.	

Activity 3: Identifying and drawing a diagram of the SPA's key stages

It is necessary to identify the key stages☞ of the SPA. In other words, we need to sequence the process of the SPA's development, separating the different stages leading to the final objective. Once these key stages or phases are identified, it will be helpful to produce a diagram that presents the SPA in a simple manner and allows for subsequent activities.

It is important to bear in mind that this activity considers the SPA as it currently is (and not as we would like it to be).

The simplest way to present the SPA's key stages is to follow the diagram that comes next, though it may prove more useful when working with programmes and actions than with strategies:



Diagramming must be a flexible and dynamic process, taking into account there is no unique or true way of representing the key stages. The best option will be the one that best suits the specific situation of every SPA and the needs of the working team. In fact, it is possible that changes to the diagram will be introduced as we move forward in the review.

WHAT NEEDS TO BE DONE?

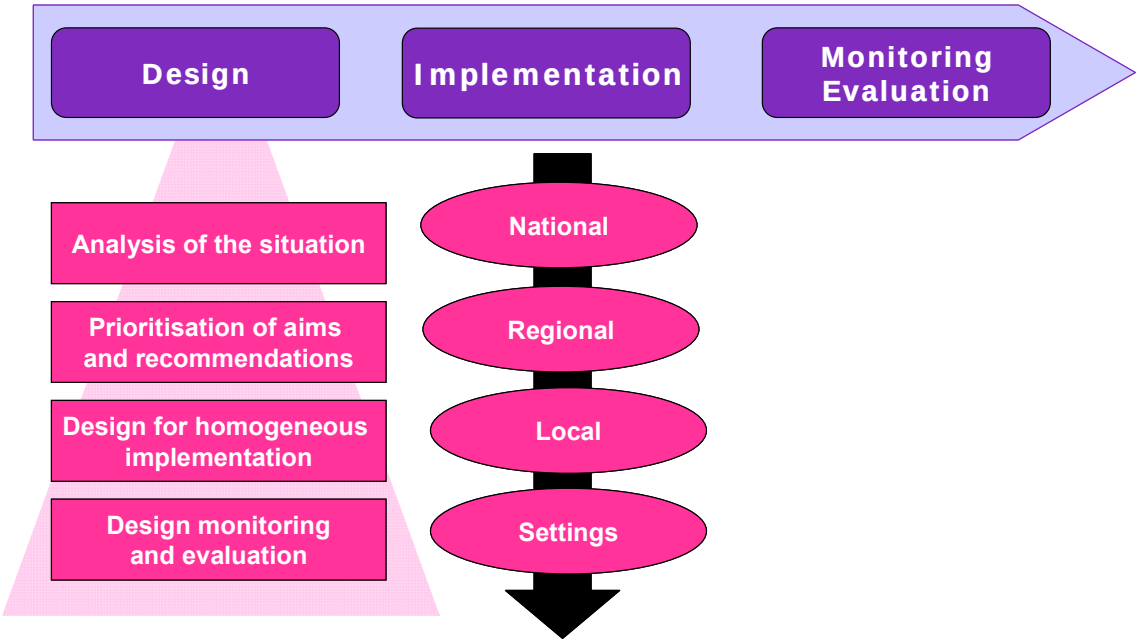
- Diagram key stages of the SPA.

Examples of diagrams of the key stages are presented below; they can be very useful to see the different kinds of representations.

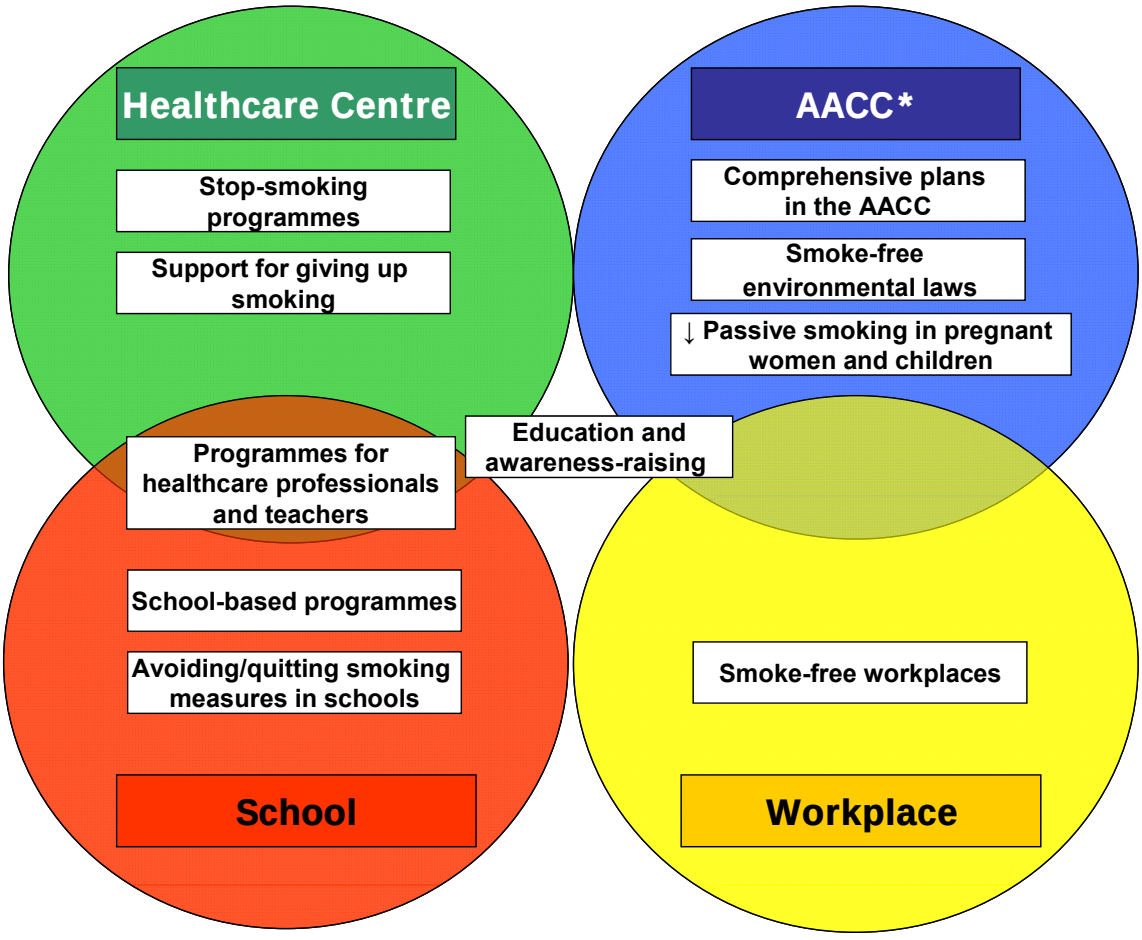
☞ See definition of key stage in the Glossary.

Example 3: step E activity 3.

Diagram of key stages (and sub-diagram of settings) made by the working team that analysed the strategic line on Health Promotion and Protection within the Cancer Strategy of the National Health System.



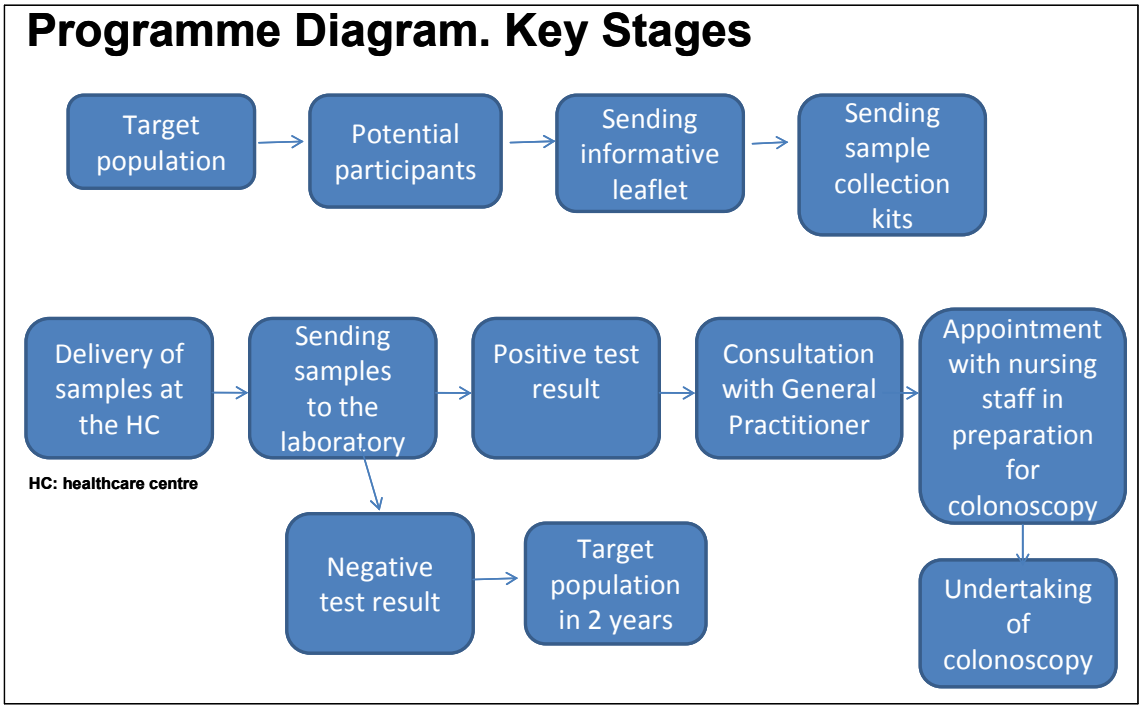
SETTINGS:



*AACC: Autonomous Communities.

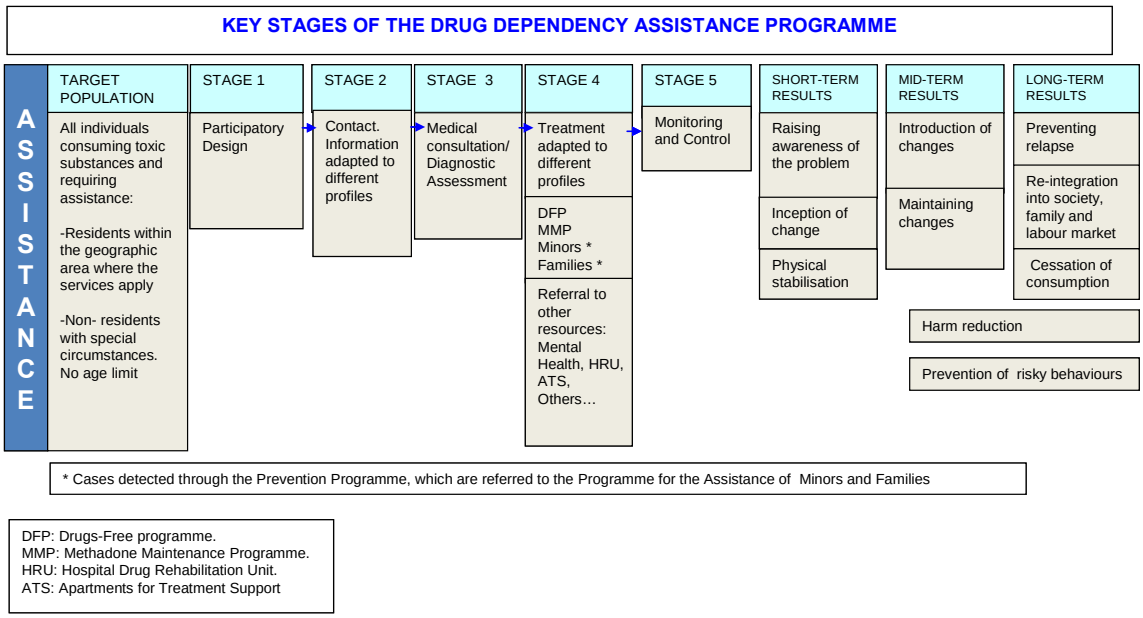
Example 4: step E activity 3

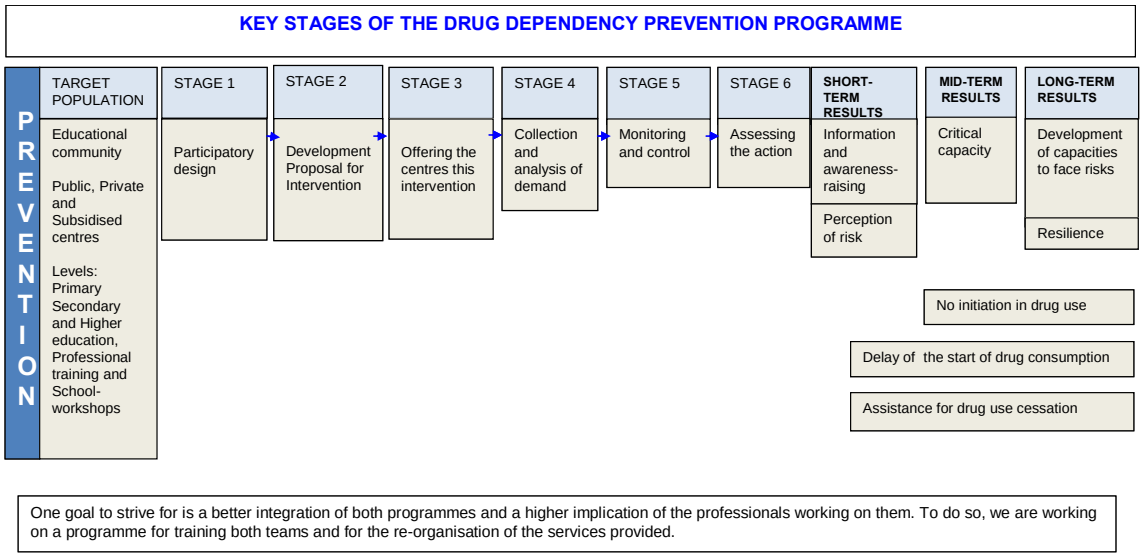
Diagram of key stages made by the working team that analysed the Screening Programme for colorectal cancer.



Example 5: step E activity 3

Diagram of key stages made by the working team that analysed the Municipal Plan for Prevention and Assistance in Drug Dependency.





One goal to strive for is a better integration of both programmes and a higher implication of the professionals working on them. To do so, we are working on a programme for training both teams and for the re-organisation of the services provided.

Activity 4: Defining the SPA's theory

The SPA's theory is the set of fundamentals, evidence and hypothesis which the SPA is based on. The SPA's theory will help us to find out more about the theoretical premises the SPA is built on and which justify the use of the SPA as a means to achieve the expected goals. Frequently, the SPA theory is not explicit, therefore it can be useful to analyse how the SPA is organised, the interventions involved as well as the goals and the attained results[20].

Reflection and analysis regarding the SPA's theory is a must. The following questions can be used as a guide:

1. What is the general situation of the problem being tackled by the SPA?
2. In what way will the SPA's implementation moderate the problem?
3. What are the fundamentals, evidence and hypothesis that justify the SPA's implementation?
4. What are the expected results in each intervention of the SPA?

WHAT NEEDS TO BE DONE?

- Define the SPA's theory.
- There are two possible ways to define it:
  - Write a summary of the SPA's theory.
  - Draw a diagram of this theory.

[20] For carrying out this analysis, it can be useful to consult: Pawson R and Sridharan S. Theory- driven evaluation of public health programmes. Chapter 4 in Evidence-based Public Health, Effectiveness and Efciciency. Oxford University Press 2010.

Some examples of different SPA's theories are presented below:

Example 6: step E activity 4

Drafting of the SPA's theory by the working team that analysed the programme for promoting youth health of the Regional Government of Andalusia called *Forma Joven*.

SPA's theory

Whether explicitly or implicitly, the **SPA's theory** is based on the portrayal of youth as a group highly exposed to risk behaviour and with little information and training in health-related issues. They are also likely to have limited contact with healthcare centres as they consider these services to be hard to access and to be lacking in privacy as a place for them to address their doubts.

On the other hand, there is a lack of knowledge and skills required to deal with issues relating to young people's health among health professionals.

Accordingly, if professionals who are motivated to inform young people get information to the places they frequent, it will be possible to create the resources and capabilities required to help them face risks, combine health with fun and lean towards adopting healthy behaviours.

The programme's design comes from the idea that if professionals and young mediators are trained, helping them to acquire knowledge and develop skills, it will be possible to get information to boys and girls in the locations where the *Forma Joven* Units will be established. Therefore, it will be possible to work with them on areas relating to healthy lifestyles, sexual and affective issues, mental health, etc. either one-to-one (through personal consultations) or in group settings (through workshops). These working areas are based on the assets model and the model of health promotion competencies. In contrast to the deficit model, this model encourages personal, family, school and community resources which provide the necessary support and experience to foster positive development during adolescence[1].

In conclusion, the SPA's theory is based on the following idea: improving the information and training offered to young people will increase their capability to face risks and, therefore, healthy lifestyles will be encouraged.

---

[1] ***Deficit Model versus Asset Model***

Over the course of the past few decades, the portrayal of adolescents throughout the western world has brought about a model of teenage health care which focuses on deficit and risk factors. However, in recent years, this model has started to be called into question by other approaches that put an emphasis on competence and positive development of teenagers and young people.

Both professionals and the general population confuse healthy development with the absence of problems. This view places excessive emphasis on the idea of deficit and tends to overlook the values and skills that should be promoted among teenagers and young people.

The deficit model or paradigm is focused on risks, diseases, pathologies and their symptoms, with few references to competencies, optimism, future expectations or significant relationships. It is focused on identifying problems and imbalances. The **positive** teenage **development model** defines the competences that lead to a healthy development and is connected to the concept of personal, family, school and community resources that provide the necessary support and experiences for promoting positive development during adolescence.

Example 7: Step E activity 4

Diagram made by the working team that analysed the strategic line of Health Promotion and Protection within the Cancer Strategy of the National Health System.

