



A discussion tool to take better account of social inequalities in health

Presentation document



Centre intégré
de santé et de
services sociaux de
la Montérégie-Centre



Direction de santé publique

The RÉFLEX-ISS discussion tool to take better account of social inequalities in health is a prime example of what can be achieved through partnership between university researchers, professionals from a public health department, and front-line health professionals. We would like to thank the Direction de santé publique de la Montérégie, which was closely involved throughout the course of this project and made its funding possible. We also thank all the partners, consultants, and participants for their invaluable contributions to the study on conditions for promoting the use of this tool.

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ACKNOWLEDGEMENTS

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Recommended reference:

GUICHARD, A., RIDDE, V., NOUR, K. et LAFONTAINE, G. (2015). *RÉFLEX-ISS - Outil de réflexion pour mieux prendre en considération les inégalités sociales de santé*. Longueuil: CISSS de la Montérégie-Centre, Direction de santé publique de la Montérégie.

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Bibliothèque nationale du Québec

Library and Archives Canada

ISBN: (printed version) **978-2-89342-696-9**

ISBN: (PDF version) **978-2-89342-697-6**

November 2015

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PREAMBLE

A short history

In 2010 in France, Anne Guichard, from the Institut national de prévention et d'éducation à la santé (INPES) and Valéry Ridde, from the Université de Montréal, disseminated an initial version of the RÉFLEX-ISS tool for intervention workers wishing to pay particular attention to how their actions took into account social inequalities in health. The grid's construction can be reviewed on pages 297–312 of the INPES publication *Réduire les inégalités sociales en santé*.^a The tool, which was developed from three existing grids in the domain of health promotion (*Closing the gap*, *Preffi*, and *Canadian Consortium*), laid a foundation for reflexive analysis of interventions aimed at reducing, or at least not aggravating, social inequalities in health. This experimental grid was intended to stimulate discussion and to support project leaders tally the strengths and weaknesses of their approach, thereby helping them to improve their actions and increase their potential for reducing SIH. Initially designed as part of a research project, it was soon evident that the tool met a strong need among actors on the ground who felt somewhat ill-equipped to take on the complexities of actions to fight against SIH. Two ideas grew out of the tool's potential: the first, to test the tool at a larger scale to strengthen its external validity, the second, to make it available to a wider pool of public health professionals. In Québec, these ideas, combined with a willingness on the part of the Direction de santé publique de la Montérégie to take SIH into account in all of its public health actions, led to a collaborative project to adapt the tool to the realities of the practices, context, and organizational particularities of the Québec healthcare system.

RÉFLEX-ISS: the result of a collaborative process

The adapted tool is, and has been from the outset, the product of a close collaboration between the research, planning and intervention communities. It was based on the results of a study aiming at understanding users' perspectives on the conditions for use of the tool, in the context of the Direction de santé publique and of the Montérégie CSSS. By means of conceptual mapping and several group discussions bringing together a wide range of actors from the local and regional levels, the conditions necessary for using the tool in the Montérégie context were identified. These results were then refined through discussions with the steering committee of the Direction de la santé publique, consultation with different groups of local and regional actors on the grid's contents, and analysis of various local and regional projects at various stages of the process. The final step in the grid adaption was a review of the wording of items to ensure they were clear.

a. Guichard, A., & Ridde, V. (2010). Une grille d'analyse des actions pour lutter contre les inégalités sociales de santé. In *Réduire les inégalités sociales en santé*. Edited by Louise Potvin, Marie-José Moquet, and Catherine M. Jones. Saint-Denis: Inpes, 297–312. (<http://www.inpes.sante.fr/CFESBases/catalogue/pdf/1333.pdf>)

PRESENTATION OF THE RÉFLEX-ISS TOOL

RÉFLEX-ISS is a tool for analyzing how social inequalities in health are taken into account in public health interventions (The pdf interactive grid – REFLEX-ISS Tool can be downloaded from the website : <http://www.equitesante.org/chair-realisme/tools/reflex-iss/>). At its core is a grid divided according to four well-established stages of a project's development, namely planning, implementation, evaluation, and sustainability. An additional fifth stage has been included, which is empowerment. Indeed, empowerment is viewed as an intermediary result (or stage) that is needed to achieve the objective of reducing social inequalities in health and is an expected outcome of health promotion interventions.¹

