

Social Determinants of Health Discussion Paper 9



Integration of social determinants of health and equity into health strategies, programmes and activities: health equity training process in Spain

DEBATES, POLICY & PRACTICE, **CASE STUDIES**

Integration of social determinants of health and equity into health strategies, programmes and activities: health equity training process in Spain

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Executive summary

A training process to integrate a focus on social determinants of health and equity into health strategies, programmes and activities (SPAs) was carried out by the Spanish Ministry of Health, Social Services and Equality in 2010–2011. The training process was part of the equity action lines launched by the Ministry and reflected its interest in promoting and developing tools for moving towards the concept of health in all policies.

The training methodologies applied in Spain drew from the experience of the Chilean Ministry of Health in 2008–2009 of revising health programmes for greater health equity. Both the Chilean and Spanish trainings were guided by the work of the Commission on Social Determinants of Health. The training was technically supported by the World Health Organization (WHO) Regional Office for Europe and the Virtual Public Health Campus of the Pan American Health Organization/WHO Regional Office for the Americas.

The goal of the Spanish health equity training was to develop and strengthen the capacity of the management teams of professionals working at the Ministry of Health, Social Services and Equality (national level), regional health departments and other key administration levels in areas considered critical for reducing health inequities. The three specific objectives of the training process were:

- ✔ to build participants' theoretical understanding of health equity, social determinants of health, and programme evaluation cycles;
- ✔ to build participants' methodological capacity to review public health SPAs from the perspective of health equity and social determinants of health;
- ✔ to produce a guide that synthesized the methodology, background resources, and experience of the training.

The guide – entitled the *Methodological guide to integrate equity into health strategies, programmes and activities* – was published in 2012. The guide was developed with the aims of raising awareness on health equity and the social determinants of health approach among professionals in the health sector and in those sectors with an impact on the health of the population, and providing a practical tool to ease the effective integration of equity into health SPAs. The guide is available in both English and Spanish.¹

This paper aims to describe the methods and process used for the Spanish health equity training, highlight some of the emerging results and describe lessons learnt across the Spanish experience. It therefore aims to contribute to the Rio Political Declaration on Social Determinants of Health by supporting specifically the priority area *on further reorienting the health sector towards reducing health inequities, including moving towards universal health coverage that is accessible, affordable, and good quality for all*.

¹ The Spanish edition is entitled *Guía metodológica para integrar la equidad en las estrategias, programas y actividades de salud*. For the English version, See http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/jornadaPresent_Guia2012/docs/Methodological_Guide_Equity_SPAs.pdf.

There were two parts to the process of reviewing and redesigning key public health SPAs:

- ① Review of key concepts, frameworks and definitions, including the social production of health and disease, the WHO Commission on Social Determinants of Health framework, the health system as a social determinant of health, intersectorality, social participation, equity in health and health care, the Tanahashi framework for effective coverage, and theoretical models of programme evaluation, including the theory of programme change.
- ② Integration of a focus on social determinants of health and health equity into the SPAs, which was composed of three main activities:

Checklist for the initial equity analysis through the review of nine areas: objectives, target population, needs assessment, analysis of actions, implementation, intersectoral action, social participation, outcomes and evaluation, and equity challenges.

- 2.2 Five-step review cycle, referred to in the Spanish methodological guide with the acronym: **E-Q-U-I-T-(Y)**:

step E: Examine the SPA

step Q: the Question of who accesses the SPA and who benefits from it

step U: Understanding the barriers and facilitating factors

step I: Interrelating the SPA with the social determinants of health

step T: Thinking of the redesign plan

- 2.3 Last step, redesign, letter Y of the acronym (E-Q-U-I-T-) **Y**:

step Y: Your time to redesign

This paper includes a lessons learnt section based on the experience of Spain, describing aspects considered relevant for the transferability of the process:

- ✔ criteria for the selection of SPAs and team participants;
- ✔ organization of the training (in person and online);
- ✔ training as an integrated part of government strategies for the reduction of health inequities;
- ✔ integrating an equity focus in the ongoing evaluation, design and revision of SPAs;
- ✔ required resources and tools, and sustainability.

In summarizing the key points of this section, it is important to emphasize:

- ✔ the usefulness of a methodology that combines learning and action through presentations, readings, exercises, discussions and forums that promote a progressive learning of concepts;
- ✔ the relevance of interdisciplinarity, intersectorality and social participation in the composition of the working teams, as these aspects are required for an ideal equity review process (in the Spanish process, the integration of those elements was a weak point for the review and redesign of the SPAs);
- ✔ the high level of political commitment required to ease the entire process and contribute to the sustainability and mainstreaming of equity, though even without a high level of political support, the process can contribute to awareness raising, help create a critical mass for change, and support the transition from a biomedical approach to a social determinants of health approach.

In conclusion, it is important to have available practical and effective methodologies that allow integration of a focus on social determinants of health and health equity into SPAs, not only in the review and reorientation of the already existing SPAs but also in the design of new ones. The methodology described in this paper can support these objectives and, moreover, is also useful as a comprehensive process that aims to improve SPAs.

One of the main values of this innovative experience at international level is its transferability. The Spanish experience has proved the transferability of the Chilean methodology after adaptation to the national context.

Furthermore, based on the Spanish experience, and following the *Methodological guide to integrate equity into health strategies, programmes and activities*, the WHO Regional Office for Europe, in collaboration with the Interuniversity Institute of Social Development and Peace, University of Alicante (WHO Collaborating Centre on Social Inclusion and Health) and the Spanish Ministry of Health, Social Services and Equality are conducting an equity training process on reorienting strategies, programmes and activities related to Millennium Development Goals 4 and 5 to promote greater health equity with an explicit but not exclusive focus on the Roma population.

