# THE GRADIENT EVALUATION FRAMEWORK

## GEF

A European framework for designing and evaluating policies and actions to level-up the gradient in health inequalities among children, young people and their families



Tackling the GRADIENT in health

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# GEF

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**www.health-gradient.eu**

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# ABOUT THE GRADIENT PROJECT

The Gradient Project is a collaborative research project involving 12 institutions (universities, research institutes and public health institutes) from all over Europe. The project is coordinated by EuroHealthNet and has received funding from the European Community's Seventh Framework Programme (FP7 2007-2013) Health Research under grant agreement No. 223252.

As a core part of the project, the Gradient Evaluation Framework (GEF) has been developed as a European action-oriented policy tool to guide and inform technical experts in (modern) public health[1] working at the Member State level. Linked directly to the policy cycle, GEF is designed to assist those involved in the development, implementation, and evaluation of policies that aim to reduce health inequalities and level-up the gradient in health and its social determinants among children, young people and their families. Specifically, it is intended to facilitate the evaluation of policy actions[2] for their current or future use in terms of their 'gradient friendliness' i.e. their *potential* to level-up the gradient.

*1. By technical experts we mean those individuals with a relatively high knowledge of the values, concepts, and principles of modern public health whom may (or may not) work in the health sector.*

*2. From here on in, we use the term 'policy action(s)' to recognise that policy has to be operationalised through specific interventions which may include activities.*

# USING THE GEF PACK

This pack presenting the Gradient Evaluation Framework (GEF) is divided into four key sections:

**SECTION ONE** Provides a brief background and context to GEF including an overview of health inequalities and the gradient; the life course and the focus on children, young people and their families; policy approaches to reducing health inequalities; evaluating policy actions to level-up the gradient; and the conceptual foundations of GEF.

**SECTION TWO** Provides a User Guide that introduces GEF and its use in practice which includes an explanation of what it is, why it is needed, how it has been developed, when to use it, what it is not, who can use it, and key points about its use.

**SECTION THREE** Provides GEF in Action which is the core interactive tool. This enables users to apply the Gradient Equity Lens (GEL) and carry out more in-depth evaluation activities related to their specific needs.

**SECTION FOUR** Provides a useful exemplar case study of GEF in action from Slovenia, as well as a glossary of terms and references.

Depending on your own (or team's) background, experience, expertise, interests, and so on, this report can be used either in a more traditional linear fashion (e.g. by going through each Section in turn), or more flexibly by 'dipping' in and out as required. For instance, if you are not familiar with the area of health inequalities and the gradient, then you might find it useful to read Section One thoroughly including following up on some of the key references highlighted in the text. Alternatively, if you are more familiar with the area and the main concepts, then it may perhaps be more appropriate for you to skip Section One and move straight to Section Two and Three of GEF.

# ACKNOWLEDGEMENTS

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# SECTION ONE
# INTRODUCTION



# 1.1 HEALTH INEQUALITIES AND THE GRADIENT

There are established and growing inequalities in health both between, and within most European Member States, even though their populations are healthier than at any time in their history (Crombie, Irvine, Elliott & Wallace, 2005; Judge, Platt, Costongs & Jurczak, 2006; Mackenbach, 2006; Mackenbach, Stirbu, Roskam, Schaap, Menvielle, *et al*., 2007). These inequalities are growing, and form a systematically patterned 'gradient' between health and social circumstance with substantive evidence demonstrating that health becomes worse as you move down the socioeconomic scale (Davies & Sherriff, 2011; Graham, 2001; The Scottish Government, 2008; see Figure 1).

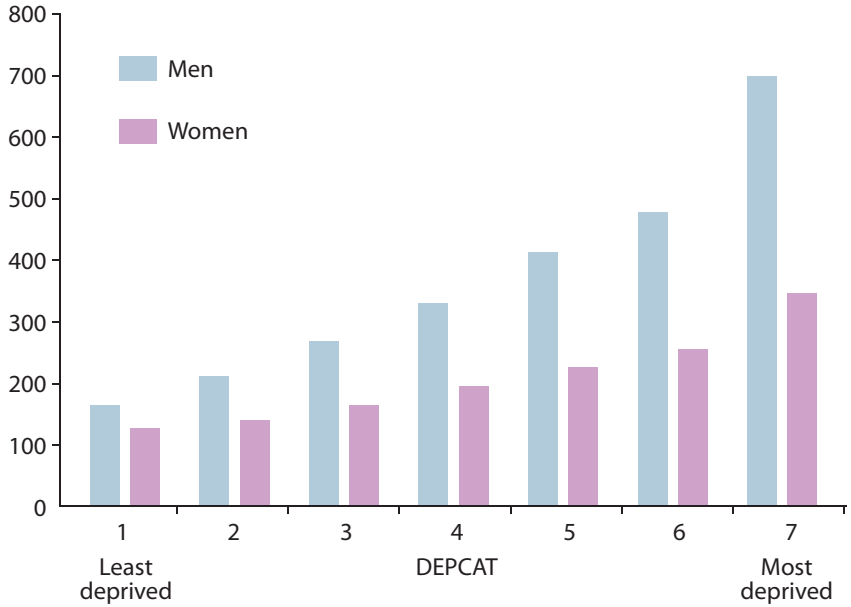



***Figure 1 - The gradient across the population:*** *All cause death rate per 100,000 population for Scotland 2001 for men and women (The Scottish Government, 2008).*

> *...interventions and policies to reduce health inequalities must not limit themselves to intermediary determinants, but must include policies specifically crafted to tackle underlying structural determinants: the social mechanisms that systematically produce an inequitable distribution of the determinants of health among population groups.* (CSDH, 2007, p.65).

However, it is not just that the poorest experience less than optimal health; rather there is a gradient of risk across entire populations and affecting all individuals (Chen, Martin & Matthews, 2006; Chen *et al*., 2007; Poulton, Caspi, Milne, *et al*., 2002; Wilkinson & Pickett, 2009; see Figure 2). As health inequalities are not always the result of individual behavioural choices or lifestyle factors they are often inequitable. This is important as whilst inequality can apply to any variation in health, inequity is applied to those variations which are deemed to be unjust and preventable. Consequently, there is a need to differentiate between addressing the structural determinants of social inequalities in health (inequity) and addressing the social determinants of health (inequality)[3].

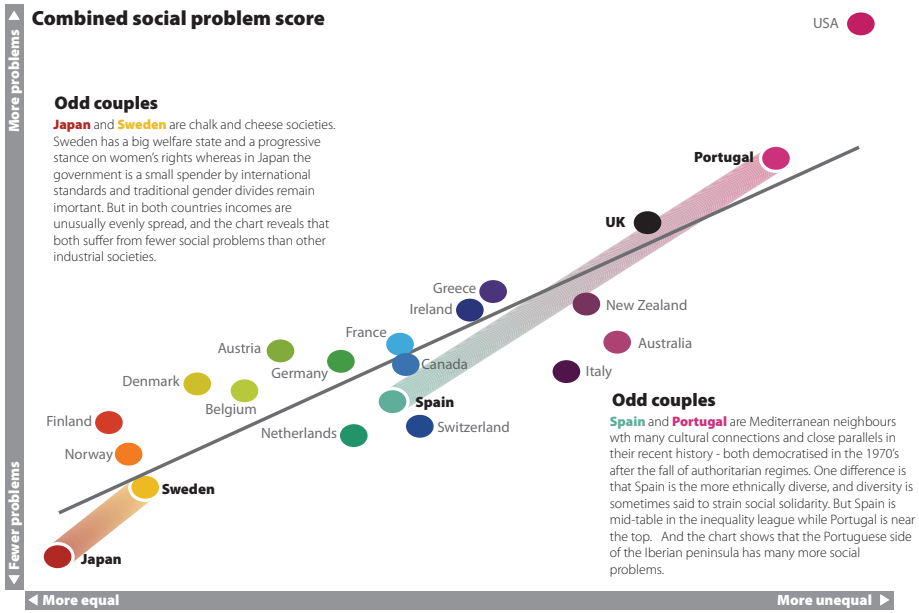



***Figure 2 - The gradient between countries**: Combined social problem score vs. level of equality (lowest vs. highest quintile of the population) (Wilkinson and Pickett, 2009).*

*3. Although this is an important distinction, in our experience literature (academic and 'grey') is often inconsistent in differentiating between health inequalities and health inequities. Consequently, although we acknowledge this distinction, throughout the document we adopt the broader term 'health inequalities' synonymously with health inequities both for convenience and brevity.*

# 1.2 THE LIFE COURSE AND THE FOCUS ON CHILDREN, YOUNG PEOPLE AND THEIR FAMILIES

The reasons for the existence of health inequalities are complex and involve a wide range of factors which relate to the wider social determinants of health including the circumstances and context within which children develop. However, the impact of these wider social determinants on health varies at different points in the life course, particularly when people are most dependent or vulnerable, for example in childhood, pregnancy or older age.

In terms of the former, Poulton and his colleagues' life-course study demonstrates that low childhood socioeconomic circumstances can have long-lasting negative influences on adult health, irrespective of where one ends up in the socioeconomic hierarchy as an adult (Poulton *et al*., 2002; see also Graham & Power, 2004 ). Specifically, their findings demonstrate that the social gradient in health actually emerges in childhood. Consequently, it is argued that interventions designed to reduce health inequalities early in childhood, and those that seek to create equal opportunities in childhood and adolescence, may help move children onto healthier trajectories, with the hope of maximising health across the life course (Chen, 2004; Chen *et al*., 2007). In other words, such interventions may not only have a positive impact on health, but may also assist in addressing inter-generational inequalities in health (Chen *et al*, 2007; Hertzman, Siddiqi, Hertzma, Irwin, Vaghri, *et al*., 2010). This notion is supported by the wider literature which suggests that any effort to level-up the gradient in health should pay special attention to children and young people, as interventions at these early stages in the life cycle offer the greatest potential of levelling up the gradient and facilitating long-term

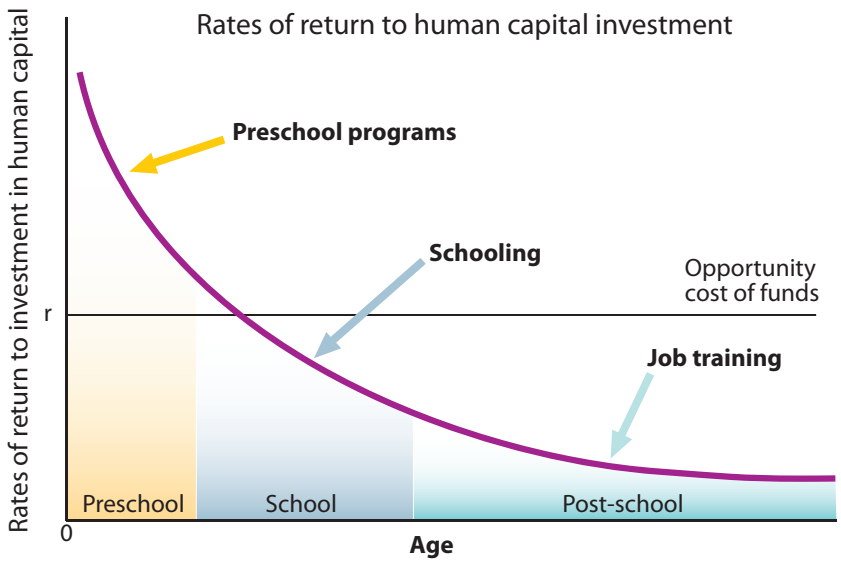



*Figure 3* *Rates of Return to Human Capital Investment (from Heckman, 2006)*

positive health outcomes (Irwin, Valentine, Brown, Loewenson, Solar, *et al*., 2006; Poulton *et al*., 2002). Moreover, investing economically in 'gradient-friendly' policy actions to level up the health gradient among children is not only a financial investment in young people and adults, but also in healthy aging (see Heckman, 2006; Figure 3).

A life course perspective therefore provides a useful framework for understanding how social determinants generate health inequalities and potential entry points for policy actions. For this reason the Gradient Evaluation Framework (GEF) and the wider Gradient Project focuses on children, young people and their families.

# 1.3 POLICY APPROACHES TO REDUCING HEALTH INEQUALITIES

Reducing health inequalities (and inequities) is regarded as one of the most important public health challenges facing the European Union (EU) and it's Member States (European Commission, 2009). It is also a major policy focus at global level with the Global Commission on the Social Determinants of Health (CSDH) recommending to the World Health Organisation (WHO) and all governments:

> *...to lead global action on the social determinants of health with the aim of achieving health equity. It is essential that governments, civil society, WHO, and other global organizations [sic] now come together in taking action to improve the lives of the world's citizens. Achieving health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it.* (WHO, 2008, p.22)

In general, three policy approaches have been adopted to reduce social inequalities in health, which seek to:

1. Reduce health inequalities by targeting interventions aimed at the most disadvantaged groups.
2. Reduce health inequalities by narrowing the health gap between the better-off and worse-off groups.
3. Reduce health inequalities by levelling-up the social gradient in health inequalities across the whole population. For example, universal action, but with a scale and intensity that is proportionate to the level of disadvantage – this has been termed 'proportionate universalism' (Marmot, 2010).

Ideally all three approaches would operate at the same time. This means that a multi-level and integrated approach involving a variety of policies and actions would be required to effectively address the problem (Dahlgren & Whitehead, 2006; Pan American Health Organization [PAHO], 2004; Whitehead & Dahlgren, 2006). In reality the majority of policy actions tend to adopt approaches 1 and/or 2. This is partly because the third approach which seeks to use policies and actions to level-up the gradient, presents major challenges as these involve complex interventions with multiple levels, stages of operation and time lags that require structural instruments with a focus on differential distribution effects within the population (Graham, 2004; Graham & Kelly, 2004).

An additional challenge for those seeking to reduce health inequalities is that the literature base on these respective policy approaches often conflates or 'fudges' the distinction between levelling-up the gradient and reducing health inequalities more broadly (i.e. reducing health gaps and reducing disadvantage). This is problematic because, whilst there is stronger evidence available for approaches 1 and 2, this is not the same as levelling-up the gradient. In other words, both approaches 1 and 2 contribute to approach 3, but they are different. Policy makers claim to be 'reducing health inequalities' by which they often mean lifting some loosely-defined disadvantaged group closer to the best off/average. We suspect that if one was to analyse policy documents for different countries, where it is claimed that the aim is to reduce health inequalities, it is the 'gap' rather than gradient that is being addressed. However an important exception is the Norwegian national strategy to reduce social inequalities in health which attempt to focus specifically on levelling-up the gradient (Norwegian Directorate for Health and Social Affairs, 2005; Norwegian Ministry of Health & Care Services, 2007; Norwegian Directorate of Health, 2009).

The Gradient Project (and GEF itself) focuses its efforts on this third approach to reducing health inequalities. Arguably, this is the ultimate objective for all approaches that aim to reduce health inequalities, but ideally all three approaches should complement each other. Worthy of note here is that although the term 'tackling the gradient' is often used in the literature we prefer to use 'levelling-up the gradient' to be clearer about the intention i.e. improving the health of all groups closer to the best-off and not just focusing on the worst off.

# 1.4 EVALUATING POLICY ACTIONS TO LEVEL UP THE GRADIENT

Despite the existence of considerable rhetoric regarding the need to reduce health inequalities (e.g. in policy documents and the academic literature), there is a surprising lack of attention and knowledge around which policy actions are effective in reducing health inequalities and, in particular, those actions required to level-up the gradient (Bambra, Joyce & Maryon-Davis, 2009; Davies & Sherriff, 2011; House of Commons Select Committee [HCSC], 2009). Moreover, there has been scarce attention paid to both the policy process involved in developing such solutions and to the evaluation of relevant interventions (Crombie *et al*., 2005; European Commission [EC], 2009; Judge *et al*., 2006; Stronks, 2002). Where evaluative evidence does exist, it tends to be based on downstream initiatives which focus on specific determinants (e.g. smoking cessation among low-income groups or increasing breastfeeding continuance), rather than on more upstream initiatives (e.g. taxation policies) which influence the wider social determinants of health (Davies & Sherriff, 2011, Davies & Sherriff, 2012; Marmot, 2010).

This lack of focus on evaluative evidence is exacerbated in part by the fact that the measurement and monitoring of inequalities in health is neither standardised nor common across all countries and over time. No consensus has been reached on the best and most meaningful measure(s) since the choice of measure is mainly dependent on the country in question, the availability of data, on the specific determinant chosen to be assessed, and on the nature of policy action that needs to be evaluated and/or monitored. Moreover, although the WHO Commission on the Social Determinants of Health (CSDH, 2008) has proposed a comprehensive surveillance framework for monitoring health inequalities (see Table 1); in reality it is often difficult to put in place such a comprehensive system. Only a few countries have developed similarly comprehensive data systems to monitor health inequalities (including the UK, Norway & Sweden). However, even in these countries, only a few similarities in the indicators are apparent:

> *The lack of appropriate routinely available and comparable data within each country and across the EU was highlighted as a key barrier to greater knowledge and effective analysis... needed to reduce inequalities in health... Current challenges include the inability to collect and analyse data from the health sector and other sectors and a lack of adequate measures of social position or advantage (equity stratifiers).*
> (WHO/UCL, 2010, p. 28).

An additional problem also exists in that most existing data surveillance systems provide country and sometimes regional health outcome data stratified only by age and gender. In the context of addressing the gradient, this is problematic because, although analysing health indicators and the determinants of health for the general population by such stratifiers is important, it is not sufficient for identifying and analysing health status across the gradient. Social determinants of health and causal factors in particular, require careful additional analysis as the most important determinants of health may differ between different socio-economic groups. Thus, to identify, monitor and evaluate health inequalities health outcome indicators

| HEALTH INEQUITIES | HEALTH OUTCOMES | |
|---|---|---|
| **Include information on:** | Mortality (all cause, cause specific, age specific)<br>ECD<br>Mental health<br>Morbidity and disability<br>Self-assessed physical and mental health<br>Cause-specific outcomes | Health care:<br>• coverage<br>• health-care system infrastructure |
| Health outcomes stratified by:<br>• sex<br>• at least two socioeconomic stratifiers (education,<br>• income/wealth, occupational class)<br>• ethnic group/race/indigeneity<br>• other contextually relevant social stratifiers; place of residence (rural/urban and province or other relevant geographical unit) | **DETERMINANTS, WHERE APPLICABLE INCLUDING STRATIFIED DATA** | Social protection:<br>• coverage<br>• generosity |
| The distribution of the population across the sub-groups | Daily living conditions | Structural drivers of health inequity |
| A summary measure of relative health inequity: measures include the rate ratio, the relative index of inequality, the relative version of the population attributable risk, and the concentration index. | Health behaviours:<br>• smoking<br>• alcohol<br>• physical activity<br>• diet and nutrition | Gender:<br>• Norms and values<br>• economic participation<br>• Sexual and reproductive health |
| A summary measure of absolute health inequity: measures include the rate difference, the slope index of inequality, and the population attributable risk. | Physical and social environment:<br>• water and sanitation<br>• housing conditions<br>• infrastructure, transport, and urban design<br>• air quality<br>• social capital | Social inequities:<br>• social exclusion<br>• income and wealth distribution;<br>• education |
| | Working conditions:<br>• material working hazards<br>• stress | Socio-political context:<br>• civil rights<br>• employment conditions<br>• governance and public spending priorities<br>• macroeconomic conditions |
| | | **CONSEQUENCES OF ILL-HEALTH** |
| | | Economic consequence |
| | | Social consequences |

*Table 1* *Towards a comprehensive national health equity surveillance framework (Source: C.S.D.H, 2008 p.182)*

(e.g. mortality, self-assessed physical and mental health, etc.) need to be stratified by sex, at least two socio-economic stratifiers (such as education, income/wealth, occupational class), ethnic group, and place of residence. For example, health inequalities in mortality have been calculated using the ratio of mortality rate in lower socio-economic groups as compared to higher socio-economic groups. The socio-economic measure included the level of education, occupation or housing tenure as stratifiers (the indicator was obtained from national-census linked mortality data sources; Mackenbach, 2006).