These five stages are made up of 44 discussion elements presented in the form of questions listing the foundations that are deemed important to successfully carry out actions in the domain of social inequalities in health. For each discussion element within a stage, the team has to assess to what degree the element has been considered or addressed, on a 5-point scale. In addition to the rating scale, space has been provided to indicate the reasoning supporting the rating and to note any elements of context and specifics of measures undertaken. At the end of the review for each stage, there is a section set aside for recording the assessment and indicating any possible improvements.

Because interventions are dependent on context,² the tool's strength lies in how it accounts for context and its relationship to the intervention's action processes. The tool focuses on the inextricable links between context, intervention processes, and observed effects. It views complex public health interventions as being closely linked, and dependent on, the elements – political, historical, social, spatial, cultural, organizational – of the context in which it is taking place. From such a perspective there can be no such thing as a 'one-size-fits-all' type of intervention. It is because such interventions are in constant interaction with their implementation contexts that one must consider the implications of these interactions in terms of the action's acceptability, effectiveness, and sustainability. Thus when analyzing a health intervention's effects on a group of individuals, we must consider that the observed effects depend on significant contextual factors that often extend far beyond just individuals' interactions with the services provided.

At the end of the grid is a section for recording an overall assessment of the project and suggesting courses for improvement to be sustained or undertaken.

Two glossaries have been produced to assist tool users. The first, included directly at the end of the analysis grid, introduces key terms to facilitate filling out the grid. The second, which is more complete, is in the last section of this document, along with a list of references on the subject of social inequalities in health. Finally, two examples of using the grid are also available.

¹ Ridde, V., Delormier, T., & Gaudreau. L. (2007). Evaluation of Empowerment and Effectiveness: Universal Concepts? In *Global Perspectives on Health Promotion Effectiveness*. Edited by David McQueen & Catherine M. Jones. New York: Springer, 389-403.

² Blaise, P., Marchal, B., Lefèvre, P. & Kegels, G. (2010). Au-delà des méthodes expérimentales : l'approche réaliste en évaluation. In *Réduire les inégalités sociales en santé*. Edited by Louise Potvin, Marie-José Moquet & Catherine M. Jones. Saint-Denis: INPES, 285-296.

FOR WHOM IS THE RÉFLEX-ISS TOOL INTENDED?

This tool is intended for all actors (managers, professionals, volunteers, elected officials, etc.) involved in planning, implementing, or evaluating projects/programs/interventions³ designed with population health improvement and health equity in mind.

In particular, RÉFLEX-ISS can be useful for those planning public health projects, e.g. prevention or health promotion projects, in collaboration with intersectoral partners. It is the persons, groups, and communities who will be the recipients of the interventions and with whom you will be working in partnership who will benefit the most from efforts to take better account of social inequalities in health.

Examples

- ⌚ Work teams who are putting together an action plan in collaboration with several partners, such as school boards in a territory or standing intersectoral collaboration round tables.
- ⌚ Managers of health professionals in an integrated health and social services network in a rural setting, whose mission is to support community development in coordination with municipalities on the territory.

"Certain sections will seem more relevant to you, depending on where you are at"

WHY AND UNDER WHAT CIRCUMSTANCES SHOULD THE RÉFLEX-ISS TOOL BE USED?

Note: Quotes excerpted from the discussions groups that took place during the study on conditions for use and feasibility of the tool are used to convey the thoughts and opinions of people on the ground.

There is no 'right' time or 'right' number of sessions to sit down together and use the tool. It can be used for one session or several, according to your needs. You can use it at various stages of a project: when conducting a joint planning exercise, adjusting an existing plan/intervention, implementing a project, evaluating its appropriateness, or taking the steps required to make it sustainable.