Further work on concrete mechanisms and tools to support health equity planning and evaluation are needed, first in the health sector, and later in other sectors with an impact on health.

1 Introduction

Between November 2010 and September 2011, the Spanish Ministry of Health, Social Services and Equality carried out a training process to integrate a focus on social determinants of health and equity into health strategies, programmes and activities. The goal of the training was to develop and strengthen the capacity of the management teams of the Ministry, autonomous communities and other key areas¹ to integrate a focus on social determinants of health and health equity into selected public health strategies, programmes and activities (SPAs). The training methodologies applied in Spain drew from the experience of the Chilean Ministry of Health in 2008–2009 of revising health programmes for greater health equity. Both the Chilean and Spanish trainings drew from the work of the Commission on Social Determinants of Health of the World Health Organization (WHO).

The purpose of this document is to describe the methods and process used for the Spanish health equity training, highlight some of the emerging

results, and describe lessons learnt from the Spanish experience. The document is divided into the following sections:

- ❶ Introduction
- ❷ Background
- ❸ Goals and objectives of the Spanish training
- ❹ Methodology: introduction and stages
- ❺ Methodology: components
- ❻ Lessons learnt from the Spanish experience
- ❼ Conclusions

This document aims to contribute to the global evidence base and information exchange between countries in support of implementation of the Rio Political Declaration on Social Determinants of Health.² Specifically, the information in this document supports the Declaration's priority area on *further reorienting the health sector towards reducing health inequities, including moving towards universal health coverage that is accessible, affordable, and good quality for all.*

¹ Key areas included local authorities and others such as entities responsible for health in prisons.

² More information on the Rio Political Declaration and related activities can be found at <http://www.who.int/sdhconference/background/en/>.

2 Background

The Spanish training was organized, coordinated and financed by the Health Promotion Area of the General Directorate for Public Health, Quality and Innovation, Ministry of Health, Social Services and Equality. It was part of a process in Spain through which national work on social determinants of health and health equity has become increasingly systematized, with key milestones including:

- ❖ the appointment in 2008 of a National Experts Commission on the Reduction of Social Health Inequalities¹ in Spain;
- ❖ elaboration by the aforementioned Commission of a report of recommendations for policies and interventions to reduce health inequities in Spain, which contains a proposal of 166 specific recommendations for the short, medium and long term (1);
- ❖ identification of health equity (monitoring social determinants of health and health inequities) as a priority for the Spanish European Union Presidency in 2010 and resulting adoption the Spanish Presidency-backed *Council conclusions on equity and health in all policies: solidarity in health* (2);
- ❖ creation and adoption by the Government of the National Strategy on Health Equity, followed by priority setting with the autonomous communities of action lines for implementation of the strategy at national and regional level;
- ❖ incorporation of “health in all policies” and “equity” as general principles in the development of the first Law on Public Health in Spain (Law 33/2011), which includes monitoring of social determinants of health and health inequities in the public health information system and makes health impact assessment mandatory for “norms, programmes and projects with a significant impact on health”;
- ❖ ongoing commitment by the Ministry of Health, Social Services and Equality to improve the health of populations experiencing social exclusion, through initiatives such as the comparative study of the National Health Surveys for the Roma population and the general population (3), the Action Plan for the Development of the Roma Population of Spain 2010–2012 (4) and, recently, the National Roma Integration Strategy in Spain 2012–2020 (5).

The training process was developed in the framework of the National Strategy on Health Equity (box 1) within the B strategic line: To promote and develop knowledge and tools for intersectoral work: moving forward to the concept of “health and equity in all policies”.

¹ The word inequalities here has the same connotation as inequities; that is, health differences that are unfair and unjust.

Box 1. Pillars of the Spanish National Strategy on Health Equity

A. To develop health equity information systems to guide public policies

- National health equity monitoring network
- Health impact assessment of public policies
- Report on health inequities in Spain

B. To promote and develop knowledge and tools for intersectoral work: moving towards the concept of “health and equity in all policies”

- Creation of intersectoral bodies
- Inclusion of specific [equity-relevant] objectives in health plans
- Training on health equity for health sector professionals
- Awareness-raising actions on the importance of addressing health inequities

C. To develop a comprehensive plan for the health of children and young people that provides equal opportunities for all children and young people regardless of their parents’ or caregivers’ social conditions

- Comprehensive support to childhood (equity from the start)

D. To develop a plan for increasing political awareness and the visibility of the National Strategy on Health Equity and the Social Determinants of Health

- Plan for increasing political awareness and visibility

The training methodologies applied in Spain drew from the experience of the Chilean Ministry of Health in 2008–2009 for revising health programmes within the framework of the workplan of its Social Determinants of Health Technical Secretariat. The Spanish training process was carried out with the teaching support and guidance of Dr Jeanette Vega and Dr Orielle Solar, both experts in health equity and main leaders of the Chilean process.

The Spanish training received technical support from the WHO Regional Office for Europe and the Virtual Public Health Campus

of the Pan American Health Organization/WHO Regional Office for the Americas. Both the Spanish and preceding Chilean experience drew from the orientations provided by the WHO Commission on Social Determinants of Health with regard to integrating a focus on social determinants of health and health equity into work on priority public health conditions (6). WHO followed the development and implementation of these trainings, documenting lessons that could inform other countries in follow-up actions.

3 Goals and objectives of the Spanish training

The goal of the Spanish health equity training was to develop and strengthen the capacity of the management teams of the Ministry of Health, Social Services and Equality, autonomous communities and other key areas¹ to integrate a focus on social determinants of health and health equity into selected public health SPAs.