Initial Theory

- **Raising awareness and understanding**
- **Intervening in places frequented by young people: schools, workplaces**
- **Making smoking difficult: smoking ban in public places**
- **Making withdrawal easy**
- **Setting an example: educators and healthcare staff**

↓

↓ Prevalence of tobacco comsumption among young people
+ Delay age of first consumption

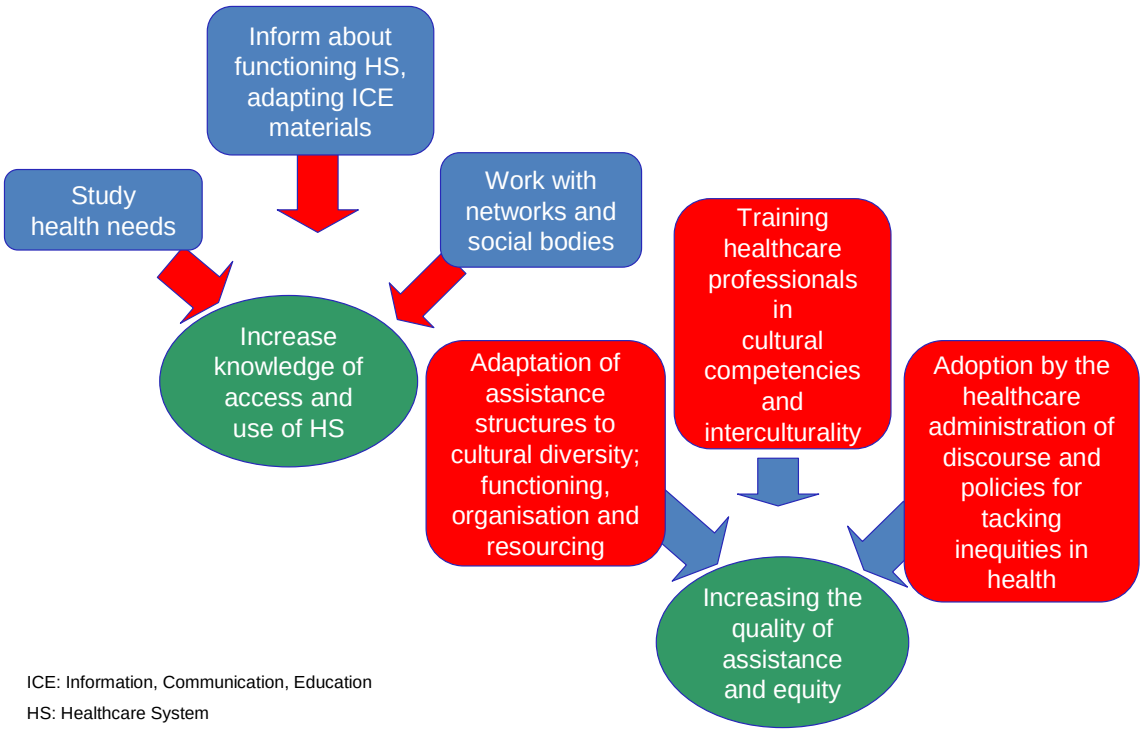
↓

↓ Tobacco-related morbility and mortality

Example 8: Step E activity 4

Diagram of the SPA's theory made by the working team that analysed the programme aimed at vulnerable migrants of the line Vulnerable Groups of the Health Promotion and Prevention Plan 2011-2013.

SPA's theory Diagram



ICE: Information, Communication, Education

HS: Healthcare System

Activity 5: Assessing whether the SPA's theory incluyes an equity and SDH approach

In this activity, the working team must consider whether the equity and SDH approach is included in the SPA's theory, in other words: **how does the SPA's theory conceptualise the problem of health inequities?** In order to specify the answer, two aspects must be reviewed:

a. ***HETEROGENEITY:*** **Does the SPA's design take into account in its interventions the heterogeneity of the target population?**

This section invites reflection on how the SPA's design has taken into account the specific needs of the different segments of the population, either in terms of content or the intensity of actions; does the SPA recognise different needs and hence propose different interventions or actions? Is there a different method of working depending on social groups, territories or individuals within the SPA? What actions are proposed in order to tackle these differences?

b. ***HEALTH EQUITY: Has the impact of the SPA on health equity been explicitly defined in the design?***

The working team should analyse whether the SPA design takes into consideration the way health inequities show up, their origin and what impact the SPA has on them. In this sense, the inclusion of equity-related indicators or aims in the SPA is not enough. We need to consider whether the mechanisms, actions and interventions lead to the reduction of inequities and whether they tackle SDH or not. If they do, we need to think about which ones they tackle and in what way.

WHAT NEEDS TO BE DONE?

The working team must carry out an initial reflection including the following aspects:

- Heterogeneity:

  How does the SPA deal with heterogeneity of the target population?

  Are interventions differentiated according to different target groups?

- Health equity:

  Does the SPA generate inequities? How?

  Does the SPA lead to greater effective health equity?

These questions are intended as first lines of inquiry about the inequities in the SPA and not as a means of detailed analysis, which will take place during the subsequent steps of the process.

Example 9: step E activity 5.a

Analysis of heterogeneity developed by the working team that analysed the call for grants to fund non-profit organisations-based programmes for HIV and AIDS prevention and control.

The SPA explicitly recognises the heterogeneity of target populations and takes into consideration the issue of geographic dispersion; consequently, it tries to identify inequities regarding the distribution of the grants. Nonetheless, many of these populations are heterogeneous themselves and can be stratified in terms of inequities and this is not always noticeable through the interventions. To avoid this, more efforts were made to spread the call among those organisations that do not normally participate but may have better access to sub-populations; moreover, the TUE (Temporal Unions of Entities) was established in order to stimulate interventions in the whole Spanish State, whenever the entities are state-owned.

Example 10: step E activity 5.b

Analysis of health equity made by the working team that analysed the Screening Programme for colorectal cancer.

There are no interventions in the programme that truly lead to greater health equity in an effective manner.

The programme does not consider in its definition any specific social group: The target population is the population between the ages of 50 and 59. No additional action regarding age or sex is implemented even though in men the incidence of colorectal cancer (CRC) is twice as high as in women; and even though in both sexes the incidence of CRC is three times larger in the 65-69 age range than in the 50-54 range.

Nor does the programme take into account the socioeconomic level of the target population. A review of 51 studies published in Canada demonstrates that access to CRC screening is influenced by an individual's level of income while age and place of residence determine access to treatments (André R. Maddison, Yukiko Asada and Robin Urquhart).

With regard to the implementation of the programme, it has to be noted that it has been developed in a progressive geographic manner that does not reach 100% of the target population. Furthermore, it is linked to an inequity that is conditioned by the lack of professionals and appropriate rooms for carrying out colonoscopies.

A small percentage of people (less than 3%) are not invited to the programme due to not possessing the Spanish Health Card.

Activity 6: Framing the review, if needed

In many cases the SPA is complex and comprises several sub-programmes. This can make it difficult to review the SPA in its entirety. Before taking the next step, the working team must decide whether a complete review of the SPA is applicable or whether it is preferable to prioritise one or several parts of it.

WHAT NEEDS TO BE DONE?

- Specify which of the SPA's goals will be included in the review.

*Note: if the final goal/goals included for the review do not match the initial approach, a review and adaptation of the diagram of the SPA's key stages (activity 3) will be needed. The adaptation of the SPA's theory to the new approach (activity 4) must also be assessed.

Example 11: Step E activity 6

Frame made by the childhood working team that analysed the Health strategic goal of the National Strategic Plan for Childhood and Adolescence.

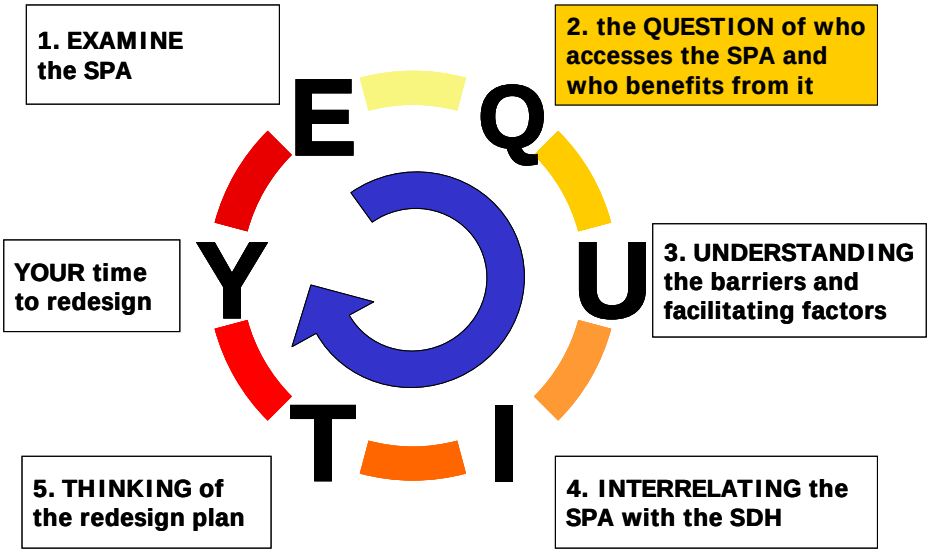
The working team decided to apply the review cycle to the National Plan for Childhood and Adolescence (PENIA), analysing it through the perspective of health equity. This is because, as PENIA is a plan of national scope, this work may be of interest.

At an initial stage, the working team was thinking about reviewing the whole plan. Yet, given that it has 11 strategic goals, analysing each of these in depth, with its correspondent measures, was going to be a very complex task so the working team decided to delimit the review to the health goal, which reads as follows:

> *Aim 9. Encouraging the development of health promotion, protection and prevention aimed at children and teenagers, and at the prevention of accidents and other causes of disability, including aspects of affective and sexual education and education for a responsible consumption, paying particular attention to the diagnosis and treatment of deficiencies and to mental health in childhood and adolescence.*

As a working team, we think it is important to note that, even if the selected goal is the one most directly connected to health, we are aware that the remaining objectives can also contribute to health.

5.2.2. Step Q: The QUESTION of who accesses the SPA and who benefits from it



Aim

1. To analyse which groups/sub-groups of the target population are able to access and benefit the SPA during each key stage and which aren't.

2. To identify and prioritise the group or subgroups in a situation of inequity.

Development

In the *Step E*, general characteristics of the SPA, its theory, key stages and interventions have been studied and the objective of the review has been decided. The next step, **step Q,** consists of analysing the SPA from the point of view of the access and the benefit it offers the population.

In the following table, the development of step Q is summarised and divided into four activities:

Step	Activity
Step Q: **The QUESTION of who accesses the SPA and who benefits from it**	**Activity 1:** Identification of target groups/sub-groups of the SPA
	Activity 2: Initial assessment of groups/sub-groups in each key stage of the SPA
	Activity 3: Analysis of groups/sub-groups in each key stage of the SPA
	Activity 4: Identification and prioritisation of group(s) or sub-group(s) in a situation of inequity

Figure 4 clearly illustrates that different social groups face different barriers to achieving health: some people are born with more opportunities and it is easier for them to attain good health -"for them the race is already won" while others have to "jump" hurdles whilst progressively accumulating disadvantages for their whole lifetime, and may even be born with additional burdens or disadvantages.

It seems obvious that health SPAs must take into account this heterogeneity if all segments of the target population are expected to obtain the highest health outcomes.

In this step, groups/sub-groups within the population the SPA intends to reach (target population) must be identified, whilst attempting to understand the circumstances or contexts that determine their health outcomes. In other words, the SPA's interventions can result in differing outcomes according to different groups or sub-groups and at each of the different key stages; all of which is also determined by the characteristics, contexts or circumstances of these groups or sub-groups. Analysing these differences will allow us to study how the SPA works within each population group or sub-group, enabling to successfully tackle the specific needs of groups or sub-groups, and therefore contributing to equity.

Activity 1: Identification of target groups/sub-groups of the SPA

The first activity in this step is to identify which groups or sub-groups of the target population must be considered for analysis of their differences with regard to the SPA.

Groups/sub-groups can be defined by:

- Income, education, occupation, social class or other socioeconomic indicator.
- Gender.
- Age group (adults, elderly, teenagers, etc.).
- Employment situation (employed-unemployed).
- Ethnic group.
- Disability.
- Location:
    - Urban–rural.
    - Autonomous Community, province, town, etc.
- Others.

WHAT NEEDS TO BE DONE?

By means of an initial debate and reflection, undertake a preliminary identification of the population groups/sub-groups that must be taken into consideration to analyse their differences regarding the SPA. Complete this table for implementing this task:

Identify the groups/sub-group to be analysed	It has additional health needs Which ones? Why?	It has greater difficulty in accessing/benefiting Which ones? Why?	Other reasons Which ? Why?

Example 12: step Q activity 1

Preliminary identification of target groups made by the working team that analysed the Plan on Health education in schools of the Region of Murcia 2005-2010.

Identify the group(s) to be analysed	It has additional health needs. Why?	It has greater difficulty in accessing/benefiting Why?	Other reason. Which one?
Women (comprises all sub-groups)	Yes, because women are still in a disadvantaged situation.	Yes, certain stereotypes are still socially and culturally present.	o The education received. o Lack of resources in the school: human, structural resources…
Migrant population (It has been taken into account for the analysis of the situation but no direct interventions are planned for this population)	Yes o Coming from underdeveloped countries with poorer healthcare situations. o Uprooting.	Yes o Language. o Irregular situation. o Lack of understanding of how healthcare services work.	o Socioeconomic level. o Educational level. o Lack of social skills. o Lack of resources in the school: human, structural resources…
Family dysfunction (social exclusion, unemployment, , single-parent families…)	Yes o Situations involving stress and anxiety. o Poverty. o Disruptive behavior.	Yes o School truancy. o Parental neglect.	o Lack of social skills. o Lack of resources in the school: human, structural resources…
Ethnic groups	Yes o Certain ethnic groups are associated with social exclusion situations, which lead to declining health.	Yes o Due to their own culture. o Lack of understanding of how healthcare services work.	o Socioeconomic level. o Educational level. o Lack of social skills. o Lack of resources in the school: human, structural resources…

Example 13: step Q activity 1

Preliminary identification of target groups made by the working team that analysed the programme aimed at vulnerable migrants of the line Vulnerable Groups of the Health Promotion and Prevention Plan 2011–2013.

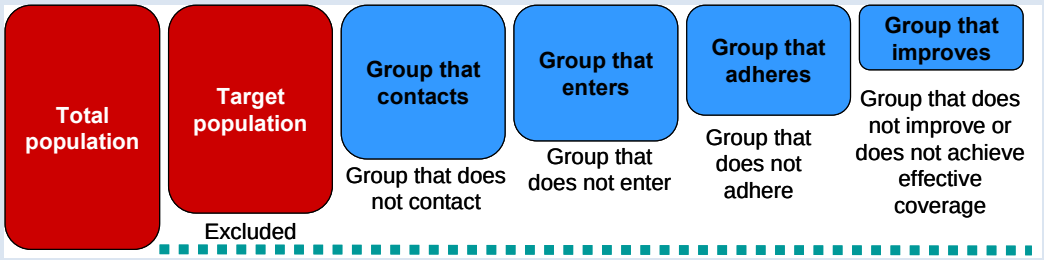
Groups to analyse	They have > health needs. Which ones? Why?	They have > difficulties in accessing/ benefiting. Why?	Other reasons. Which ones? Why?
Women and men not speaking Spanish.	> family planning and mental health needs as general population of same age and sex	Communication problems.	
Women and men without documentation (problems deriving from lack of National Identity Card).	Probably > social and health vulnerability Adverse habitat/ working conditions.	Problems in obtaining the Spanish Health Card to access healthcare system.	Working in informal economy.
Women from Morroco, China and Eastern Europe.	Language, barriers male healthcare staff.	Different health-disease concepts.	Isolation, lack of language knowledge, gender roles.
Pregnant migrant women. Children.	Lack of follow-up during pregnancy. Lack of social support network. Transnational family network long-distance caregiving/ stress.	Different pregnancy care, influenced by the way this care is provided in the country of origin, and healthy child follow-up programme.	Migrant women >> demands. Remittances /sustaining domestic economy/ family care.
Pregnant women in prison.	Absent family network Lack of specialised assistance.	Insufficient healthcare assistance.	Decision to have children in prison Oversight/stigma.
Low-wage working women, long working hours, domestic workers and carers of dependant persons.	Poor health due to lower back and osteoarticular problems related to type of work. Lack of social relationship/ support network.	Difficulty attending healthcare consultations due to long working hours.	Low wages, many obligations.
Low-wage working men, long working hours. Unemployed women and men.	Problems such as accidents at work if they work in the construction. Difficulty in meeting basic needs.	No time to go to the doctor, only when it is a serious matter.	Lack of knowledge of rights and work safety measures.

Activity 2: Initial assessment of groups/sub-groups in each key stage of the SPA

Once the groups or sub-groups of interest have been identified for the analysis, the working team must examine—using its experience—the key stages of the SPA and describe the groups they think are accessing and benefiting in each stage.

WHAT NEEDS TO BE DONE?

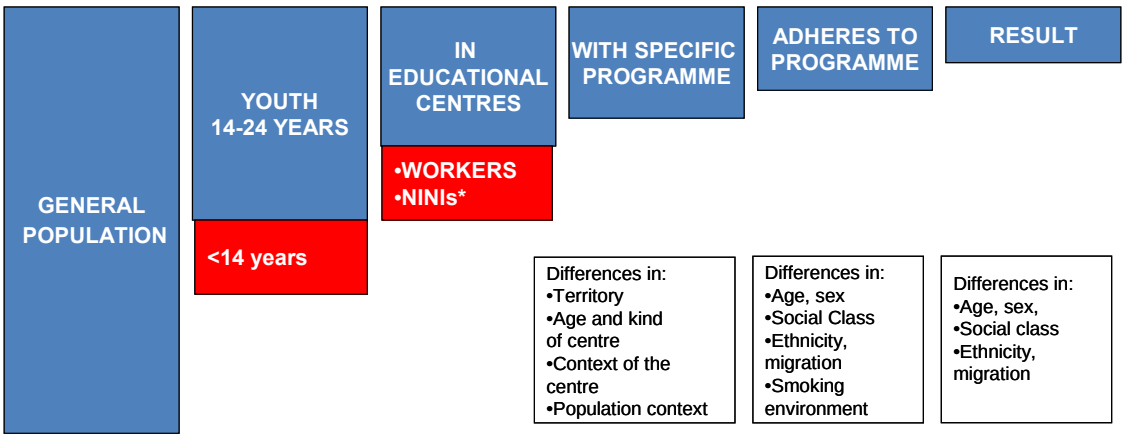
Carry out a preliminary assessment according to the experience of the working team: who accesses and benefits in each key stage. For that purpose, use the following scheme:



Example 14: step Q activity 2

Preliminary assessment of who accesses and benefits from the SPA and who does not, made by the working team that analysed the strategic line of Health Promotion and Protection within the Cancer Strategy of the National Health System.