"We had nothing to rely on, no strong arguments. With this, we get evidence"

"The tool is useful for improving and enhancing projects"

"This will help us act differently"

"To bring a fresh perspective to the intervention »"

³ The terms "project" and "intervention", and sometimes also "program" or "plan", are used interchangeably to describe the action being carried out by your team, even though they may represent different scales. Whether you describe your action as a project or as an intervention, the tool is equally useful!

It can be used to support a discussion on how to support collaboration and empowerment processes related to the project. It is very useful in preparing to advocate with partners to get actors and settings engaged in the fight against SIH. You can also use it to raise awareness among the media and decision-makers. At a more basic level, you can use it as a memory aid, to identify practical steps that your team can take to improve its actions with regard to SIH!

Although the presentation is linear, in the form of questions, which might suggest a top-down, directive, or normative approach, the tool is above all an

invitation for project stakeholders to discuss and reflect among themselves.

"I am just going to be inspired, this will be a tool that will help me move a project forward"

"Everyone must do their part to get us there"

"It should not be a concern just within our organizations, it should be a concern elsewhere, in fact it should form a backdrop"

the project, for example, you can go straight to section 2 of the tool, "Implementation". Whatever you choose, we remind you that is important, from the outset, to **consider evaluation checkpoints at all stages of your project**, to ensure key elements are taken into account and not left out. For each question in this section, you are asked to situate yourselves based on the five choices that illustrate different possible levels of progress in considering and addressing the element.

In the column on the far right of the grid, you can indicate the reasoning behind your assessment of the level achieved and note any elements of the context and specific measures undertaken, as applicable. Finally, at the end of each section, a space is provided to record your assessment and possible improvements to be considered. This is where the reflexive approach is key and enables you to keep track of your discussions and analyses. In this way, you can come back to them periodically, to review progress with your team and look together at decisions or actions needed to strengthen how social inequalities in health are taken into account.

"I see it as a memory aid tool so we can say: let's make sure we are doing what we can to help reduce social inequalities, and let's think about it"

"It also becomes something we can rely to defend our ideas"

HOW TO FILL OUT THE RÉFLEX-ISS TOOL?

A few recommendations before starting

First of all, to encourage reflexive thought and dialogue, it is recommended that you:

- 1) Involve as many project team members and stakeholders as possible in this exercise, especially persons representing the target subgroups...to see, decide, and act together!
- 2) Take steps to have a third-party facilitator support your discussions.
 - ⇒ The tool was developed to be used during an in-depth discussion, led by someone who has a good knowledge of social determinants of health and of social inequalities in health. Therefore, you are encouraged to seek out such a person in your professional environment, your networks, your region, etc. and to solicit their support.
 - ⇒ If no facilitator is available, you are encouraged to read more about the issue of social inequalities in health, starting with the glossary and the list of references provided at the end of this document.
- 3) Resist temptations to simplify, which can undermine the process supported by the tool.
 - ⇒ For optimal consideration of SIH, it is recommended that you use the entire tool, with facilitation/training by an external expert resource.
 - ⇒ It is not a matter of using the tool for normative purposes, to assign a grade, or good or bad marks. You should use it to support your discussions and exchanges, and to make decisions on action.

Instructions for filling out the sections

You are then asked to assess the discussion elements in the section you have chosen to complete, using a five-point scale. It is important to remember that the rating first and foremost represents the outcome of a team agreement based on your intimate acquaintance with the situation. Here is a more detailed description of the meanings of the five different levels within which your project's level of progress with regard to SIH can be situated.

The status of the discussion element regarding taking into account social inequalities in health (SIH) is...

(0) “Not considered”: means that the element has not been considered in the intervention, or that the team is not able to express its position with respect to this question. A discussion should be held!

(1) “Discussion initiated”: means that the element has been discussed briefly and the thought process is still in an early stage. There is more work to be done!

(2) “Concrete measures proposed”: indicates that the element has been discussed at length within the team, that concrete proposals are being reviewed, but that they now have to be carried out. It is now time to work on achieving concrete measures!