The specific objectives of the training process were to:

- ✔ build participants' theoretical understanding of health equity, social determinants of health, and programme evaluation cycles;
- ✔ build participants' methodological capacity to review public health SPAs from the perspective of health equity and social determinants of health;
- ✔ produce a guide that synthesized the methodology, background resources, and experience of the training.

The guide – entitled the *Methodological guide to integrate equity into health strategies, programmes and activities* – was published in 2012, and is available in Spanish and English (7).²

¹ Key areas included local authorities and others such as entities responsible for health in prisons.

² The Spanish edition is entitled *Guía metodológica para integrar la equidad en las estrategias, programas y actividades de salud*. For the English version, see http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/jornadaPresent_Guia2012/docs/Methodological_Guide_Equity_SPAs.pdf.

4 Methodology: introduction and stages

The training process was carried out over a 10-month period using a mixed methodology of face-to-face workshops and online work. Drawing on the methods, approach and tools developed and implemented by the Ministry of Health of Chile, the Spanish Ministry of Health, Social Services and Equality coordinating team planned the training process and its adaptation to the Spanish context.

The training process was intended for a selection of professionals working at the Ministry of Health, Social Services and Equality, regional health departments and other key administration levels in areas considered critical for reducing health inequities. The participants were designated by the concerned general directorates of the Ministry and by the public health directorates at regional and local levels.

During the training process, participants were divided into two groups: one group comprised public health professionals from the Ministry of Health, Social Services and Equality (national level group) and the other was formed by public health professionals from the autonomous communities and other key administration levels (regional- and local-level group). Participants were organized into working teams; each team comprised two to nine persons and was encouraged to consult with wider interdisciplinary and intersectoral groups for their work. Ten working teams conducted the whole process for the following areas: childhood, HIV/

AIDS, cancer prevention, healthy eating and physical activity, vulnerable groups, tobacco, school, colorectal cancer, youth, and healthy cities. These were selected in light of various factors, including (a) their relevance to the Spanish National Strategy on Health Equity; (b) expressions of interest by programme managers; and (c) the timeliness of a parallel redesign or update of a given programme already under way.

The whole training process planning was developed in three stages, starting in August 2010 and finishing in June 2012:

1. The first stage involved the planning and definition of the specific activities and timelines between the Chilean expert facilitators and the leadership team of the Spanish Ministry of Health, Social Services and Equality, and the development of training materials appropriate for the Spanish context that could be used by participants.
2. During the second stage, the training programme was implemented through a teaching model that combined four in-person workshops and interim online e-learning with suggested readings, work assignments, coaching and mentoring.
3. The third stage involved the documentation, evaluation and feedback of the process by the teams involved. Also, a methodological guide for the integration of equity into health SPAs was developed (7).

5 Methodology: components

The methodology to review and make proposals for the redesign of key public health SPAs involved two parts:

1. Review of key concepts
2. Integration of a focus on social determinants of health and health equity into the SPAs, which was composed of three main activities:
 - 2.1 Checklist for the initial equity analysis
 - 2.2 Five-step review cycle, referred to in the Spanish methodological guide with the acronym E-Q-U-I-T-(Y)
 - 2.3 Last step, redesign, letter Y of the acronym (E-Q-U-I-T-) Y

- ❖ theoretical models of programme evaluation, including the theory of programme change.

These are explained in greater detail in the sections that follow.

5.1 Review of key concepts

During the first workshop, the participants reviewed frameworks, key concepts and definitions related to health equity, social determinants of health and programme evaluation models. This initial training provided an overview of:

- ❖ the social production of health and disease
- ❖ the WHO Commission on Social Determinants of Health framework
- ❖ the health system as a social determinant of health
- ❖ intersectorality
- ❖ social participation
- ❖ equity in health and health care
- ❖ the Tanahashi framework for effective coverage

Programme theory has been described by Rogers as the representation of the mechanisms by which it is understood that a programme's activities contribute to the expected outcomes, in the short, medium and long term (8). In other words, programme theory answers why and how does a programme make a difference? During the first training workshop, the theory of programme change (covering connections between activities, context, inputs, outputs and outcomes) was extensively discussed. While every SPA is based on a theory, usually it has not been spelled out in writing and figures. Most of the time, the theory of change of the SPA can be only partially inferred from its goals and objectives, although it involves an important reflection process. At the same time, from a health equity and social determinants of health perspective, the construction of a solid SPA theory of change that explicitly incorporates equity is critical, because if not, the SPA can in itself contribute to, maintain or even increase inequities across the social gradient but particularly impacting the most disadvantaged subgroups.

5.2 Integration of a focus on social determinants of health and health equity into SPAs

5.2.1 Equity checklist

Between the first and second training workshops the teams completed an “equity checklist” for their SPAs (box 2). This consisted of responding to a set of questions on the

inclusion of equity in the SPAs' rationale, objectives, inputs, outputs, outcomes, impacts, targets and indicators. The purpose of applying the checklist was to explore, on an initial basis, potential equity problems in the SPAs' definition, structure, organization, process of implementation, monitoring and evaluation. The task was elaborated through each team, meeting independently and discussing among members, combined with online coaching for each team with a trainer.

Box 2. Main exploration areas of the equity checklist

- Objectives
- Target population
- Needs assessment
- Analysis of actions
- Implementation
- Intersectoral action
- Social participation
- Outcomes and evaluation
- Equity challenges

During the second training workshop each team finalized the analysis of their SPA using the equity checklist and identified potential changes through which the SPA could better contribute to health equity. The teams exchanged experiences, sharing their analysis and giving feedback to each other with inputs from the trainers.