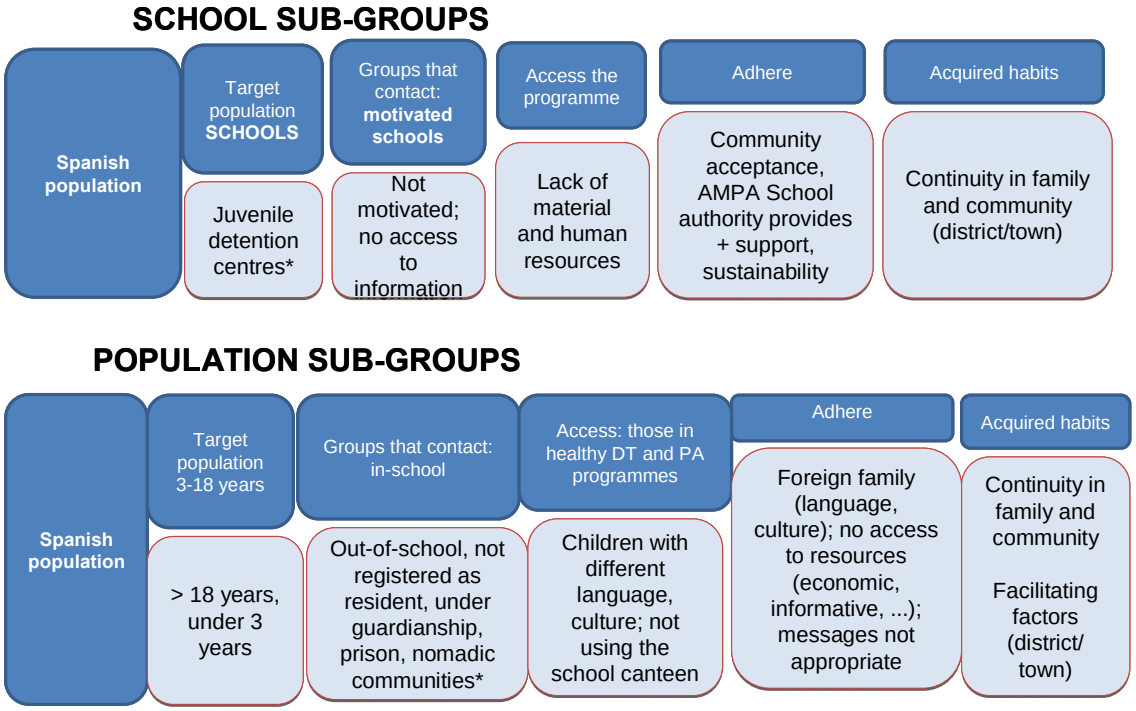
Smoking prevention in educational centres



* NINIs: Spanish acronym referring to young people who neither study nor work

Example 15: step Q activity 2

Preliminary assessment of who accesses and benefits from the SPA and who doesn't, made by the working team that analysed the NAOS (Strategy for nutrition, physical activity and the prevention of obesity).



* This differentiation is not present in all situations or all Autonomous Communities.

AMPA: Parents' association

DT and PA: Diet and Physical Activity

Activity 3: Analysis of groups/sub-groups in each key stage of the SPA

Once the preliminary assessment is made of which groups and sub-groups access and benefit from the SPA according to the experience of the working team, it is important to undertake an analysis of this assessment using the sources of information which are available —quantitative and qualitative— that will enable the analysis undertaken in activity 2 to be completed and adapted.

In order to do that, the following activities will be implemented:

A. Identification of the information available.

B. Data extraction and analysis.

C. Interpretation of data.

A. Identification of the information available

The working team must identify the existing sources of information with quantitative data related to each key stage of the SPA. Both primary and secondary data sources must be searched. For example:

- Records of the SPA's activities.
- Follow-up or evaluation indicators of the SPA.
- Demographic data relating to the population.
- Morbidity and mortality statistics.
- Surveys analysing access to, and use of services.
- Surveys on health status and quality of life, such as the National Health Survey, the regional or local Health surveys or Quality of Life and Health surveys.
- Relevant national, regional or local studies.

At the same time, qualitative sources of information must be considered: Studies, working group discussions, consultation with key players as well as with those responsible for the planning and implementation of the SPA, and with other key informants.

The following table can assist in systematising the information available and the possibility of analysising differences according to group/sub-group in each key stage of the SPA:

Key stage	Quantitative data sources	Qualitative data sources	Possible groups/sub-groups for analysis
1			
2			
3			

B. Data extraction and analysis

This will be undertaken in different ways depending on the data available:

- If there are primary sources of quantitative data: analysis of data will be developed according to the statistic disaggregation which is either possible or desirable, and through the use of the relevant measures for studying the SPA. The key questions are: is it possible to disaggregate information for each social group or to use stratificators? I.e. can the results of the SPA be analysed according to group/sub-group?

- If there are secundary sources of quantitative data: the information perceived as useful for analysing the different population groups/sub-groups related to the SPA will be collected.
- Furthermore, qualitative information must also be analysed. For this purpose, as is the case for quantitative data, available primary and secondary sources of information must be studied and, on the other hand, the experience of the working team can be contrasted with consultations with different people, especially with the local operators and executors of the SPA. To achieve this, the working team can use different methods of qualitative research: interviews, focus groups, etc.

Alternative analysis by territorial areas:

Comparation between territorial areas selected according to vulnerability or other social position indicator.

Another alternative is make the analysis using available territorial information in order to estimate the situation of the target group. For example, if the working team has prioritised the most socially vulnerable groups, those with the lowest income or educational level, it may be possible to extract the information indirectly, analysing according to AACC, towns, etc.

In other words, comparing the functioning of the key stages in different territories. Territories somehow representing the different sub-groups for analysis—by means of vulnerability, income or ethnic group—must be selected. For example, territories characterised by a low wage level and family income can be selected and compared to those with higher income. This is feasible through the use of socioeconomic characterisation or living conditions surveys.

If quantitative information at local level allows it, an effort to differentiate sub-groups in each key stage can be carried out as well as a calculation of proportions, rates or other relevant measures for the SPA according to differences in terms of access or results.

C. Interpretation of data[21]

Regarding the interpretation and limitations of the analysis of the SPA's access, it is important to consider the conceptualisation of need within the population and the expression of demand, as they present differences according to factors such as education, income, ethnic group and social class, among others. Some international studies on this topic argue that even if access gaps are wider between socioeconomic quintiles, people with lower income level use Primary Healthcare more often and are hospitalised more frequently than those with higher income experiencing the same health need. It has also been observed that Specialised Healthcare works the other way round as it is most commonly used by individuals with higher incomes. Dental care services are used more regularly by individuals with higher incomes, this fact being related to the absence of public funding for oral health in most countries. It has also been noted that screening and preventive services normally favour the most privileged

[21] Sub-Secretariat of Public Health, Ministry of Health, Government of Chile. *Documento técnico III. Guía para analizar equidad en el acceso y los resultados de los programas y su relación con los determinantes sociales* [Technical document III. Guide for the equity analysis on programmes' access and results and their link with social determinants of health] [in Spanish].

social classes. This implies that merely analysing the utilisation of services can lead to incorrect conclusions, because a higher utilisation does not always imply a greater need; at the same time, this need is not only determined by the offering of services, but also by the conceptualisation of need.

In order to interpret the results it is important to take into consideration that needs are differential and therefore we can expect to find differential utilisation rates. Even the activities included within each stage should be differential. As such, when the health need is greater, the response cannot only be to intensify actions but also to develop different actions in terms of their contents.

The following general overview may be helpful to the debate, when taking into account the limitations mentioned above:

		NEED	
		HIGH	LOW
UTILISATION	HIGH	Appropriate access	Over-utilisation
	LOW	Poor access	Appropriate access

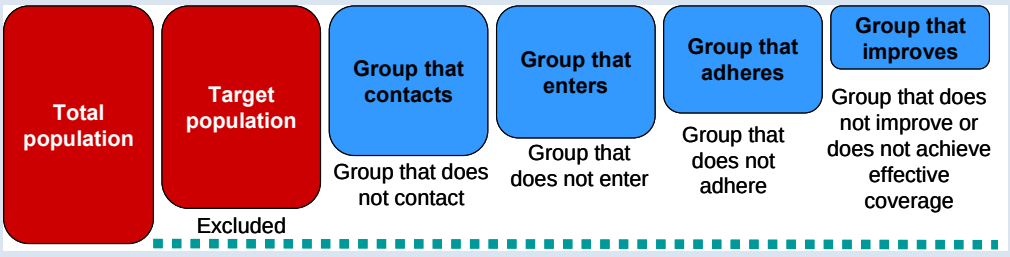
Source: White 1978.

WHAT NEEDS TO BE DONE?

Analyse sub-groups and how they access and benefit from the SPA:

- Identify the information available.
- Extract and analyse data.
- Interpret data.

As the final outcome of this activity, the working group will fill in and adapt the diagram begun in activity 2 of stage Q:



Example 16: step Q activity 3.a

Identification of the information available undertaken by the working team that analysed the Plan on Health education in schools of the region of Murcia 2005-2010.

SPA: HEALTH EDUCATION PLAN FOR SCHOOLS IN THE REGION OF MURCIA

Key stages	QUANTITATIVE sources and type of data	Possible sub-groups for analysis at each stage
Target population	* Study on behaviours and health-related factors of students in the Region of Murcia. * National Health Survey. * HBSC (Health Behaviour in School-aged Children-Murcia). * Report on the state of the Murcia Educational System.	* Women. * Family dysfunction. * Students.
Action 1: Implementation of the Plan in schools	* Report on the Health Education Plan for Schools in the Region of Murcia. * Evaluation questionnaire of Health Education Plan for Schools in the Region of Murcia. * Report on the provision of funding to non-university centres of the Autonomous Community of the Region of Murcia for the development of the Health. Education Plan for schools.	* Students. * Teachers. * Social and healthcare professionals. * Family.
Action 2: Training	* Reports on courses aimed at teachers. * Reports on courses aimed at social workers/healthcare professionals. * Editions of the Master of Public Health. * Report on subsidies to associations of parents (of students from non-university centres financed by public bodies) to fund projects of Schools for Parents in Health Education.	* Teachers. * Social and healthcare professionals. * Family.
Action 3: Implementation of Social Participation Groups	* Report on the Health Education Plan for Schools. * Records of the Social Participation Groups.	* Teachers. * Healthcare professionals. * Family. * Municipal officers.
Action 4: Curriculum support	* Report on the Health Promotion and Education Service: educational materials made and distributed. * Report on the Centre of Resources for the Health Promotion and Education.	* Teachers. * Healthcare professionals. * Family. * Students.
Action 5: Evaluation	* Evaluation questionnaire of the Health Education Plan for schools in the Region of Murcia.	* Educational stages: pre-school, primary and secondary centres. * Type of centre: public, private, subsidised. * Location: rural, urban. * Training: Teachers having/not having received training.
Immediate Result	* Evaluation questionnaire of the Health Education Plan for schools in the Region of Murcia.	* Students. * Teachers. * Family. * Healthcare professionals.
Intermediate Result	* Study of behaviours and health-related factors of students of the Region of Murcia.	* Women. * Family Dysfunction. * Students. * Teachers. * Family.

Key Stage	QUALITATIVE sources and type of data	Possible sub-groups for analysis at each stage
Target population Students of non-university centres	– Study on the integration of Moroccan students in the Region of Murcia. 2000. – The intercultural school. First Meeting of the school board of the Region of Murcia. 2000. – Study on Youth and Health in the Region of Murcia. 2008. – School coexistence plans in educational centres. 2009.	– Immigration, ethnic groups, gender.
Action 1 Implementation of the Plan in schools	– Study on Needs and Problems for the development of HE in schools. 2003. – Study on Needs and Problems for the development of HE in Primary Healthcare. 2010 (in press). – Perceptions of HE in School for teachers in the Region of Murcia. Constructs and educational methods. 2007. – Evaluation Questionnaires on the Health Education Plan for schools in the region of Murcia.	– Educational community: Students, Teachers, non-teaching staff, Families. – Social and healthcare professionals.
Action 2 Training	– Perceptions of HE in Schools for teachers in the Region of Murcia. Constructs and educational methods. 2007. – Report of Training Activities of the Centres of Teachers and Resources. – Report of Training Activities of the Regional Health Management Departments. – Report on the Schools of Parents for Health Education created from subsidies convened for that purpose.	– Teachers. – Social and healthcare professionals. – Families.
Action 5 Evaluation	– Evaluation Questionnaires on the Health Education Plan for schools in the Region of Murcia.	– Teachers. – To a lesser extent, social and healthcare professionals, and families.
Immediate result	– Evaluation Questionnaires on the Health Education Plan for schools in the Region of Murcia.	– Students. – Teachers. – Family. – Healthcare professionals.

*HE: Health education

Example 17: step Q activity 3.a

Identification of data sources undertaken by the working team that analysed the NAOS Strategy (Strategy for nutrition, physical activity and the prevention of obesity).

- Qualitative: Focus groups with different sub-groups relating to habits.
- Quantitative:
  - Data relating to habits, utilisation of resources, BMI (by Autonomous Community (AACC), gender, social class, educational level...).
  - National and AACC Health Surveys.
  - Studies of obesity prevalence and eating habits (ENRICA, ENKID…).
  - Data relating to prevalence of obesity (by AACC and municipality, district, gender, social class, educational level…).
  - Further data: Active transport policies (data relating to utilisation of public transport, local public bicycle service if it exists, etc.), agricultural policies, agreements…

Example 18: Step Q activity 3

Scheme of the analysis of subgroups made by the working team that analysed the Municipal Plan for Prevention and Assistance in Drug Dependency - Assisstance Programme.

ASSISTANCE PROGRAMME

DIFFICULTIES IN ACCESSING AND OBTAINING BENEFITS IN EACH KEY STAGE

Total population	Target population	Group that contacts	Group that accesses	Adheres	Effective coverage
190.000 inhabitants in San Sebastián de los Reyes and 15 municipalities sharing healthcare centres	Population aged between 18–64 130.000 Depending on the prevalence, estimations range between 570-727	543	478	*DFP 305- 87% *MMP 153- 98.6% MINORS 12- 60%	*DFP 83- 27.2% *MMP 11- 7% MINORS 2- 10%
	Non-drug addict population excluded	1.	2.	3.	4.

* DFP: Drugs-Free programme
* MMP: Methadone Maintenance Programme.

1. Do not contact: immigrants, especially women. Roma people. Women with a low level of education, dedicated to household chores. Unemployed individuals. Youth aged between 18 and 30. Individuals without higher education, low socioeconomic level, poor family and social support and with no stable residence. Difficulties of physical accessibility.
2. People with psychosocial problems, relapses and several admissions a year, abandoning after rehabilitation. Imprisonment.
3. The MMP sub-group, greater adherence because methadone is a substitute for the substance causing addiction. He/she needs it. DFP sub-group, relapses. Minors sub-group lesser sense of risk.
4. For the above reasons.

REFLECTIONS: Lack of studies relating to the effectiveness of different treatments. The successful ones should become extensive. The MMP is the one most studied and it is effective in reducing consumption of illegal drugs, risk behaviours and criminal offences but there is no evidence of improvement in patients' health. The offer of treatment in penal institutions does not cover the demand. Programmes must be better adapted to the characteristics or profiles of sub-groups and the teams must be better motivated in order to carry out differential treatments.

Activity 4: Identification and prioritisation of group(s) or sub-group(s) in a situation of inequity

Results from the previous analysis must be reviewed and a reflection has to be made regarding:

- Which groups have less probability of accessing each stage or benefiting from it? If working with territories, identify those with the greater differences and interpret the implications for the target social groups.
- At which stages are the differences greater?
- Is there any other group harmed by the intervention (negative externalities)?
- Are there any consequences for other sectors?

Potential consequences of the actions or interventions of the SPA for other sectors must be analysed. For example, a recommendation for the restriction of the tuna consumption could have a negative economic impact on the fishermen and the tuna-related industry. This is how a preventive health action can have a relevant social impact on other sectors, especially regarding those groups or territories that are more vulnerable.

Once the groups have been characterised, they can be classified by priority according to their inequity situation. If the revision is considered as not feasible for all groups identified, one or several groups will be chosen to focus the review and redesign of the SPA according to the prioritisation employed. It is important to justify the prioritization cristeria used. In order to ease the process, a brief summary of the main criteria used in different methods of Public Health prioritisation has been provided in Annexe III.

WHAT NEEDS TO BE DONE?

- Characterise groups experiencing inequity.
- Prioritise those group(s) experiencing inequity for the SPA's review and redesign.

Example 19: step Q activity 4

Prioritisation of the working team that analysed the Programme promoting youth health of the Regional Government of Andalusia called Forma Joven.

Priority Group:

Young people over the age of 16 (age at which Compulsary Secondary Education finishes) not continuing their education in either the formal or informal system.

Justification for the choice:

Forma Joven is aimed at teenagers and young people aged between 12 and 25 years old (1,600,000 inhabitants). This represents 25% of the population of Andalusia.

As a consequence of the dynamics and development of the Programme, the majority of the *Forma Joven* Units established between 2001 and 2011 are located in Secondary Schools.

The Programme has been developed to a limited degree in community spaces, which make us think that the goal of approaching places frequented by young people has been achieved in a biased fashion. Thus, the programme has been taken to formal spaces (schools) through an organised system and with a successful formula but has not been able to reach the population outside of the educational system or those who have already left and are most likely to be the ones with the greatest need of finding resources, assessment and places providing information and training on topics related to lifestyles.

In Andalusia, individuals over the age of 16 suffer more direclty from the unemployment problem, being the population without any basic education the one which is worst affected.

It should be noted that, according to the Health Survey of Andalusia (2007) and the HBSC (Health Behaviour in School-Aged Children) in Andalusia in 2007, young people with the lowest levels of education and coming from families with the lowest economic resources and levels of education were those with the lowest health levels.

It can then be presumed that the educational context is an element that guarantees, to a certain extent, access to training opportunities, and that in-school youth increase their opportunities for constructing a healthier individual and group health model (sense of consistency) within the educational framework. Considering the opportunities provided by the school, we think that the population outside the educational system—leaving school prematurely or not continuing their studies—have fewer opportunities to build this healthier model.

Example 20: step Q activity 4

Prioritisation made by the working team analysing the Health strategic goal of the National Strategic Plan for Childhood and Adolescence.

PRIORITY GROUP: The working team has prioritised the group aged between 0–3 years. It is well known that everything that happens during the first years of life is crucial for the development trajectory and life cycle of each individual. International evidence supports the theory that inequities at the stage of child development will unequivocally contribute to inequities in adult life, thereby creating a cycle of intergenerational disadvantage. Consequently, intervention during the first years of life will lead to a greater equity in adulthood.

Nevertheless, even if the group aged 0–3 were to be prioritised, we believe that a re-orientation of the plan should be made towards equity for all age groups, taking into account the specific needs in each stage of life.