(3) “Concrete measures undertaken”: means that several concrete actions have been undertaken, but they are not yet sufficient to fulfill your action's full potential for reducing SIH. You are on the right path, only a bit more effort is needed!

(4) “Element accounted for”: means that the element has been significantly taken into account in the actions implemented. Now you need to sustain what has been achieved!

Instructions for completing the section “Reasoning, measures undertaken, and contextual elements”

The last column of the grid is intended for elements that arose from your team discussion and that support the rating level on which you agreed. This is where you can describe elements of the context (political, social, organizational, cultural, individual, community-related, financial, etc.), documents and data on which you relied to make the assessment (or not, in cases where data may not have been available), actions undertaken, or discussions that may have taken place within your team. We also encourage you to note in this section any questions left unanswered while reviewing the discussion element. Thus, there is no ‘right way’ to fill out this section, nor any right or wrong answers. Its contents should serve as a useful working tool to keep track of the project’s progress and to facilitate follow-up later on.

Instructions for completing the section “Overall evaluation, stage assessment, and suggested improvements”

At the end of your review of each stage, there is section dedicated to recording the overall evaluation, to provide a summary of the assessment for that stage, and to suggest potential paths for improvement, taking into account a few parameters: the cultural and historical context of the target subgroups’ environments, organizational contexts, your human and financial resources, and the values shared or not shared by the project stakeholders.

Two examples illustrating how this grid can be completed

Finally, we have provided two example of the grid in use. They are based on the review of projects that have been locally implemented for a few years. You are encouraged to look through them before beginning your own work. In these two examples, you will see the occasional challenge of linking discussion elements to the question items. This brings us back to the key role of facilitation when completing the grid and when performing the overall assessment. All of these documents can be downloaded from the website : <http://www.equitesante.org/chair-realisme/tools/reflex-iss/>

Two examples of the tool in use:

- The use of the REFLEX-ISS Tool for the implementation of Sentinel networks (Sentinel project)
- The use of the REFLEX-ISS Tool by the Quit Smoking Centre (Centre d’abandon du tabagisme – CAT)

A TOOL FOR YOU, TO BE FILLED OUT AMONG YOURSELVES!

Remember: RÉFLEX-ISS is not intended to make you live up to standards or serve as a model example; it is a tool to help teams meet and think about ways to adapt their actions so they can contribute to reducing gaps between social groups – or at least, to not aggravating them.

GLOSSARY AND LIST OF REFERENCES

Definitions and concepts around the issue of social inequalities in health, with regard to the RÉFLEX-ISS tool

Social determinants of health

Social determinants of health are interdependent social, political, economic, and cultural factors that generate the conditions in which individuals are born, live, grow up, learn, work, have fun, and grow old. Interaction between social determinants of health transforms and changes them over time and over life periods, affecting the health of individuals and groups in different ways. Inequitable distribution of social determinants of health among social groups is at the root of the establishment and perpetuation of social inequalities in health within a country or between various countries.

http://nccdh.ca/images/uploads/Glossary_EN_Feb_26.pdf

Equity in health

Equity means fairness. It means that people's needs, rather than social privileges, guide the distribution of opportunities for well-being. (Equity in health and health care. WHO, Geneva, 1996).

Health equity exists when all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance.

http://nccdh.ca/images/uploads/Community_Engagement_EN_web.pdf

Evaluation

A process that assesses an intervention or some of its components, following a critical process supported by systematic data collection, in order to make decisions on how to improve actions already undertaken, or on actions to be undertaken. The advantage of this relatively simple definition is that it clearly states that the evaluation process is not a control process, although that may sometimes be the case, nor a research project, although scientific methods may sometimes be used. Evaluation is a process for improving projects and practices, in other words a driver for change, even of social change for some. [Authors' translation]