The checklist compilation resulted in dynamic interactions, which were mostly related to differences amongst team members in conceptual thinking due to their diverse disciplines and backgrounds. The process required changes in thinking, beliefs and attitudes. It entailed decreasing the orientation towards a biomedical and technological point of view and increasing the understanding of the sociopolitical contexts in which the SPAs operate.

Some of the main themes emerging from the application of the equity checklist are featured below.

- ❖ In most of the SPAs, there were no explicit equity objectives, targets or prioritization of vulnerable subgroups based on equity indicators.
- ❖ "Equity in health" was understood by participants using the checklist as equality of access to both preventive services and health care (horizontal equity). That is, it did not take into account that equal access for all to the health services does not necessarily correlate with health equity, given the differential needs and heterogeneity of groups within the target population. This deeper understanding of equity in health was typically not reflected in the work of the SPAs.
- ❖ Some SPAs were designed and implemented without any prior systematic needs assessment. In cases where there was an assessment, it was a normative needs assessment. In other cases, felt needs of the population were incorporated. Generally, there was minimal or no use of comparative needs assessments.
- ❖ The checklist findings showed that interventions carried out through the SPAs were mostly individual. There were very few population-based interventions.
- ❖ Most participants considered that universal actions done through SPAs would be sufficient for addressing health inequities. There was limited questioning or awareness that in some cases universal actions could risk increasing equity gaps if specific measures were not taken to adjust the services to the population group's differential needs and heterogeneity.
- ❖ The checklist findings highlighted difficulties associated with intersectoral work, with these including differing sectoral objectives and challenges in finding common ground, administrative barriers, vertical budgeting and vertical accountability.
- ❖ In responding to the checklist, participants reported that social participation in the SPAs was low.

There were very few examples of participation in any of the stages of assessment, planning, implementation, monitoring and evaluation of the SPA. On the scale of increasing levels of engagement and participation – (a) informing, (b) consulting, (c) co-production, (d) delegated power, and (e) community control – engagement was at the lowest level (informing).

- ✔ Checklist findings highlighted the scarcity of stratified data on equity used for surveillance and monitoring. Most SPAs used traditional aggregated indicators, with no equity indicators applied for monitoring of progress.
- ✔ According to the checklist findings, SPA evaluations typically did not evaluate for any impact on equity, and there were no disaggregated data to analyse the SPAs' impacts on health equity, so it was difficult to prioritize groups experiencing situations of inequity.
- ✔ Participants reported that, in many cases, limited financial resources were a factor for the current status

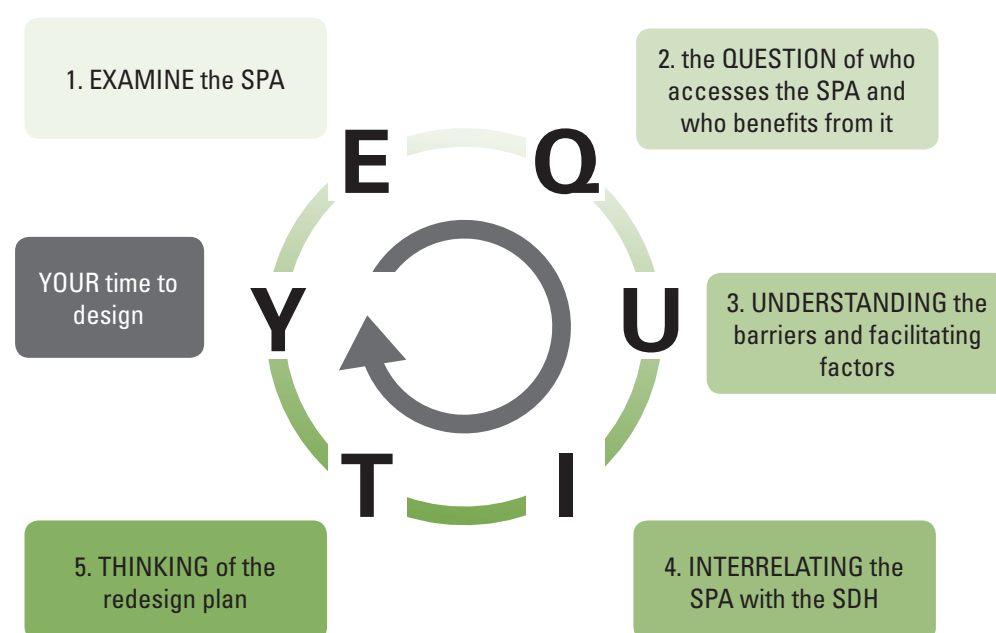
and scope of the SPA. The need to maintain political commitment to the programmatic area and ensure sufficient resource allocation was considered essential.

5.2.2 Review cycle

Figure 1 delineates a five-step cycle to review how an SPA addresses health equity and social determinants of health. In anticipation of and during the third and fourth training workshops, the teams drew on the knowledge that they had acquired to work on the steps in the figure.