Consequently, if any progress is to be made in terms of developing a relevant and appropriate evaluative evidence-base regarding policy actions to level-up the gradient, then considerable further attention is required at European level in terms of scoping the types and availability of indicators collected regularly in Member States, as well as a concentrated effort on the development of specific 'gradient sensitive' indicators (some possible examples of the latter can be found in Dimension Two of GEF; see also Marmot, 2010).

# 1.5 CONCEPTUAL FOUNDATIONS AND THE STRUCTURE OF THE GRADIENT EVALUATION FRAMEWORK (GEF)

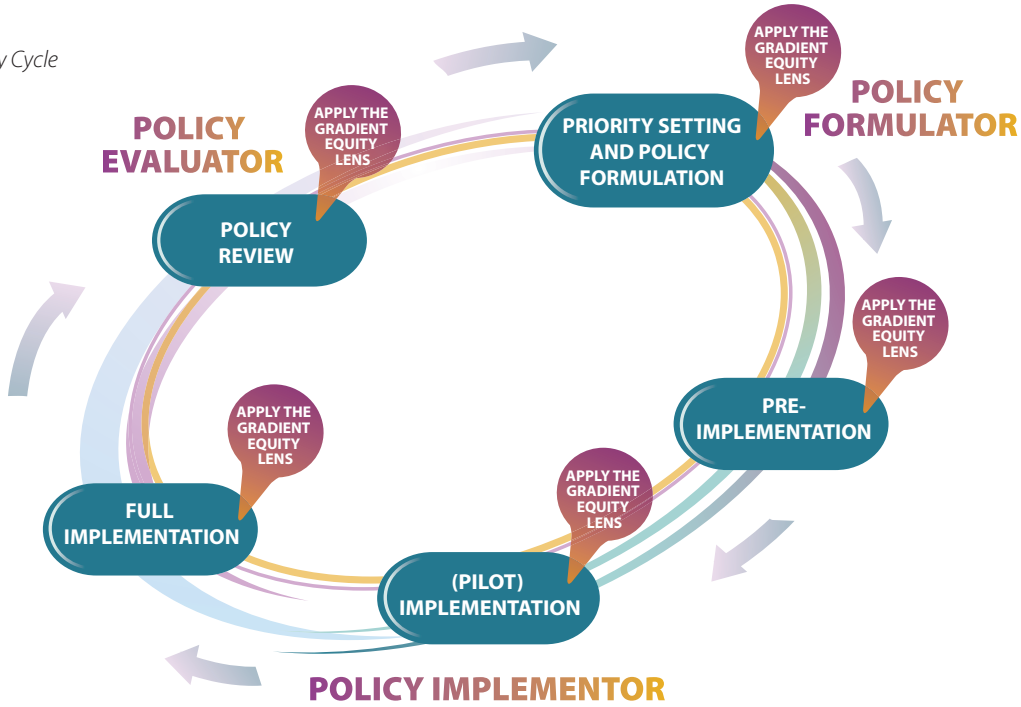
Taking the above considerations into account, as a core part of the Gradient Project, the Gradient Evaluation Framework (GEF) has been developed as a European action-oriented policy tool to guide and inform technical experts in (modern) public health working at the Member State level. The starting point for the development of GEF was the completion of a realist review to understand better the strengths and weaknesses of using evaluation frameworks to explore policies and related actions that could be used to level-up the gradient (Davies & Sherriff, 2011). In total, 34 evaluation frameworks were reviewed and analysed using a bespoke protocol or set of dedicated analytical criteria drawn primarily from three sources: the EUHPID (European Health Promotion Indicator Development) health development model (Bauer, Davies, Pelikan, Noack, Broesskamp & Hill, 2003; Bauer, Davies & Pelikan, 2006) the Ottawa Charter for Health Promotion (WHO, 1986) and the wider literature on health inequalities (e.g. Marmot, 2010; Themessl-Huber, Lazenbatt & Taylor, 2008). As no one existing framework emerged that was deemed 'fit for purpose' in terms of the Gradient Project, a new evaluation framework was developed. This new Gradient Evaluation Framework (GEF) has been progressed through a formal consensus-building process involving external experts from a wide range of European Member States. Although it is only a first developmental step, GEF aims to guide those involved in the policy process (e.g. technical experts working in modern public health) by reducing their possibility of error having developed, or when developing, policies and related actions to increase the potential of levelling-up the gradient in health inequalities.

## THE STRUCTURE OF GEF

GEF conceptual model sets the formulation, implementation, monitoring and evaluation of policies and their related actions firmly within the well-established policy cycle (Figure 4). Although the policy cycle has been challenged by some for being unresponsive, simplistic, and unrealistic; nevertheless is also generally accepted as being a useful heuristic and iterative device for understanding the lifecycle of a policy, especially when evaluating complex policy actions.

Whilst the specific core components of the policy cycle may vary, in GEF it consists of five core elements including: priority setting and policy formulation; pre-implementation; (pilot) implementation; full implementation; and policy review. It should be emphasised that the stages of the cycle are interdependent; they need not operate in a linear or incremental way, and evaluation can apply at each and every stage, as appropriate to the policy action context and stage of development under consideration.

Figure 4 *The Policy Cycle*




**THE GRADIENT EQUITY LENS**

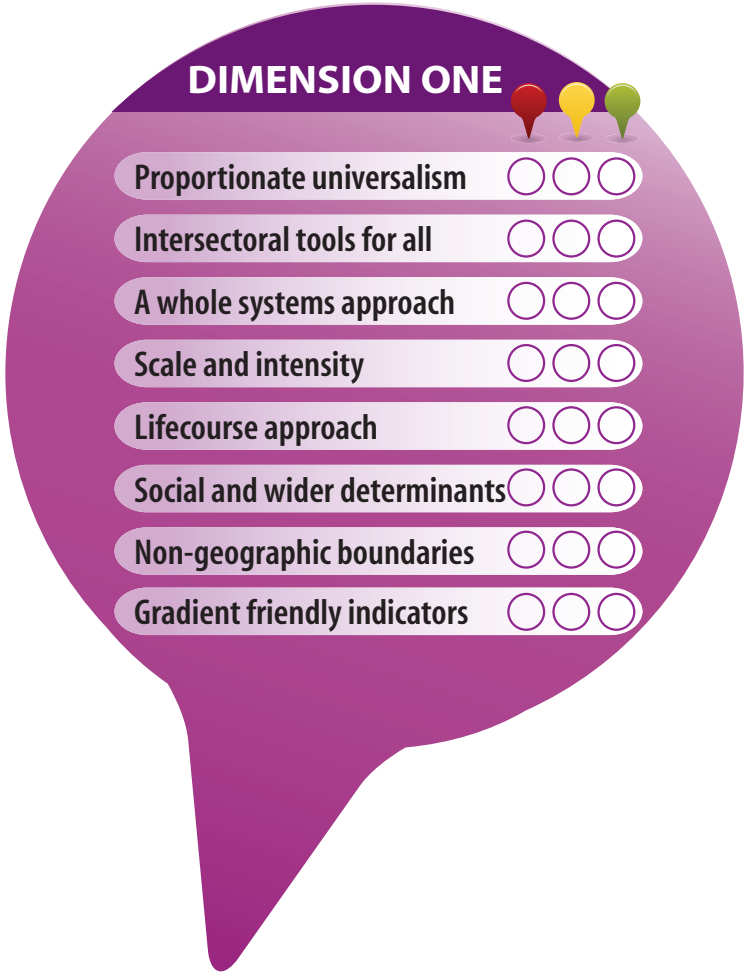
With the above in mind, GEF also offers a **Gradient Equity Lens (GEL)** which can be applied iteratively and flexibly to facilitate appropriate evaluation of policy actions at *each* stage of the policy cycle. This GEL comprises two key inter-related dimensions which together provide a Gradient perspective on evaluating policies and their related actions.

## THE GRADIENT EQUITY LENS (GEL)

GEL comprises Dimension One and Two, and raises a series of questions and issues that decision-makers can pose and/or consider to better understand the unique nature of each policy action by linking them to their particular circumstances (e.g. political, socio-economic, cultural, and historical contexts). Posing such questions offers the opportunity for wider participation in the developmental learning process. It is therefore much less prescriptive. It allows for variation and flexibility among the multiple perspectives involved in levelling-up the gradient. The two dimensions are outlined below:

**Dimension One** *(Figure 5)* guides the user through **eight key areas** which form a relative quick 'check-list' of key components deemed important to underpin the design and evaluation of effective policy actions (proposed or in place) in terms of their potential to be 'gradient-friendly' i.e. to level-up the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families. A summative traffic-light system (at the end of each key component) is used to provide an overall rating of the policy action. This rating can help in restructuring policy and devising effective actions.

*Figure 5* *The Gradient Equity Lens: Dimension One*



**Dimension Two** (Figure 6) guides the user through a  linked to particular exemplar activities relevant for the design and evaluationof policy actions proposed or in place, again in terms of their potential to be 'gradient-friendly'. Drawing on aspects of Dimension One (where appropriate), Dimension Two is a more detailed and in-depth series of self-assessment tasks outlining specific cyclical, iterative, and cross-cutting evaluation activities. Although it is presented as a series of incremental steps this is purely for demonstration and clarity purposes. Experience shows that the different stages can overlap with each other and may not necessarily proceed in a linear or cyclical fashion; this depends on the stage of development and policy context under analysis.

*Figure 6* *The Gradient Equity Lens: Dimension Two*



## DIMENSIONS ONE AND TWO

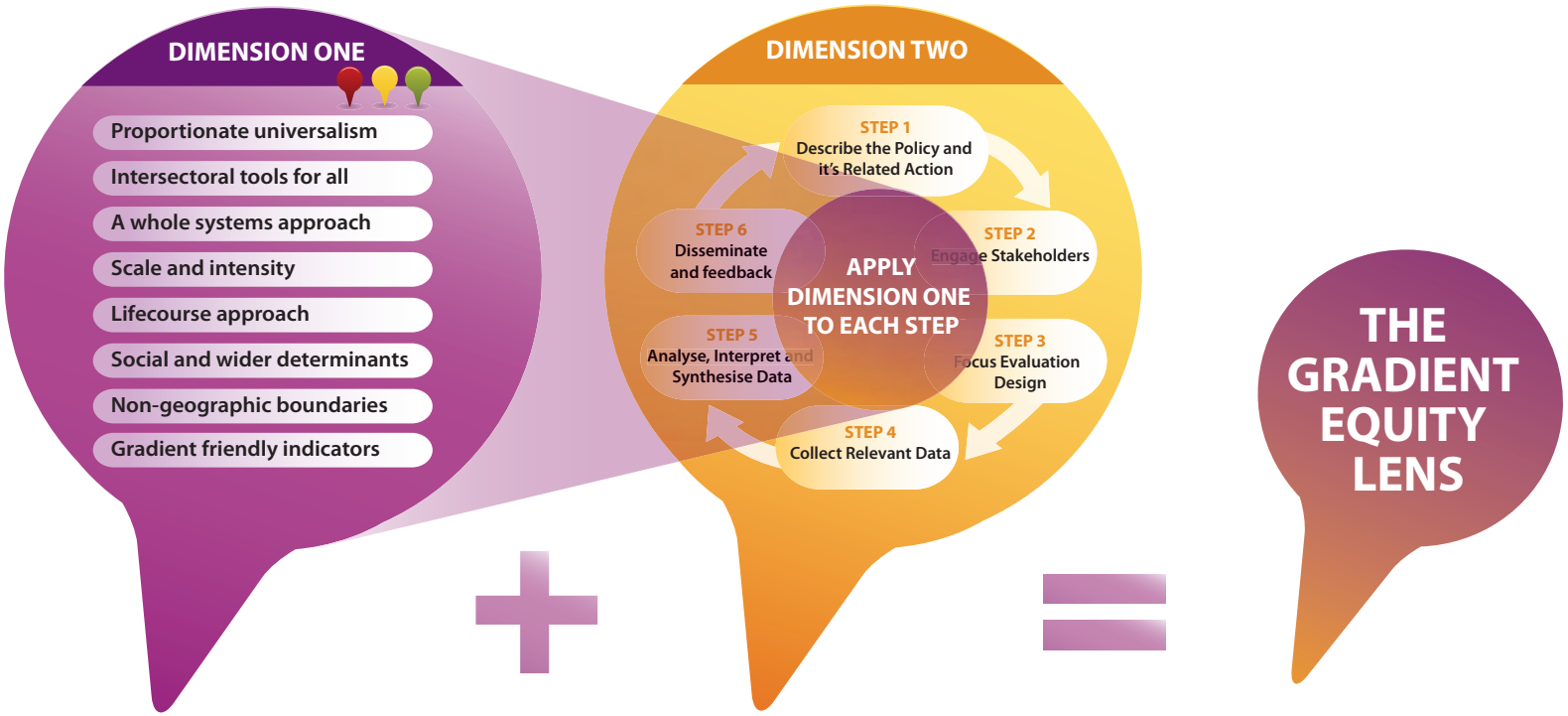



***Figure 7*** *The Gradient Equity Lens in action.*

## GEF IN ACTION

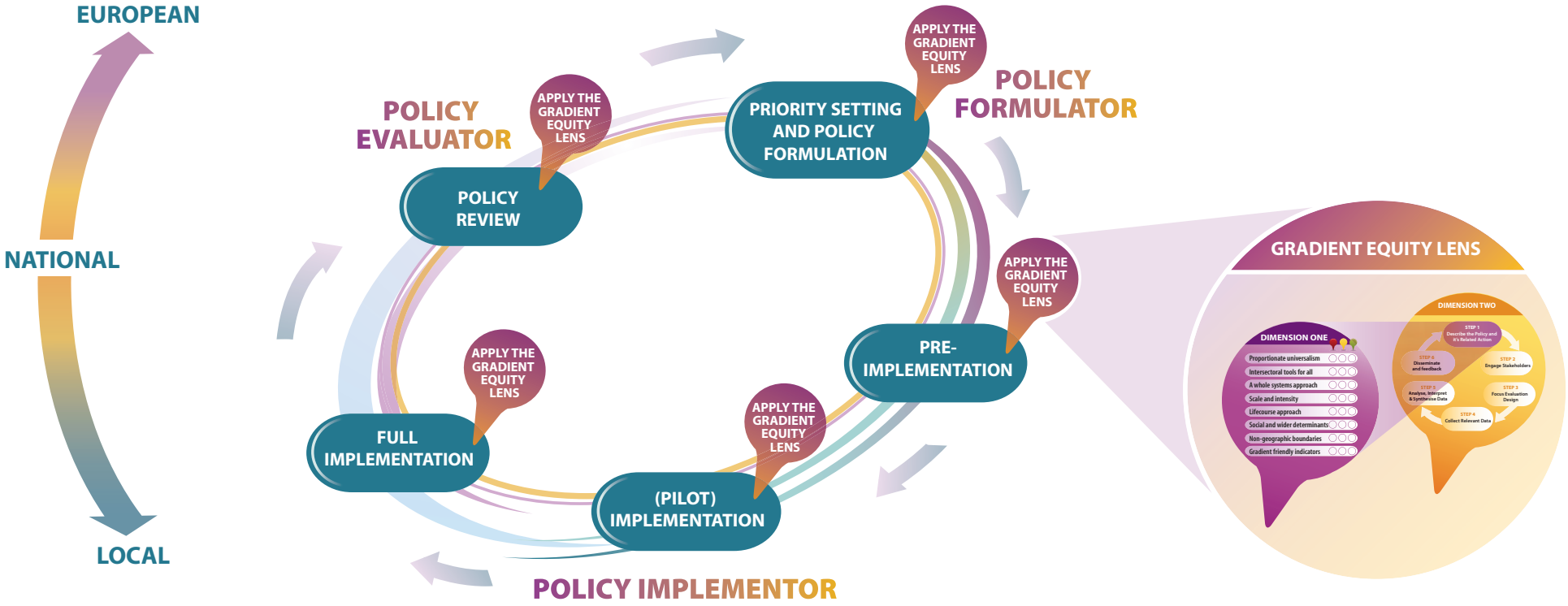
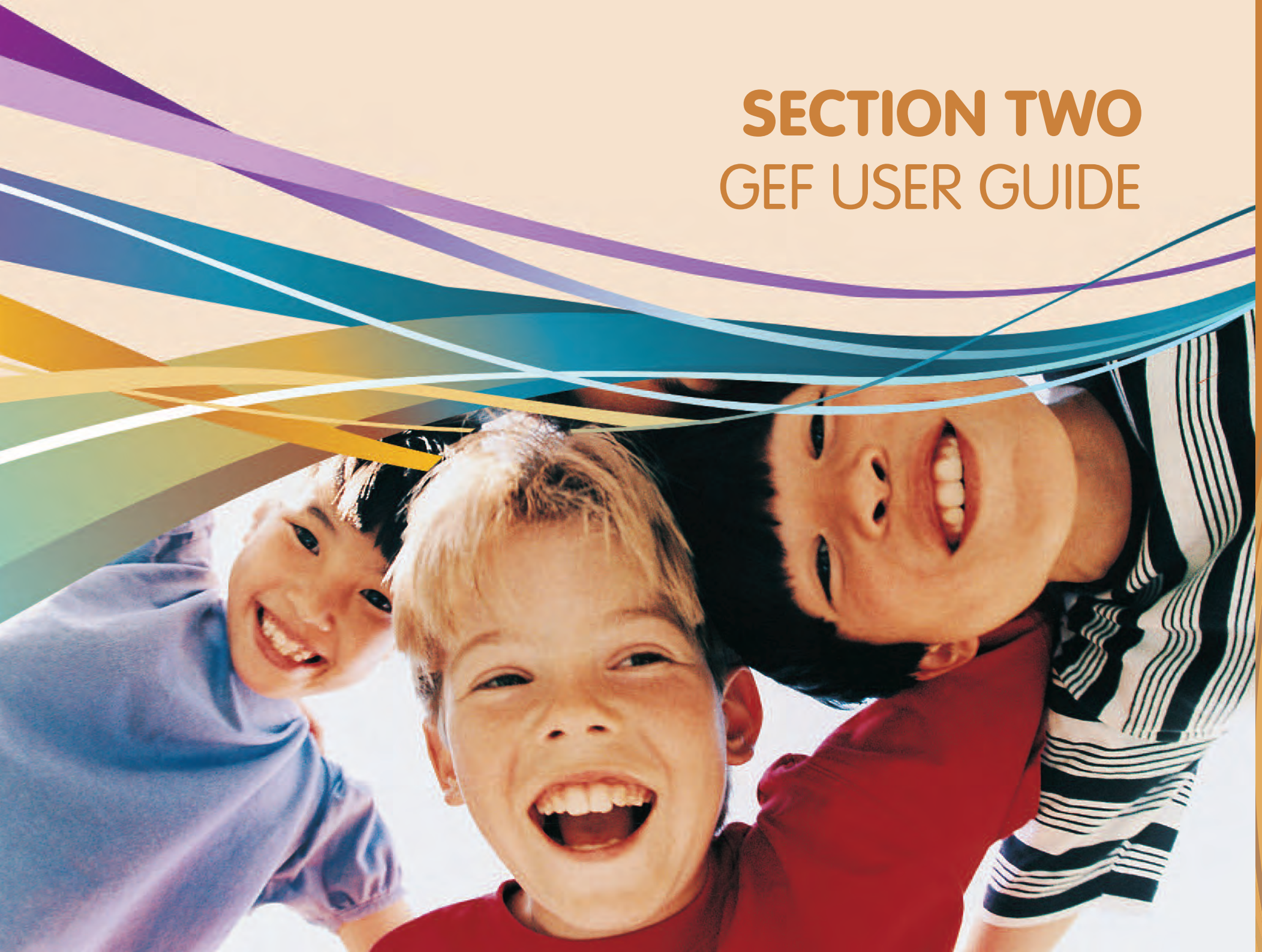



***Figure 8*** *The Gradient Evaluation Framework (GEF)*

# SECTION TWO
# GEF USER GUIDE



# 2.1 WHAT IS GEF?

GEF is a European action-oriented policy tool that provides a framework for the evaluation of policy actions at each of the key stages of the policy cycle. It includes a set of principles, procedures and mechanisms that can be applied to:

- Public health policies that comprise of a complex mix of actions, including programmes;
- Specific health policy actions (e.g. nutrition programmes in schools);
- Non-health policies that have a potential to impact on the social determinants of health inequalities (e.g. education, employment, and agriculture sectors).