<http://www.inpes.sante.fr/CFESBases/catalogue/pdf/1333.pdf p. 258>

The social gradient in health

The social gradient implies a continuum, that is, that individuals' state of health correlates with their socioeconomic status (for example their level of education or of income). Social gradient serves to describe the phenomenon by which those at the top of the social pyramid enjoy better health than those directly beneath them, who in turn are healthier than those below, and so on, all the way to the bottom levels. [Authors' translation]

(Guide INPES, 2010) <http://www.inpes.sante.fr/CFESBases/catalogue/pdf/1333.pdf>

↳ “If [through our interventions] we target only the poorest 10%, then we are missing the essence of the issue that is social inequalities in health.” (Marmot, 2008)

↳ “Equity in general provides a just solution with regard to inequalities, not only for the poorest, but for everyone and at all levels.” (Mooney, 1999)

<http://www.tribuneiss.com/les-inegalites-sociales-de-sante/>

Social inequalities in health

Social inequalities in health are avoidable gaps between men and women, between socioeconomic groups, and between territories, that have an impact on many aspects of health. Social inequalities in health also refer to any relationship between health and belonging to a social group. [Authors' translation]

http://www.centrelearoback.org/coup_d_oeil

Social inequalities in health refer to the disparities in health associated with social advantages or disadvantages (e.g., income, schooling, social inclusion). These disparities are unjust and avoidable, and it is possible to mitigate them. Social inequalities in health are distributed according to a social gradient. The terms "social inequalities in health" and "health inequities" are sometimes used interchangeably.

http://nccdh.ca/images/uploads/Glossary_EN_Feb_26.pdf

Intersectorality

An area where actors from different sectors collaborate to set common goals for resolving complex issues. According to the WHO Commission on Social Determinants of Health, improving living conditions is the top priority for reducing social inequalities in health. Since most of these conditions (education, housing, nutrition, urban environment) depend on sectors other than the health sector, pursuing this objective means that public health actors must become involved in actions in partnership with relevant intersectoral actors.

http://ped.sagepub.com/content/12/3_suppl/20.full.pdf+html

Leadership

Leadership is the capacity to influence self and others to work together to achieve a constructive purpose.

http://leadscollaborative.ca/uploaded/web/Resources/LEADS_Brochure_2015.pdf

Health literacy

Health literacy is "the ability to access, comprehend, evaluate, and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course."

http://www.cpha.ca/uploads/progs/literacy/examples_e.pdf

Best practices

Best practices are activities based on sound scientific evidence, extensive community experience, and cultural knowledge. They also refer to interventions developed based on recognized criteria to increase their potential effectiveness. Health-centred interventions will be more effective if based on established best practices.

<http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/ipchls-spimmvs/glossary-glossaire-eng.php>

Partnerships

Action in partnership can be defined as a joint negotiated action. Negotiation implies the possibility of conflict. The first point: above all, do not deny conflict, but seek to resolve it. Potential compromises or agreements are not usually based on organizations' founding values or their mission, but rather on the objectives they may share or on projects to be carried out together. Second point:

the success of a partnership action is never guaranteed, since it is the result of negotiation. It depends on the often unequal resources of actors, on their willingness, as well as on the constraints and opportunities of the environment. It is a process that moves slowly, i.e. that takes time to set up and to move forward. [Authors' translation]

http://publications.santemontreal.qc.ca/uploads/tx_assmpublications/2-89494-404-7.pdf

Participation

Includes the various forms of action through which individuals, groups, or organizations actively contribute to decisions or actions for which they are not the main leaders and in which they become stakeholders by virtue of being included in the decision-making or in the action. [Authors' translation]

<http://www.inpes.sante.fr/CFESBases/catalogue/pdf/1333.pdf> p.314

Making health promotion interventions sustainable

Sustainability is a process that enables activities and effects linked to interventions to continue.