Example 21: step Q activity 4

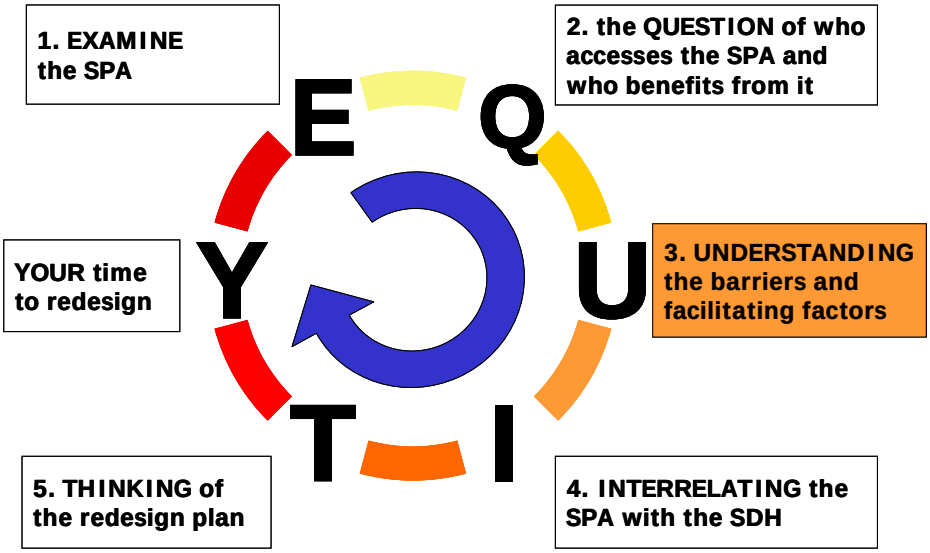
Prioritisation made by the working team examining the Programme of Information on Smoking in the Region of Murcia.

After analysing the most in need, and therefore vulnerable groups, it was decided that the Roma population be prioritised due to their greater health inequity and high prevalence of tobacco smoking.

Prioritised Group(s)	It has more health needs. Why?	It has more difficulties for accessing/benefiting Why?	Other reasons. Which?
– **Roma people.**	– **High prevalence of tobacco smoking in men.** – **Significant lack of information about the risks of tobacco consumption.**	– **They don't access healthcare and social services mainly due to insufficient integration in society.** – **Low acceptability of healthcare and social services.** – **Low utilisation of preventive services.**	– **Shortage of specific materials for this population adapted to their cultural needs.**

For this redesign, we have focused specifically in the Roma group as detailed below. Later all the SPA will be reviewed and re-designed, taking into account all vulnerable groups.

5.2.3. Step U: UNDERSTANDING barriers and facilitating factors in each key stage



Aims

1. To identify the barriers☞ hindering access and the obtaining of benefits in each key stage of the SPA.

2. To identify faciliting factors (facilitators)☞ of access and the obtaining of benefits in each key stage of the SPA.

Development

The development of **step U** is summarised in the following table; it has only one activity but it is a broad and complex one:

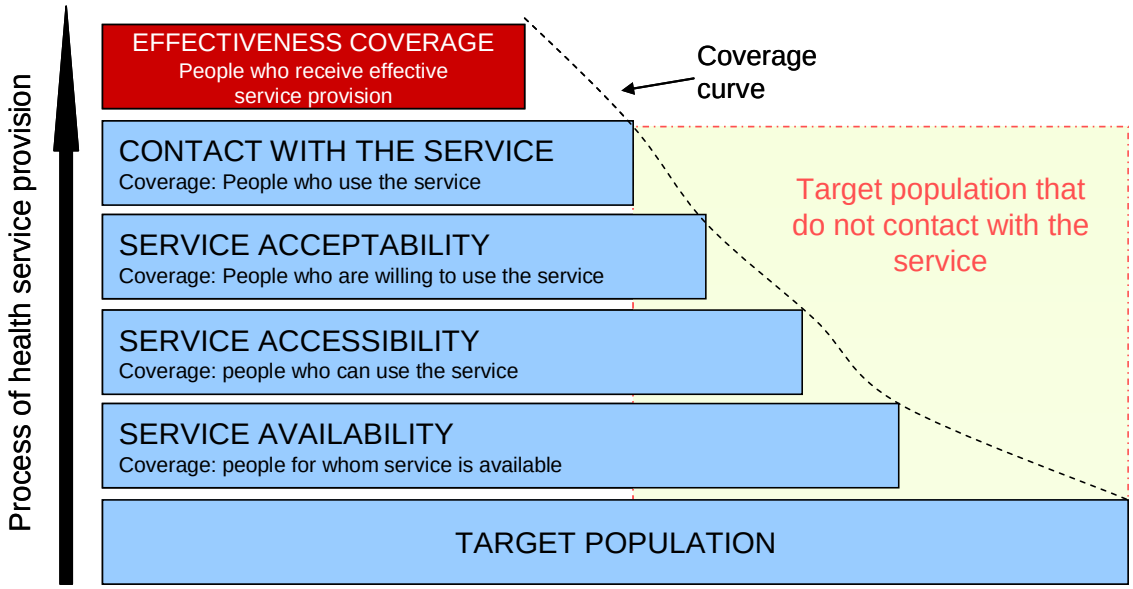
Paso	Activity
Step U: UNDERSTANDING the barriers and facilitating factors	**Activity 1**. Analysing the main difficulties and support that the prioritised sub-group finds in each key stage of the SPA

☞ See definition of barriers and facilitators in the Glossary.

Activity 1: Analysing the main difficulties and support that the prioritised sub-group finds in each key stage of the SPA

Having prioritised the group(s) without access to the SPA or which have not obtained the expected results from the SPA (last activity of step Q), the aim in this step is to identify the main difficulties the prioritised group(s) have to face and the main forms of support they have in each key stage. Using the Tanahashi model of effective coverage (see Figure 16)[22], the question must be asked as to whether the problems related to lack of access or benefits that the prioritised group confronts are linked to the presence of barriers or the absence of facilitators, and their relative weight which these have.

Figure 16. Model of coverage of Health Services.



Source: Adapted from Tanahashi T, 1978

The Tanahashi model of effective coverage is 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.

For the **SPAs providing services to people**, barriers and facilitators can be categorised and defined in the following way:

[22] Tanahashi T. Health service coverage and its evaluation. Bulletin of the World Health Organization 1978, 56(2): 295-303.

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.	

The analysis can be quantitative if specific data about availability, accessibility, acceptability and utilisation is available; if not, other methods must be employed, for example, reflection by the group, consultation with key informants, etc. The experience of the working team is crucial in this analysis as well as the consultation with direct managers and the gathering and analysis of information from local or national studies.

Example 22: step U

Barriers and facilitators identified by the working team that analysed the Screening Programme for colorectal cancer.

Key Stage	Barriers	Facilitators
Delivery of FOBT sample in healthcare centre	**Accessibility** ▪ Physical accessibility/ opening hours: a. Large distance between the healthcare centre and the place of residence and work. b. Difficulty reconciling working hours. ▪ Social/cultural accessibility: a. Difficulties understanding and interpreting the invitation letter regarding disadvantaged groups not mastering Basque/Spanish. b. Less prioritising of possible (forthcoming) health-related problems compared to other actual (current) and greater problems. **Acceptability** ▪ Less risk perception and less comprehensive health self-care among men. ▪ Lack of knowledge and awareness of the disease. ▪ The programme intervenes in aspects that can interfere in values identified with a male identity and the concept of a man's body and its management. ▪ Fear of positive result and lack of knowledge of how to manage it.	**Accessibility** ▪ No need for appointment. ▪ Flexible hours in most of the healthcare centres (continuous morning and afternoon timetables). ▪ No need to make the delivery in person. ▪ Reminders addressed to people not delivering samples. ▪ Toll-free telephone where a continuous information service about the programme is provided. **Acceptability** ▪ Delivery of letters respond to a geographical schedule so it may encourage neighbours talking about the programme among them and its acceptability may be raised. ▪ Toll-free telephone where a continuous information service about the programme is provided.
General Practitioner (GP) and nurse consultation with positive FOBT	**Accessibility** ▪ Physical accessibility/ opening hours: a. Long distance between the healthcare centre and the place of residence and work. b. Difficulty reconciling working hours with two consultations (GP and nurse). **Acceptability** ▪ Fear of diagnostic testing and positive confirmatory test. ▪ Although it will have less impact than in the previous phase, it is worth considering: a. Lesser risk perception and less comprehensive health-care among men. **b.** Rejection of colonoscopy due to the type of intervention involved.	**Accessibility** ▪ Possibility of choosing the timetable for the GP and nurse consultation. **Acceptability** ▪ Toll-free telephone where a continuous information service about the programme is provided. ▪ The programme revolves around the healthcare centre so that either GPs or nurses can solve doubts and provide healthcare advice.
Colonoscopy	**Accessibility** ▪ Physical accessibility: a. Large distance between the hospital and certain geographic areas. b. Great difficulty reconciling working hours due to the need of asking for permits. **Acceptability** ▪ Rejection of the type of intervention involved.	
Whole SPA	**Availability** ▪ The programme is currently only available in 33% of BAC healthcare centres.	**Availability** ▪ The programme will be progressively implemented in all BAC HC in the next years.

* FOBT: Faecal Occult Blood Testing.
HC: Healthcare Centre.
BAC: Basque Autonomous Community.

Even if the model was developed focusing on the access to health services or benefits from a healthcare centre, these terms can be adapted to the reality of other programmes or strategies. Presented below is an example which attempts to provide an analogy for **SPAs not linked to individual services provision.**

Example 23: step U

Barriers identified in the stage of the SPA, "Publication and dissemination of the call for grants", by the working team that analysed the call for grants to fund non-profit organisations-based programmes for HIV and AIDS prevention and control.

The example is part of the work carried out by the working team that analysed the programme to subsidise programmes for AIDS and HIV infection prevention and control. One of the key stages of this programme is the "Publication and dissemination of the call for grants"; in the following table, the barriers identified by the working team in relation to the prioritised group (sub-Saharan immigrants) are presented:

Type of barrier	Explanation of barrier and example
Availability	**All factors influencing the publication and dissemination of the call for grants:** The working team did not identify any barrier of this type.
Accessibility	**All variables related to access to information, for example, some groups working with MSM may not be aware of the existence of this grant:** **Example:** The entities working with this population do not access the sources of dissemination of the call, due probably to a lack of knowledge and because HIV may not be a priority work issue in these entities.
Acceptability	**All variables related to the decision of making a proposal based on the framework of the grants:** **Examples:** 1. General health problems and HIV in particular do not tend to be priority topics for immigrants from sub-Saharan countries when they arrive to the country of destination, meaning that entities working with them do not consider this a priority. 2. Dissemination not tailored to the culture or values of the population/entity.

* MSM: Men who have sex with other Men.

Example 24: step U

Barriers identified by the working team that analysed the Health Education Plan for Schools of the Region of Murcia 2005-2010.

As we have prioritised the group of schools not-enrolled in the programme, our programme is based only on the first key stage, the enrolment stage. Essentially, we have detected five large barriers in this stage, all of these being acceptability barriers:

I. "Different concepts of Health Education (HE)". This problem can lead to a lack of interest in this issue and contention between the teachers' interests and the proposal and methods of the Plan. It is also important to highlight that this problem is present at all levels, from the Coordination Committee itself, to political representatives, senior officials of the Regional Departments of Education and decision-makers.

II. "The Health Education Plan for Schools is just another plan that arrives at the school". The school receives an enormous offer of projects, plans and programmes, many of these promoted and driven by the Administration, causing an excess of teaching activities. From the moment where all are applied as individual plans, without assuming that HE includes a great part of their components, the working scheme becomes disintegrated and without synergies. What could have been an advantage and a facilitator of activities turns into an increase in workload, duplication of responsibilities and commitments and, therefore, a negative influence. The excessive offer of this kind of interventions in schools reduces the implication of professionals in the intervention they are responsible for, often being unaware of other initiatives that are implemented in the school and therefore with little bearing on the final results. The Education and Health Joint Committee will need to give evidence of the need to re-organise and rationalise the offer in schools.

III. "The Plan does not require a project or report". This decision is made in the first instance to facilitate and offload the work of teachers, which theoretically should encourage them to enrol. However, it has not always been the case because teachers, who are used to writing down any of their activities, need a document containing the information about the programme they are developing. On the other hand, not demanding a formal project can be interpreted as a lack of seriousness in the proposal. ("You can do whatever you want, they don't demand anything"). Nor can we forget about the "need" of giving prestige or validity to our work. If this possibility does not exist—because there is no report or document collecting this information—the effort made is left up in the air, it is not valued or reinforced and, furthermore, mistakes are not corrected and they are perpetuated in time. Also, it is worthy mentioning the data loss that suggest a lack of knowledge of what schools are doing. Schools will be asked to make a HE project, reflecting results of the analysis of the situation, the progress of the implementation of the Plan in the school, the HE prioritised issues, the decisions of HE being made, the activities proposed or developed, the difficulties that have shown up and the proposals for improvement.

IV. "The access to the possible benefits offered by the Plan exists for all centres, not only for those that enrol". This decision, which tries to treat all centres equally, is discouraging. If a school is going to have the same benefits (training offer, materials, coordination network, assessment, call for grants to fund projects for the creation of Schools for Parents, allocations for covering the development of health education in schools…) either enrolling or not, why to do so? On the other hand, the inequity gap increases as the different needs of each centre are not taken into account. From the information exchange with the administrators of not-enrolled schools, their needs will be identified and the training, (including the creation of tailored materials) will be scheduled.

V. "The Plan does not offer economic resources to the schools that enrol". Without judging whether this measure is appropriate or not, the truth is that a work proposal as ambitious as the one the Plan proposes without any funding provision does not encourage enrolment. The ideal situation would be to provide some financial budget when enrolling. The current situation is not the most encouraging one but it is something to take into consideration.

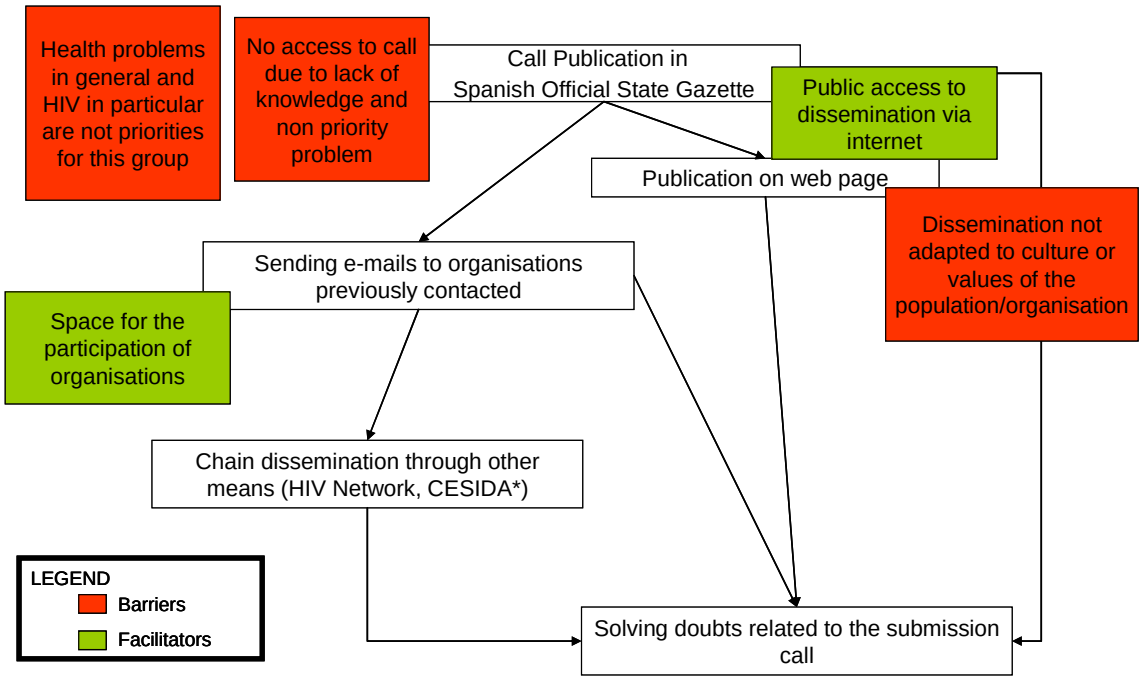
Once the barriers and facilitators have been identified, **these need to be included in the diagram of the key stages**.

As such, we should ask ourselves the following questions regarding each identified barrier: Which key stage is limited or hindered in its development or implementation when this barrier shows up or takes effect?

At the same time, we will review the identified facilitators and we will ask ourselves which key stage is boosted or better developed when this facilitator shows up or takes effect?

Example 25: step U

Inclusion of barriers and facilitators identified in the diagram of the key stages by the working team that analysed the call for grants to fund non-profit organisations-based programmes for HIV and AIDS prevention and control. Below is a diagram of the key stages of one part of the SPA (sub-stage of publication and dissemination of the SPA) and at which key stage the different barriers and facilitators are.



*CESIDA: Spanish HIV / AIDS Coordination Agency

WHAT NEEDS TO BE DONE?

- Define the key stages of the SPA for the priority sub-group chosen in step Q, based on the theory of the programme. Not all key stages must apply to all sub-groups.
- For each key stage: determine the barriers that hinder individuals from accessing and benefiting from the SPA by using the Tanahashi conceptual framework, filling in the next table:

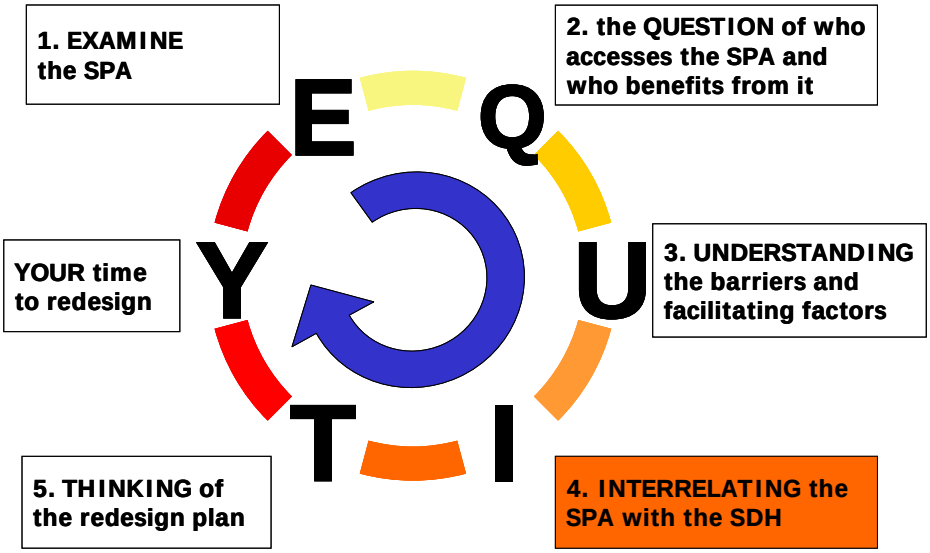
SPA's key stage	Barrier (specify type)	Evidence (quote)
1.	Availability Accessibility Acceptability Contact Effective coverage	
…	Availability Accessibility Acceptability Contact Effective coverage	

- For each key stage, facilitators for accessing the SPA and benefiting from it must be determined for the chosen priority sub-group, using the Tanahashi conceptual framework. Complete the following table for implementing this task:

SPA's key stage	Facilitator (specify type)	Evidence (quote)
1.	Availability Accessibility Acceptability Contact Effective coverage	
…	Availability Accessibility Acceptability Contact Effective coverage	

- Include barriers and facilitators in the key stages diagram.