A tool that can be applied to different policy contexts including upstream (targets the circumstances that produce adverse health behaviours such as the determinants of health that are ingrained in structural inequalities of society); mid-stream (affects working conditions or targeted lifestyle measures) and/or downstream (attempts to change adverse health behaviours and lifestyles directly). However, GEF places more of a focus on up-stream actions which can have a greater impact on addressing the determinants of social inequalities in health, and thus levelling-up the gradient in health inequalities.

In addition to issues of evaluation, GEF also aims to support, advocate, and sensitise its users regarding the need for action to reduce health and social inequalities and make progress towards levelling-up the gradient in health among children, young people, and their families.

# 2.2 WHY DO WE NEED GEF?

The evidence base defining which policies and interventions are most effective in reducing health inequalities is extremely weak. This applies in particular to those policies and interventions that aim to level up the gradient (Bambra *et al*., 2009; HCSC, 2009). It is important therefore that policies and interventions that seek to influence the gradient need to be more adequately evaluated (Davies & Sherriff, 2011; Davies & Sherriff, 2012).

Yet this is by no means an easy and straightforward task. No single study can demonstrate which policies are the most effective and there is a need therefore to invest in evaluation to build up an aggregated body of evidence over time. However, our review of existing evaluation frameworks found no suitable framework that could be used to evaluate whether policies and/or interventions targeting children and families have the *potential* to reduce health inequalities and the gradient (Davies & Sherriff, 2011). Thus, a bespoke Gradient Evaluation Framework (GEF) has been developed as the first developmental step in addressing this gap

## 2.3 HOW HAS GEF BEEN DEVELOPED?

GEF is a key output from the GRADIENT Project which has been funded between 2009-2012 by the EC's Seventh Framework Programme (FP7). The Project is a research collaboration involving 12 institutions from all over Europe. The focus of the project is on children, young people and their families since the greatest impact on reducing the gradient in health inequalities can be achieved through effective early life policy interventions and by creating equal opportunities during childhood and adolescence.

GEF has been developed through a series of consensus-building workshops, involving experts from a wide range of European Member States, as well as consultations with experts in policy, evaluation, and health inequalities through individual meetings and a formal peer review process. GEF has also been informed by the results of an extensive literature review and a realist review of existing evaluation frameworks (see Davies & Sherriff, 2011). Finally, GEF has been developed in collaboration with members of Work Package Two of the GRADIENT Project, the wider GRADIENT Consortium, and members of the GRADIENT Scientific Committee.

## 2.4 WHEN TO USE GEF

GEF can be used on any policy, action, programme, intervention or project that either affects, or is intended to affect (if not yet implemented), the health and equity of a given population. It is intended to guide those involved in the policy process (e.g. technical experts working in modern public health) by reducing their possibility of error having developed, or when developing, policies and related actions to increase the potential of levelling-up the gradient in health inequalities. GEF can be used retrospectively in terms of reviewing existing initiatives, and also prospectively when designing new ones.

## 2.5 WHAT GEF IS NOT

Although GEF can optimise the chances of addressing the gradient in health inequalities, it is not a universal bullet that guarantees to inform the user whether or not a specific policy action has had an impact on the gradient. This is due (*inter alia*) to the complexity of attempting to demonstrate direct causal links, the effects of time lags, and current lack of appropriate measurements/indicators and measurement tools (such as when attempting to demonstrate inter-generational impacts). Moreover, GEF is not intended to be a comprehensive technical manual on how to conduct evaluation as there are already many technical resources readily available for this.

# 2.6 WHO CAN USE GEF?

GEF is intended to be used by technical experts working at Member State (i.e. national) level. As stated earlier, specifically those individuals with a relatively high knowledge and understanding of the values, concepts, and principles of modern public health whom may (or may not) work in the health sector. However, GEF may also be of interest to other groups of stakeholders particularly policy-makers and/or decision-makers, researchers, evaluators, and practitioners working locally, nationally, or at European level.

# 2.7 KEY POINTS ABOUT USING GEF

GEF is designed to be flexible and adaptable to the needs of its (different) users. The 'questions to consider' and 'example activities' provided in GEF therefore, are meant to be indicative rather than exhaustive. They merely provide examples of the kinds of questions and activities users might want to consider. Consequently, some GEF questions and/or activities will be more relevant than others for different users, at different times, and for different policy actions. This will also be the case depending on what stage of the policy cycle GEF is being applied to. Users of GEF should thus feel free to address any additional relevant questions and/or areas to consider depending on their own particular context, policy action area and stage of policy development.

Given the above, users may want to consider exactly *how* they want to use GEF. For example, GEF can be used either for rapid assessment (e.g. using Dimension One only) or in a more in-depth way (Dimensions One and Two). Moreover, at times it may be more appropriate to work sequentially through GEF questions and examples when, for example, a policy action or programme is being developed from the beginning. Whereas, at other times, some questions or parts may be more relevant than others and users of GEF may therefore wish to 'dip-in-and-out' of Dimensions One and Two as and when required. The decision of *how* to use GEF is up to the user and their particular requirements and policy action in question.

The *process* of using GEF to evaluate and/or design a policy action is as important as the outcome itself. So regardless of the actual questions addressed, or how GEF us used (e.g. rapid assessment *vs*. in-depth use of the full tool), the particular component, step, and/or dimension of GEF should be discussed and explored as widely as possible by the individual user or evaluation team. In doing so, users should be prepared to have their assumptions and their thinking challenged, either by others in the evaluation group or by the evidence that is presented, or of course both. This is because the *process* of completing GEF can help to sensitise users regarding the need for action to reduce social inequalities in the determinants of health in order to make progress towards levelling-up the gradient in health inequalities.

Given that the completion of GEF can be complex, it might be beneficial to record any discussions, key answers and comments, findings, action points and so on for each question for later reference (space is provided at the back of this document for user notes as well as at other points throughout GEF). This record will help make use of GEF as transparent and accountable as possible to stakeholders. It will also help to provide a rationale for decision-making. For this reason, such records can also be shared with others involved in applying GEF and with other key stakeholders.

GEF is designed to be used alongside other tools that seek to tackle a similar equity agenda such as health impact assessments (HIA), health equity assessments (HEA), as well as other evaluation tools that provide more detailed guidance on particular evaluation techniques and methods (e.g. Public Health Agency of Canada [PHAC], 2004).

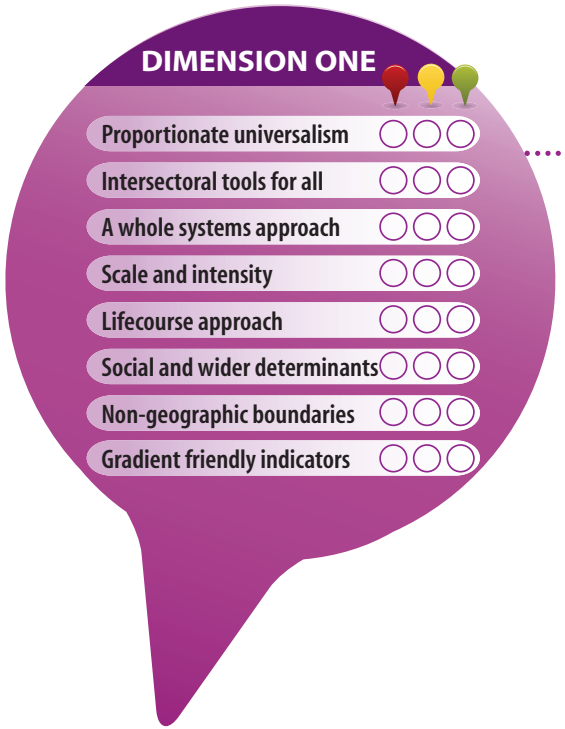
## INFORMATION GATHERING AND RESEARCH

For a number of reasons, users of GEF should bear in mind that to use the framework in its entirety requires information, data, and research that may not always be readily available. Evidence will be required to support any evaluative judgments of GEF's questions and activities. Some of this information is likely to be readily available; however, if sufficient data is not available at any stage during the use of GEF it may be possible to pause and analyse existing data, seek community input or commission new research. Once this is done, working through the tool can continue. In cases where gathering further data may not be possible, for example due to lack of appropriate gradient-friendly indicators, steps should be taken to notify relevant decision-makers about the need for such data.

# SECTION THREE
# GEF IN ACTION



# 3.1 APPLYING THE GRADIENT EQUITY LENS: DIMENSION ONE




## DIMENSION ONE CONSISTS OF:

**Eight key components** to underpin the evaluation and design of effective policies and actions in terms of their potential to be 'gradient-friendly'

**Background information** to provide relevant contextual information about each component

**Example questions** to encourage reflection on key issues relating to each component in terms of evaluating policy actions with respect to being 'gradient-friendly'

**Guidance notes** that may be useful to consider responses to the above questions

**Summative traffic-light system** to provide an overall rating of the policy action in terms of its potential to be 'gradient-friendly'. Simply respond **green**, **amber** or **red** where and when applicable. This summative judgement should be made based on a combined consideration of the background information relating to each component, your responses to the example questions, and the guidance notes provided

**Comments section** to provide space to record assessment of relevant issues (e.g. highlighting particular strengths and weaknesses, explanatory notes, and references to other documents and indicators)

**Action section** to provide space to record any key action points arising

**Gradient Equity Lens overview sheet** to provide a snapshot of the overall position in terms of 'gradient friendliness' for each of the eight key components constituting Dimension One of GEF. Additional space is also provided to summarise overall comments and to note any key action points.




# 1. PROPORTIONATE UNIVERSALISM

Tackling the GRADIENT in health

The gradient approach to policy action consists of broad universal measures combined with targeted (proportionate) strategies for high-risk/disadvantaged groups (e.g. low income families). When combined, universal and targeted measures affect the whole gradient, but with a scale and intensity that is (more or less) proportionate to the level of disadvantage. This is termed 'proportionate universalism'. Approaches targeting only the most disadvantaged are unlikely to be effective in levelling-up the gradient and may even contribute to an increase in health inequalities (e.g. when means-testing stigmatises). Instead, the underpinning concept to reducing the gradient is that "*fair distribution is good public health policy*" (Strand, Brown, Torgersen & Giaever, 2009). Furthermore, a gradient approach to policy also necessitates a focus on the upstream determinants of health inequities (such as income, education, living, and working conditions) and not just midstream or downstream approaches.

The questions in this section thus make these two crucial aspects explicit. Using the guidance notes to help you, tick 'yes', 'no' or 'N/A' (not applicable) to each of the following:

> *To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and an intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.* (Marmot, 2010)

## Is the policy action designed to:

| | Yes | No | N/A |
|---|---|---|---|
| **1.** Reduce health inequalities by targeting actions aimed solely at the most disadvantaged groups? | ☐ | ☐ | ☐ |
| a. If so, are other universal policies in place to ensure action across the gradient? | ☐ | ☐ | ☐ |
| b. If so, might the targeting mechanism contribute to stigmatisation of the targeted groups? | ☐ | ☐ | ☐ |
| **2.** Reduce health inequalities through universal action? | ☐ | ☐ | ☐ |
| a. If so, are targeted measures in place to ensure a scale and intensity that fits the level of disadvantage? | ☐ | ☐ | ☐ |
| **3.** Embrace principles of modern public health/health promotion, e.g. holistic approach to health, attention to the social determinants of health inequalities, empowerment, social justice, equity, sustainable development, etc? | ☐ | ☐ | ☐ |
| **4.** Is the policy action a downstream measure e.g. seeking to alter adverse health behaviours such as smoking or increasing breastfeeding rates through the health sector alone? | ☐ | ☐ | ☐ |
| **5.** Is the policy action a midstream measure e.g. focusing on psychosocial factors, behavioural risk factors, and risk conditions? | ☐ | ☐ | ☐ |
| **6.** Is the policy action an upstream measure e.g. focusing on the wider circumstances that produce 'adverse' health behaviours (e.g. social conditions, employment, macro-environmental policies, and social justice policies)? | ☐ | ☐ | ☐ |
| **7.** Does the policy action represent an interaction between upstream, midstream, and downstream measures? | ☐ | ☐ | ☐ |

## Guidance notes

**1-3** As the gradient runs across all social groups, selective measures focused only on the worst off (although valuable) are not enough to level-up the gradient in health inequalities. In fact such attempts may actually increase inequalities (e.g. stigmatisation due to means testing). Universal population approaches are required and not just targeted strategies focused on high-risk groups or attempts to narrow the 'gap'. Combining targeted selective approaches to help the most vulnerable, with broad universal welfare approaches, addressing the population is internationally considered as being the best approach to attempt to level-up the gradient in health inequalities.

**4.** The concepts stated here are ones that are generally considered to be important aspects when attempting to level the gradient in health inequalities. For example, adopting a holistic approach to health is important as it recognises positive aspects of health i.e. the notion that health is more than simply the absence of disease.

**5-7.** Levelling-up the gradient in health inequalities requires a focus on the whole causal chain of inequalities; in other words, a focus on upstream, midstream, and downstream measures. See Torgerson, Giaever & Stigen (2007, p.8) for a policy intervention map from the Norwegian context that demonstrates how this can be done.




# OVERVIEW
# PROPORTIONATE UNIVERSALISM (DIMENSION ONE)

Tackling the GRADIENT in health

## Overall rating

Consider *all* of your responses to the example questions particularly in relation to the background information and guidance notes provided. Now offer an overall rating of your policy action in terms of this component. Simply respond **'green'**, **'amber'** or **'red'**. As amber is a particularly broad category, it may be useful to identify the scope for improvement within this category. This rating will give you an indication of the 'gradient-friendliness' of your policy action in terms of this particular component.



## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Proportionate Universalism? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

## Key action point 1

**Person responsible:**
**By when:**
**Review date:**

## Key action point 2

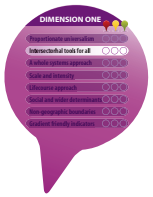
**Person responsible:**
**By when:**
**Review date:**

## Key action point 3

**Person responsible:**
**By when:**
**Review date:**

## Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# 2. INTERSECTORAL TOOLS FOR ALL



Effective policy actions to level-up the gradient in health inequalities require tools that are able to assist intersectoral collaboration and planning. This is because efforts to reduce social inequalities means addressing the determinants or root causes of health and social inequality; and that means addressing many issues beyond the control of the health sector (e.g. poverty, unemployment, poor housing, social exclusion, transport policies, environmental issues and so on). Consequently, it is necessary to raise awareness among those involved in policy and decision making from *all* sectors about the need to level-up the gradient. Intersectoral tools can be important policy instruments to achieve this. Although such tools are not always used routinely in all European countries (e.g. Germany), good examples are available for reference.

The questions in this section thus make explicit whether such intersectoral tools have been considered for the particular policy action in question. Using the guidance notes to help you, tick 'yes', 'no' or 'N/A' (not applicable) to each of the following:

*Inequalities in health are closely related to social inequalities (e.g. in income, housing, transport). Efforts to reduce social inequalities in health therefore, must also include sectors other than the health system.*

| | Yes | No | N/A |
|---|---|---|---|
| **9.** There are many different intersectoral tools widely available. These are just some examples. Have you conducted any of the following? | | | |
| • Heath Impact Assessment (HIA) locally and/or nationally (e.g. see Cameron, 2000; Douglas, Thomson, Jepson, Higgins, Muirie & Gorman, 2007; Metcalfe, Higgins & Lavin, 2009). | ☐ | ☐ | ☐ |
| • Health Equity Assessment (HEA) (e.g. Signal, Martin, Cram & Robson, 2008). | ☐ | ☐ | ☐ |
| • Poverty Impact Assessment (e.g. Office for Social Inclusion, 2009) | ☐ | ☐ | ☐ |
| Land Use Planning Tools (e.g. see Amler, Betke, Eger, Ehrich, Hoesle, et al., 1999) | ☐ | ☐ | ☐ |
| • The Equity Gauge (e.g. McCoy, 2003) | ☐ | ☐ | ☐ |
| • Other (please specify) ..... | ☐ | ☐ | ☐ |
| ..... | | | |
| **10.** Does a dedicated intersectoral committee exist, anchored firmly in the sectors represented, to give oversight and co-ordinate all issues relating to strategy, implementation, and monitoring/evaluation of the policy action? Examples of members might include senior ministers from finance/treasuries, education, justice, environment, social inclusion, health services and social care, regional development, and culture. | ☐ | ☐ | ☐ |

## Guidance notes

**8** Failure to use such tools means that you could be at risk of overlooking key opportunities to inform the design, implementation, monitoring and evaluation of policy actions intending to level-up the gradient. Although not used routinely in all European countries, intersectoral tools can help you to consider the potential effects (unintended or otherwise) of processes, strategies, and measures both within and beyond the health sector.