<http://www.sciencedirect.com/science/article/pii/S0398762006767402>

It is possible that your project may be made sustainable with external support from different sources. For example, it might be helpful to look into whether the CISSS/CIUSSS for your region can provide certain kinds of support for your project (e.g., training program, subsidy, guidance). It might also be able to help make your project known in the region and the province. [Authors' translation]

<http://www.ipcdc.qc.ca/sites/default/files/files/OUTIL%20POUR%20R%C3%89FL%C3%89CHIR%20%C3%80%20LA%20P%C3%89RENNISATION%20D%E2%80%99UN%20PROJET%206%282%29.pdf>

Health advocacy

Advocacy is an active process that uses strategic actions to influence others to shift opinion, initiate positive change, and address the underlying factors that contribute to a healthier community. It is different than an information, education and communication campaign as it focuses on policy change to address the social and environmental causes of an issue, rather than on individual behaviour change.

http://www.cpha.ca/uploads/progs/_/sopha/advocacy-booklet-colour-en-final.pdf

Target population and target subgroups

An intervention's target population consists of subgroups that can be distinguished from each other for the purposes of adapting the action to each one. To be effective, an intervention must plan activities for each of the target subgroups. This means notably that not all target subgroups will be addressed in the same way, as they vary by language, level of education, socioeconomic level, etc. For example, an intervention targeting the children in neighbourhood x must address the different needs of the target subgroups identified, such as children 0–5 years old in migrant families, children in single-parent families, or children in families within middle-level socioeconomic groups. Thus, an intervention aiming to reduce social inequalities in health will not try to reach only the poorest, but rather all of the various groups within the concerned population affected by the health issue, all along the social gradient, while modulating the intervention's intensity according to socioeconomic level and needs.

Empowerment

Empowerment is a process or an approach that aims to help individuals, communities, or organizations have greater power to act and take decisions on the important aspects of their life, and have greater influence on their environment. For the purposes of developing this discussion tool, the framework proposed by Ninacs, outlined below, has been used to define empowerment. Individual empowerment occurs on four levels: participation, competencies, self-esteem, and critical awareness (Ninacs, W., 2003).

- ↳ Participation manifests progressively, from silent participation to exercising the right to speak (including the right to refuse to speak), followed by the right to be heard, and culminating in the right to participate in decision-making;
- ↳ Competencies include the knowledge and skills necessary for participation, on the one hand, and execution of the action on the other. They can involve both the acquisition of new skills and the re-evaluation of skills already possessed;
- ↳ Self-esteem leads individuals to perceive that they have the capacity to act to achieve personal or collective objectives;
- ↳ Critical awareness represents the development of a collective conscience (the individual is not the only one with a problem), a social awareness that assuages individual feelings of guilt through the realization that individual or collective problems are influenced by the way in which society is organized.

<http://envision.ca/pdf/w2w/Papers/NinacsPaper.pdf> (Authors' translation)

Health promotion

All actions and processes implemented to strengthen individual and collective capacities to act in ways that promote health. Moreover, health promotion advocates certain principles and values, such as a positive and comprehensive view of health, empowerment, participation, and equity, which must form the basis for action. [Authors' translation]

<http://www.inpes.sante.fr/CFESBases/catalogue/pdf/1333.pdf>

Undesirable outcomes/effects of interventions

[...] we too often forget in planning that the way of defining a health problem contributes to the problem itself. When we design an intervention without taking into account the great vulnerability of the persons it targets, for example, then the tools and information disseminated do not match up with the capacity for assimilation of those for whom they are intended. By simplifying the social problem, in short, we end up designing solutions that do not correspond to what we wanted to resolve at the outset. [Authors' translation]

http://centrelaroback.org/assets/PDF/04_activites/CLR-PUBAUTRE_CACIS2009_Inegalites.pdf

Unforeseen consequences that go against the intended goal, e.g., increasing social inequalities in health, increasing stigmatization, deterioration in the target group(s) state of health, negative change in attitude of the general population or of certain actors with respect to the target subgroup(s).