5.2.4. Step I: INTERRELATING the SPA with the Social Determinants of Health



Aims

1. Link the analysis of the SPA made in previous steps (E-Q-U-) to the SDH.
2. Analyse intersectoral action and social participation in the development of the SPA and its role when tackling the identified barriers.

Development

In this step, the working team must analyse the results of the previous steps, fundamentally reviewing the SPA's theory, the prioritised group(s) and the identified barriers and facilitators; and linking them to the SDH. For that purpose, we need to consider the SDH conceptual framework of the WHO Commission on Social Determinants of Health. This step is important because it allows us to identify the starting points of interventions to tackle inequities, placing the SPA and the Health system in this conceptual framework.

This step is comprised of 3 activities:

Step	Activity
Step I: **INTERRELATING the SPA with the SDH**	**Activity 1**. Interrelating barriers and facilitators to intermediary determinants (Social Determinants of Health)
	Activity 2. Interrelating the SPA analysis to structural determinants (Social Determinants of health inequities)
	Activity 3. Intersectoral action and social participation in the SPA´s development

Activity 1: Interrelating barriers and facilitators to intermediary determinants (Social Determinants of Health)

Analysing which intermediary determinants are linked to the different barriers and facilitators.

Using the following table, interrelate the identified barriers and facilitators with the intermediary determinants. Mark with an X the one(s) which is/are linked.

SPA		Intermediary Determinants				
Key stage	**Barrier or facilitator**	**Material circumstances (living and working conditions)**	**Psychosocial factors**	**Behaviours and habits**	**Health system**	**Social Cohesion**

WHAT NEEDS TO BE DONE?

- Interrelate barriers and facilitators with intermediary determinants.

Example 26: Step I activity 1

Interrelation of barriers and facilitators with intermediary determinants made by the working team that analysed the programme aimed at vulnerable migrants of the line Vulnerable Groups of the Health Promotion and Prevention Plan 2011–2013.

Interrelation with health determinants						
Description of the barrier	***Interrelated SPA's key stage: SPA's design***	***Material circumstances***	***Psychosocial factors***	***Behaviours and habits***	***Health system***	***Social Cohesion***
No information available about the difficulties of MWCLWH* in accessing the SPA's activities: - Free time availability and when.	Choosing the timetable and resources needed to carry out the workshops.	X				
Need of completing the information about administrative barriers for accessing the Health System: - Difficulties for registration at the town hall and/or - To get the Spanish Health Card (HC)	Choosing the contents that must be emphasised in the workshops.				X	
Need to complete information about: - their physical and psycosocial status. - specific occupational risks.		X	X	X	X	X
Need to complete information about: - Concepts of health and healthcare services determined by country of origin. - Knowledge of each group about health topics (utilisation of services, preventive practices...).	Tailoring the contents of workshops to the knowledge and concepts of each group.				X	X
Description of the barrier	***Interrelated SPA's key stage: Implementation***	***Material circumstances***	***Psychosocial factors***	***Behaviours and habits***	***Health system***	***Social Cohesion***
Lack of healthcare professionals available for developing the workshops due to healthcare burden and lack of habit.	Identification of information-givers.				X	
Healthcare professionals' lack of training in cultural competence.					X	
Problems to contact women targeted for intervention.	Workshops call.	X				
Lack of resources for: - Interpretation into languages such as Romanian, Arabic, Berber dialects… - Distributing leaflets and posters.	Organisation of workshops.				X	
Description of the barrier	***Interrelated key stage: Monitoring and evaluation***	***Material circumstances***	***Psychosocial factors***	***Behaviours and habits***	***Health system***	***Social Cohesion***
Obstacles for establishing quantitative indicators due to a lack of numerical data about MWCLWH*.	Monitoring activities.				X	
Lack of registered Health education activities in Primary Healthcare.					X	
Obstacles to make evaluations related to healthcare burden and lack of evaluation culture among healthcare professionals.	Evaluation activities.				X	

Facilitators synthesis						
Facilitator's description	***Interrelated SPA's key stage: Design***	***Material circumstances***	***Psychosocial factors***	***Behaviours and habits***	***Health system***	***Social Cohesion***
Existence of qualitative studies about the concept of health in migrant women working as domestic workers.	Problem framing. Background study. Organisation of workshops.		X	X	X	
Existence of a network of associations: NGOs, social services centres.			X			X
Facilitator's description	***Interrelated SPA's key stage: Implementation***	***Material circumstances***	***Psychosocial factors***	***Behaviours and habits***	***Health system***	***Social Cohesion***
We are aware of: - Places where it is possible to contact the population targeted for the workshops: Hairdresser salons, call centres, parks. - Channels of communication: Media of their own, free newspapers.	Workshops call.		X			X
Existence of a wide network of healthcare centres where services are offered with no charge, available for people in a regular administrative situation or simply registered in the Town Hall.	Implementation of workshops.				X	
Existence of culturally tailored materials translated into several languages about the access and utilisation of the Health system.					X	X
The majority of women targeted for workshops are from Latin America.	Organisation and implementation of workshops					X
Facilitator's description	***Interrelated SPA's key stage: Monitoring and evaluation***	***Material circumstances***	***Psychosocial factors***	***Behaviours and habits***	***Health system***	***Social Cohesion***
Existence of a network of associations: NGOs, social services centres.	Evaluation				X	

*MWCLWH: Migrant Women Carers, Live-in domestic workers, low-Wage earners and/or performing Household chores.

Activity 2: Interrelating the SPA analysis to structural determinants (Social Determinants of health inequities)

Within the structural determinants, we need to analyse socioeconomic position on one hand and context on the other. As such, this activity is comprised of two parts:

a) Characterisation of the prioritised social group(s) in relation to their socioeconomic position

The prioritised group(s) in step "Q" is placed in a specific stratum of society. In this activity, the goal is to characterise the groups regarding its **socioeconomic position.**

Taking into account the conceptual framework of SDH of the WHO Commission on Social Determinants of Health, the following actions will be required:

a.1) Description of the prioritised social group from the perspective of resources and prestige.

Summarise in one paragraph how you would characterise the social group prioritised from the perspective of resources, prestige, impact of belonging to a specific group throughout life-cycle, especially in the first years, etc.

a.2) Analysis of the existence of barriers within the social group prioritised.

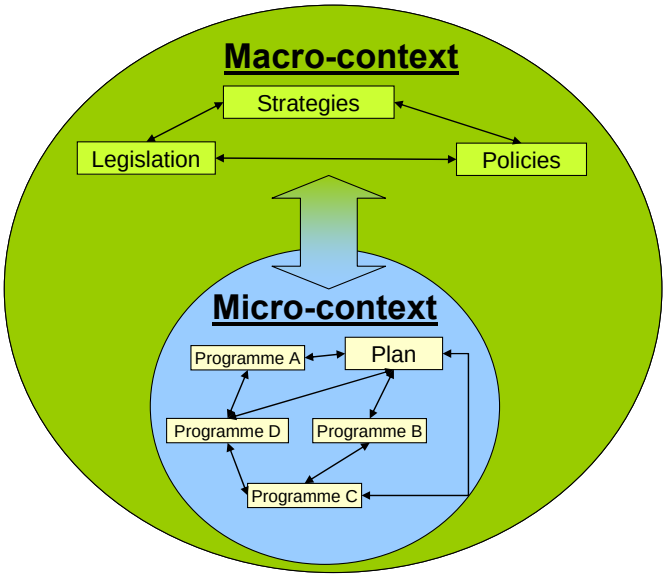
The team must discuss and reflect on the hypothesis about why barriers are present and why they are greater in this group; summarise it in one paragraph. The following questions may serve as a guide for the discussion:

- How would you link the socio-economic position of the prioritised social group with the identified barriers and facilitators?
- Why are they present in these groups and not in others?
- Why barriers are greater in the social group prioritised by the working team?

b) Analysis of the SPA's context

The context analysis can be structured in the following way:

b.1) Analysis of micro-context: Micro-context where the SPA is developed can be assessed as the positive or negative influence of other programmes and interventions during the development of the SPA, as shown in the following diagram.



Specify in the following table which programmes and interventions are influencing, in a positive or negative way (synergy or barrier), the SPA.

Programmes and interventions influencing the SPA		
Name of the programme or intervention	**Description**	**How it interacts with the SPA (synergy or barrier)**

b.2) Analysis of macro-context: Select one or two policies or strategies linked to the political and socioeconomic context described in the conceptual framework impacting the SPA and complete the following table:

Name of the public policy or strategy	
How this public policy affects or influences the SPA	

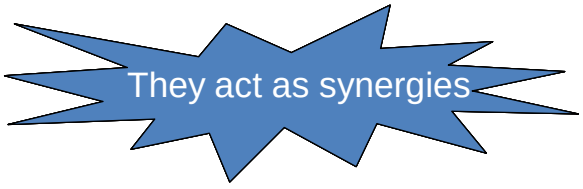
WHAT NEEDS TO BE DONE?

- Identify the characteristics of the prioritised social group(s) in relation to their socioeconomic position.
- Analyse the SPA's context: analysis of the SPA's micro and macro-context.

Example 27: Step I activity 2.b.1

Analysis of micro-context made by the working team that analysed the call for grants to fund non-profit organisations-based programmes for HIV and AIDS prevention and control.

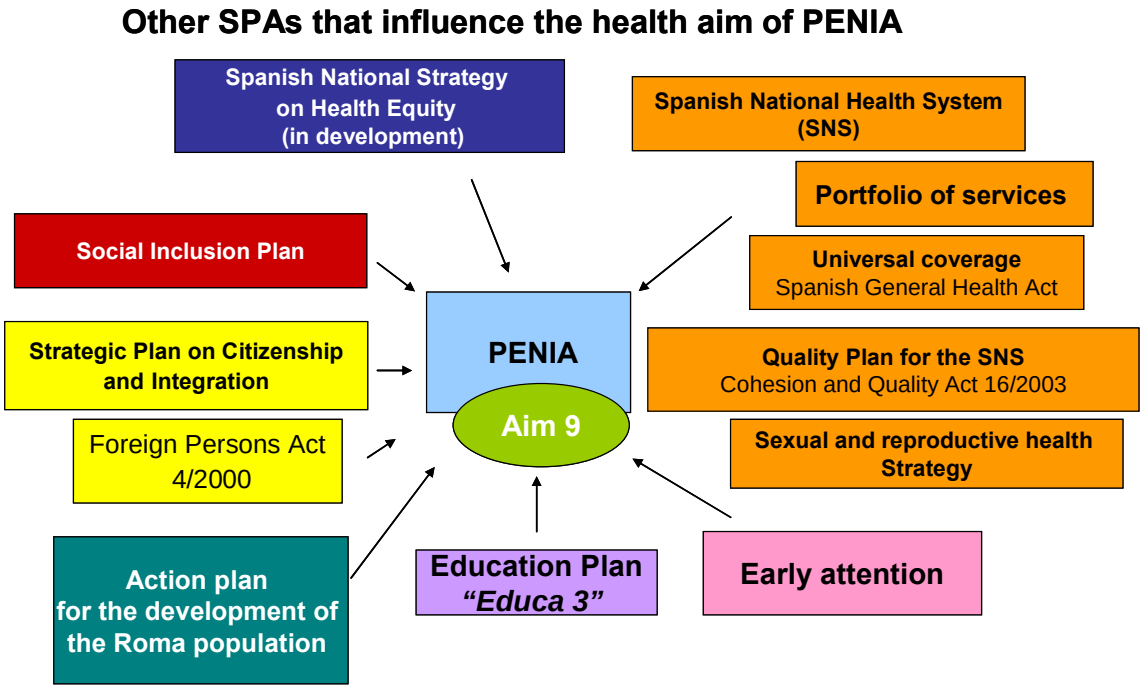
Programmes and interventions influencing the SPA
1. Grants for HIV prevention programmes of the AACC 2. Social investment calls 3. IRPF (Spanish personal income tax) calls 4. Private companies calls 5. Informative campaigns on HIV prevention 6. Sexual and reproductive health Strategy



* The 6 identified programmes act as synergies for the analysed SPA.

Example 28: Step I activities 2.b.1 and 2.b.2

Analysis of micro-context and macro-context made by the working team that analysed the Health strategic goal of the National Strategic Plan for Childhood and Adolescence.



Example 29: step I activity 2.b.2

Analysis of macro-context made by the working team that analysed the call for grants to fund non-profit organisations-based programmes for HIV and AIDS prevention and control. It was made taking into consideration that the group prioritised for the analysis was the sub-Saharan immigrant population.

Name of the public policy or strategy	Foreign Persons Act, Organic Law 4/2000, 11th January. And subsequent modifications: OL 8/2000, 14/2003 and 2/2009. Regulation Royal Decree 557/2011, 20th April (Spanish Official State Gazette, 30th April).
How this public policy affects or influences the SPA	Rights and obligations contained in this law can ease or hamper the socioeconomic integration and the administrative situation of immigrant people, determining a larger or smaller number of obstacles to cover the basic needs of a person beginning his/her migration process in the host country. The fewer barriers found to cover basic needs (work, housing, etc.), the easier it will be to place healthcare within their priorities. It is a policy that acts on the generation of stratification and influences the vulnerability of groups regarding HIV and the consequences of the infection in terms of diagnosis and prognosis.

Activity 3: Intersectoral action and social participation in the SPA's development

Intersectoral action and social participation are two key strategic axes for addressing SDH and health inequities. In order to analyse how the SPA integrates these strategic aspects, we will develop the following activities:

a) Identification of the role that intersectoral action plays in addressing the barriers found in the SPA:

Identify, where appropriate, which are the other sectors—apart from health—involved in the creation of barriers, or that are necessary for addressing them or giving a solution. Complete the following table:

SPA's key stage where the barrier is located	Name of the barrier	Sectors involved in creating or addressing barriers

b) Identification of social participation aspects in addressing the barriers found in the SPA:

Identify which aspects of social participation would be important to integrate in the SPA to reduce or remove barriers. Complete the following table:

SPA's key stage where the barrier is located	Name of the barrier	Identify the role social participation plays in addressing the barrier

WHAT NEEDS TO BE DONE?

- Identify the role that intersectoral action plays in addressing the barriers found in the SPA.
- Identify the role that social participation plays in addressing the barriers found in the SPA.

Example 30: Step I activity 3.a

Identification of the role that intersectoral action plays in addressing barriers made by the working team that analysed the Health strategic goal of the Spanish National Strategic Plan for Childhood and Adolescence.

The sectors which are more relevant to achieving the aim of healthy development during childhood are likely to be health, education and social services. The employment sector also has a significant involvement. All these sectors should work in partnership and in a coordinated manner in order to offer a comprehensive and integrated approach to childhood. This intersectoral action should be present at all levels: national, regional and local.

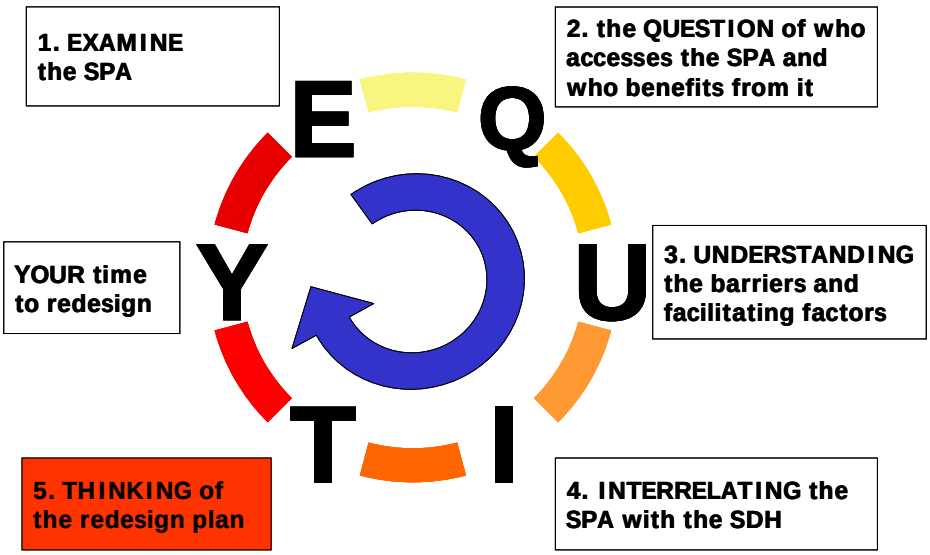
Moreover, all the aforementioned players and sectors, or others with influence on strategies, programmes and activities driving synergies with the PENIA, should be better coordinated in order to foster these synergies.

Example 31: step I activity 3.b

Identification of the role that social participation plays, made by the working team that analysed the call for grants to fund non-profit organisations-based programmes for HIV and AIDS prevention and control.

SPA's level or stage where the barrier is present	Name of the barrier	Identify the role participation plays in addressing the identified barrier
DISSEMINATION	No access to the call due to lack of awareness and non-priority problem.	Identify the population's needs related to HIV. Identify the channels of communication employed by organisations working with this population. Reinforce the social organisation of entities. Development of the terms and conditions of the call and its priority setting.
DISSEMINATION	Health problems in general and HIV in particular are normally non-priority topics for this group.	Identify the population's needs related to HIV.
DISSEMINATION	Dissemination not tailored to the culture or values of the population/organisation.	Ease the cultural and linguistic adaptation of the call's dissemination.
EVALUATION	Not meeting requirements.	Ease information flow about how to apply for the call for grants (requirements and how to fulfil them, grouping of organisations, etc.).
EVALUATION	Projects that are not in line with the SPA's priorities.	Identification of organisations working with immigrants to hold a meeting with those with showing interest and capabilities for implementing projects of HIV prevention within this population, making them aware of the call.
EVALUATION	Shortage of projects.	Identification of those institutions working with immigrants to arrange a meeting and provide them with technical advice about the procedure.
EVALUATION	Low quality projects.	Identification of those institutions working with immigrants to arrange a meeting and provide them with technical advice about the procedure.
MONITORING AND EVALUATION	Delay in the publication and resolution, availability of the money granted.	Reduce as far as possible the time dedicated to the call's publication in order to make it correspond with the financial year start date or to make a publication previous to that date (i.e. to be implemented in the next year). Reduce as far as possible the time dedicated to the evaluation, both for organisations and for projects. Create mechanisms that reduce dependency on the public funding interventions and that favour private co-funding to foster the organisations' autonomy.
MONITORING AND EVALUATION	Lack of culture of evaluation.	The working team has identified no role.
MONITORING AND EVALUATION	Evaluation focused on process and not on results.	The working team has identified no role.
MONITORING AND EVALUATION	Criteria for the distribution of projects among technical staff for their monitoring.	Assess if the person in charge of the monitoring and assessment of the project is appropriate (training, sensitiveness with the population/topic, interest, experience...).

