



Reduction of health inequalities in Tenerife, Canary Islands, by means of health promotion

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EXECUTIVE SUMMARY

Social inequalities in health are unfair and avoidable differences in health between population groups defined socially, economically, demographically or geographically. A growing number of publications have described and analysed social inequalities in health in Spain on the grounds of social class, gender, ethnicity, territory and country of origin. These inequalities have an enormous impact on population health and, therefore, must be a priority for public health policies and a cross-cutting issue within health policies in our country, following the line traced by the main international organisations and several surrounding countries (Campos Esteban, P. y col., 2010).

Scientific evidence also reveals that health inequalities can be reduced if the appropriate public social and health interventions and policies are undertaken (Dahlgren & Whitehead, 2006; Whitehead et al., 2004).

Reducing health inequalities at national level and between regions in Spain has been set as a priority task of the Spanish Government during the Spanish Presidency of the European Union in 2010. Since then many working documents have been published by the Ministry of Health, Social Affairs and Equity, in order to raise capacity building in the field of health inequalities.

This document shows a draft proposal of an action plan at regional level to reduce health inequalities by means of health promotion.

The main goal is the reduction of intraregional and interregional health inequalities in Canary Islands.

The strategic action plan focuses on the contribution to the reduction of health inequalities. Also it is based on a systematic analysis of the current situation of health status of the Canarian population.

We have identified five main aims which focus on place health inequalities in the attention of communities and individuals, increase community capacity and participation/community empowerment, improve healthy behaviours through health promotion activities, reduce intraregional health inequalities by supporting vulnerable groups and support healthy physical environment.

We believe that the implantation of this action plan will contribute to the general goal of reduce health inequalities in Tenerife.

INTRODUCTION

Spain has a total population of 47,265,321 (male 23,298,356; female 23,966,965) inhabitants.

The Canary Islands, one of 17 autonomous regions of Spain, consists of 7 larger islands and 6 smaller islands. The islands are located off the north-western coast of the mainland of Africa, more or less 100 kilometres west of the coast of southern Morocco. The total population of the Canary Islands in year 2012 was 2,118,344 (male 1,056,240; female 1,062,104).

The Canary Islands are located rather far away from the mainland of Spain and are quite isolated. This has an effect on the social and economic position of the islands.

THE DEVELOPMENT OF THE ACTION PLAN

Some facts about Canary Islands

Canary Islands is an archipelago in the Atlantic Ocean which forms one of the seventeen autonomous communities of Spain, recognized as one of the outermost regions of the European Union, which gives them the status of an ultraperiferic region. It has seven main islands: El Hierro, La Gomera, La Palma and Tenerife, which are the province of Santa Cruz de Tenerife, and Fuerteventura, Gran Canaria and Lanzarote, which make up the province of Las Palmas. There are some other islands territories also part of the Canary Islands Archipelago, Chinijo (La Graciosa, Alegranza, Montaña Clara, Roque del Este and Roque del Oeste) and Isla de Lobos, all belonging to the province of Las Palmas. La Graciosa is the only of these islands which is inhabited.

The archipelago is located in the north of Africa, off the coast of southern Morocco and the Sahara, between latitudes 27° 37' and 29° 25' north latitude and 13° 20' and 18° 10' west longitude. Because of this situation, Canary Islands used during the winter the Western European Time (WET or UTC) and during the summer the summer Time Western Europe (WEST or UTC +1).

The distance from Canary Islands and the African coast is about 1.400 km. The island of Fuerteventura is the closet to African coast just about 95 km.

The islands are of volcanic origin, are part of the region of Micronesian archipelagos along with Cape Verde, the Azores and Madeira. The climate is subtropical, but varies locally by altitude and the north or south side. This climate variability leads to biological diversity, along with the rich landscape and geology, justifies the existence of four National Parks and several islands are biosphere reserves of UNESCO, and other areas have been declared World Heritage like "Teide National Park", the most visited park in Spain with the highest mountain of Spain and third largest volcano in the world from its base, the Teide. These natural attractions, good weather and beaches make

the islands a major tourist destination, being visited each year by about 12 million people, mainly British, Spanish from mainland and Germans.

The total population of the Canary Islands in year 2012 was 2,118,344 (male 1,056,240; female 1,062,104) and a density of 284.46 inhabitants / km², being the eighth region of Spain in population. The archipelago's population is concentrated mainly in the two main islands, Tenerife and Gran Canaria. The total area of the archipelago is 7,447 km².

Tenerife with an area of 2,034.38 km² and a population of 898,680 inhabitants (INE, 2012), is the largest island of the Canary Islands.