**9**. Working with social determinants is complex; it can take a long time for the effects of an intervention to show (inter-generational for example in relation to children and young people) and if or when they do, they can rarely be traced back to a specific action. Moreover, a policy that appears not to be successful in the short-term may well be successful in the longer-term. Consequently, establishing an intersectoral system that can report and feedback on the policy can be useful; in particular if indicators do not improve over time, the policy can be adjusted. It can also help to create policy coherence and encourage joint-delivery mechanisms that are crucial in addressing social inequities. The Norwegian experience provides a useful working example of how this can be done (see Strand *et al.*, 2009).




# OVERVIEW
# INTERSECTORAL TOOLS FOR ALL (DIMENSION ONE)

Tackling the GRADIENT in health

## Overall rating

Consider your responses to the example questions particularly in relation to the background information and guidance notes provided. Now offer an overall rating of your policy action in terms of this component. Simply respond **'green'**, **'amber'** or **'red'** As amber is a particularly broad category, it may be useful to identify the scope for improvement within this category. This rating will give you an indication of the 'gradient-friendliness' of your policy action in terms of this particular component.



## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Intersectoral Tools for All? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

## Key action point 1

**Person responsible:**
**By when:**
**Review date:**

## Key action point 2

**Person responsible:**
**By when:**
**Review date:**

## Key action point 3

**Person responsible:**
**By when:**
**Review date:**

## Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# 3. A WHOLE SYSTEMS APPROACH

*A whole systems approach is required to tackle health inequalities and the gradient in health inequalities…*

Tackling the GRADIENT in health

Adoption of 'whole-system' approaches have been used effectively in a range of disciplines across the public and private sectors particularly in relation to addressing complex strategic and social issues such as health inequalities. A whole social systems approach is required to tackle the gradient in health inequalities (Davies & Sherriff, 2011; Marmot, 2010).

Social systems theory perceives a system as being made up of interdependent and related parts which must be considered as a whole. Adopting a whole systems approach is thus concerned with looking at the 'big picture' of issues across a range of different interests within complex organisational environments (Department of Health [UK], 2000). Thus, a system cannot be viewed in isolation from its environment and context as it is built around the three concepts of its structure, the process it supports, and the outcome of its use. These three categories are not independent but are linked in an underlying framework which in turn distinguishes between quality of outcome, which is produced by quality of process, which is determined by quality of structure (Donabedian, 1966, 1988, 2003).

The questions in this section therefore make explicit whether such a whole systems approach has been considered for your policy action; they then focus on the necessary aspects of structure, process and outcome. Using the guidance notes to help you, tick 'yes', 'no' or 'N/A' (not applicable) to each of the following:

| **Structure** considers the attributes of the settings in which the policy action(s) is/are intended to occur: | Yes | No | N/A |
|---|---|---|---|
| **10.** Is the policy action sensitive to the socio-environmental context in which it operates, including the political and economic determinants of the welfare system? | ☐ | ☐ | ☐ |
| **11.** Is social equity in relation to children, young people and their families high on the political agenda? | ☐ | ☐ | ☐ |
| **12** Are health equity aspects related to children, young people and their families included in other sector's policies (i.e. other than the health sector)? | ☐ | ☐ | ☐ |
| **Process** considers the series of programmes or operations needed to deliver the policy and carry out its related actions: | | | |
| **13.** Do programmes exist in relation to health equity for children, young people and their families? | ☐ | ☐ | ☐ |
| **14.** Do they seek to increase investment in early years proportionately across the social gradient in terms of early years' education and care? | ☐ | ☐ | ☐ |
| **15.** Do they seek to support families in achieving progressive improvements in early years' development (e.g. parental leave during first year; support during pre-school years?) | ☐ | ☐ | ☐ |
| **16.** Do they consider the beliefs, needs, and interests of the target group(s)? | ☐ | ☐ | ☐ |
| **17.** Do they provide accessible support and advice to 16-25 year olds concerning training, employment and social skills; and work-based learning, for example? | ☐ | ☐ | ☐ |
| **18.** Are these programmes based on the best available evidence of effectiveness? | ☐ | ☐ | ☐ |
| **19.** Are these programmes being built on and scaled up to increase the likelihood of impacting on the gradient? | ☐ | ☐ | ☐ |
| **20.** Do these programmes complement existing attempts to level up the gradient? | ☐ | ☐ | ☐ |
| **Outcome** (focuses on the goals of the policy action/s) | | | |
| **21.** Does the action/s aim to have a proportionate effect across the social gradient? | ☐ | ☐ | ☐ |
| **22.** Does the action/s aim to only affect the most disadvantaged groups of children, young people and their families? | ☐ | ☐ | ☐ |
| **23.** Has a realistic time frame related to impact, output and outcome from the action/s been established? | ☐ | ☐ | ☐ |




# 3. A WHOLE SYSTEMS APPROACH

Tackling the GRADIENT in health

## Guidance notes

**10-12.** Policy actions focusing on children, young people, and their families which intend to level-up the gradient cannot be viewed in isolation from their environmental and socio-political context which influence the social determinants of their health. Therefore you need to explore the key contextual issues relating to your policy action/s by defining their 'structure' (e.g. the socio-political aspects of the welfare model in which you are operating); 'process' (e.g. the evidence-based programmes you are adopting to seek to level up the gradient); and 'outcome' (e.g. your expectations in attempting to level up the gradient in the short, medium, and long term). Moreover, those policy actions which seek to address health equity in other sectors (e.g. education, transport, housing) also need to be considered (see Intersectoral Tools for All). For example, as education and learning can contribute significantly to inequalities in health, the education sector must be a core partner in any action/s aiming to level-up the gradient.

**13-20.** Many important policy actions lie outside the health sector and therefore you need to adopt an intersectoral approach (see Intersectoral Tools for All). These include potential actions by civil society and the private sector as well as by national and local government. For example, your policy action/s could include a progressive range of support in early years development such as increased parental leave for both parents during the first year with a minimum healthy living income; routine support through parenting programmes, provision of specialist health workers, intensive home visiting and monitoring; and transition to nursery and school programmes.

**21-23.** You should ensure that outcomes from your action/s demonstrate a proportionate effect across the social gradient. If they only affect the most disadvantaged groups or reduce health inequalities by narrowing the health gap between the better-off and worse-off groups, they will not level up the gradient across the whole population. Consider the time frame for your action/s as this is an important factor as the causal chain between policy actions and outcomes is extremely complex.




# OVERVIEW
# A WHOLE SYSTEMS APPROACH (DIMENSION ONE)

Tackling the GRADIENT in health



## Overall rating

Consider *all* of your responses to the example questions particularly in relation to the background information and guidance notes provided. Now offer an overall rating of your policy action in terms of this component. Simply respond **'green', 'amber' or 'red'** As amber is a particularly broad category, it may be useful to identify the scope for improvement within this category. This rating will give you an indication of the 'gradient-friendliness' of your policy action in terms of this particular component.



## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to a Whole Systems Approach? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

## Key action point 1

**Person responsible:**
**By when:**
**Review date:**

## Key action point 2

**Person responsible:**
**By when:**
**Review date:**

## Key action point 3

**Person responsible:**
**By when:**
**Review date:**

## Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# 4. SCALE AND INTENSITY

Tackling the GRADIENT in health

Policy actions to level-up the gradient in health and its social determinants need to be piloted carefully and pre-tested whenever possible. All actions should be evaluated adequately with at least 10% of a programme budget being allocated for this purpose. Sufficient investment in terms of funding and person power needs to be allocated to ensure appropriate impact. Concern should also be given to capacity-building and staff development to ensure adequate numbers of trained people with the necessary skills to bring about any potential change in the gradient. Sustainability is a key factor and sufficient investment needs to be made over a long enough period (allowing for piloting) to facilitate sufficient impact on the gradient.

The questions in this section thus make the above issues explicit to see whether they have been considered for the particular policy action in question. Using the guidance notes to help you, tick 'yes', 'no' or 'N/A' (not applicable) to each of the following:

| | Yes | No | N/A |
|---|---|---|---|
| **24.** Have the necessary financial resources for your policy action been clearly identified and specified? Are these resources sustainable in the mid to long-term? | ☐ | ☐ | ☐ |
| **25.** Is the financial investment of sufficient scale (and sustainability) to have (or potentially have) an impact at the Member State (national) level? | ☐ | ☐ | ☐ |
| **26.** Do you have sufficient staff available with appropriate training, skills and technical expertise? | ☐ | ☐ | ☐ |
| **27.** Are resources and/or opportunities available to build capacity in terms of supporting staff development? | ☐ | ☐ | ☐ |
| **28.** Linked to the above, has funding and appropriate skilled personnel been allocated for conducting comprehensive evaluation of your policy action? | ☐ | ☐ | ☐ |

*Any policy action intended to level-up the gradient in health and its determinants needs to be piloted and pre-tested wherever possible – and at a sufficient scale and intensity to enable potential impacts to emerge.*

## Guidance notes

**24-28** Financial and personnel resources need to be sufficient and available for a sustainable period in order to any policy action to demonstrate (potential) impact on reducing health inequalities in the mid and long term. Thus sufficient sustainable investment in terms of finance and skilled staff resources is required and needs to be allocated appropriately to ensure effectiveness and efficiency, not only for policy actions to be delivered, but also, for them to be evaluated appropriately in the short, medium and long term as necessary. These resources should ideally be sizeable enough to make an impact at Member State (national) level.

Capacity in terms of staff resources (and staff development such as training) including those with appropriate competency and experience who understand fully the policy action's aims and objectives and the context of its delivery, is required. Teams should be assembled that are capable of pooling their skills and abilities, together with a team leader to aid continuity. It is advantageous for you to engage staff with partnership working experience and skills who can engage proactively with other key stakeholders and empathise with them. In addition you need to ensure that appropriate funding is allocated to engage the skilled and experienced staff necessary to carry out evaluation activities.




# OVERVIEW
# SCALE AND INTENSITY (DIMENSION ONE)

Tackling the GRADIENT in health



## Overall rating

Consider *all* of your responses to the example questions particularly in relation to the background information and guidance notes provided. Now offer an overall rating of your policy action in terms of this component. Simply respond **'green', 'amber' or 'red'** As amber is a particularly broad category, it may be useful to identify the scope for improvement within this category. This rating will give you an indication of the 'gradient-friendliness' of your policy action in terms of this particular component.



## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Scale and Intensity? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

## Key action point 1

**Person responsible:**
**By when:**
**Review date:**

## Key action point 2

**Person responsible:**
**By when:**
**Review date:**

## Key action point 3

**Person responsible:**
**By when:**
**Review date:**

## Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# 5. LIFE COURSE APPROACH

*Interventions early in the life course may not only have a positive impact on health, but may also assist in tackling inter-generational inequalities.*

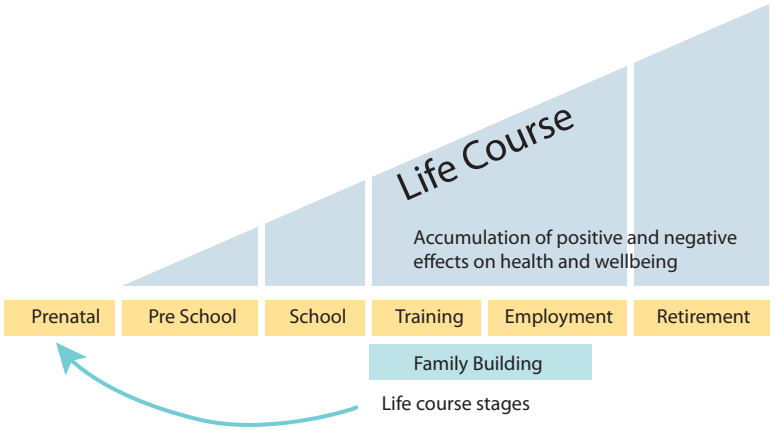



*Figure 9* *The Life course Approach (from Marmot, 2010)*

In addressing the gradient, a life course perspective is important, as biological and social determinants influence an individual's health development from conception through to death. Social determinants of health work together in a complex accumulation which can be pathogenic (health damaging), health protective, and/or resilient and thus, salutogenic. Disadvantage at different stages of the life has therefore been highlighted as evidence to adopt a life course approach to tackling inequalities (Power & Kuh, 2006; Oliver, Kavanagh, Caird, Lorenc, Oliver, et al., 2008).

Efforts to reduce inequalities in health should thus pay special attention to children, young people, and their families as actions at these early stages in the life course offer the greatest potential of levelling-up the gradient and procuring long-term positive health outcomes (Chen, et al., 2007; Marmot, 2010). A range of policy actions should thus be appropriately designed for each age group. Such actions early in the life-course can be a long term investment.

The questions in this section thus make the above issues explicit to see whether they have been considered for the particular policy action in question. Using the guidance notes to help you, tick 'yes', 'no' or 'N/A' (not applicable) to the following:

| | Yes | No | N/A |
|---|---|---|---|
| **29.** Is the policy action based on a life course perspective? | ☐ | ☐ | ☐ |
| If so, please indicate which specific period(s) are covered by the policy action | | | |
| Before and around birth (Pre-natal) | ☐ | ☐ | ☐ |
| 1st year of life | ☐ | ☐ | ☐ |
| Early childhood (Pre-School/Nursery/School) | ☐ | ☐ | ☐ |
| Late childhood (School) | ☐ | ☐ | ☐ |
| Adolescence (School/Training/Employment/Family building) | ☐ | ☐ | ☐ |
| Early adulthood(School/Training/Employment/ Family building) | ☐ | ☐ | ☐ |
| Mid adulthood(School/Training/Employment/ Family building) | ☐ | ☐ | ☐ |
| Retirement | ☐ | ☐ | ☐ |

## Guidance notes

**29.** Depending on the periods of the life course your policy action focuses on, examples relating to children, young people, and their families might include: priority to pre- and post–natal actions that prevent, or reduce, the adverse outcomes of pregnancy (Pre-natal); good quality nursery provision made available to all children with no barriers due to financial cost (Pre-school); good quality early years education provision along with universal proportionate quality child care and outreach services (School); support and advice provision for young people on social and life skills training to facilitate access and opportunities to employment (Training and Employment); Work-based learning and training development opportunities available to young people e.g. through apprenticeship and work internship schemes (Employment). All policy actions need to be provided on the basis of tested and evaluated pilot programmes with proven success.




# OVERVIEW
# LIFE COURSE APPROACH (DIMENSION ONE)

Tackling the GRADIENT in health



## Overall rating

Consider *all* of your responses to the example questions particularly in relation to the background information and guidance notes provided. Now offer an overall rating of your policy action in terms of this component. Simply respond **'green', 'amber' or 'red'** As amber is a particularly broad category, it may be useful to identify the scope for improvement within this category. This rating will give you an indication of the 'gradient-friendliness' of your policy action in terms of this particular component.



## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to a Life Course Approach? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

## Key action point 1

**Person responsible:**
**By when:**
**Review date:**

## Key action point 2

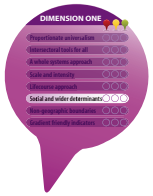
**Person responsible:**
**By when:**
**Review date:**

## Key action point 3

**Person responsible:**
**By when:**
**Review date:**

## Key action point 4

**Person responsible:**
**By when:**
**Review date:**



# 6. SOCIAL AND WIDER DETERMINANTS



*The conditions, in which people are born, grow, live, work, and age are responsible for health inequalities and are therefore unfair and avoidable.*

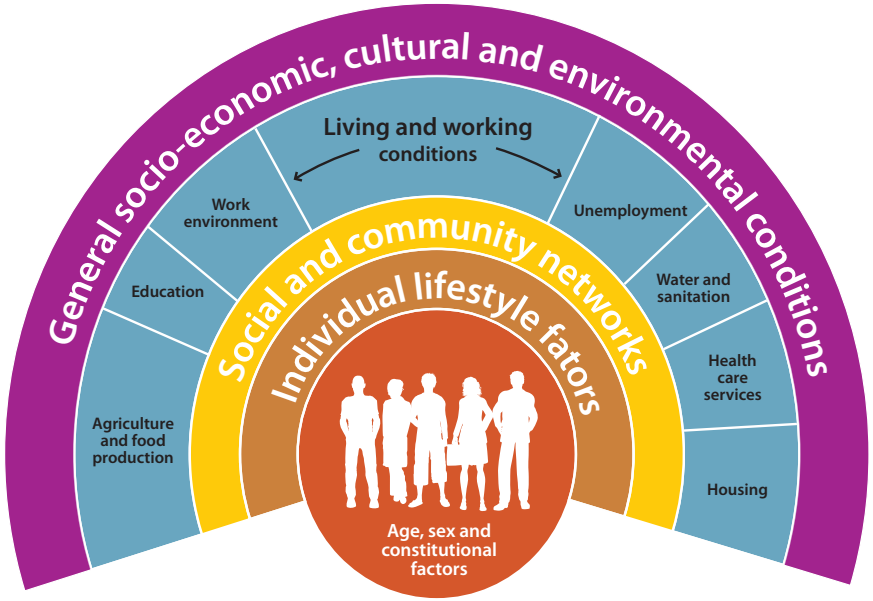



***Figure 10*** *The Social Model of Health (Dahlgren and Whitehead, 1991*

There is clear evidence that the conditions in which people are born, grow, live, work, and age are responsible for health inequalities, and that such health inequalities form a gradient across society. Policy objectives (including targets and thus, by proxy, outcomes) must therefore not be based purely on 'hard' medical (health) outcomes such as mortality and morbidity. Instead policies (and thus measurement indicators) need to be set with a view to enabling sensitivity and measurement of the social and wider determinants of health inequalities, such as income equity, poverty, employment, transport, and social inclusion, for example.

The main question in this section makes the above issues explicit to identify whether they have been considered for the particular policy action in question. Using the guidance notes to help you, tick 'yes', 'no' or 'N/A' (not applicable) where relevant. N.B. The social and wider determinants of health inequalities listed below are not meant to be prescriptive but rather indicative. It is of course unrealistic and/or unlikely for any policy approach to be able to address them all at the same time.

## Guidance notes

**30**. The social (and wider) determinants of health have been described as 'the causes of the causes'. They are the social, economic and environmental conditions that influence the health of individuals and populations. They include the conditions of daily life and the structural influences upon them, themselves shaped by the distribution of money, power and resources at global, national and local levels. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances. As noted in a 'Life Course Approach', social and wider determinants of health work together in a complex accumulation which can be pathogenic or salutogenic.