Socioeconomic status

SES is a measure of an individual's or family's economic and social position relative to others. It is based on a range of measures including income, education and occupation.

http://earlylearning.ubc.ca/media/publications/proportionate_universality_web_november_2015.pdf

Stigmatization

Behaviours, life habits, life conditions, or other personal characteristics are linked to a moral judgment that defines illnesses or ill people as either “good” or “bad”. The stigmatization process is based, among other things, on the idea that persons are responsible for their problem or illness, at least in part, and therefore deserve to be blamed given their behaviour. In this way, individuals who smoke, drink alcohol, eat rich foods, or have unprotected sexual relations are judged negatively and blamed when their health is affected or even just because it could be affected. [Authors’ translation] (http://www.inspq.qc.ca/pdf/publications/1637_DimensionEthiqueStigmatisation_OutilAideReflexion.pdf)

Proportionate universality

This refers to “....programs, services, and policies that are universal, but with a scale and intensity that is proportionate to the level of disadvantage”

http://earlylearning.ubc.ca/media/publications/proportionate_universality_web_november_2015.pdf

This approach consists in offering the entire population a certain number of universal services, and then intensifying action to address the specific needs of persons, depending on the difficulties they are facing (Marmot Review (2012). Fair society, healthy lives: Strategic review of health inequalities in England post-2010).

Thus, the approach does not focus only on the poorest people, but rather seeks to address the whole range of realities and suffering, at varying levels of intensity, faced by persons and groups, regardless of socioeconomic status.

List of references on the issue of social inequalities in health⁴

QUÉBEC

ASSS de Montréal. (2014). Vivre une ville en santé, Capsule vidéo – *Inégaux – Le film*
<https://www.youtube.com/watch?v=l9IIHDrNNXo>

Direction de santé publique de la Capitale-Nationale. (2012). *Rapport du directeur régional de santé publique sur les inégalités sociales de santé. Comprendre et agir autrement pour viser l'équité en santé dans la région de la Capitale-Nationale.* Agence de la santé et des services sociaux de la Capitale-Nationale.

http://www.dspq.qc.ca/documents/RapoportISS_versionintegrale.pdf

Direction de santé publique de la Mauricie et du Centre-du-Québec. (2012). *Rapport du directeur de santé publique sur les inégalités sociales de santé en Mauricie et au Centre-du-Québec. Les inégalités sociales de santé ne sont pas une fatalité : voyons-y !* Agence de la santé et des services sociaux de la Mauricie et du Centre-du-Québec.

http://www.agencesss04.qc.ca/images/images/santepublique/direction/RapportDSP/rapportdsp_2012_finale_version_web.pdf

Direction de santé publique de la Montérégie. (2007). *Rapport de la directrice de santé publique 2007. Pour des communautés en santé : des environnements sociaux solidaires.* Longueuil, Agence de la santé et des services sociaux de la Montérégie.

http://extranet.santemonterege.qc.ca/depot/document/2555/dsp_pub_rapport_annuel_directrice_2007.pdf

Direction de santé publique de Montréal. (2011). *Rapport du directeur de santé publique 2011. Les inégalités sociales de santé à Montréal. Le chemin parcouru.* Montréal: Agence de la santé et des services sociaux de Montréal.

http://publications.santemontreal.qc.ca/uploads/tx_assmpublications/978-2-89673-133-6.pdf

Lamber, R et coll. (2014). Avenues politiques : intervenir pour réduire les inégalités sociales de santé. Institut national de santé publique du Québec.

http://www.inspq.qc.ca/pdf/publications/1822_Avenues_Politiques_Reduire_ISS.pdf et blogue

<http://www.inspq.qc.ca/politiquespubliques/post/2014/07/17/Avenues-politiques-intervenir-pour-reduire-les-inegalites-sociales-de-sante.aspx>

Lasnier, B., Leclerc, B. S., & Hamel, D. (2012). *Les inégalités sociales de santé en matière de tabagisme et d'exposition à la fumée de tabac dans l'environnement au Québec.* Institut national de santé publique du Québec.

http://www.inspq.qc.ca/pdf/publications/1487_ISSTabagExpoFumeeTabacEnviroQc.pdf

Direction du programme de santé publique du ministère de la Santé et des Services sociaux et Institut national de santé publique du Québec. (2007). *Troisième rapport national sur l'état de santé de la population du Québec. Riches de tous nos enfants.* Québec: Directions des communications, MSSS.