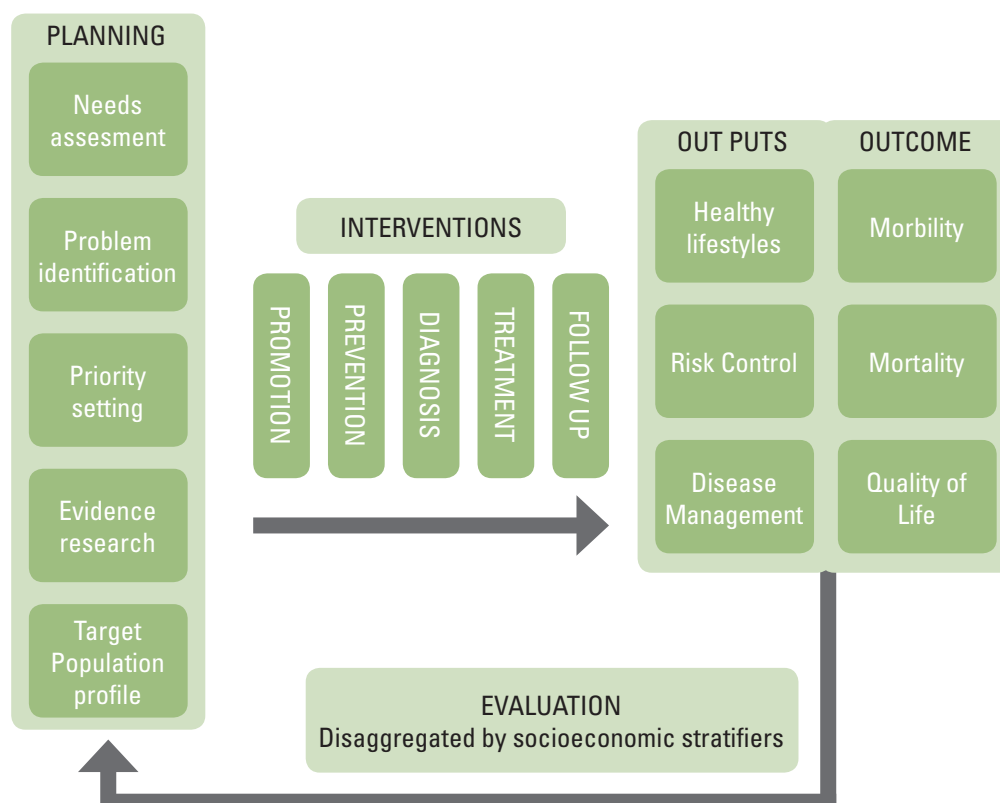
The first step involved defining and understanding the explicit or implicit SPA theory in order to identify the key levers of change. The main questions used to guide discussions were: what is the underlying theory of the SPA, and what are the *key stages* included in it for achieving the expected outcomes and impact? The information was then presented in a diagram or map of key SPA stages, following the sequence shown in figure 2.

Figure 1. Five-step review cycle



Note: This acronym emerged during the development of the methodological guide.

Figure 2. Sequence of stages of a hypothetical programme



Source: Elaborated by the authors.

Note: Although it is not highlighted in the above figure, a key step in the planning process was the consideration of the health system capacity to support the evidence-based interventions. This entailed considering issues related to the health system building blocks, which are service delivery; health workforce; health information systems; health systems financing; medical products, vaccines and technologies; and leadership and governance.

After mapping the theory of the SPA and the key SPA stages, the teams performed step 2: an analysis of subgroups by equity stratifiers (for example socioeconomic status, sex, ethnic origin, geography) to identify those who accessed and benefited in each key stage of the SPA and those who did not.

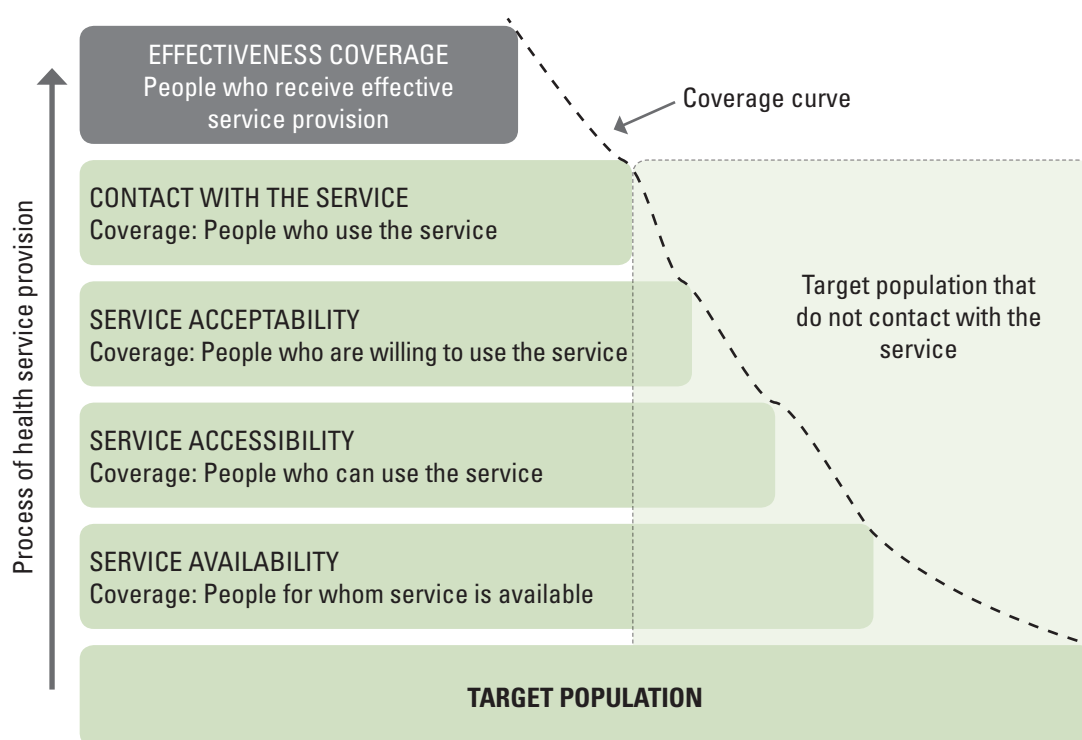
The third step entailed the identification, using the Tanahashi framework for effective coverage, of barriers and facilitating factors for each key SPA stage in relation to each subgroup (in a situation of inequity). The barriers examined included structural social determinants such as employment, working

conditions, education, income and social exclusion, as well as intermediate social determinants such as risk factors, health behaviours and those related to access to health promotion and preventive and curative health services. The Tanahashi framework was also used to identify the facilitating factors that could enable the priority groups to access at each key stage of the SPA.