In adopting a gradient perspective, it is thus crucial that policy actions targeting children, young people, and families should focus specifically on addressing the social determinants of health (e.g. Marmot, 2010; Strand et al., 2009). This of course challenges the notion that health is the domain of the traditional health services sector (e.g. the NHS in England). Instead, reducing the gradient in health inequalities requires engaging with sectors outside of the traditional health sector (e.g. education, transport, and finance)

**30** Does the policy action focus on the social and wider determinants of health inequalities with a particular focus on health equity and sensitivity to diversity? What evidence and sources are available? What is the strength of any available evidence/sources? (Tick all that apply)

| Categories of determinants | Examples of specific social and wider determinants of health* | Yes | No | N/A |
|---|---|---|---|---|
| **Wider socio economic factors** | Employment | ☐ | ☐ | ☐ |
| | Education and opportunities for skill development | ☐ | ☐ | ☐ |
| | Income and equitable distribution of wealth | ☐ | ☐ | ☐ |
| | Affordable, quality, housing | ☐ | ☐ | ☐ |
| **Social and cultural factors** | Social support, Social cohesion | ☐ | ☐ | ☐ |
| | Participation (e.g. in community and public affairs) | ☐ | ☐ | ☐ |
| | Family and friends connections, and support | ☐ | ☐ | ☐ |
| | Cultural participation | ☐ | ☐ | ☐ |
| | Expression of cultural values and practices | ☐ | ☐ | ☐ |
| | Experience of racism, ageism etc and discrimination | ☐ | ☐ | ☐ |
| | Perception of safety (e.g. personal and community) | ☐ | ☐ | ☐ |
| **Physical and social environment** | Housing conditions and location | ☐ | ☐ | ☐ |
| | Working conditions | ☐ | ☐ | ☐ |
| | Air quality, water, and soil (including pollution e.g. noise) | ☐ | ☐ | ☐ |
| | Waste disposal including sanitation | ☐ | ☐ | ☐ |
| | Land use | ☐ | ☐ | ☐ |
| | Biodiversity | ☐ | ☐ | ☐ |
| | Climate | ☐ | ☐ | ☐ |
| | Infrastructure, public transport, urban design | ☐ | ☐ | ☐ |
| | Social and capital | ☐ | ☐ | ☐ |
| | Transmission of infectious disease (e.g. exposure to pathogens) | ☐ | ☐ | ☐ |
| **Population-based services Access to, and quality of, services** | Public transport | ☐ | ☐ | ☐ |
| | Health care services provision (including structure and coverage) | ☐ | ☐ | ☐ |
| | Social services | ☐ | ☐ | ☐ |
| | Child care provision | ☐ | ☐ | ☐ |
| | Leisure services | ☐ | ☐ | ☐ |
| **Individual and behavioural factors** | Personal behaviours (e.g. diet, physical activity, smoking, alcohol) | ☐ | ☐ | ☐ |
| | Life skills | ☐ | ☐ | ☐ |
| | Autonomy | ☐ | ☐ | ☐ |
| | Employment status | ☐ | ☐ | ☐ |
| | Educational attainment | ☐ | ☐ | ☐ |
| | Self-esteem and confidence | ☐ | ☐ | ☐ |
| | Age, disability, sexuality | ☐ | ☐ | ☐ |

*Table adapted from Signal et al., (2008) and CSDH, (2008)*



# OVERVIEW
# SOCIAL AND WIDER DETERMINANTS (DIMENSION ONE)

Tackling the GRADIENT in health

## Overall rating

Consider *all* of your responses to the example questions particularly in relation to the background information and guidance notes provided. Now offer an overall rating of your policy action in terms of this component. Simply respond **'green', 'amber' or 'red'** As amber is a particularly broad category, it may be useful to identify the scope for improvement within this category. This rating will give you an indication of the 'gradient-friendliness' of your policy action in terms of this particular component.



## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Social and Wider Determinants? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families??

## Key action point 1

**Person responsible:**
**By when:**
**Review date:**

## Key action point 2

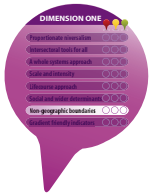
**Person responsible:**
**By when:**
**Review date:**

## Key action point 3

**Person responsible:**
**By when:**
**Review date:**

## Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# 7. NON-GEOGRAPHIC BOUNDARIES



There are regional variations in how the social gradient relates to mortality (Marmot, 2010). These regional variations expand as one travels further down the social gradient. Efforts to meet national targets may therefore mask inequalities that exist both at local/regional level and within deprived areas, as well as neglecting pockets of deprivation that exist in more affluent areas.

Consequently, focusing on achieving improvements in only the most deprived areas will not alter the distribution of social determinants of health and would therefore be unlikely to address the health inequalities gradient as there maybe pockets of deprivation existing in all areas. Moreover, there is the danger of widening both social and health inequalities by adopting non-whole population strategies.

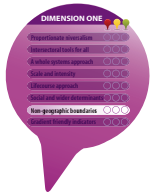
| | Yes | No | N/A |
|---|---|---|---|
| **31** Is the policy action designed to be implemented in one specific geographic area (e.g. county, region etc.)? | ☐ | ☐ | ☐ |
| a) If so, have you considered implementing the action across geographic boundaries i.e. adopting a whole population approach? | ☐ | ☐ | ☐ |

## Guidance notes

**31.** Deprived neighbourhoods tend to have poorer people living in them. The more deprived the neighbourhood the more likely it will have poorer social and environmental conditions that produce related health risks (Marmot, 2010). So although targeting the worst off is important this needs to be complemented by stressing universal aspects of policies in order to level up the gradient (See Proportionate Universalism). It is most important that *"...an integrated approach at national and local level is adopted if synergy is to be achieved to secure the maximum impact"* (Marmot, 2010, p.91). In this way targets can reflect' proportionate universalism' at local and regional as well as national levels.

If your policy action is confined to a regional or local area then consider how you can create entry points for it to influence the social determinants of health by combining both selective and universal measures. Although allowance should be made for regional or local variations and needs, policy actions should take account of European regional policy goals and be aligned to national policies to ensure optimum strategic investment. Investment in both local health and social infrastructure can help to level-up the gradient. National and regional health authorities can play a key role in supporting inter-country learning to ensure effective and efficient use of resources to impact on the gradient

*Focusing on improvements only in the most deprived areas would not alter the distribution of social determinants of health and would therefore be unlikely to address the health inequalities gradient… there is also the danger of widening both social and health inequalities by adopting non-whole population strategies.*




# OVERVIEW
# NON-GEOGRAPHIC BOUNDARIES (DIMENSION ONE)

Tackling the GRADIENT in health

## Overall rating

Consider *all* of your responses to the example questions particularly in relation to the background information and guidance notes provided. Now offer an overall rating of your policy action in terms of this component. Simply respond **'green', 'amber' or 'red'** As amber is a particularly broad category, it may be useful to identify the scope for improvement within this category. This rating will give you an indication of the 'gradient-friendliness' of your policy action in terms of this particular component.



## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Non-Geographic Boundaries? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

## Key action point 1

**Person responsible:**
**By when:**
**Review date:**

## Key action point 2

**Person responsible:**
**By when:**
**Review date:**

## Key action point 3

**Person responsible:**
**By when:**
**Review date:**

## Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# 8. GRADIENT FRIENDLY INDICATORS





In general, policy action objectives including targets and outcomes need to be able to capture the fact that social inequity in health forms a gradient across society. However, analysing health indicators and the determinants of health for the general population while necessary, is not sufficient for identifying and analysing the health status across the gradient. Social determinants of health and causal factors in particular, require careful additional analysis as the most important determinants of health may differ between different socio-economic groups.

*A gradient perspective means that choices of indicators need to be set with a view to enabling sensitivity and measurement of the social determinants of health inequalities such as income equity, poverty, and inclusion in the work force.*

As noted in Section One, to identify, monitor and evaluate health inequalities health outcome indicators (e.g. mortality, self-assessed physical and mental health) should be stratified by sex, at least two socio-economic stratifiers (e.g. education, income/wealth, occupational class), ethnic group, and place of residence. When analysing the determinants of health, indicators related to daily living conditions (e.g. health behaviours, housing conditions, water and sanitation, transport infrastructure, urban design, air quality, social protection, working conditions, and health care) can be developed based on existing data systems. Where applicable these indicators should also include a socio-economic stratifier. For identifying and monitoring health inequalities, data on structural drivers of health inequity should be included, such as gender (e.g. norms and values, economic participation), and socio-political context (e.g. employment conditions, public spending priorities, income distribution, etc.).

The questions in this section thus make the above assumptions explicit. Using the guidance notes to help you, tick 'yes', 'no' or 'N/A' (not applicable) to each of the following:

| | Yes | No | N/A |
|---|---|---|---|
| **32.** Do the indicators selected for your policy action include a focus on the social determinants of health? (e.g. daily living conditions, health behaviours, housing conditions, social protection, etc.). | ☐ | ☐ | ☐ |

If so which determinants? *(You may want to cross-reference to your earlier responses)*

.....

.....

.....

.....



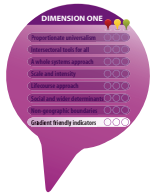

# 8. GRADIENT FRIENDLY INDICATORS

Tackling the GRADIENT in health

| | Yes | No | N/A |
|---|---|---|---|
| **33.** Do the chosen indicators include socio-economic stratifiers? If so which ones? *(please tick)* | ☐ | ☐ | ☐ |
| Sex | ☐ | ☐ | ☐ |
| Place of residence (rural/urban and/or other geographical unit e.g. province, ward, state etc.) | ☐ | ☐ | ☐ |
| Ethnic group race/indigenity | ☐ | ☐ | ☐ |
| Socio-economic (e.g. education/income/occupation) | ☐ | ☐ | ☐ |
| Other contextually relevant social stratifier *(please specify)* ..... | ☐ | ☐ | ☐ |
| ..... | | | |
| **34.** Do the indicators selected for your policy action include a focus on structural drivers of health inequity? If so which ones? *(please tick)* | ☐ | ☐ | ☐ |
| Gender (e.g. norms and values, economic participation, sexual and reproductive health) | ☐ | ☐ | ☐ |
| Social inequities (e.g. social exclusion, income and wealth distribution, education) | ☐ | ☐ | ☐ |
| Socio-political context (civil rights, employment) | ☐ | ☐ | ☐ |
| Are the indicators selected for your policy action qualitative and quantitative? | ☐ | ☐ | ☐ |

## Guidance notes

**32-34.** Measurement and monitoring of inequalities in health over time and across countries is not a straightforward process since the choice of the measure or indicator will influence the results. Moreover, no consensus has been reached on the best and most meaningful measures, and not all indicators one may wish to use are actually available. Thus, if no comprehensive data system is in place, indicators can be developed and used to ensure the monitoring and evaluation of the policy in question. Indicators for monitoring health inequalities needs to be developed based on the context and specificities of the policy and action to be analysed. There is a large panel of indicators that have been developed and used so far in identifying health inequalities or monitoring various policies and actions undertaken. See Step Four of GEF (in Dimension Two) for more details and examples of indicators.




# OVERVIEW
# GRADIENT FRIENDLY INDICATORS (DIMENSION ONE)

Tackling the GRADIENT in health

## Overall rating

Consider *all* of your responses to the example questions particularly in relation to the background information and guidance notes provided. Now offer an overall rating of your policy action in terms of this component. Simply respond **'green', 'amber' or 'red'** As amber is a particularly broad category, it may be useful to identify the scope for improvement within this category. This rating will give you an indication of the 'gradient-friendliness' of your policy action in terms of this particular component.



## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Gradient Friendly Indicators? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

## Key action point 1

**Person responsible:**
**By when:**
**Review date:**

## Key action point 2

**Person responsible:**
**By when:**
**Review date:**

## Key action point 3

**Person responsible:**
**By when:**
**Review date:**

## Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# THE GRADIENT EQUITY LENS (DIMENSION ONE) OVERVIEW SHEET

This **Gradient Equity Lens overview sheet** is to help you gain a snapshot of the overall position of your policy action in terms of its 'gradient friendliness' i.e. its likely potential to impact on levelling-up the gradient in health and its social determinants among children, young people and their families. Simply tick **red, amber**, or **green** as applicable, noting any major action points or comments as required.

| Gradient Equity Lens: Dimension One | | Comments | Action Points (including by when and by whom) |
|---|---|---|---|
| Proportionate universalism | ○ ○ ○ | | |
| Intersectoral tools for all | ○ ○ ○ | | |
| A whole systems approach | ○ ○ ○ | | |
| Scale and intensity | ○ ○ ○ | | |
| Life-course approach | ○ ○ ○ | | |
| Social and wider determinants of health inequalities | ○ ○ ○ | | |
| Non-geographic boundaries | ○ ○ ○ | | |
| Gradient friendly indicators | ○ ○ ○ | | |

# 3.2 APPLYING THE GRADIENT EQUITY LENS: DIMENSION TWO






## DIMENSION TWO CONSISTS OF:

**Six key steps** linked to exemplar activities relevant for the evaluation (and design) of policy actions proposed or in place, in terms of their potential to be 'gradient-friendly'

**Background information** to provide relevant contextual information about each step

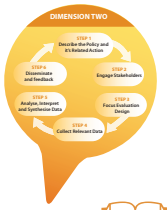
**Example questions to consider,** and **example activities** regarding cyclical, iterative, and cross-cutting evaluation activities to assess the potential of a policy action to be 'gradient-friendly'

**'Gradient friendly' measures and/or indicators** relevant for evaluating policy actions with regards to their potential impact on levelling-up the gradient in health inequalities and its social determinants

**Comments section** to provide space to record assessment of the issues (e.g. highlighting particular strengths and weaknesses, explanatory notes, and references to other documents and indicators)

**Action section** to provide space to record any key action points arising

**Gradient Equity Lens overview sheet** to provide a snapshot of the overall evaluative position in terms of all six key steps of Dimension Two. Additional space is also provided to summarise overall comments and to note any key action points.




# STEP ONE: DESCRIBE THE POLICY AND ITS RELATED ACTIONS

Describing a policy action is an important part of the evaluation process. It provides an opportunity to explain explicitly what the policy is trying to accomplish and how it tries to bring about those changes. Moreover, it illustrates the policy action's core components; establishes its ability to make changes; specifies its stage of development or implementation; and describes how the policy fits into the larger socio, cultural, and political environment. Such descriptions therefore set the frame of reference for all subsequent decisions in the remainder of the evaluation activities. Six core elements of an appropriate policy action description include:

a. **Overall statement of need and goals (e.g. outline of the magnitude and scope of the problem, needs identification and assessment, level of aggregation of the policy)**
b. **Context (e.g. within which the policy and its related actions operate)**
c. **Values, principles and underlying approach (e.g. WHO Health 21 principles, holistic conceptualisation of health)**
d. **Expectations (e.g. a description of the expected or desired immediate and intermediate impacts and/or long-term outcomes)**
e. **Activities and resources (e.g. relating to the implementation of policies)**
f. **Stage of development (e.g. policy formulation, planning, pre-implementation, and review).**

# STEP ONE: DESCRIBE THE POLICY AND ITS RELATED ACTIONS

Tackling the GRADIENT in health

## a Overall statement of needs and goals

Describe the overall problem and/or opportunity that the policy action(s) aims to addresses with regards children, young people, and their families. Features that should be included here when describing and/or assessing 'need' are a) the nature and magnitude of the problem or opportunity b) which (sub) populations are affected, c) whether the need is changing, and d) in what manner the need is changing.

In order to produce this overall statement of needs and goals of the policy action, some useful example activities and/or check-lists are outlined below:

### Example questions to think about:

- Is the policy action intended to be specific to children, young people and their families' health across the social gradient or is it a part of a wider strategy (e.g. housing, education, transport?)
- With reference to children, young people and their families, what are the overall policy action goals? (e.g. improvements in health for all children across the social gradient?).
- Have you conducted formative research to investigate the need for the policy action? If not, why not?

### Example activities:

- Conduct formative research to investigate the need and/or problem for the policy action. e.g. observations, interviews, mapping, focus groups with relevant stakeholders from across the social gradient. This might include recipients of policy actions as well as decision makers with responsibility for establishing child and family health in your country. Such activities can help to clarify both the need and proposed goals of the policy action.
- Identify existing evidence of any policy actions that have attempted to impact on the gradient and focus on children, young people and their families. This could be done by completing a scoping review or identifying existing reviews (e.g. systematic review, comprehensive literature review, realist review).
- Assemble knowledge of any existing innovative policy drivers.
- Identifying/developing theory – develop a theoretical understanding of the (likely) process of change.
- Consider possible alternative policy options using examples in relation to children, young people and their families.

# STEP ONE: DESCRIBE THE POLICY AND ITS RELATED ACTIONS

## b Context

Policy actions that aim to level-up the health gradient must be responsive to the social, economic, political, cultural and historical context in which they operate. For instance, areas such as macroeconomic policies including taxation, education, the labour market (occupation, income,) housing; power relationships as well as more setting and/or environmental influences (e.g. geography) may need to be considered. Some useful example activities and/or check-lists are outlined below:

### Example questions to think about:

- Is there an intersectoral cross-governmental policy forum in the policy area related to your policy action?
- What is the Member State welfare regime (i.e. liberal; corporatist; social democratic) within your country where the policy action will be located? How might this impact on the effectiveness of the policy?
- What is the nature of civil society in your country? For example, what kinds of non-governmental organisations, community organisations, voluntary groups and so on, are active in the field relating to your policy action?
- What are the political priorities in the area related to your policy action(s)?
- Are health, educational, and social services provided through subsidisation and/or taxation or directly by users?
- What systems are in place to support parents (e.g. parental leave, flexible working, etc.)?

### Example activities:

- Conduct a situational analysis exploring the political, and organisational context of the policy action as well as the related Member State welfare regime (i.e. liberal; corporatist; social democratic) within which the policy will be located.
- Produce an inventory of relevant policy actions that have already been implemented in your country.
- Investigate how many young people in your context are not in education, training, or employment (NEET). As part of this, it may be useful to also, scope job opportunities for young people (including apprenticeships) as well as further and vocational opportunities.

# STEP ONE: DESCRIBE THE POLICY AND ITS RELATED ACTIONS

Tackling the GRADIENT in health

## C Values, principles and underlying approach

WHO, Marmot, and others have proposed a number of values and principles that should underpin any policy action/strategy for attempting to level the gradient in health inequalities relating to children and families. Identify whether these are accepted in your country and whether or not they have been explicitly adopted or acknowledged (e.g. politically in documentation; see WHO, 2005, p.6).

### Example questions to think about:

- Does the policy action adopt of holistic concept of health? - i.e. health not just as absence of illness, but as a resource for everyday life and not the objective of living; achieving a socially and economically productive life; health has positive and negative aspects whereby disease and well-being co-exist.
- Does the policy action draw upon WHO Health 21 principles? i.e. grounded in the human right to good health; participation and empowerment of people to be involved in decisions about their health; social justice and diversity; equity for all - with a particular focus on health equity and sensitivity to diversity.
- Does the policy action involve stakeholders meaningfully, and in particular, engage directly with children, young people and their families across the social gradient? (See Step Two).
- Have you considered a community engagement approach to involving stakeholders (e.g. parents from across the social gradient)
- Does the policy action adopt a life course approach with a particular focus on the early years (See Dimension One).

### Example activities:

- Consider carrying out a Health Equity Assessment of your policy action.
- Analyse the settings-based approach to intersectoral action e.g. health promoting nurseries, schools, workplaces, hospitals etc. This approach may be useful to underpin your policy action.