⁴ Taken from the proceedings of the forum *Dialogue entre tenants de divers savoirs pour plus d'équité en santé:*

<https://drive.google.com/open?id=0By87PSk8EK1tTkV5Rk5TS0dPc2tuZWJudG5TaVNDY1Z5RkFj&authuser=0>

<http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2007/07-228-05.pdf>

Pampalon, R., Hamel, D., Alix, C., & Landry, M. (2013). *Une stratégie et indicateurs pour la surveillance des inégalités sociales de santé au Québec*. Institut national de santé publique du Québec
http://www.inspq.qc.ca/pdf/publications/1698_StratIndicSurvISSQc.pdf

Potvin L., Moquet M.-J., Jones C. (sous la dir.). (2010). *Réduire les inégalités sociales en santé*. Saint-Denis : INPES, coll. Santé en action, Institut national de prévention et d'éducation pour la santé (INPES) éditions, 380 p. <http://www.inpes.sante.fr/CFESBases/catalogue/pdf/1333.pdf>

Ridde, V., & Dagenais, C. (2012). *Théories et pratiques en évaluation de programme : Manuel d'enseignement (2e éd.)*. Montréal, QC: Presses de l'Université de Montréal.

Ridde, V., & Guichard, A. (2008). Réduire les inégalités sociales de santé : aporie, épistémologie et défis, In *Lutter contre les inégalités sociales de santé : Politiques publiques et pratiques professionnelles*, Christophe Niewiadomski & Pierre Aiach (eds.), Presses de l'EHESP, 57–80.

Simard, P. (2012). *Connaître et mobiliser pour mieux intervenir : évaluation de la démarche de caractérisation des communautés locales de la région de Chaudière-Appalaches*, Institut national de santé publique du Québec, Québec.

http://www.google.ca/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB8QFjAA&url=http%3A%2F%2Fwww.inspq.qc.ca%2Fpdf%2Fpublications%2F1649_CommLocalesChaudiere_Appa.pdf&ei=mHS5VLX9GbDksAS5y4LwDg&usg=AFQjCNHHTuPX6Q_sLrMkvf6t73Y7FP3cDA&bvm=bv.83829542,d

CANADA

The National Collaborating Centre for Determinants of Health. (2012). Website: *Cliquez pour l'équité en santé*.

<http://www.cwhn.ca/en/node/45150>

National Collaborating Centre for Healthy Public Policy. (2011). *Thirteen Public Interventions in Canada That Have Contributed to a Reduction in Health Inequalities*.

http://www.ncchpp.ca/docs/13interventions_Inequalities_EN_sansISBN_FINAL.pdf

Martens, P., & et coll. (2010). *Health Inequities in Manitoba: Is the Socioeconomic Gap in Health Widening or Narrowing over Time?* Winnipeg, Manitoba: Manitoba Centre for Health Policy.

http://mchp-appserv.cpe.umanitoba.ca/reference/Health_Ineq_final_WEB.pdf

Morisson, V. (2013). *Wicked Problems and Public Policy* National Collaborating Centre for Healthy Public Policy. Montréal, Québec.

http://www.ncchpp.ca/docs/WickedProblems_FactSheet_NCCHPP.pdf

Public Health Agency of Canada (2011). Brochure. *Reducing Health inequalities: A challenge for our Times*.

http://publications.gc.ca/collections/collection_2012/aspc-phac/HP35-22-2011-eng.pdf

INTERNATIONAL

International Monetary Fund. (2014). Online bulletin. *Sound Policy Design: the Efficient Way to Cut Inequality.*

<http://www.imf.org/external/pubs/ft/survey/so/2014/POL031314A.htm>

World Health Organization. (2009). Closing the gap in a generation: Health equity through action on the social determinants of health: Final Report of the Commission on Social Determinants of Health.

http://apps.who.int/iris/bitstream/10665/69832/1/WHO_IER_CSDH_08.1_eng.pdf