The Tanahashi framework for effective coverage (figure 3) provides an analytical scheme for identifying the groups in need that do not contact or do not gain maximum benefit from the health services that the

Figure 3. Tanahashi framework for effective coverage

The Tanahashi framework has five core domains – availability, accessibility, acceptability, contact coverage and effective coverage – examples of which are briefly described below.



Source: Adapted from Tanahashi (9).

Examples of what is addressed in each domain:

- ✔ **Availability:** which and how many resources are available to deliver services for the target population.
- ✔ **Accessibility:** physical and financial accessibility.
- ✔ **Acceptability:** users' acceptance of services in light of cultural and religious issues, gender, social networks, confidentiality, and age-appropriateness of services.
- ✔ **Contact:** proportion of the population who contact services.
- ✔ **Effective coverage:** proportion of the population that fully completes the recommended treatment programme (or standard defined for a set of activities), hence addressing adherence, compliance by both providers and patients, and effective referral and follow-up.

SPA provides. The model seeks to identify and characterize that portion of the target population that never contacts or uses the services and those that do contact but do not benefit fully, as well as highlight the causes for this across key domains.

The fourth step in the review cycle was the identification of social determinants that explained why certain barriers are concentrated in determined groups or subgroups. Key questions included:

- ✔ How are the barriers and facilitating factors to access the SPA (at each of its key stages) related to the social conditions of the subgroups?
- ✔ What interventions to address the barriers and improve facilitating factors emerge from this analysis?
- ✔ How would intersectoral action and social participation contribute to such interventions, helping to ensure sustainability?

Based on the analysis developed during the previous steps, all teams then completed step 5: defining goals and priorities for the SPA's redesign so that it better addresses health equity and social determinants of health.

5.2.3 Last step: redesign

The last step of the process of integration of a social determinants of health and equity focus is the SPA redesign. Not all the SPAs involved in the Spanish process were redesigned in practice. While some teams did in fact reorient their SPAs, others just presented a proposal for redesign or recommendations for integrating equity. The primary reason in these cases was that the team members were not the main responsible staff for the SPA analysed. In addition, for those teams that looked at strategies, an actual reorientation

would have required high levels of political commitment. Box 3 features example outcomes of the training process in Spain.

To conclude the process, consolidate work and exchange experiences between the national and subnational teams, a meeting was carried out at the Public Health School of Menorca in September 2011. All teams presented the equity analysis for their SPA and their proposed reorientations for it. Specific attention was given to intersectoral actions and participatory mechanisms. In this meeting, an evaluation of the whole process was done, using a questionnaire specifically developed for the purpose, and its results were discussed with participants.

In relation to the contents of the process in itself, the evaluation showed that the most valued knowledge acquired was related to the elaboration of the SPA theory, as well as the relationship between social determinants of health and the SPA. Through the evaluation, participants positively ranked the training's contents and their applicability to daily work.

One recommendation shared by all the participants was to give an overview of the whole process and to provide more information on the key concepts and the review cycle before applying them to the SPAs. The quality of the teaching and the work of the coordination team received positive feedback through the evaluation, although some participants reported difficulties in following the online components of the training.

In addition to the evaluation, an analysis of lessons learnt was conducted to improve the organization of future editions of the training. Selected findings are shared in the next section of this document.

Box 3. Examples of outcomes of the training process in Spain

National Strategic Plan for Childhood and Adolescence

In Spain, the national-level team that reviewed the health objective of the National Strategic Plan for Childhood and Adolescence (PENIA) identified various ways through which it could be adapted to better account for health equity. For instance, the analysis illuminated that the specific needs of different age groups had not been taken into account in the original formulation of the strategic plan, and therefore specific actions for addressing the different life-course stages of childhood were not included. Other findings were that mechanisms to assure both effective intersectoral action and coordination between national, regional and local levels were needed, and that ongoing monitoring needed to reflect social determinants of health and health inequities. For the proposed revision, the team prioritized equity from the start (through early child development interventions) and the 0–3 age group, in light of the importance of this age period for moving forward health equity. PENIA II (new plan covering the period 2012–2015) includes equity in its underlying principles and an intersectoral objective on “health equity from the start”, which involves the education, social and health sectors.

Basque country colorectal cancer screening programme

The team from the Basque Government of Spain focused on the colorectal cancer screening programme. In their review of this SPA, they found that the SPA – although it targeted persons in the 50 to 69 age group – was not adapted for differences according to gender, age or socioeconomic level. Equity analysis results showed that men had a lower participation rate in the screening programme than women, although they had a higher percentage of positive tests (faecal occult blood) than women. In addition, the health centres presenting the worst results were located in the most disadvantaged socioeconomic areas. Recommendations for each stage of the programme were developed, taking into account socioeconomic inequities in access and factors related to gender norms surrounding “masculinity”, which influenced the lower participation of the male population in the screening programme.

6 Lessons learnt from the Spanish experience

This section reviews key lessons learnt on conducting training for the revision of health SPAs from the perspective of health equity and social determinants of health. For a better understanding it is important to know the characteristics of the Spanish context in which the training process was carried out (table 1).