5.2.5 Step T: THINKING of the redesign plan



Aims

1. To identify the aims and priorities of the redesign.
2. To integrate intersectoral action and social participation into the SPA's redesign.

Development

Step T closes the review cycle and leads to the SPA's redesign. There will be cases where implementing the redesign in the review process will not be feasible, but conclusions and recommendations for the redesign can be drawn from this step, even if it has a later application.

The redesign phase is the most creative and critical part of the process. The working teams have to combine what they have learnt from the review and the evidence on the effectiveness of interventions, and complement these with their experience and knowledge so as to make a redesign proposal for the SPA as the final product of the process, including among other things --what to do, at what level, how to do it and who should participate.

The step is organised into 3 activities:

Step	Activity
Step T: THINKING of the redesign plan	**Activity 1**. Identification of aims and priorities for the redesign
	Activity 2. Identification of areas and levels of action in the redesign
	Activity 3. Integration of intersectoral action and social participation into the SPA

Activity 1: Identification of aims and priorities for the redesign

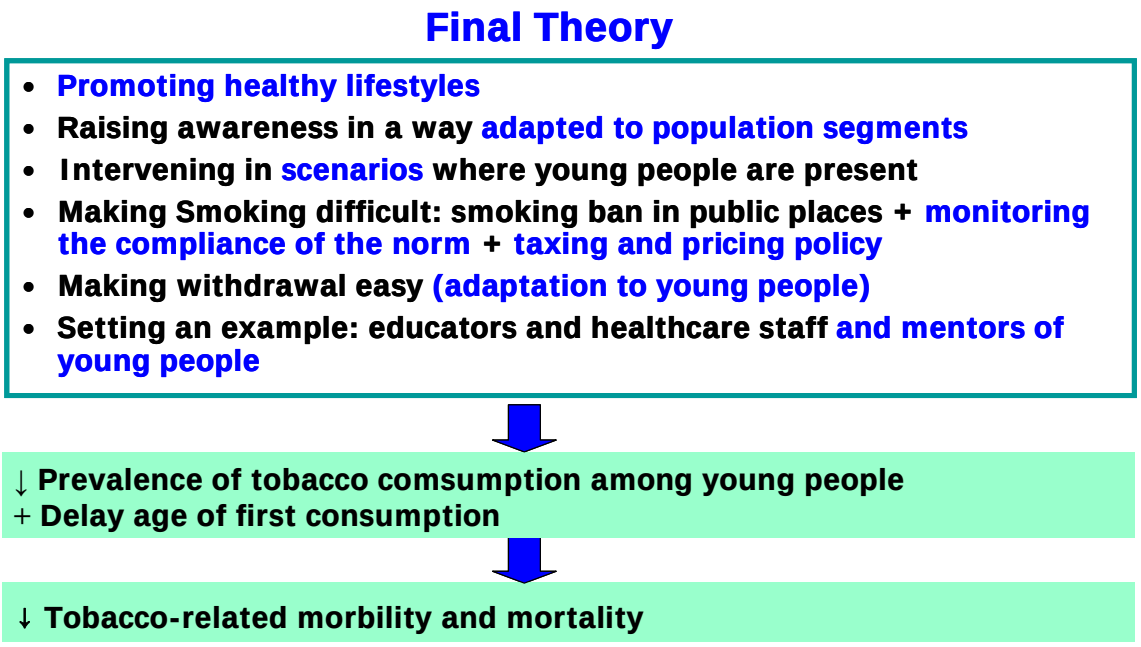
For this activity, the following aspects will be developed:

a) Defining a new theory for the SPA including the equity and SDH approach:

The working team will need to review the materials of the four steps prior to the review, and reach a consensus of the new SPA theory: based on the SPA's theory made by the team at the outset, assess what modifications will need to be made for the integration of the health inequities theory approach.

Example 32: Step T activity 1.a

Diagram of the new SPA theory made by the working team that analysed the strategic line of Health Promotion and Protection within the Cancer Strategy of the Spanish National Health System.



Within the working team, the need for widening the approach of health promotion and of adapting the actions to the context of the young population was discussed (in blue).

Example 33: Step T activity 1.a

New SPA theory made by the working team analysing the Screening Programme for colorectal cancer.

Equitable access to the screening programme will be effective for the whole target population if the different steps take into consideration that not all social groups access in a homogeneous fashion, rather they demonstrate different behaviour due to socioeconomic conditions and gender. For this reason, just sending an informative leaflet and a letter inviting all people aged 50-69 in the Basque Country to take part in the screening programme will only guarantee a response of approximately 60%. This percentage is liable to vary considerably among the different social groups.

The screening programme needs to be included in a more general strategy of prevention of colorectal cancer and Health promotion. Promoting a healthy diet or physical activity requires action across sectors other than health, such as transport, urban planning or regulation of the food industry, as it is proposed by the strategy of Health in All Policies (HiAP).

Acting upon the determinants of determinants or upon the causes of causes will allow us to put an end to the underlying causes that influence the different degree of exposure and vulnerability of several social groups facing certain risk factors that contribute to the development of the disease.

b) Reviewing the SPA's key stages and interventions and proposing the inclusion of new stages and interventions for addressing the SDH:

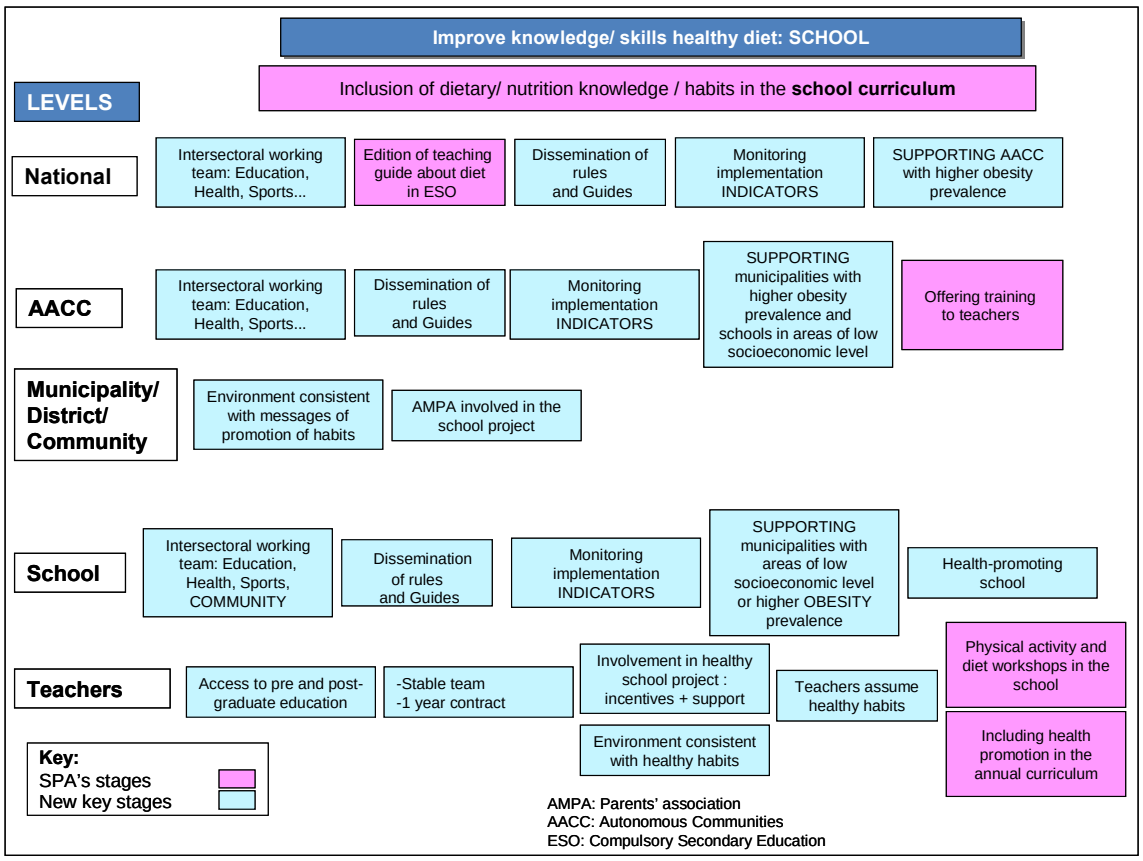
Within the team, discuss the following questions:

- Which are the most important access barriers? In which of the SPA's key stages?
- Which are the most important access facilitators? In which of the SPA's key stages?
- Are all necessary interventions envisaged? Are there interventions addressing the barriers identified in the review process? If there are not, propose interventions to act upon the barriers.
- Are there interventions to boost the facilitators identified? If there are none, propose interventions to boost facilitators.
- Are there interventions addressing the aspects included in the new SPA theory to reach equity and social determinants approach? If there are not, point out which would be feasible or advisable.

This reflection will need to be translated into a new version of the key stages diagram in which the new stages included must be emphasised in order to differentiate them from the ones made at the beginning. Also, the new set of interventions drawn from the review must be gathered.

Example 34: Step T activity 1.b

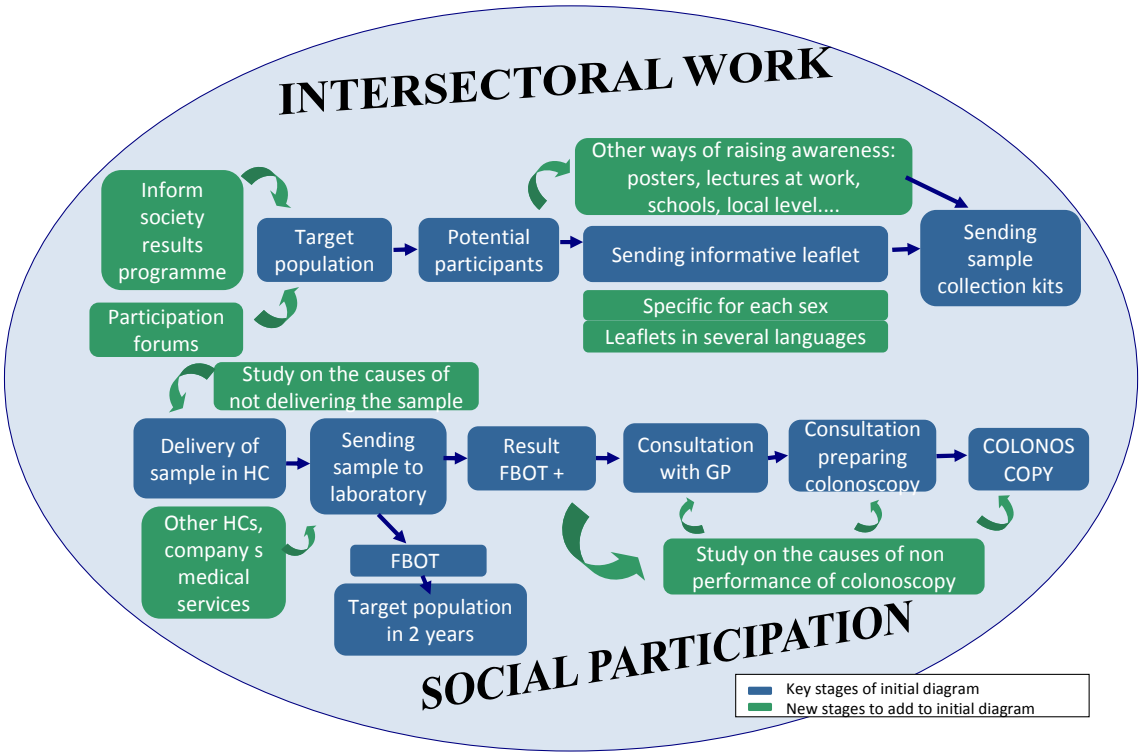
Diagram of new key stages made by the working team that analysed the NAOS Strategy (Strategy for nutrition, physical activity and the prevention of obesity).



Example 35: Step T activity 1.b

Diagram of the key steps made by the working team that analysed the Screening Programme for colorectal cancer.

New diagram of key stages proposed for the programme.



HC: Healthcare Centre
FOBT: Faecal Occult Blood Testing

c) Clearly defining the aims and priorities of the redesign:

It is important to review the basis of the evidence in order to address health inequities in an effective manner. However, given that this evidence is frequently limited, it must be combined with the systematic knowledge and practical experience of the decision-makers[23], integrating different sources of knowledge and transforming the knowledge into recommendations and practices. In short, the interventions or recommendations adopted must reflect the knowledge generated by the working team on the social causes of inequities in terms of access and results, their interrelation and mediation. This may be done through the use of the SDH framework and the Tanahashi inequity theoretical framework (1978)[24] and the integration of all other information available.

[23] Speller V, Kelly MP. Getting evidence into practice to reduce health inequalities. Context and progress on HDA implementation. Health Development Agency. 2003. Available at: http://www.nice.org.uk/niceMedia/pdf/EIP_March03.pdf

[24] Tanahashi T. Health service coverage and its evaluation. Bulletin of the World Health Organization 1978, 56(2): 295-303.

The working team must propose the objectives which are to be met as a result of the SPA's redesign. If necessary, the working team must also be able to prioritise these objectives, and provide justification for this prioritisation. In order to ease prioritisation, a brief summary of the core criteria used in different methods of prioritisation in Public Health is provided in Annexe III.

Example 36: Step T activity 1.c

Aims for the redesign made by the working team that analysed the programme aimed at vulnerable migrants of the line Vulnerable Groups of the Health Promotion and Prevention Plan 2011–2013.

Priorities and aims for the redesign phase:

Taking into account the aforementioned topics relating to the actions to be implemented with the selected group of MWCLWH*, the new drafting of aims and priorities for the SPA's redesign could read as follows:

General aim:

To improve equity by providing the particularly vulnerable migrant population with instruments to improve the control and management of their health.

Specific aims:

- To increase the flow of adapted information regarding law, labour rights and systems of social protection which are in force in Spain and in the Autonomous Community of Madrid.
- To provide information regarding resources and legal advice in administrative and labour matters.
- To provide information regarding resources, current social benefits (training for employment, for carers, children's education, language…).
- To boost the creation of support networks—community health workers fostering empowerment of these groups—collaborating with social and healthcare resources in the development of the aforementioned aspects.
- To improve the health status of economic immigrant women coming from low-income countries, working as domestic workers and carers for the elderly and children.
- To improve awareness of how the healthcare system operates and the quality of information received regarding benefits and healthcare assistance in the different phases of the healthcare process.
- To improve the access these women have to social and healthcare services.
- To foster meetings between the administration and the technicians responsible for the different spheres involved in the SDH, in order to improve the intersectoral coordination regarding the effective care of social and healthcare needs of the target group.
- To improve the cultural competences of social workers and healthcare professionals involved in assisting these women.
- To promote and foster the participation of associations and social bodies, as well as society as a whole, in assisting these women in the different stages of the SPA.

*MWCLWH: Migrant Women Carers, Live-in domestic workers, low-Wage earners and/or performing Household chores.

Example 37: Step T activity 1.c

Aims for the redesign made by the working team that analysed the Programme of Information on Smoking (PiS) in the Region of Murcia.

Redesign aims

To incorporate the equity perspective in the PiS to reduce the health gap between different population groups, focusing on populations facing greater vulnerability due to their social characteristics.

By stage:

1. Involve mediators from vulnerable groups at the stage of materials development in order to tailor the existing materials to the needs of those groups.

2. At the dissemination stage:

   - Identify these groups and the dissemination points, request their active participation with the PiS through the establishment of a collaboration agreement able to guarantee its development. For that purpose, advantage must be taken of the working teams which are already in place, and of the actions contained in the regional Health Plan and in the Municipal Health Plans. In some circumstances, subsidies, grants, partnership projects with other sectors (social bodies, NGOs, associations…) can be established.

   - Create specific distribution channels for these groups that increase accessibility to resources, whilst including them in the distribution list employed for the dissemination of the PiS materials.

3. In the training stage, incorporate the equity perspective in training activities organised by the Department of Health and Social Policy, in particular those targeted at healthcare and educational professionals. For example, in courses relating to smoking cessation or Health education for schools.

4. Move forward with the evaluation stage of the programme**:**

   - Carry out improvement cycles within the PiS.

   - Propose qualitative studies providing information about the understanding of materials, their usefulness and effectiveness in addition to studies evaluating the results achieved in health through the utilisation of these materials. For this purpose, it is necessary to carry out research projects in this line and to search specific funding for its development. For example: Advantage could be taken of the relationship with the Department of Social and Health Sciences of the University of Murcia for them to include a research line in this direction and also to introduce this approach in the research projects developed by the Service of Promotion and Health education with medical residents of Preventive Medicine and Public Health or with post-graduate and PhD students.

   - Guarantee the evaluation of the materials distribution process. Systematise the evaluation by including it in the project of the World No Tobacco Day, for example.

   - Preserve funding for the evaluation of the SPA.

   - Include in the different questionnaires employed for health-related research (i.e. in schools and universities' students) items which allow an analysis by socio-economic level or other social determinants, and also study the awareness and utilisation of leaflets of PiS and the interventions on smoking addiction made in the media.

   - Incorporate indicators to evaluate the SPA's progress in relation to the intersectoral coordination and the participation of the community. For example: the number of intersectoral working teams established for fostering the PiS, number of educational centres that ask for PiS educational materials and use them, number of Roma population's associations that use the materials, and the number of mediators participating in the adaptation of materials.

WHAT NEEDS TO BE DONE?

Review the four previous steps of the review, reach an agreement and develop:

- The SPA's new theory.
- The new version of the diagram of the key stages with the new stages that the group proposes to include in the redesign.
- The inclusion of new interventions drawn from the review.
- The aims of the SPA's redesign or the proposed recommendations.