Tackling the GRADIENT in health

# STEP ONE: DESCRIBE THE POLICY AND ITS RELATED ACTIONS

## d Expectations

Descriptions of expectations (objectives) convey what the policy action must accomplish in order to be considered successful. However, progress concerning policies to level the gradient and/or reduce health inequalities regarding children, young people and their families are difficult to measure and establish. Working with social determinants is extremely complex; it can take a long time for the effects of an action to show, and when or if they do, they can rarely be traced to a specific policy action(s). Moreover, a policy that appears to not be successful in the short-term, may well be successful in the long-term (Strand et al., 2009). Thus, it is important to differentiate between short-term (immediate), medium-term (intermediate) and long-term outcomes or expected effects. Consideration should also be given to potential unintended consequences of the policy action(s).

### Example questions to think about:

- Is there a clear statement of the policy action's objectives/expected outputs, processes, and outcomes? Is the formulation of these objectives/expectations SMART? i.e. are they:
  - Specific - do they specify the target group (e.g. children, young people, and their families) and the factors that need to change?
  - Measurable - are they written in a measurable format (e.g. magnitude of effects, numbers to be reached)?
  - Acceptable for the target group? - - -
  - Realistic - are they feasible given the available time, money, staffing, political climate and so on?
  - Time-framed - do they state the time period within which the objectives or expected effects must be reached?
- Do the expected outcomes show what the final achievement of the policy action will be?
- How will potential unintended consequences of the policy action be captured and/or evaluated? Following reflection, how will these consequences be addressed?

### Example activities:

- Being clear about objectives/expected outputs, processes, and outcomes is the key to successful evaluation of policy actions. Before starting evaluation activities it is crucial to be clear about what the policy action is trying to achieve (without this you cannot measure whether or not it has been achieved!) A simple way to do this is to use SMART objectives - see above)..
- Map planned policy action activities against targets (e.g. see Marmot, 2010).
- Try setting out a series of link steps to achieving expectations using a Theory of Change mode and/or logic model, for example.
- Reflect on relevant past policy actions in order to help clarify your thinking with regards expected effects, mechanisms of change and so on.
- Consult key stakeholders across the social gradient to gain input into their expectations of outcomes or effects of the policy action.

# STEP ONE: DESCRIBE THE POLICY AND ITS RELATED ACTIONS

## e Activities and resources

Descriptions of activities detail what the policy action actually does in order to bring about the expected effects or changes. In other words, it demonstrates how each planned activity or programme of action relates to one another and clarifies the routes through which change is expected to occur. Such descriptions should also distinguish between those activities that are the direct responsibility of the policy from those that are conducted by related policies or partners. Similarly, descriptions of the necessary (and available) resources (e.g. time, talent, technology, equipment, information, money, assets and so on) to conduct the policy implementation activities are required (see also Dimension One - Scale and Intensity). Useful resource descriptions should convey the amount and intensity of activities and highlight situations where a mismatch exists between the desired activities and the actual resources available to implement those activities.

### Example questions to think about:

- Have planned policy action activities been pre-tested and/or piloted? Has enough time lapsed in order for you to assess whether the activities are appropriate?
- How sustainable are the planned activities within your policy intervention? For instance, in terms of sufficiently trained and/or experienced staff, sufficient funding, etc.
- How do you intend to action proportionate universalism in practice?

### Example activities:

- Carry out a sustainability review on activities and resources.
- Create an implementation 'map' of how proportionate universalism is intended to be operationalized in practice.
- Produce a timeline of milestones when policy action activities are planned to be pre-tested and/or piloted. Make sure you allow time for the activities to be evaluated appropriately, and be prepared to not implement the action (or adopt changes) if the findings dictate.

Tackling the GRADIENT in health

# STEP ONE: DESCRIBE THE POLICY AND ITS RELATED ACTIONS

## e Stage of Development

Policy actions develop and change over time. It is therefore important to set evaluation against a backcloth of the policy cycle given that evaluation activities, goals and so on, may need to differ depending on the particular stage of policy development (see Figure 4).

Evaluation should occur at each stage of the policy cycle. During planning, policy actions are likely to be untested, and hence the aim of evaluation at this stage is to inform and refine plans. During implementation, policy actions are being field-tested and modified; thus the aim of evaluation at this stage is to identify 'what works' and 'what doesn't work' in practice and under what circumstances, and to make revisions accordingly. During the last stage of the policy cycle, the aim of evaluation is to identify and account for both intended and unintended effects or outcomes –findings can then be fed back into the start of the policy cycle i.e. priority (re)setting and policy (re)formulation.

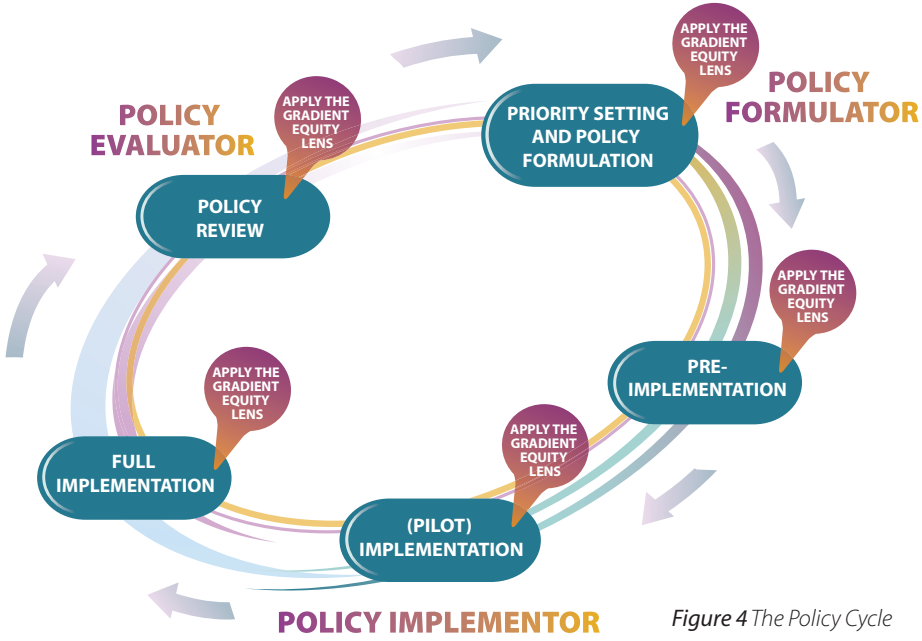



*Figure 4* The Policy Cycle

### Example questions to think about:

- What stage of the policy cycle is your policy action at? (Priority setting and policy formulation; Pre-implementation; (Pilot) implementation; Full implementation; policy review?)
- How might the evaluation methods, measurement tools, base-line data, indicators you use etc need to be different depending which stage of development your policy action is at?

### Example activities:

- Refer to Step 3 for guidance on focusing the evaluation design appropriate to the stage of development of your policy action.
- Select the most appropriate tools at each stage of the policy cycle – both for data collection (refer to GEF Step 4) and data analysis (Refer to GEF Step 5).




# OVERVIEW

# STEP ONE: DESCRIBE THE POLICY AND ITS RELATED ACTIONS

Tackling the GRADIENT in health



## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Describe the Policy and Its Related Actions? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

### Key action point 1

**Person responsible:**
**By when:**
**Review date:**

### Key action point 2

**Person responsible:**
**By when:**
**Review date:**

### Key action point 3

**Person responsible:**
**By when:**
**Review date:**

### Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# STEP TWO: ENGAGE STAKEHOLDERS



In terms of evaluation, stakeholders are those individuals, organisations, or groups who have a 'stake'; that is they care about what will be learned from the evaluation and about what will be done with any knowledge that is elicited. Stakeholders may be categorised as those who are:

- Involved in implementing a policy (e.g. funding agencies, managers, delivery partners, administrators, and project staff)
- Targeted or affected by the implementation of a policy (e.g. young people and their families, clients, neighbourhood groups, advocacy groups, and community residents)
- Primary users of the policy evaluation (e.g. are those included in the previous two categories individuals or groups but who are in a position to decide and/or act upon the findings of the evaluation of the policy intervention)

Evaluation cannot be done in isolation. Almost everything done in public health and health promotion regarding children/young people and families necessitates partnership working and therefore, any serious effort to evaluate a policy action in terms of the gradient in health inequalities must identify, engage, and consult meaningfully with relevant stakeholders across the social gradient. This latter point is particularly important; any evaluation of policy should always try and promote inclusion and empowerment of less powerful and/or visible stakeholders. However, it is of course also necessary to be somewhat selective in your choice of stakeholder to engage with in order to ensure the evaluation is as credible and as useful as possible. Recent interview evidence from Work Package 3 of the Gradient Project (see Dorgelo, Spitters, & Vervoordeldonk, 2011) demonstrates that the concept of policy participation (engagement of the stakeholders at all the stages of the policy development) can actually enhance the uptake of the policy itself.

Some examples of useful indicators and activities or questions to ensure appropriate engagement with stakeholders are listed below:

### Example questions to think about:

- How will you reach and engage stakeholders across the social gradient relevant to your policy action?
- Have members of each category of stakeholder (see above) been identified and engaged with meaningfully in the evaluation process?
- What challenges/barriers might there be in 1) selecting which stakeholders should be included? 2) reaching stakeholders across the social gradient and 3) engaging meaningfully with them? How might these challenges be resolved?
- What strategies (and how might they be differentiated) could be used to ensure that the different interests of stakeholders can be represented appropriately?
- Will the participation of internal and external stakeholders be formalised via agreements?
- Have conflicts of interest between stakeholder (groups) been discussed explicitly to ensure that the results or findings of the evaluation will not be compromised?
- Have steps been taken to minimise any potentials harm to evaluation participants, particularly the most vulnerable stakeholders (e.g. youngest)?
- Have you considered how new stakeholders can be included (if relevant) as the evaluation progresses?

### Example activities:

- Conduct a stakeholder analysis or mapping exercise to identify individuals or groups likely to be of relevance to the policy action (for example, those whom fall within the three stakeholder categories identified above)
- Identify potential challenges/barriers and solutions in engaging with stakeholders across the social gradient.




# OVERVIEW

# STEP TWO - ENGAGE STAKEHOLDERS (DIMENSION TWO)

Tackling the GRADIENT in health



## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Engaging Stakeholders? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

### Key action point 1

**Person responsible:**
**By when:**
**Review date:**

### Key action point 2

**Person responsible:**
**By when:**
**Review date:**

### Key action point 3

**Person responsible:**
**By when:**
**Review date:**

### Key action point 4

**Person responsible:**
**By when:**
**Review date:**



# STEP THREE: FOCUS EVALUATION DESIGN

In this section six main steps should be followed in order to focus the design of the evaluation appropriately including:

- a Decide on an appropriate design
- b Decide on evaluation methods
- c Understanding and measuring process
- d Understanding and measuring outputs
- e Understanding and measuring outcomes
- f Disseminate and feedback

## a Decide on an appropriate design

There are a variety of evaluation designs available. Each tends to be appropriate for a different policy action(s) and thereby has different objectives related to the context in which it is required to be used. These designs include approaches which can be experimental, quasi-experimental, or non-experimental and/or observational depending on the objectives specified by the stakeholders involved. Design is an important aspect of an evaluation for it has implications for what will count as 'data' or 'evidence', how such data/evidence will be gathered (i.e. methods and protocol), interpreted, and disseminated, for example. No one design is better than any other; rather one design may be more appropriate than another in a particular context.

An evaluation must be focused appropriately related to the objectives specified by relevant stakeholders from across the social gradient whilst using time and other resources as efficiently as possible. Taking time to focus the design of the evaluation increases the chance of the activities being useful, feasible, ethical, and accurate (CDC, 1999).

### Example questions to think about:

- Have you prepared a detailed work plan and timetable setting out what is to be done and when?
- Do you have an appropriate level of funding (circa.10% of the policy action's budget) to conduct the evaluation? If not, how will this affect the design of the evaluation?
- How will you decide which is the most appropriate evaluation design to use? Who can you consult with?
- Have you focused the purpose/objectives of the evaluation? For instance, is it to gain insight, change practice, influence policy decisions, assess effects (between activities and observed changes) or something else? How will these purposes impact on your choice of design?
- Does the design adopt a purely qualitative/quantitative approach or more of a mixed methodological approach?
- What kinds of data or evidence (and its strength) are required to answer the objectives of the evaluation? How does this impact on your choice of design?
- How will evaluation findings be used? By whom? Which audiences?
- Does the design encourage the use of pluralistic methods? (e.g. drawing on a variety of disciplines & employ a broad range of information gathering procedures). If so, which ones? What are the advantages and disadvantages of these methods?

### Example activities:

- Identify key stakeholders (e.g. children, young people, and families from across the social gradient whom are affected by the policy action) and form an evaluation team (see Step 2)
- Identify key people who can actually use findings and orient design to meet their needs (see Step 2)
- Be aware sometimes of the different objectives of different stakeholders
- Consult with potential stakeholders (see Step 2) to clarify the purpose of evaluation
- Work with practitioners and policy makers to understand scope and character of planned action(s)
- Produce an evaluation procedures protocol specifying the roles and responsibilities of stakeholders involved (see Step 2)
- Clarify explicitly evaluation questions (see Step 1)
- Periodically review and change evaluation plan as appropriate to circumstances.




# STEP THREE: FOCUS EVALUATION DESIGN



## b Decide on evaluation methods

The specific evaluation methods to be used are dependent on the objectives of the policy action, and are influenced by various factors such as the epistemological position adopted (interpretivist, positivist, or pragmatist), what type of data or evidence is required, and practically, the skills and/or experience and preferences of the evaluators. Other practical issues which may influence the choice of methods include cost, coverage, feasibility, sampling, and data analysis. What is important is to select the most appropriate methods for the evaluation (e.g. rather than personal preference of the evaluator). Thus, there is often a necessity to adopt a flexible pragmatic approach that may need to be iterative and reflexive if aspects of the evaluation change (e.g. discovery of unintended effects).

Evaluation design and methods must also be flexible enough to encompass unintended outcomes. Because each method of data generation has its own advantages and disadvantages, evaluations that mix methods (i.e. adopt pluralistic methods) can generally be more effective.

### Example questions to think about:

- How best can intended outcomes, gradient-sensitive indicators and evaluation methods be interlinked?
- How can both qualitative and quantitative methods be used?
- What are the strengths and weaknesses of the various research methods available?
- Consider the relative benefits of the need to achieve depth or breadth of data collection
- What evidence can be collected as part of routine activities and what need to be collected at set points?
  The research methods you close must be compatible with the values underpinning the policy action.

### Example activities:

- Carry out a review or skills analysis of the evaluation team to scope existing skills and expertise regarding use of particular methods and identify gaps and needs for training or resourcing external expertise.
- Think clearly about the purpose of the evaluation and the need for various types of evidence
- Will questionnaires and interviews provide the right evidence?
- Consider the ethical issues that will influence your choice of evaluation methods
- What are the practical issues that will influence your choice of evaluation methods e.g. availability of resources and equipment, experience of undertaking evaluation using particular methods, time-scale, coverage, etc.?




# STEP THREE: FOCUS EVALUATION DESIGN

## C Understanding and measuring process

As noted previously, a whole social systems approach is required to tackle health inequalities and level-up the health gradient (Davies & Sherriff, 2011). Thus, effective policy actions should focus both on structure and process, and not just on outcome/s.

Process refers to the series of activities, programmes, or operations that are required to deliver a policy action. Understanding process is important as it can provide valuable insight into i) why aspects of a policy action failed to meet its objectives or perhaps delivered unintended consequences, or on the other hand; ii) why particular aspects of a policy action were successful and therefore should be expanded. Process evaluation can be carried out a various stages of policy development and implementation. For example, in terms of the latter, during a pilot intervention process evaluation can be useful to assess the quality of implementation, identify problems, improve processes and methods and highlight contextual factors related to variations in outcome. Examples of process indicators relating to policy interventions targeting children, young people, and their families to level-up the gradient may include:

- Measured increase in number of children accessing quality early education and childcare across the gradient
- Increased recruitment of well-qualified staff into the early years workforce
- Increased engagement by health visiting and family nurses in each early year of the child's life (e.g. quantity, quality, and reach measures).
- Increased number and quality of parenting programmes (increased take-up of programmes across the gradient).
- Take-up of parental leave.

### Example questions to think about:

- Process evaluation requires a wide variety of evaluation methods and measurements. Linking to earlier sections, which evaluation methods are most appropriate for your policy action? (e.g. interviews, focus groups, text analysis, field notes, satisfaction surveys etc.)
- What are the potential facilitating and/or inhibiting factors to conducting process evaluation of your policy action?
- What procedures are in place to ensure that findings from process evaluation activities are fed back appropriately and in a timely manner to relevant stakeholders?
- How will you measure or judge whether your policy action has been delivered as originally planned?
- Which data sources and related indicators will you use to measure process?
- During an evaluation, process indicators may need to be modified or new ones adopted. How will this be monitored and/or managed?

### Example activities:

- Review Marmot (2010) *Policy Objective A* for additional examples of process indicators relating to children, young people, and their families.
- Ensure that data and indicators related to process are integrated with policy's outcomes indicators.




# STEP THREE: FOCUS EVALUATION DESIGN



## d Understanding and measuring outputs

Output refers to the products of a policy action's implementation or activities, and is generally measured in terms of activities such as the amount of service delivered, staff hired, systems developed, sessions conducted, materials developed, policies, procedures, and/or legislation created, for example. In relation to policy action areas targeting children, young people, and their families to level-up the gradient, examples of output indicators may include (taken from Marmot, 2010, p.181):

- Growth in services and quality
- Improved parenting skills across the gradient
- Child development milestones
- Social and emotional skills at age six years
- Improved quality standards in early education

Output indicators are important because they tell us how the programme is performing. Useful output indicators need to be relevant to the policy action's activities, feasible to collect, easy to interpret, and ideally enable tracking over time.

### Example questions to think about:

- Have outputs been established to show what tasks or activities are being carried out to achieve the expected objectives/outcomes of the policy action?
- How will be the achievement of outputs be monitored, when and by whom?

### Example activities:

- Ensure that data and indicators related to outputs of the policy's implementation mechanisms (i.e. interventions) are integrated with policy's outcomes indicators.
- Involve stakeholders in defining output indicators and gathering data to assist credibility and acceptance of the evaluation findings.



# STEP THREE: FOCUS EVALUATION DESIGN

*Health outcomes are a change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status…Such a definition emphasises the outcome of planned interventions (as opposed, for example, to incidental exposure to risk), and that outcomes may be for individuals, groups or whole populations.* (WHO, 1998, p.10).

## e Understanding and measuring outcomes

Outcomes need to match the objectives set for the policy action. Once this is clear then appropriate measurements or indicators can be defined. Health outcomes are normally assessed using health indicators and may relate to areas such as behaviours, attitudes, skills, knowledge, values, conditions, or other attributes. In general, outcomes can be considered at three levels:

- Immediate short-term (e.g. programme) impacts
- Intermediate medium-term (modifiable determinants of health) impacts
- Long-term health/social outcomes

For small scale actions it is often only possible to measure the immediate or perhaps intermediate outcomes. It is important therefore to understand how these may influence long-term health and social outcomes (Nutbeam, 1999). Differentiating outcomes in this way means that different indicators may be required to measure health outcomes in the short, medium, and long term.