Based on the experience of Spain, this section discusses the following aspects considered relevant for future adaptations of this process:

- ✔ criteria for the selection of SPAs and team participants;
- ✔ organization of the training (in person and online);
- ✔ training as an integrated part of government strategies for the reduction of health inequities;
- ✔ integrating an equity focus in the ongoing evaluation, design and revision of SPAs;
- ✔ required resources and tools, and sustainability.

Table 1. Characteristics of the training process in Spain

Criterion	Observations
Political context in which the training process is carried out	
Degree of centralization of public health policy	Decentralized (through autonomous communities)
Political priority given to the training	Medium
Specific coordination structure for health equity	No. Within the functions of the health promotion area
Political agenda on equity	Yes. National Strategy on Health Equity Strategic level
Characteristics of the training process	
Main purpose of the training	To raise awareness of participants on social determinants of health and health equity, and provide them with knowledge on how to review SPAs for greater health equity
Methodology	In person and online Two groups (national and regional-local) Working teams
Specific resources and budget	Yes
Participants in the training process	
Previous knowledge on social determinants of health and equity	No (national-level group) Yes (regional- and local-level group)
Manager and staff for the selected SPA were involved in the training process	Staff from SPA were only involved for some teams
Working team involved representatives of other sectors or civil society	No, but external consultations with them by some of the teams
SPAs selected	
Type of SPA	Programmes and strategies National, regional, local
SPAs with redesign implemented as of June 2012	5 of 13

6.1 Criteria for the selection of SPAs and team participants

One of the crucial aspects identified in the process is the need to select for the training process SPAs that are already in implementation phase. Existing SPAs that have been prioritized for undergoing reformulation or updating are particularly relevant. Regarding the type of SPA, the current methodology works better and is more adapted to programmes or activities (which have more concrete and operative planning in a shorter time horizon) than to strategies.

The formation of teams is essential, as they establish a mechanism for consensual validation of the key stages in both the process of review and the definition of redesign priorities. Regarding team participants, these should be professionals with experience in the management of the selected SPA and, if possible, who have influence in their areas of work. Having representation from national and subnational levels is important, so that implementation can be reviewed from different perspectives. Teams should be formed of participants from different backgrounds and sectors but with common expectations and needs. The participants will work together throughout the various stages, so they should build common expectations from the beginning, yet during the process the specific expectations and needs of each SPA should be integrated. On the basis of the experience acquired in developing working teams, it is highly recommended to include a group facilitator or establish rotating leadership among the group members. At the beginning it is useful to discuss expectations linked to the training and highlight the potential usefulness of the results of the process in the participants' concrete ongoing work responsibilities.

It is important to emphasize the relevance of interdisciplinarity, intersectorality and social participation in the composition of the working teams, as these aspects are required for an ideal equity review process. In the Spanish process, these elements were underrepresented,

as the training was originally conceived as a capacity-building process, and the majority of the working teams were organized to conduct a practical exercise and were mainly formed by only health professionals. The absence of intersectorality and social participation was a weak point for the review and redesign of the SPAs. Nevertheless, through the Spanish training process, the participants acquired knowledge that could help them in the future to engage other sectors and civil society for the review and reorientation of their own SPAs. However, as has been mentioned before, a high level of political commitment is required for this purpose.

6.2 Organization of the training (in person and online)

It is important to use a methodology that combines learning and action through presentations, readings, exercises, discussions and forums. This mix supports the concrete review and reorientation towards greater equity of each of the SPAs.

In Spain, having enough space for discussion and sharing among all team participants was not feasible using only in-person teaching methodology because of the geographical dispersion of the participants and the timespan of the training process. That is why the workshops were supplemented with online training and coaching in between, using Moodle (Modular Object-Oriented Dynamic Learning Environment) as the course management system. This allowed for online coaching to support generation of knowledge; development of skills and competencies; teamwork; exercises; and virtual discussions and forums between workshops. It also enabled validation of learning and progress during the workshops.

Through the web-based platform and at the in-person workshops, information on the progress of the teams was available for all participants. In every workshop, advancements were presented and

discussed with other teams. Each team had the opportunity to present slides on their progress, answer or ask questions or voice doubts, and jointly analyse issues that were relevant to the work. In addition, monthly videoconferences or virtual meetings (via the Elluminate web conferencing tool) were held to discuss progress, with virtual inter-meeting discussions and forums. This mixed methodology generated a virtuous cycle of continuous improvement and linked learning to concrete work experiences.

6.3 Training as an integrated part of government strategies for the reduction of health inequities

One of the main lessons from the work in Spain is that in order to maintain the health equity agenda, there should be high-level political commitment within the Ministry and at the cross-government level, translated into programmatic and financial levers for change that form the basis for sustainability and mainstreaming. The type of equity review performed during the training can be an important step towards building that commitment where it does not exist, or strengthening it where it does.

The leadership necessary to initiate and sustain actions to improve health equity involves building support with actors based inside and outside the health sector and government. This type of training contributes to that process through the development of a set of competences in the participants, including:

- ❖ understanding key theoretical concepts such as social causation of health and disease, social determinants of health, health equity, theory of change and programme theory;
- ❖ awareness of differences in health status between different subgroups (by social stratifiers and geographical locations);
- ❖ ability to define barriers and facilitating factors to access their SPAs with regard to availability, accessibility, acceptability, contact and effective coverage;
- ❖ knowledge of critical venues for engaging other sectors and the community in the support of the health equity agenda;
- ❖ ability to identify obstacles to making the SPA more equity oriented and define a plan to strategically work around them.