Activity 2: Identification of areas and levels of action in the redesign

The working team will have to identify the areas and levels of action needed to accomplish the aims and recommendations of the redesign. The area of the actions necessary for the redesign must be taken into consideration and those actions to be implemented in the SPA must be specified (changes or recommendations). For example, the redesign areas could include:

- *Modification of the SPA's contents:* incorporation of a new service or adjustment of an existing service.
- *Structural and organisational changes*.
- *Improvement of management and implementation at local, regional and national levels*: Training, supervision and management control.
- *Actions at a core level to improve the implementation:* Regulations, guides, follow-up and monitoring systems (indicators).
- *Improvement of knowledge, abilities and implication of the prioritised social group with regard to the programme.*

Once the actions which are to be carried out and their corresponding areas have been established, the level or levels of implementation of the proposed action must be defined: national, regional or local.

WHAT NEEDS TO BE DONE?

Identify the areas and levels of action which are needed to accomplish the outlined aims and recommendations.

The following table can help in summarising the conclusions:

Areas of action	Action (specific change)	Level of action (national, regional or local)
Modification of the SPA's contents		
Structural and organisational changes		
Improvement of management by local, regional and national level implementers		
Actions at a core level to improve the implementation		
Other redesign area		

Activity 3: Integration of intersectoral action and social participation into the SPA

For the results to be effective and sustainable, it is important to integrate social participation and intersectoral action in the redesign of the SPA.

In the same way that inequities are the result of a complex accumulation of disadvantages, interventions must normally be tackled through a network of multiple sectors and levels. The sequence and coordination of other sectors' implication and the level and type of social participation must be part of the redesign.

From this perspective, **intersectoral action** becomes an essential requirement for addressing inequities and SDH.

In this step, to approach the issue of intersectoral action, the working team needs to analyse the interrelated sectors that have previously been identified (Page 98: Step I, activity 3).

The team must answer the question: What actions or interventions are needed from other sectors to address the identified barriers and the health inequities and to attain the aims of the redesign?

In relation to **social participation**, spaces and conditions for participation allowing vulnerable communities to reach a greater control on material, social and political determinants of their own welfare must be created. Empowerment, as conceived from the Health Promotion perspective, is inseparably connected with the achievement of effective control by communities of the political and economic processes that affect their welfare. Participation on its own cannot be considered a real empowerment without paying attention to the results of the political processes, that is to say, the redistribution of resources and power. It is necessary to go beyond participation in the decision-making process, emphasising control and transparency. The growing capacity of communities to control key processes affecting their lives and the quality information is the basis for empowerment.

The type of participation predominant in the SPA and the keys stages of the SPA in which it was present or absent has already been discussed in the previous steps. Moreover, based on the identified barriers, an analysis of the role played by social participation in overcoming these barriers has already been analysed. In this step, the type of participation that the team will foster in the SPA's redesign and the actions and spaces needed for its development will be defined.

For this purpose, the team will answer the following question: Which mechanisms, actions or recommendations could the SPA establish to redistribute power from the participatory spaces (giving more participation to the SPA's target individuals and to other civil organisations)?

WHAT NEEDS TO BE DONE?

Define the inclusion of intersectoral action and social participation in the SPA's redesign.

The following table can be useful to summarise conclusions:

Identified sectors other than Health	What is "SPECIFICALLY" recommended to be done from the perspective of other sectors?	What should be done from the perspective of the Health sector for this to happen?

"SPECIFIC" recommendation for the inclusion of participation in the SPA's redesign or recommendations	What should be done from the perspective of the Health sector for this to happen?

Example 38: Step T activity 3

Integration of intersectoral action made by the working team that analysed the Programme "promoting youth Elath" of the Regional Government of Andalusia called *Forma Joven*.

Different important sectors have been identified in the programme's development and implementation, to which the following recommendations are directed:

- **Youth Institute:** Definition of Action Plan to improve the quality of life of young people over 16 without education, training or employment.
- **Department of Employment:** Establishment of active employment policies for young people facing dismissal.
- **Department of Housing:** Active first home policies for young unemployed people.
- **Department of Housing:** Development of support strategies for avoiding poor school attainment, positive parenting programme and family conciliation policies for use in cases of generational conflict.
- **Department of Equality and Social Welfare:** Development of integrated family conciliation and consolidation programmes and integrated strategies for action in socially excluded groups.
- **Department of Governance and Justice:** Integration of Health promotion activities in institutionalised young people deprived of their freedom and others.
- **Town councils:** Analysis of needs in this realm. Coordination with other administrations. Making *Forma Joven's* information points available outside the educational system.

The responsibility of **Health** will be to highlight the problem, raising awareness of its significance and importance, and to share public and institutional responsibility.

For Group B, young people aged between 16 and 25 years old in formal and informal educational spaces, work could be at a coordination level. That is to say that joint efforts, adjusting policies to reach a greater level of efficiency and effectiveness, are desirable to reach a level of integration.

Regarding Group A, young people aged 16 to 25 years old neither studying nor working, the relationship among sectors must clearly be at an integration level, from the approach **Health in All Policies** —a sole policy involving all indicated sectors with a joint program and common aims.

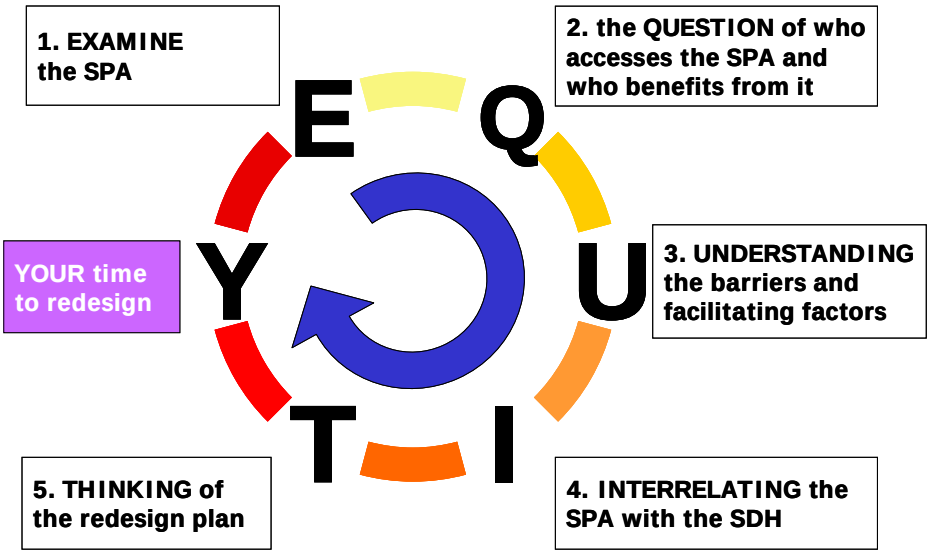
Example 39: step T activity 3

Integration of social participation made by the working team that analysed the NAOS (Strategy for nutrition, physical activity and the prevention of obesity).

"SPECIFIC" recommendation for the inclusion of participation in the SPA's redesign or recommendations	What does the Health sector need to do for this to happen?
REDESIGN NAOS STATEGY WITH PARTICIPATION Professionals from the following fields: health, education, urban planning, sports, agriculture, economy, social and citizens' affairs (including groups with high prevalence of obesity, cultural minorities).	-Foster this redesign by easing mechanisms of participation for AACC. -Compile the results in a "new" strategy document.
Spaces for municipal and AACC participation.	-Inform about the different obesity rates in different territories or AACC and of the importance of common strategies to reduce inequities. -Seek alliances for fostering the creation of policies, programmes, strategies.
-Inform teachers about the importance of Health promotion and inequities. -Record examples of good practice and encourage participation of teachers in the design of possible actions.	-Inform about obesity and inequities and the importance of school-based strategies. -Seek alliances. - Health promotion programmes aimed at teachers (PA, DT, smoking cessation). -Incorporate teachers in the creation of appropriate training about Health promotion programmes for different groups.
Spaces of local community participation. -Promote health diagnoses and prioritisation of actions aimed at preventing sedentary lifestyles.	-Participate in spaces of community participation. -Inform about community obesity data and inequity patterns. -Support the diagnosis and prioritisation of actions. -Assist with the proposal of specific actions. -Economic and human resources (PHC) in areas with low SEL or high prevalence of obesity.

* PA: Physical activity.
DT: Diet.
PHC: Primary Healthcare
SEL: Socioeconomic level.

5.3. Re-design (Step Y): Recommendations for the implementation, monitoring and evaluation of the SPA's redesign



As the last phase of the process, we need to plan how the aims of the redesign are going to be implemented whether this redesign is implemented within this review process or not. The working team will determine which steps can be taken regarding the redesign proposal and how to carry them out.

Difficulties and facilitators for the implementation of the redesign phase must be identified in order to suggest actions for solving or boosting them in advance.

Basic elements for the planning of the SPA redesign	
WHAT	Priority interventions Aims Monitoring indicators (process, results and equity indicators)
WHO	Responsible parties Other sectors Target population Others
HOW	Activities Resources Tools and instruments Participation and intersectoral action strategy
WHEN	Schedule

Evaluation and monitoring of the changes introduced in the redesign are an integral part of the process. Aims and questions regarding evaluation lead to a new review cycle: Do the changes lead to greater equity in the access and results expected from the SPA? Why? For this purpose, evaluation and monitoring of the SPA will include those aspects deemed to be necessary for assessing these changes, for example, new indicators, tools needed for their evaluation, etc.

WHAT NEEDS TO BE DONE?

- Plan the implementation of the redesign of the SPA.
- Include in the evaluation and monitoring of the SPA those aspects needed to assess the changes introduced in the redesign.

It is important to understand that the review and reformulation of the programme is a continuous process, not ending with the submission of a report or redesign proposal.

6. Glossary

6. Glossary

Activities: The set of processes or tasks that are carried out to acomplish the aims of a programme through the utilisation of human, material, technical and financial resources assigned.

Barriers: Those factors that hinder the target population (or a segment of it) from benefiting from the results expected from the health programme or services offered. They decrease the effective theoretical coverage of a service or are responsible for results being achieved only for some groups. As a consequence, the impact of the programme in the population is lesser than expected and inequity situations are generated and perpetuated. (Reference: Sub-Secretariat of Public Health, Ministry of Health, Government of Chile. Documento técnico III. Guía para analizar equidad en el acceso y los resultados de los programas y su relación con los DSS [Technical document III. Guide for the equity analysis on programmes' access and results and their link with social determinants of health] [in Spanish]).

Social capital: Degree of social cohesion that exists in communities. It refers to processes among people which establish networks, norms and social commitments in order to facilitate coordination and cooperation for their mutual benefit. (Reference: World Health Organisation. Health Promotion Glossary. Second edition. Geneva1998. Available at:http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf).

Context: Physical or situational enviroment, whether political, historial, cultural or of any other nature, where a fact in considered. (Reference: Diccionario de la Real Academia Española, Vigésima segunda edición, 2001 [Dictionary of the Spanish Language of the Royal Academy. Twenty-second Edition, 2001]).

Culture: Set of meanings and behaviours shared and developed over time by groups of people as a consequence of their common experiences, their social interactions and their exchanges with nature. It creates patterns of meanings codified in symbols that are transmitted and by which people communicate, perpetuate and develop knowledge and actitudes in relation to life. (Reference: Freud S. The Future of an Illusion , 1927. Complete works, vol.XXI).

Empowerment for health: In Health promotion, it is a process by which people gain a greater control over the decisions and actions affecting their health. (Reference: World Health Organisation. Health Promotion Glossary. Second edition. Geneva1998. Available at: http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf)

Health strategy: Instrument of strategic long-term planning by which orientations, aims and priorities are gathered to address a health topic in an integrated way in order to promote, maintain and improve the health of the population.

SPA's key stages: Essential phases of the development process of a SPA which are necessary for the achievement of the intented targets.

Needs assessment: A systematic procedure for determining the nature and extent of health needs in a population, the causes and contributing factors to those needs and the human, organisational and community resources which are available to respond to these. (Reference: Smith BJ, Tang KC, Nutbeam D. WHO Health Promotion Glossary: new terms. Health Promotion International 2006. Available at: http://www.who.int/healthpromotion/about/HP%20Glossay%20in%20HPI.pdf).

Facilitators: Those factors helping the target population to benefit from the results expected from the programme, including those that allow for the overcoming of access barriers and achieving an effective use (Reference: Sub-Secretariat of Public Health, Ministry of Health, Government of Chile. Documento técnico III. Guía para analizar equidad en el acceso y los resultados de los programas y su relación con los DSS [Technical document III. Guide for the equity analysis on programmes' access and results and their link with social determinants of health] [in Spanish]).

Governance: Action or effect of governing. Manage a group issuing and enforcing rules for its orderly development (Reference: Diccionario de uso del español. 3ª ed [Spanish usage dictionary. Third edition]. María Moliner. Editorial Gredos).

Indicator: Quantitative or qualitative variable providing a simple and reliable means of measuring achievements, helping to evaluate results or reflecting the changes related to an intervention. (Adapted from: OECD (2002). Glossary of the key terms in evaluation and results-based management).

Process indicators: Indicators measuring aspects related to the implementation of the SPA's activities.

Results indicators: Indicators measuring the achievement of the aims of a process.

Equity indicators: Process or result indicator measuring and differentiating the situation of relevant social groups in comparison to the average or other reference.

Intersectoral action: A recognised relationship between part or parts of the Health sector and part of parts of another sector, that 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 alone. (Reference: WHO Commission on Social Determinants of Health. A Conceptual Framework for Action on the Social Determinants of Health. Discussion paper for the Commission on Social Determinants of Health. DRAFT April 2007. Available at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf).

Universal coverage intervention: Intervention targeted at the whole population affected by the problems or issues tackled by the same intervention.

Focused or selective intervention: Intervention specifically focused on a concrete segment or segments of the population affected by the problems or issues tackled by the same intervention.

Downstream, midstream, upstream interventions:

1. Interventions on the **consequences that the problem creates** (***Downstream***), mainly those linked to the healthcare system: Services of curative care or secondary prevention.

2. Interventions aimed at reducing the **magnitude of exposures and/or giving greater support to those experiencing more vulnerability** (***Midstream***); there are:

    - Interventions for changing behaviours and lifestyles.

    - Interventions on living and working conditions.

3. Interventions that intend to modify the **context and/or social stratification (*Upstream*)**, i.e. the distribution of power that leads some social groups to experience a greater degree of exposure and vulnerability.

Example of interventions:

	Social reform Upstream	Risk's reduction Midstream	Effects' reduction Downstream
Universal measures	Public education system, taxes, labour market policies	Measures on the environment, working environment, conventional lifestyles	Health system
Selective measures	Social benefits according to level of income	Specific lifestyles measures for certain social groups	Specific health services for certain social groups

Source: Torgersen TP, Ø. Giæver and Stigen OT. Developing an Intersectoral National Strategy to Reduce Social Inequalities in Health-The Norwegian Case. Oslo, 2007.

Macroeconomy: Term used in modern economic literature to characterise an approach towards economic analysis based on the study and perception of global quantities or aggregates (national product, national income, national expenditure, savings, investments, etc. are the magnitudes arising from macroeconomic study). It consists of the collective study of economic phenomena, and is essentially based on scientific measures and on the construction of models able to explain the functional realities between the aggregates hereto measured. It is distinguishable from microeconomics, which is based on the analysis of the fundamental units of economic life (the producing company, the consumer or other consumption units, such as the family, etc.). (Reference: Economic and Financial Dictionary. Bernard-J.C. Colli. 4th edition).

Primary prevention: Interventions aimed at preventing the onset or incidence of disease. (Reference: Piédrola Gil (2008). Medicina Preventiva y Salud Pública. [Preventive Medecine and Public Health] 11th edition. Elsevier, Spain).

Secondary prevention: Interventions aimed at avoiding the progression of biological injury or disease. (Reference: Piédrola Gil (2008). Medicina Preventiva y Salud Pública. [Preventive Medecine and Public Health] 11th edition. Elsevier, Spain).

Terciary prevention: Interventions for preventing disabilities in patients in the symptomatic stage of disease. (Reference: Piédrola Gil (2008). Medicina Preventiva y Salud Pública. [Preventive Medecine and Public Health] 11th edition. Elsevier, Spain).

Health programme: Organised, consistent and integrated set of activities and services made simultaneously or successively, with the necessary resources and with the goal of reaching specific objectives related to concrete health problems in a defined population (Reference: Pienault, Daveluy (1987). La planificación sanitaria. Conceptos, métodos y estrategias [Health planning. Concepts, methods and strategies]. Masson, Barcelona).

Health promotion: Process of enabling people to increase control over their health and to improve it. Health promotion is a comprehensive social and political process that embraces not only actions directly aimed at strenghthening the skills and capabilities of individuals but also actions aimed at changing social, environmental and economic conditions in order to alleviate their impact on public and individual health. (Reference: World Health Organisation. Health Promotion Glossary. Second edition. Geneva1998. Available at: http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf)

Health system: Collection of all organisations, institutions and public and private resources whose main goal is to promote, maintain or re-establish health. Health systems embrace services targeted both at individuals and at the population as a whole, as well as activities that have an influence on the policies and actions of other sectors aimed at addressing social, environmental and economic determinants of health. (Reference: WHO Regional Office for Europe (2008). The Tallinn Charter: Health Systems for Health and Wealth).

Social values: Set of ideas and beliefs typical from a society that determine the human behaviour and the system of social norms. The set of values and norms of a society influences, in different ways, the health and welfare of individuals and populations.

7. Recommended Readings

7. Recommended readings

1. WHO Commission on Social Determinants of Health (2008). Closing the gap in a generation. Final report of the Commission on Social Determinants of Health. Available at: http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf

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4. Pawson R and Sridharan S. Theory - driven evaluation of public health programmes. Chapter 4 in Evidence-based Public Health, Effectiveness and Efficiency. Oxford University Press 2010.

5. Rose G (1985). Sick individuals and sick populations. Epidemiological Bulletin, Vol 6 N° 3. PAHO. http://www.paho.org/english/dd/ais/EB_v6n3.pdf.

6. Sub-Secretariat of Public Health, Ministry of Health, Government of Chile. Documento técnico I. Antecedentes para apoyar la revisión y rediseño de los programas de salud pública desde la perspectiva de equidad y determinantes sociales [Technical document I. Background to support the review and redesing of pulic health programmes from the equity and social determinants perspective].

7. Sub-Secretariat of Public Health, Ministry of Health, Government of Chile. Documento técnico III. Pauta para iniciar la revisión de los programas: Lista de chequeo de Equidad [Guidance for inititiating the programmes's review: Equity check-list].

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11. WHO Commission on Social Determinants of Health (2007). A Conceptual Framework for Action on the Social Determinants of Health. Discussion paper for the Commission on Social Determinants of Health. DRAFT April 2007. Available at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf).

12. WHO European Region (2011). Interim second report on social determinants of health and the health divide in the WHO European Region. Available at: http://www.instituteofhealthequity.org/projects/who-european-review.

8.