The following have been suggested as example 'headline' indicators relevant to the gradient amongst children, young people and their families:

- Readiness for school (childhood conditions; Strand *et al.*, 2009)
- Not in education, employment or training (NEET) (Work and working environment; Strand *et al.*, 2009)
- Disability free life expectancy (Marmot, 2010).

### Example questions to think about:

- Some outcomes will be complex and difficult to measure – in these cases select the most relevant and practical ones.
- Often indicators only measure a phenomenon indirectly – this needs to be documented as a limitation in discussion of outcomes.
- Consider the additional complexities involved in evaluating complex community actions – what are the appropriate evaluation approaches?
- What implications does time-span have for evaluation – what about longer-term outcomes which pay occur long after the policy action is completed?
- Relative concentration index - Is often proposed by health economists and used to measure income-related health inequality as it simultaneously captures the socio-economic dimension of inequality, reflects the experiences of the entire population, and is sensitive to changes in the distribution of the population across socio-economic groups.
- Slope and relative index of inequality (SII and RII) - This has been used to summarise socio-economic gradients and is calculated from a regression line drawn through a health measure stratified by a measure of socioeconomic status e.g. social class.

### Example activities:

- Reiew Marmot (2010) *Policy Objective A* for additional examples of outcome indicators relating to children, young people, and their families.
- Involve stakeholders in defining outcome indicators and gathering data to assist credibility and acceptance of the evaluation findings.
- Establish a robust data collection system to underpin your monitoring and evaluation.
- Detail the following: the goals of your policy action; the values underpinning your approach; its immediate objectives; its intermediate objectives.
- Make a list of the relevant indicators to measure the success of your policy action.




# STEP THREE: FOCUS EVALUATION DESIGN



## f Disseminate and feedback

A crucial step in focusing the design of a gradient sensitive evaluation is to consider how any findings will be appropriately disseminated and fed back to relevant stakeholders. Lessons learned in the course of an evaluation do not automatically translate into informed decision-making and appropriate action. Instead, specific focus and effort is needed to ensure that the evaluation processes and findings are used and disseminated appropriately to relevant stakeholders across the social gradient, as well as being fed back into the on-going development and review of the policy action.

Like other aspects of the evaluation, the dissemination strategy should therefore be discussed in advance with intended users and other stakeholders to ensure that the disseminated information needs of relevant audiences will be met.

### Example questions to think about:

- Have you developed an appropriate dissemination plan for how the evaluation findings will be used and communicated to relevant audiences across the social gradient? (see Step 6)
- Who will be responsible for implementing any dissemination plan?
- What methods could be used reach intended target audiences across the social gradient? (e.g. internet, email, printed and electronic reports and publications, reports, workshops, presentations, focus groups, advocacy etc.).
- What do you see as the role of disseminating your findings in relation to your policy action? E.g. to inform stakeholders, to input into policy review, advocacy etc.?
- What procedures will you put in place to ensure continuous feedback can be provided to stakeholders? e.g. with regards interim findings from process evaluation that may affect the take-up of a policy action?

### Example activities:

- Create a dissemination/communications plan differentiating and targeting relevant stakeholders across the social gradient.
- Consult with relevant stakeholders across the social gradient to consider how appropriate communications (e.g. flyers, electronic mailing lists, websites, newsletters, press releases, focus groups, workshops, and presentations) might need to be used, adapted or modified to suit the needs of different audiences/stakeholders. Such consultation may also consider what types of information may be relevant to different stakeholders (e.g. lessons learned, strengths and weaknesses of evaluation methodology, outcomes).




# OVERVIEW
# STEP THREE: FOCUS EVALUATION DESIGN (DIMENSION TWO)

## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Focus Evaluation Design? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

### Key action point 1

**Person responsible:**
**By when:**
**Review date:**

### Key action point 2

**Person responsible:**
**By when:**
**Review date:**

### Key action point 3

**Person responsible:**
**By when:**
**Review date:**

### Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# STEP FOUR: COLLECT RELEVANT DATA





## Produce credible evidence including indicators, quality and quantity of data and data sources

*See also Dimension One (Gradient Sensitive Indicators).*

An evaluation of a policy action should strive to collect information (data or evidence) that will convey a fully-rounded picture that is deemed credible by its stakeholders (Centre for Disease Control [CDC; US], 1999). This is important given that having credible evidence strengthens the conclusions and recommendations that can be drawn from the evaluation and increase the likelihood that actions on such recommendations will ensue. However, the measurement and monitoring of inequalities in health over time and across countries is not a straightforward process since the choice of the measure or indicator will influence the results. Moreover, no consensus has been reached on the best and most meaningful measures, and not all indicators one may wish to use are actually available.

As policy action objectives (including targets and thus by proxy outcomes), need to be able to capture the fact that social inequity in health forms a gradient across society, objectives and milestones must not be based purely on health indicators, but also on the social determinant of health as focusing on the former tends to stimulate narrow downstream actions on health care services. Choices of 'gradient' indicators thus need to be set with a view to enabling sensitivity and measurement of structural drivers of inequalities (relating to policy action's objectives) such as income equity, poverty, inclusion in the work force, and so on. As noted earlier, it is also important that indicators for a policy action are differentiated by process, output and outcome (immediate, intermediate, and long-term); although of course when considering short-term objectives it is often difficult to differentiate between process and outcomes indicators.

Some examples questions to consider, example activities to conduct, and some indicative indicators are outlined below.

# STEP FOUR: COLLECT RELEVANT DATA

## Example questions to think about:

- How will you establish clear needs, priorities and methods for the data collection process? Who will do this and by when?
- What data has already been collected relevant to your policy action?
- How available, accurate, and reliable is this data?
- What format are the data in? What format are the data required to be in?
- Are there routine data collection systems already in place relating to your policy action? (e.g. perhaps from documentary sources, records, diaries, etc.)
- What additional data collection needs to be instigated?
- Can any existing secondary data be used as evidence?
- When does data/evidence need to be collected, by whom (e.g. can practitioners with training incorporate data collection into their role?) and what are the resource implications?
- Which data sources will you use? Examples might include:
  - Routine records of the policy action or other mechanism used in policy implementation
  - National and regional health information systems (when these include health data stratified by socio-economic status and place of residence)
  - Data from health interviews or multi-purpose surveys
  - European Union Statistics on Income and Living Conditions (EU SILC)
  - Multiple Indicator Cluster Survey (UNICEF)
  - Health Behaviour in School-aged Children Survey (HBSC)
  - Long-term monitoring of health inequalities (Scottish Government, 2009)
  - Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010 (Marmot, 2010)
  - The Norwegian Directorate of Health's strategy to reduce social inequalities in health (Norwegian Directorate of Health, 2009)
- During an evaluation, indicators may need to be modified or new ones adopted. How will this be monitored and/or managed particularly when indicators might be influenced by changing conditions that are beyond your policy area and control?

## Example activities:

- Ensure that data and indicators related to process and outputs of the policy's implementation mechanisms (i.e. actions) are integrated with policy's outcomes indicators.
- Involve stakeholders in defining indicators and gathering data to assist credibility and acceptance of the evaluation findings.
- Review Marmot (2010) *Policy Objective A* as an example on how indicators should be established in relation to policy objectives relating to children, young people, and their families.
- Identify whether existing information systems are providing data stratified by socio-economic status; if not, use correlations of individual level data from health information systems with data from other general information sources on the relevant population(s) (e.g. census data); develop composite indicators and perform additional studies or surveys to complement your data base; use multi-purpose surveys and EU reporting systems to identify relevant data for evaluating your policy from the social gradient impact perspective.
- Review and identify both quantitative *and* qualitative indicators but consider selecting those which are more easy to collect, preferably through the policy/programme implementation process or from already established information systems (e.g. health information systems, censuses, multi-purpose surveys, and local and regional databases).
- Provide a framework for the collection (and interpretation) of data, including timeline, periodicity, quality control mechanisms, procedures for collection and analysis.
- Check the amount of evidence gathered for the evaluation – ideally this will be sufficient to detect effects and analyse impact of the policy/programme but with a minimal burden on respondents and/or stakeholders.
- Conduct a training needs analysis of staff likely to be involved in collecting relevant data to identify gaps in knowledge and skills, and set out a timescale and resource plan for subsequent training. Areas you may need to consider might include the number of staff required to collect data, knowledge and skills required, recruitment and selection, and so on.




# STEP FOUR: COLLECT RELEVANT DATA





## Indicative gradient friendly indicators

The indicators chosen must be relevant for the policy and its implementation mechanisms as well as for the stakeholders involved. Here are some examples of upstream, mid-stream and down-stream policies with examples of process, output and outcome indicators that could be used in evaluation (these are only indicative examples adapted from Marmot (2010) and the Norwegian Directorate of Health (2009).

| Universal (upstream; social reform) | | Example of data sources | Stakeholders involved |
|---|---|---|---|
| **Policy objective** | • Provide good quality early years education and child care proportionately across the gradient | N/A | Primary and secondary schools, Parent's Associations, Local authorities, Ministry of Education, Ministry of Health, Regional and Local public health authorities, Civil Society Organisations |
| **Example of Mechanism** | • Early years provision e.g. quantity, reach and quality | N/A | |
| **Process indicators** | • Numbers of children accessing quality early education and childcare by socioeconomic group<br>• Numbers of well qualified staff into the workforce by geographical areas<br>• Number of early years settings with staff with graduate backgrounds by geographical area | Project/programme records<br><br>Routine quality monitoring (e.g. training) | |
| **Output indicator** | • Programmes and interventions developed for under 3 to incorporate greater level of structure play, involvement and participation of families in school's educational programmes | Programme monitoring<br>Project/programme records<br>Routine project/programme monitoring | |
| **Outcome indicator** | • Readiness for school at 5 years (e.g. physical, emotional, behavioural, cognitive) | Research studies | |

| Selective (upstream; social reform) | | Example of data sources | Stakeholders involved |
|---|---|---|---|
| **Policy objective** | • Review and implement systems of taxation benefits, pensions, and tax credits to provide a minimum income for healthy living standards for children and families. | N/A | Ministry of Finances, Economy, Ministry of Health, Ministry of Social Affairs, regional and local authorities, Civil society organisations |
| **Example of Mechanism** | • Give priority to progressive tax and fiscal measures which have proportionately beneficial impact on lower income households. | N/A | |
| **Process indicators** | • Number of regressive taxes. Employment benefits, tax system aligned to meet minimum income for healthy living. | National statistics<br>treasury/fiscal data<br>Income measures | |
| **Output indicator** | • Income ratios reduced. Reductions in numbers of those living below minimum income for healthy living. | Programme monitoring<br>Project/programme records<br>Routine quality monitoring | |
| **Outcome indicator** | • Reduction in adverse health outcomes attributable to living on low incomes. | National statistics<br>Research studies and surveys | |

| Universal (mid-stream; risk-reduction) | | Example of data sources | Stakeholders involved |
|---|---|---|---|
| **Policy objective** | • Improving energy efficiency housing for children and families across the social gradient | N/A | Commercial (e.g. property developers, builders)<br>Housing associations<br>Local authorities<br>Residents including young people,<br>Civil society organisations<br>Ministry of Economy, Energy, Sustainable Development (if available) |
| **Example of Mechanism** | • Active energy management schemes, changes to benefits systems, regulation of utilities, housing improvement programmes | N/A | |
| **Process indicators** | • Fuel prices and affordability based on level of income<br>• Percentage of people with poorly insulated housing<br>• Percentage of population using energy alternatives by geographical area. | National statistics<br>treasury/fiscal data<br>Programme monitoring<br>Project/programme records<br>Routine quality monitoring | |
| **Output indicator** | • Reduced energy usage per household in different socio-economic groups<br>• Affordability of fuel/housing energy for families with lowest income | Research studies and surveys | |
| **Outcome indicator** | • Reduction in adverse (ill) health outcomes attributable to living in fuel poverty | National statistics<br>Research studies and surveys | |

| Selective (mid-stream; risk-reduction) | | Example of data sources | Stakeholders involved |
|---|---|---|---|
| **Policy objective** | • Improving programmes to address the causes of obesity in children and adolescents across the social gradient | N/A | Local authorities<br>Health sector/ministry<br><br>Civil society organisations,<br>Pupil's organisations,<br>School's board<br>Parent's Associations |
| **Example of Mechanism** | • Increasing physical activity at school<br>• Free distribution of fruits and vegetables to school kids aged 6-10 years old | N/A | |
| **Process indicators** | • Percentage of pupils who consume fruit and vegetables daily by SES<br>• Percentage of adolescents who are obese/overweight by parental SES<br>• Physical activity among young people by parental SES | Programme monitoring<br>Project/programme records<br>Routine quality monitoring | |
| **Output indicator** | • Reduction in obesogenic environment and behaviours leading to obesity | Health and behaviour studies and surveys (e.g. HBSC survey) | |
| **Outcome indicator** | • Reduction in levels of obesity and diseases associated with obesity, in children and adolescents across the social gradient | National statistics<br>Health system<br>Research studies and surveys (e.g. HBSC survey) | |

| Universal (down-stream; effect reduction) | | Example of data sources | Stakeholders involved |
|---|---|---|---|
| **Policy objective** | • Prioritise investment in ill-health prevention and health promotion among children and families across the social gradient | N/A | Health sector/ministries<br><br>Retailers<br><br>Food manufacturers<br><br>Tobacco/alcohol industries<br><br>Social Care<br><br>3rd Sector<br><br>Local authority |
| **Example of Mechanism** | • Effort and resources in lifestyle and behavioural interventions (e.g. in schools, nurseries, kindergarten and youth services) are focused on having a progressive impact on the social gradient among children and families | N/A | |
| **Process indicators** | • Number of information, education campaigns targeting different socio-economic groups<br>• Number of people targeted/reached by socio-economic group<br>• Level of knowledge and skills on healthy living acquired by socioeconomic group | National statistics<br>Health system<br>Research studies and surveys (e.g. HBSC survey) | |
| **Output indicator** | • Improvement in indicators related to healthy living behaviours across the social gradient<br>• Increased number of people actively involved in specific disease prevention and health promotion programmes by socio-economic groups | National statistics<br>Health system<br>Research studies and surveys (e.g. HBSC survey) | |
| **Outcome indicator** | • Improved disease specific outcomes (incidence, prevalence, mortality) | National statistics<br>Health system<br>Research studies/surveys (e.g. HBSC survey) | |

| Selective (down-stream; effect reduction) | | Example of data sources | Stakeholders involved |
|---|---|---|---|
| **Policy objective** | • Reduce social inequalities in smoking and alcohol use amongst children, young people, and families across the social gradient | N/A | Children, young people, and families<br>Education sector (e.g. schools. teachers)<br>Health sector/ministries<br>Local authority<br>Parents including parenting associations |
| **Example of Mechanism** | • Focused public health and health promotion interventions such as smoking cessation programmes and alcohol reduction on children, young people, and families .targeting differently socioeconomic groups | N/A | |
| **Process indicators** | • Scale, number, and intensity of evidence-based prevention programmes<br>• Number of people included in the programme by socioeconomic group | Programme monitoring | |
| **Output indicator** | • Reduced smoking in children, young people, and families across the social gradient.<br>• Reduced exposure to tobacco smoke for young people and families across the social gradient. | National statistics<br>Health system<br>Research studies and surveys (e.g. HBSC survey) | |
| **Outcome indicator** | • Improved disease specific outcomes e.g. linked with tobacco and alcohol (incidence, prevalence, mortality) | National statistics<br>Health system<br>Research studies and surveys (e.g. HBSC survey) | |



# OVERVIEW
# STEP FOUR: COLLECT RELEVANT DATA (DIMENSION TWO)

Tackling the GRADIENT in health

## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Collect Relevant Data? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

### Key action point 1

**Person responsible:**
**By when:**
**Review date:**

### Key action point 2

**Person responsible:**
**By when:**
**Review date:**

### Key action point 3

**Person responsible:**
**By when:**
**Review date:**

### Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# STEP FIVE: ANALYSE, INTERPRET, AND SYNTHESISE DATA

Analysis, interpretation, and synthesis of data is often a simultaneous and iterative process i.e. data analysis is conducting alongside data collection meaning early findings can help to inform and guide more accurate (and useful) data collection. Data analysis involves identifying and summarising the key findings, themes and information contained in the collected data. Deciphering 'facts' from a body of evidence involves deciding how to organise, classify, interrelate, compare, and display information (CDC, 1999). These decisions are (amongst other things) guided by the evaluation design and epistemological and ontological positions adopted, the questions being asked, the types of data available, and by input from stakeholders and primary users. The analytical and interpretive process is an important one as it allows the identification of outputs, processes, and outcomes. Moreover, data analysis and interpretation can be used to lead to informed judgements and the development of subsequent recommendations for action or consideration regarding the particular policy action in question.

Qualitative data requires a different type of analysis from that needed to analyse quantitative data. Furthermore, mixed-method evaluations require the separate analysis of each evidence element followed by a synthesis of all sources (triangulation) for examining patterns of agreement, convergence, or complexity. It is beyond the scope of GEF to outline in detail the different methods of data analysis, interpretation, and synthesis but some resources for doing this are outlined below under 'example activities'.

## Example questions to think about:

- What kinds of analyses will be required based on the data collected or generated?
- Who will analyse and interpret the data? What skills does your team have and which are missing? What training needs are there?
- How will you know whether the policy action has been successful compared with its objectives? What data is available to support this?
- How will you know if the policy action been delivered as planned?
- What data will help you demonstrate whether stakeholders across the social gradient have been involved appropriately in the policy action?
- What are the findings of the evaluation? What do they mean and for whom?
- Has the policy action been influenced by its setting and context? How will you know or demonstrate this?
- Has the policy action reached its intended target groups?
- Have the outcome data been compared with the evaluation base-line?
- Were there any unexpected outcomes of the policy action?
- Have the trends in the wider (comparison) area(s) been examined?
- What worked well and why, and under what circumstances?
- What has not worked well and why, and under what circumstances? (see Pawson & Tilley, 1997)
- What knowledge could be transferrable to other policy actions?
- What recommendations can be made for policy action improvement? (e.g. what, if anything could or should be done?)

## Example activities:

- Useful sources for assistance with data analysis include the following: Dey (1993); Judd and McClelland (1989); Mason (2002); Miles and Huberman (1994); Miller and Brewer (2003); Silverman (2001).
- Map out a projected timeline for data analysis and interpretation. Include areas such as training, the sequence of stages of critical reflection necessary, data cleaning, help networks, reliability and validity checks, etc.
- Conduct a training needs analysis of staff likely to be involved in data analysis and interpretation to identify gaps in knowledge and skills, and set out a timescale and resource plan for subsequent training.



# OVERVIEW
# STEP FIVE: ANALYSE, INTERPRET, AND SYNTHESISE DATA (DIMENSION TWO)

Tackling the GRADIENT in health

## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Analyse, Interpret, and Synthesise Data? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families?