The health equity agenda in any country must include a clear strategy to mobilize other sectors. Creating broader awareness is a complex political process, where contextual and structural factors related to organization and budget allocation across and between sectors often act as obstacles. Making specific SPAs more equity oriented involves sharing responsibility with other sectors to address socially determined health system access barriers and health outcomes. When joint action is not possible, the health sector has a key role in advocating health equity as a cross-cutting social goal.

6.4 Integrating an equity focus in the ongoing evaluation, design and revision of SPAs

The training provides a participatory mechanism to apply an equity focus in the evaluation, review and redesign of SPAs. One mechanism to incorporate broadly the use of all or part of this methodology is to integrate it into ongoing, systematic monitoring and evaluation processes, so that this results in all SPAs better addressing equity. Another way is to implement a training-the-trainers process, followed by a cascade training of SPA teams at national and subnational levels under the responsibility of the initial group.

6.5 Required resources and tools, and sustainability

There are some crucial prerequisites to guarantee sustainability and success of

trainings for the revision of SPAs from the perspective of health equity and social determinants of health. These include the following, to put in place prior to the beginning of the training process:

- ✔ a direct mandate of the highest possible authority within the Ministry of Health;
- ✔ an ad hoc commissioned dedicated facilitating team;
- ✔ a separate budget line;
- ✔ a detailed workplan for implementation of the training and review of SPAs, as well as support to the actual reorientation process;
- ✔ a workplan to systematize the learning from the experience and its follow-up;
- ✔ a web-based platform to provide ongoing support and interaction, particularly if the training is spread over an extended period;
- ✔ a motivated advocacy group to carry out a cascade learning process.

Implementation of a programmatic health equity agenda has to be sustained over time so that it becomes part of the taken-for-granted practices within the health system. To achieve this, the organizational culture of health systems (including the value base, management, and interactions between health system stakeholders) needs to be reframed to support health equity. SPA managers can be empowered to lead such change through training processes that nurture and develop the necessary values and skills. This is an important part of a wider health system strategy to tackle health inequities.

6.6 Overview of lessons learnt and way forward

These lessons learnt from the Spanish training process have been included for the design and development of a new equity training process that is being carried out by the WHO Regional Office for Europe, in collaboration with the Interuniversity Institute of Social

Development and Peace, University of Alicante (WHO Collaborating Centre on Social Inclusion and Health) and the Spanish Ministry of Health, Social Services and Equality.

This equity training process on reorienting strategies, programmes and activities related to Millennium Development Goals 4 and 5 aims to promote greater health equity, and has an explicit but not exclusive focus on the Roma population. It is being organized within the framework of the interagency coordination initiative “Scaling up action towards Millennium Development Goals 4 and 5 in the context of the Decade of Roma Inclusion and in support of National Roma integration strategies”, which is facilitated by WHO and also involves the United Nations Population Fund (UNFPA), Office of the High Commissioner for Human Rights (OHCHR), United Nations Development Programme (UNDP), United Nations Children’s Fund (UNICEF) and International Organization for Migration (IOM). This training process is based on the Spanish experience, and follows the *Methodological guide to integrate equity into health strategies, programmes and activities*.

Four countries (Bulgaria, Montenegro, Serbia and The former Yugoslav Republic of Macedonia) included this training in their collaborative agreements with the Regional Office for the 2012–2013 biennium and are participating in it.

New lessons learnt from this ongoing process should be included in future activities in order to improve the criteria and conditions for transferability.

7 Conclusions

The integration of a focus on social determinants of health and health equity into strategies, plans and activities of the health sector is still in a relatively early stage. In the last decade, equity in health has gained greater prominence as a concept on national and international agendas. However, further work on concrete mechanisms and tools to account for health equity in the health sector's planning and evaluation are needed. It is important to have available practical and effective methodologies that allow integration of a focus on social determinants of health and health equity into SPAs, not only in the design of new SPAs but also in the review and reorientation of the already existing ones. While it will still benefit from further refinements, the methodology described in this document can support these objectives and, furthermore, is also useful as a comprehensive process that aims to improve SPAs.

The training process presented above is an innovative experience at international level.

The Spanish experience has proved that the Chilean methodology is transferable after a deep national context adaptation, and that the results of the process will reflect contextual factors and the revised objectives of the adaptation. Intersectoral action and social participation have been shown to be key elements to move forward equity in health. Both elements should also be worked in depth, and incorporated and integrated into every planning process.

In Spain, the next step as of July 2012 is the dissemination of the methodological guide, to encourage professionals to implement this process at national, regional and local levels. For this purpose, technical support will be offered by the Spanish coordination team in order to facilitate the process. Another step will be the continuous review, update and improvement of the methodological guide, as it is designed as a living document.

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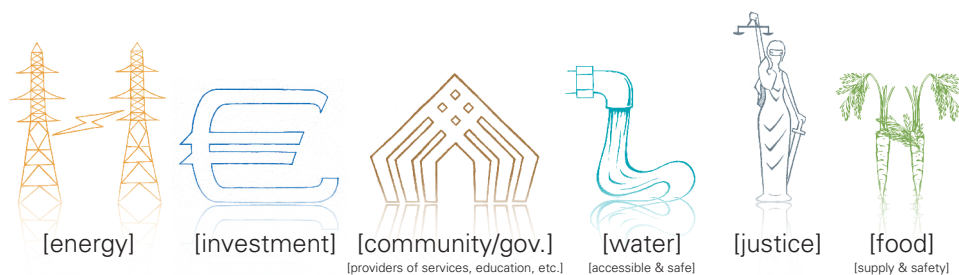
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Notes

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