Participants in the training process

8. Participants in the training process

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WORKING TEAM THAT ANALYSED THE PROGRAMME OF COLORECTAL CANCER SCREENING OF THE AUTONOMOUS COMMUNITIY OF THE BASQUE COUNTRY

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WORKING TEAM THAT ANALYSED THE PROGRAMME FOR PROMOTING YOUTH HEALTH OF THE REGIONAL GOVERNMENT OF ANDALUSIA CALLED "FORMA JOVEN"

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WORKING TEAM THAT ANALYSED THE PLAN ON HEALTH EDUCATION IN SCHOOLS OF THE REGION OF MURCIA 2005-2010

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WORKING TEAM THAT ANALYSED THE CALL FOR GRANTS TO FUND NON-PROFIT ORGANISATIONSS-BASED PROGRAMMES FOR HIV AND AIDS PREVENTION AND CONTROL

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[♣] Working teams that did not finished the process.

WORKING TEAM THAT ANALYSED THE NATIONAL PLAN ON PREVENTIVE ACTIONS FOR THE EFFECTS OF HIGH TEMPERATURES ON HEALTH ♣

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- Rosa Ramírez Fernández. Deputy General Director. General Sub-Directorate of Health Promotion and Epidemiology. General Directorate of Public Health, Quality and Innovation. Spanish Ministry of Health, Social Services and Equality.

WORKING TEAM THAT ANALYSED THE HEALTHY UNIVERSITY PLAN OF THE PUBLIC UNIVERSITY OF NAVARRA (UPNA) ♣

- Pilar Marín Palacios. Health Promotion Section. Public Health Institute of Navarra.

♣ Working teams that did not finished the process.

9.
Annexes

9. Annexes

Annexe I: Summary of the training process "Integration of Social Determinants and Equity into Strategies, Programmes or Activities related to Health"

Aims:

1. To define a method of review and reformulation of Strategies, Programmes and Activities (SPAs) related to health.
2. To analyse Health Equity in some of the current health-related SPAs.
3. To identify the social determinants that cause health inequities in each SPA and those shared by all programmes or groups of programmes.
4. To identify interventions and approaches of action which lead to improvement in equity, including possible changes in the organisation of the SPAs.
5. To reformulate the SPAs according to equity analysis, social determinants and possible interventions.
6. To foster collaborative work and the management of knowledge within the organisational structure of the MoHSSE and the AACC, as well as other institutions.
7. To consolidate a comprehensive view of the field of Public Health, intersectoral and participatory processes, reinforcing competencies and skills for their implementation.
8. To strengthen the exchange of experiences of SDH interventions and those in favour of equity among different administrations, including those based overseas.

Coordination

Health Promotion Area. General Sub-Directorate of Health Promotion and Epidemiology. General Directorate of Public Health, Quality and Innovation. Spanish Ministry of Health, Social Services and Equality.

Furthermore, the process received technical support from the World Health Organisation Regional Office for Europe and the Pan American Health Organization (PAHO) Virtual Campus for Public Health.

Participants

The process was targeted at a selection of technical professionals working on key areas for the reduction of health inequities of the Spanish MoHSSE, the Health Departments of AACC and other key institutions for health equity as Town Councils and Departments for Prison Health. Participants were appointed by the corresponding General Directorates in the case of MoHSSE and by the General Directorate of Public health of each AACC or institution.

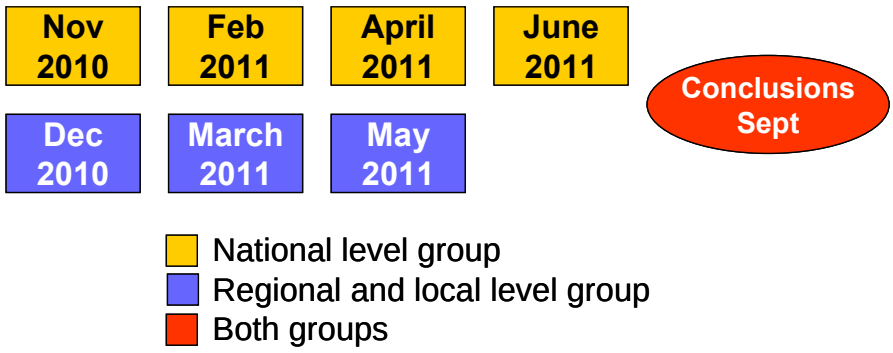
25 professionals from the Ministry and 20 from the Departments of Health of the Autonomous Communities, and other key areas, completed the process and contributed to the final outcome. In addition, 18 other professionals participated in some aspect of the process.

Methods

The Spanish training process was developed based on the experience and technical documents☞ of the Chilean Ministry of Health for the review and redesign of health programmes, developed in 2008-2009 within the work plan "Social Determinants of Health: 13 steps towards Health Equity in Chile", which was coordinated by the Technical Secretariat of Social Determinants of the Public Health Sub-Secretariat.

In Spain, the process was structured in two groups, the first group comprising professionals from the MoHSSE (national level group) and the other, professionals coming from the AACC and other key institutions (regional and local level group). In each group, participants were organised in working teams for the process of analysis and review.

Schedule (November 2010-September 2011)



The process was comprised of:

- An in-site part consisting of in-site training workshops that were developed in four training periods for the national level group and three for the regional and local level group (all the workshop programmes can be found at the end of this annexe).

☞ See technical documents of the Sub-Secretariat of Public Health of the Chilean Ministry of Health in the chapter of Recommended Readings.

- A part consisting of distance activities between workshops, with participants working and receiving on-line assistance through a virtual platform, sited in the Pan American Health Organization (PAHO) Virtual Campus for Public Health, which allowed for exchanges, meetings and forums between participants and teachers.

Lastly, with the objective of assessing results and advances of the process and proposing joint activities for reducing social inequities in health, a meeting was organised within the framework of the XXII Public Health School of Menorca (Spain) in September 2011.

Teachers

Dr. Jeanette Vega and Dr. Orielle Solar, both experts in the field of Health Equity, responsible for the Chilean experience and members of the WHO Commission on Social Determinants of Health.

Working teams and SPAs analysed

A total of thirteen working teams were established during the training process. They worked with the different issues which are compiled in the following table:

Working teams topics	Analysed SPAs	Team
Childhood	National Strategic Plan for Childhood and Adolescence.	MoHSSE
HIV	Call for grants for non-profit organisations-based programmes for HIV and AIDS prevention and control.	MoHSSE
High temperatures*	National Plan on preventive actions for the effects of high temperatures on health.	MoHSSE
Cancer	Cancer Strategy of the Spanish National Health System.	MoHSSE
Healthy diet and physical activity	NAOS strategy: Strategy for Nutrition, Physical Activity and the Prevention of Obesity.	AACC
Vulnerable groups	Health Promotion and Prevention Plan 2011-2013. Vulnerable Groups Line; Programme targeted at vulnerable migrants. Autonomous Community of Madrid.	AACC
Colorectal cancer screening	Screening Programme for Colorectal Cancer of the Autonomous Community of the Basque Country.	AACC
Youth	Programme for promoting youth health called *Forma Joven.* Regional Government of Andalusia.	AACC
Tobacco	Programme for Information on Smoking of the Region of Murcia.	AACC
Schools	Plan on Health Education in schools of the Region of Murcia 2005-2010.	AACC
Healthy universities*	Healthy University Plan of the Public University of Navarra (UPNA).	AACC
Healthy cities	Municipal Plan for Prevention and Assistance in Drug Dependency. Town Council of San Sebastián de los Reyes.	AACC
Health and reproductive health*	Community-based Sexual Education Programme. Reproductive and Sexual Health Strategy.	AACC

*Working teams that did not finished the process.

Expected results for each working team and SPA

- Equity analysis for each SPA.
- Identification of social determinants and intervention entry points for each SPA.
- Identification of intervention alternatives for each SPA.
- Proposal of total or partial redesign for the analysed SPAs.

Final products of the process

- Methodological Guide to integrate equity into health SPAs.
- Synthesis documents of the working teams.
- Technical document on the development of the training process for the integration of the social determinants and equity approach in the health-related SPAs.

Training process programmes

a) National level group Programme (64 in-person hours and 126 hours of remote participation[♣]):

First in-person workshop: 29-30 November 2010 (16 hours)	▪ Introduction to SDH conceptual frameworks. ▪ Reflections on actual applicability of SDH within the health field. ▪ Aims and basis of the review process and reformulation of strategies, programmes and activities (SPAs) with equity approach. ▪ First phase: review of initial checklist.
Remote work: December 2010-February 2011 (30 hours)	• Setting up working teams to carry out the SPAs' analysis. • Development of the checklist by strategy, programme or activity. • Guidance for participants.
Second in-person workshop: 28 February -1st March 2011 (16 hours)	▪ Presentation of advances of the checklist. ▪ Training in equity analysis: steps 1 and 2 of the review process. ▪ Agreement with participants on the support instruments for steps 1 and 2.
Remote work: March-April 2011 (24 hours)	• Development of steps 1 and 2 by participants. • Guidance for participants.
Third in-person workshop: 27-28 April 2011 (16 hours)	▪ Presentation of advances in steps 1 and 2. ▪ Training in equity analysis: steps 3 and 4 of the review process. ▪ Agreement with participants on the support instruments for steps 3 and 4.
Remote work: May-June 2011 (18 hours)	• Development of steps 3 and 4 by participants. • Guidance for participants.
Fourth in-person workshop: 15 y 16 June 2011 (16 hours)	▪ Presentation of advances in steps 3 and 4. ▪ Training in equity analysis: steps 5 of the review process. ▪ Discussion on orientations for reformulation.
Remote work: June-September 2011 (54 hours)	• Development of step 5. • Assessment of the proposals for reformulation of each SPA. • Proposal for redesign implementation and definition of possible commitments related to it.
Menorca meeting: 21-23 September 2011	▪ Conclusions and evaluation of results of the training process.

[♣] The process was recognised by the Spanish Commission of Continuing Education of the National Health System with 11,3 training credits for continuous training for the national level group.

b) Regional and local level group Programme (56 in-person hours and 126 remote participation hours[♣]):

First in-person workshop: 1-2 December 2010 (16 hours)	▪ Introduction to SDH conceptual frameworks. ▪ Reflections on the actual application of SDH within the health field. ▪ Aims and basis of the review and reformulation process of strategies, programmes and activities (SPAs) with equity approach. ▪ First phase: review of initial checklist.
Remote work: December 2010 - February 2011 (30 hours)	• Setting up working teams to carry out the SPAs' analysis. • Development of the checklist by strategy, programme or activity. • Guidance for participants.
Second in-person workshop: 2-4 March 2011 (20 hours)	▪ Presentation of advances of the checklist. ▪ Training in equity analysis: steps 1 and 2 of the review process. ▪ Agreement with participants on the support instruments for steps 1, 2 and 3 of the review process.
Remote work: March - April 2011 (48 hours)	• Development of steps 1, 2 and 3 by participants. •Guidance for participants.
Third in-person workshop: 4-6 May 2011 (20 hours)	▪ Presentation of advances of steps 1, 2 and 3. ▪ Training in equity analysis: step 4 of the review process. ▪Agreement with participants on the support instruments for steps 4 and 5 of the review process.
Remote work: May - September 2011 (48 hours)	• Training in equity analysis: step 5 of the review process. • Development of steps 4 and 5 by participants. • Assessment of the proposals for reformulation of each SPA. • Proposal for redesign implementation and definition of possible commitments related to it.
Menorca meeting: 21-23 September 2011	▪ Conclusions and evaluation of results of the training process.

[♣] The process was recognised by the Spanish Commission of Continuing Education of the National Health System with 9,7 training credits for continuous training for the AACC group.

Annexe II: Information on the SPAs analysed by each working group during the training process

Programme of Information on Smoking in the Region of Murcia intends to inform and raise awareness on the harmful effects of tobacco use and the exposure to environmental tobacco smoke. Its principal objective is to create, edit and distribute informative-educational materials aimed at different groups (smoking and non-smoking people, mothers and fathers, young people, pregnant women, educational and healthcare professionals) serving as an educational resource for social and healthcare workers in order to prevent smoking take-up and exposure to tobacco as well as to promote tobacco cessation.

Strategic line of Health Promotion and Protection within the Cancer Strategy of the National Health System (Ministry of Health, Social Services and Equality). The Cancer Strategy of the National Health System's general aim is to identify the needs for cancer prevention, diagnosis and treatment as well as to establish agreed work objectives and recommendations, which are applicable throughout the whole National Health System. This working team, given the extent and complexity of the Strategy, focused their work on the prevention of smoking, within the strategic line of Health Promotion and Protection of the Strategy.

NAOS Strategy ***(Strategy for Nutrition, Physical Activity and the Prevention of Obesity)*** of the Ministry of Health, Social Services and Equality, intends to reduce the growing trend towards obesity prevalence by means of encouraging healthy diet and promoting physical activity.

The main objective of the ***Colorectal cancer screening programme through the Faecal Occult Blood Testing (FOBT) of the Department of Health and Consumer Affairs of the Basque Government*** is the early detection (target group: asymptomatic men and women aged between 50 and 69) and the extirpation of high risk adenomatous lesions and cancer in early stages in order to reduce incidence and mortality of colorectal cancer in the population of the Autonomous Community.

The ***call for grants to fund non-profit organisations-based programmes for HIV and AIDS prevention and control*** developed by the Ministry of Health, Social Services and Equality is targeted at NGOs, which have an important role as bodies responsible for the provision of information, education and support to sectors of the population that are especially exposed to HIV infection and that social and healthcare networks find harder to reach. They are also important for the contribution they make to change the norms and values that have a bearing on the vulnerability of these groups and on the population as a whole.

The aim of the ***National Strategic Plan for Childhood and Adolescence (PENIA)*** is to promote and foster— with the involvement of public authorities and in collaboration with families, children themselves and all the other players and institutions concerned— the welfare of children and a favourable and safe social environment to meet their needs and reach the full development of their abilities as active subjects of their rights. In essence, this will be achieved through the development of comprehensive and cross-

cutting policies and actions. The main strategic lines of the childhood policies are defined within this Plan. These were agreed upon in the framework of the Childhood Observatory by the relevant institutions and child protection organisations and they will guide the actions of the different Administrations.

Plan on Health Education in schools of the region of Murcia 2005–2010 is a global and comprehensive master plan based on the principles of participation and multisectoral and multidisciplinary action that determine the philosophy and methods based on the concept of "Health Promoting School" for the development of Health Education in non-university educational centres.

Programmes integrating the strategic line dedicated to ***Health Promotion in vulnerable groups of the Health Promotion and Prevention Plan 2011–2013 of the Autonomous Community of Madrid*** seek to contribute to the prevention of social exclusion within the healthcare sphere, dealing with health-related social risk by means of specific actions aimed at individuals, families, groups and communities that are assisted by healthcare services and still have social risk factors. Within this strategic line, the working team analysed the programme dedicated to vulnerable migrants.

The objectives of the ***Municipal Plan for Prevention and Assistance in Drug Dependency of the Town Council of San Sebastián de los Reyes*** are to provide a specialised and comprehensive response to the health problems of the population consuming toxic substances, helping to delay the age of first use in children and young people and to develop prevention programmes at the educational and community level. In terms of analysis, one area of focus for the working team was the Programme for Assistance to Drug dependency, and the other, the Programme for Prevention.

Intersectoral programme for promoting youth health of the Regional Government of Andalusia called "Forma Joven" promoted by the Health Department involving the Departments of Education, Equality and Social Welfare (the Youth Council and the Women's Institute), the Andalusian Federation of Municipalities and Provinces, and the Confederation of Parents' Association of Andalusia, has as its main objective to contribute to the development of basic competences needed for social and personal development of adolescents and young people between 12 and 25 years old, especially in those aspects related to physical, mental, social and environmental health, helping to detect health-related problems or risk situations.

Annexe III: Prioritisation process

The process of prioritisation refers to the set of activities by which a ranking of the main health problems intends to be established in order to orientate resources and define programmatic actions or strategies for action.

This process, within the framework of health planning, is composed of different stages and has as final result a list of priority health problems (or the interventions required to tackle them):

1. Definition of criteria and decision tools.
2. Pre-selection of problems/programmes.
3. Analysis and comparison of problems/programmes regarding the selected criteria.

There are multiple instruments for each of the abovementioned stages. In order to achieve the aims of this guide and, given the fact that prioritisation must be made in several activities (in the selection of the SPA to be analysed by the working team, of the groups experiencing inequity and of the recommendations for the SPA's redesign), a brief summary of the main criteria employed in different methodologies of prioritisation in Public Health has been included, taking into account both the problem and the characteristics of the intervention:

Burden of the problem:

- **Magnitude:** number of individuals being affected or possibly affected by the problem. It is measured in terms of prevalence or incidence.
- **Severity:** degree to which the health problem causes deaths, disabilities and affects especially vulnerable groups (i.e. children). Indicators such as mortality rate and burden of disease are used.
- **Significance:** social impact that the problems that have to be selected have on the population, i.e. en terms of years of potential life lost (YPLL) or lost years of healthy life (LYHL).
- **Emergency:** degree of immediacy needed to solve the problem.

Characteristics of the intervention:

- **Vulnerability:** reflects the sensitiveness of the problem to the intervention and is closely linked to the concept of effectiveness of interventions to reduce or solve the problem. For quantifying vulnerability, scientific evidence is employed.
- **Economic effectiveness:** relation between the costs of the intervention and the positive results derived from it. According to how results of the interventions are measured, cost-effectiveness, costs-utility and costs-benefit analysis can be employed.

- **Feasibility:** capacity for intervening with the human and financial resources available.
- **Social interest:** from the perspective of the population or interested groups of society, i.e. social priorities established through surveys, participatory diagnoses, regional forums, etc.
- **Institutional interest:** alignment with strategic priorities of the institution.
- **Equity:** interventions aimed at reducing health inequity.
- **Intersectoral action:** Interventions enabling strategic alliances with other sectors to improve the health of the population.

Score:

A score must be determined for each of the criteria, normally using the Likert scale (for example, from 1 to 3: 1-Low; 2-Medium; 3-High).

Weighting:

Once all the criteria that are going to be used have been selected, and in the event that we consider some criteria more important than others, a relative weight can be assigned to each criterion. In the example of the matrix, 6 criteria have been selected (A-F), each of which has been assigned a different weight.

Health Problem	Criterion A Weight A=20%	Criterion B Weight B=15%	Criterion C Weight C=20%	Criterion D Weight D=10%	Criterion E Weight E=25%	Criterion F Weight F=10%	Total Score*
1							
2							
3							
4							
5							
6							
7							
…							

* The final score for each health problem is obtained by adding the weight of each criterion (score assigned in the Likert scale x weighting factor).

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