### Key action point 1

**Person responsible:**
**By when:**
**Review date:**

### Key action point 2

**Person responsible:**
**By when:**
**Review date:**

### Key action point 3

**Person responsible:**
**By when:**
**Review date:**

### Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# STEP SIX: DISSEMINATE AND FEEDBACK

## Communicating lessons learned

As stated earlier, lessons learned in the course of an evaluation do not automatically translate into informed decision-making and appropriate action. Focus and effort is therefore needed to ensure that findings are used and disseminated appropriately to relevant stakeholders across the social gradient, as well as being fed back into the on-going development and review of the policy action.

### Example questions to think about:

- How will you ensure that findings of the evaluation are disseminated to relevant stakeholders across the social gradient? How will you know if this has been done?
- How will evaluation findings feedback into the design of the policy action? What kinds of information will need to be communicated and to whom?
- How will findings be communicated at different geographic levels e.g. local, national, European? What local, national, European networks and/or partnerships are available to facilitate this?
- What facilitating or inhibiting factors may impact on effective and timely dissemination of evaluation findings?
- How might your dissemination activities raise the profile for actions to level-up the gradient among children, young people, and their families?

### Example activities:

- Revisit and update your dissemination/communications plan as necessary.
- Consider a variety of very different communication techniques to reach different stakeholders across the social gradient such as short reports, flyers, workshops, topical articles in the 'trades press', journal articles, feedback seminars and so on.
- Disseminate both procedures/processes used as well as outcomes from evaluation activities to relevant stakeholders across the gradient tailored to meet their needs.
- Consider putting together practical examples of how aspects of your evaluation findings can influence practice.




# OVERVIEW
# STEP SIX: DISSEMINATE AND FEEDBACK (DIMENSION TWO)

Tackling the GRADIENT in health



## General Comments

## Key Action Points

What key areas for action have arisen from completing this self-assessment relating to Disseminate and Feedback? What needs to be done to increase the potential of your policy action to impact on the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families??

### Key action point 1

**Person responsible:**
**By when:**
**Review date:**

### Key action point 2

**Person responsible:**
**By when:**
**Review date:**

### Key action point 3

**Person responsible:**
**By when:**
**Review date:**

### Key action point 4

**Person responsible:**
**By when:**
**Review date:**




# THE GRADIENT EQUITY LENS (DIMENSION TWO) OVERVIEW SHEET

This **overview sheet** will help you to gain a snapshot of the overall position in terms of progress towards completion of all six key steps of Dimension Two. Space is also provided to summarise overall comments and action points arising.

| Gradient Equity Lens: Dimension Two | Completed (tick) Yes | Partial | No | N/A | Comments | Action Points (including by when and by whom) |
|---|---|---|---|---|---|---|
| **Step One:** Describe the policy and its related action(s) | ○ | ○ | ○ | ○ | | |
| **Step Two:** Engage stakeholders | ○ | ○ | ○ | ○ | | |
| **Step Three:** Focus evaluation design | ○ | ○ | ○ | ○ | | |
| **Step Four:** Collect relevant data | ○ | ○ | ○ | ○ | | |
| **Step Five:** Analyse and interpret data | ○ | ○ | ○ | ○ | | |
| **Step Six:** Disseminate and feedback | ○ | ○ | ○ | ○ | | |

# SECTION FOUR
# RESOURCES



Tackling the GRADIENT in health

# 4.1 CASE EXAMPLE: A HEALTH PROMOTION STRATEGY AND ACTION PLAN FOR TACKLING HEALTH INEQUALITIES IN THE POMURJE REGION OF SLOVENIA

| | |
|---|---|
| COUNTRY | Slovenia |
| CONTACT PERSON | Dr Tatjana Krajnc-Nikolić |
| IS THE POLICY UNDER DEVELOPMENT OR BEING IMPLEMENTED? | Implemented |
| NAME OF POLICY | Health promotion strategy and action plan for tackling health inequalities in Pomurje region |
| NATIONAL OR REGIONAL LEVEL | Regional |

## DESCRIPTION OF THE POLICY

Pomurje is the most deprived region in Slovenia. In 2001, a team of local public health experts identified the main health problems and developed a culturally adjusted community based programme of health promotion for adults called "Let's live healthily". This programme constituted the main part of a wider approach of investment in health in the region called "programme Mura". In 2005, a strategic plan for reducing health inequalities in the region was developed as a result of bilateral project cooperation between the Institute of Public Health Murska Sobota (IPHMS) and the Flemish Institute for Health Promotion (VIG). This plan is aimed at the reduction of health inequalities in the region between vulnerable groups and between Pomurje and other regions of Slovenia. Five priority objectives were identified, along with appropriate strategies required to implement them. The strategic plan uses health promotion as a means to improve the health of the population, and to raise awareness of health in other sectors and policies on a regional level.

The main aims of the policy are: 1) To raise the profile of the need to reduce health inequalities among communities and individuals; 2) To increase community capacity; 3) To reduce inter-regional inequalities through health promotion; 4) To reduce intra-regional inequalities by supporting the most vulnerable groups; and 5) To facilitate a health promoting environment. Specific objectives, activities and indicators have been defined for each aim.

The policy essentially adopts a downstream approach by targeting the behaviour of individuals and their communities regarding lifestyle (e.g. nutrition, physical activity, utilisation of health services, etc.) and raising awareness and motivation for change. The strategy foresees the engagement of public health experts in order to raise awareness of regional politicians and stakeholders about health and the causes of health inequalities in order to create 'health friendly' policies and actions. Aims 3 and 4 are aimed at facilitating changes in the lifestyle of particular target groups (e.g. adults, ethnic minorities (Roma), and pregnant women). Arguably the policy also adopts a midstream approach given the strategy aims to increase community capacity in the field of decision making regarding health promoting actions to support a health promoting environment.

# **CASE EXAMPLE:** THE GRADIENT EQUITY LENS (DIMENSION ONE) OVERVIEW

This **Gradient Equity Lens overview sheet** is to help you gain a snapshot of the overall position of your policy action in terms of its 'gradient friendliness' i.e. its likely potential to impact on levelling-up the gradient in health and its social determinants among children, young people and their families. Simply tick **red, amber**, or **green** as applicable, noting any major action points or comments as required.

| Gradient Equity Lens: Dimension One |  | Comments | Action Points (including by when and by whom) |
|---|---|---|---|
| **Proportionate universalism** | ○ ✓ ○ | The strategy is planned for long-term implementation; and has been adopted into the regional development programme 2007-2013. The policy is a proportionate in a sense in that vulnerable groups are covered with specific objectives; and in a sense universal: priority health problems such as lifestyle are covered in specific objectives targeting adults in local communities. | Implementation - The coordinator and main carrier of activities is the Institute of Public Health Murska Sobota (IPHMS). |
| **Intersectoral tools for all** | ○ ○ ✓ | Available data on examples of good practices have been used in preparation and implementation of strategic documents on regional level from Australia, Europe, Canada and the USA; using available evidence and experience. During the last 6 years a step-by-step approach to building a partnership network including stakeholders from different sectors has been adopted. | On-going partnership working with stakeholders from different sectors. Action by IPHMS. |
| **A whole systems approach** | ○ ○ ✓ | Structure: the strategic document is sensitive to the socio-environmental context, respecting the existing political and welfare system. Reducing health inequities of children and young people is one of the specific objectives; health equity is indirectly involved in other sector policies, what has been connected with objectives of the document<br>There are two programmes and many serials of meaningfully connected activities, which have been implemented each year, some longer than 6 years. All programmes, project and activities are adjusted to the culture, target group and available resources and based on available evidence and empirical experience. The actions have been planned for particular vulnerable target groups, including the most vulnerable ones and for general population. Success is evaluated on a yearly basis for process and structure targets and after 5-10 years on achieved outcomes. | On-going partnership working with stakeholders from different sectors. Action by IPHMS. |

# CASE EXAMPLE: THE GRADIENT EQUITY LENS (DIMENSION ONE) OVERVIEW

| Gradient Equity Lens: Dimension One |  | Comments | Action Points (including by when and by whom) |
|---|---|---|---|
| **Scale and intensity** | ○ ✓ ○ | Resources for evaluation have not been specified. Human resources have not been explicitly specified for evaluation nor for developing and implementing activities. There are planned financial resources for capacity building on yearly basis aimed at public health in general. | There are human and financial resources, which could be aimed at evaluation, but there are no acceptable opportunities for education in evaluation of health promotion/public health within the country. Action by IPHMS is required to lobby for financing of appropriately scaled evaluation activities. |
| **Life-course approach** | ○ ✓ ○ | The policy is based on life-course approach, particularly targeting pregnant women, pre-school and school children, young people and adults. | Continuation of activities developed by IPHMS, performed with cooperation with local schools, kindergartens, NGO's etc. |
| **Social and wider determinants of health inequalities** | ✓ ○ ○ | The strategy targets some of social and wider determinants by means of health promotion at regional level. | N/A |
| **Non-geographic boundaries** | ○ ✓ ○ | Originally the strategy was developed for the Pomurje region of Slovenia, but the process of implementing a bottom-up approach has been spread to the rest of Slovenia. So now each Slovenian region has its own dedicated strategy. However, all document has some common goals and some which are regionally specific. | N/A |
| **Gradient friendly indicators** | ✓ ○ ○ | No gradient friendly indicators are available. Because of insufficient data on socio-economic stratification and health problems, mainly process and output indicators have been chosen in order to measure the realisation of activities. | Development of appropriate 'gradient sensitive' indicators by IPHMS.<br>Identification of stratifiers<br>Identification of (existing) suitable data sets. |

# 4.2 GLOSSARY

**Baseline**
The situation at the start of a policy action before any part of the action has been carried out. The information that helps to define the nature and extent of the problem.

**Decision maker**
See policy-maker.

**Determinants of health**
Determinants of health are factors which influence health status and determine health differentials or health inequalities. They are many and varied and include, for example, natural, biological factors, such as age, gender and ethnicity; behaviour and lifestyles, such as smoking, alcohol consumption, diet and physical exercise; the physical and social environment, including housing quality, the workplace and the wider urban and rural environment; and access to health care. (Lalonde, 1974; Labonté 1993) All of these are closely interlinked and differentials in their distribution lead to health inequalities.

**Effectiveness**
The measure of an ability of an action, programme, intervention, project, and/or policy to do what it was intended to do: produce a desired result or effect that can be quantitatively measured (from the European Observatory on Health Systems and Policies Glossary).

**Evaluation**
An assessment of the extent to which public health/health promotion actions achieve a particularly valued or desired outcome. However, in many cases it is difficult to trace the pathway which links particular action to health outcomes (e.g. because of the technical difficulties of isolating cause and effect in complex, 'real-life' situations). Indeed, "...good evaluation does not necessarily provide definitive answers – instead they reduce uncertainty about the consequences of a choice" (Leviton, 2010). Evaluations inform a body of evidence that over time helps to frame the issues and sharpen the focus on how we think about the net benefits for health, quality of life and other ingredients of happiness. Evaluation is thus inherently political and context specific.

**Evaluation framework**
In GEF an evaluation framework is seen as a coherent mechanism for the evaluation of all aspects of a policy and/or its relation action, programme, intervention, or project. An evaluation framework may comprise a series of relevant questions, as well as indicators, data sources, and specific methods for collecting evaluation data.

**Evidence**
Knowledge from a variety of sources including qualitative and quantitative research, programme evaluations, client values and preferences, and professional experience (Scott & Gall, 2006).

**Health**
Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living and is a positive concept emphasising social and personal resources as well as physical capacities (WHO, 1998).

### Health Equity Audit/Assessment
Health equity audits (HEAs) or assessments identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and the priority action to provide services relative to need.

### Health Equity/Equity in Health
Equity is the absence of unfair, avoidable differences among groups of people whether these groups are defined socially, economically, geographically or demographically (WHO, 2009). Health equity/equity in health means that everyone should have a fair opportunity to attain their full health potential, and no one should be disadvantaged from achieving their potential (WHO 2009). Health equity is the absence of health inequalities (Ministry of Health and Social Policy of Spain, 2010).

### Health Impact Assessment (HIA)
HIA is an approach that ensures decision-making at all levels considers the potential impacts of decisions on health and health inequalities, and the distribution of those impacts within a population. It identifies actions that can enhance positive effects and reduce or eliminate negative effects.

### Health Inequalities
Health inequalities are differences in health status or in the distribution of health determinants between different population groups. Inequality can apply to any variation but inequity is applied to variations which are deemed to be unjust and preventable; in other words it has a moral or ethical dimension. For the purposes of the Gradient framework we use the term inequalities and we take it as synonymous with inequity.

### Health promotion
The comprehensive social and political process of enabling people to increase control over and improve their health through actions aimed at strengthening individual awareness and skill; changing individual behaviour; and changing social, organisational, political, and economic conditions that support good health practices (WHO, 1986).

### Healthy public policy
Is characterised by an explicit concern for health and equity in all areas of policy, and by an accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing (WHO, 1998, p.13-14).

### Intersectoral collaboration
The factors that influence health inequalities extend far beyond the responsibilities of the health sector. The intersectoral collaboration is a recognised relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone (WHO, 1998).

### Life-course approach
The life-course approach, also known as a life-course perspective or life course theory, refers to an approach developed for analysing people's lives within structural, social, and cultural contexts. A life course is defined as 'a sequence of socially defined events and roles that the

individual enacts over time'. In particular, the approach focuses on the connection between individuals and the historical and socioeconomic context in which these individuals lived (Mortimer & Shanahan, 2003).

### Milestones

Key points during the life of a policy action. They are decided at the planning stage and can be time-based or event-based (Swanton, 2008)

### Monitoring

The process of continually assessing whether or not particular (policy) actions are achieving or have achieved their objectives. Monitoring is also used to check whether the processes being used are working effectively. Monitoring is carried out throughout the life of a (policy) action, while evaluation is only carried out at specific points in time (Adapted from Swanton, 2008).

### Output

A piece of work produced for a (policy) action. An output is not necessarily the final purpose …outputs are usually things that need to be done in order to produce the desired result. During the life of a policy action, outputs are monitored to make sure they are being achieved on time and with the resources available (Adapted from Swanton, 2008).

### Outcomes

Nutbeam and Bauman (2006) define three levels of outcomes - immediate (short-term) outcomes (e.g. programme impacts), intermediate outcomes (modifiable determinants of health) and desired long-term health and social outcomes (reductions in morbidity, avoidable mortality and disability, improved quality of life, for example).

### Policy

A policy can be defined as an agreement or consensus on a range of issues, goals and objectives which need to be addressed (Ritsatakis, Barnes, Dekker, Harrington, Kokko & Makara, 2000). For example, "Saving Lives: Our Healthier Nation" can be seen as a national health policy aimed at improving the health of the population of England, reducing health inequalities and setting objectives and targets which can be used to monitor progress towards the policy's overall goal or aims (WHO, 2011)

### Policy action

We use the term 'policy action(s)' to recognise that any policy has to be operationalised through specific actions which may include programmes, projects, and activities that bring about identifiable outcomes.

### Policy-maker/Decision-maker

A person with formal power to influence or determine policies and practices at European, international, national, regional, or local level. In GEF, we use 'policy-makers' as a generic term to refer to both policy formulators or decision makers (e.g. Ministers of Health) and their policy evaluators or senior technical advisors (e.g. civil servants, external experts etc.).

### Programme

The term programme usually refers to a group of activities which are designed to be implemented in order to reach policy objectives (Ritsatakis *et al.*, 2000). For example, many Single Regeneration Budget programmes and New Deal for Communities initiatives have a range of themes within their programmes – often including health, community safety (crime), education, employment and housing – and within these themes are a number of specific projects which, together, make up the overall programme (WHO, 2011).

### Project

A project is usually a discrete piece of work addressing a specific population group or health determinant, usually with a pre-set time limit (WHO, 2011)

### Proportionate universalism

The term "progressive (or proportionate) universalism" is based on the principle whereby 'the scale and intensity of provision of universal services is proportionate to the level of disadvantage' (Marmot, 2010). Socio-economic advantage is linked to better health across all social economic groups not just a dichotomy between the richest and poorest. Therefore targeted approaches do not provide the complete answer. Policy actions must be universal but with a different scale of intensity to reduce the steepness of the social gradient in health.

### Socioeconomic Gradient in Health

Refers to the linear or step-wise decrease in health that comes with decreasing social position (Marmot, 2004). It represents the association between socioeconomic position and health across the whole population. In whatever way health is measured, there tends to be a gradient on which the most socially and economically advantaged group have better health and well-being, and lower rates of illness and death than disadvantaged groups. In western societies, the shape of the gradient tends to be relatively smooth with mortality and morbidity increasing, and self-reported health and well-being decreasing steadily as social disadvantage increases. Over time, the gradient as a whole tends to shift upwards because overall the health of most groups is improving. However, the degree and rate of improvement tend to be greater in higher social groupings, meaning that relative differences, and therefore the degree of inequities and inequalities, also tend to increase.

### Socio-economic group

A grouping of people with similar values, interests, income, education, and occupations (Mosby's Medical Dictionary 2009).

### Socioeconomic Status (SES)

Socio-economic status (SES) describes an individual or family's relative position in society. This relative position is operationally defined by indicators such as educational attainment, occupation, income and house or car ownership. These variables are therefore considered to provide a good indication of the likelihood that they will be exposed to health damaging factors or possess particular health enhancing resources. Differences in socioeconomic status reflect differences in:

- Economic resources (income, house holding)
- Psychosocial resources (self-efficacy, social capital)
- Cultural resources (cultural capital, educational differentiation)
- Demographic resources (migration, ethnic groups)
- Geographic resources (district variations, urban and rural areas).

### Strategy

The term strategy usually refers to a series of broad lines of action intended to achieve a set of goals and targets set out within a policy or programme (Ritsatakis *et al.*, 2000). For example, within the themes of Single Regeneration Budget or New Deal for Communities initiatives it is usual to set out the strategic direction needed to be taken in order to achieve the goals and objectives of each theme, such as reducing unemployment, improving health or raising educational attainment (WHO, 2011).

### 'Tackling' or 'levelling-up' the Gradient?

The term 'tackling the gradient' is often used in the academic literature and in doing so conflates or 'fudges' the distinction between levelling-up the gradient and reducing health inequalities (i.e. reducing health gaps and reducing disadvantage). Consequently, we prefer to use term 'levelling-up' the gradient rather than 'tackling' or 'reducing health inequalities' in order to be clearer about intention.

### Targeted Policy Approach (see also: Universal Policy Approach)

The targeted program strategy identifies a target population segment and monitors the outcomes being attained as the program develops. This strategy is extensively used and may well be aligned with other social programs. However, it has limitations, since its beneficiaries are a subgroup accounting for only a small percentage of the population and its specific problems. In other words, it may not help reduce inequity because it neither integrates action on other structural or intermediary factors nor is it targeted to other social groups (WHO, 2009).

### Universal Policy Approach (see also: Targeted Policy Approach)

Universal approaches, which produce overall health improvement, involves comprehensive efforts intended to impact on the health of the entire population, including groups in different social strata. Some examples are actions against violence and traffic accidents, the improvement of work conditions and areas (smoking), or the fight to improve environmental conditions. In general, universal interventions tend to be both easier to implement and more cost effective than targeted programs in the long run (WHO, 2009).

# 4.3 REFERENCES


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# NOTES

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