Socio-economic factors

The average annual income per person in 2011 was 9,321 euros. The annual income per household in 2011 was 24,609 euros according to data from the National Statistics Institute. According to an ADECO report published in 2013, the average salary in Spain per month in 2012 was 1,639 euros while in the Canary Islands, it is less than 1,400 euros. However, the minimum salary is established by the government at 645 euros per month. The gender pay gap was 16.2% in 2011.

The total population with at least an upper secondary education on the mainland was 53.8%. In 2011 the school dropout rate was 26.5%.

With respect to education, the total population in Canary Islands with at least an upper secondary education is 34.8% (2011) which is less favourable than the rate on the mainland. In 2011 the school dropout rate was 30.4%.

Spain scores rather high with respect to the rest of Europe with regard to the unemployment rate. The total percentage of unemployed people in Spain increased to 27.1%, which are 6,202,700 people (male 26.8%, female 27.6%) in the first three months of 2013. The unemployment rate increased to 34.27% in the Canary Islands by gender 34.73% for males and 33.72% for females.

The unemployment rate of people under 25 years is even higher, namely 57.2% in the first trimester of 2013. Recent figures for 2013 show the unemployment rate for the population under the age of 25 to be 70% in the Canary Islands.

A total of 21.8% of the population of Spain is at risk of living under the income poverty line in 2012. People under 16 displayed the highest rate of risk of poverty with 25%, followed by the population aged 16-64 with 19.3% and those over 65 8.5%. The percentage of people at risk of living under the poverty line is higher for the Canary Islands: 33.8%.

In the last five years, the Canary Islands have ranked below Spain in terms of average income per person and per household. An analysis of income per capita shows that 39% of the population earned less than 500 euros per month per person, indicating the deprived situation in the Canary Islands. The data regarding Canary Islands shows the disadvantaged socio-economic position of this region, which together with the ongoing economic crisis, had resulted in serious problems for people's daily lives and consequently, for their health.

Health and health inequalities

Health is strongly influenced by internal and external factors; the environment, how we live, work and enjoy leisure time are influenced by social, cultural, economic or environmental factors. These factors can cause differences in the health status of people.

According to WHO, health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups (CSDH Employment Conditions Knowledge Network (EMCONET), 2006). Socio-economic inequalities in health pose a major challenge to health policies. Also they can be perceived as systematic and preventable differences in health status between populations, where the poor suffer from poorer health than the rich. Health inequalities exist on the supra-national level (between countries), on the national level (between regions in the same country), and within regions (between different local groups).

Health inequalities are determined by the conditions in which people are born, grow, live, work and age, and the inequities in power, money and resources that give rise to these conditions of daily life {{8399 CSDH 2008;922 Schrecker,T. 2008;}} .

Health inequalities are influenced by a variety of factors, education, poverty, employment or public policies. Social and economic differences between groups of people result in health inequalities because their impact on factors that affect health including living and working conditions, health-related behaviours and access to and quality of health care.

There are persisting health inequalities in all levels of society. We need to recognize the importance of addressing health inequalities globally, national, regional and locally.

There is clear evidence that health inequalities exist - not just because of the existence of poor health among the worst off but because there is a clear social gradient in health (measured in terms of poor health, disability or mortality) across the whole of society. It has been shown repeatedly that rates of adverse health outcomes raise as one moves down {{8399 CSDH 2008}} the social hierarchy {{734 Berkman,L.F. 2000}}

As the CSDH report showed, the distribution of health and well-being needs to be understood in relation to a range of factors that interact in complex ways. These factors include material circumstances, social cohesion, psychosocial factors and behaviours. These factors, in turn, are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. All these influences are affected by the socio-political and cultural and social context in which they sit {{8399 CSDH 2008}}.

In developing strategies to address health inequities, it is important to distinguish between upstream and downstream approaches. Downstream approaches are referred to the individual. These approaches focus on changing behaviour, ensuring access to care, monitoring quality of care, and identifying health risk factors {{8400 Gehler March/April 2008;}} . Upstream approaches build on the understanding that social, economic, and environmental inequity are root causes of health inequity, and that improving social, economic, and environmental conditions will improve health. To achieve health equity, new strategies must move beyond the traditional public health approaches to focus on social, economic, and political change (Barten, Mitlin, Mulholland, Hardoy, & Stern, 2007). Upstream strategies address inequities in education, employment, income, housing, neighbourhood safety, recreational opportunities, environmental hazards, and healthy food access, through policy, systems, and environmental change efforts ("Marmot & "Wilkinson, 2006; Demakakos, Nazroo, Breeze, & Marmot, 2008).

These new approaches that address root causes of health inequities require a long-term commitment to comprehensive multilevel and multisectorial strategies to change the social determinants of health. Broad coalitions of public, private, non-profit, and community stakeholders are required to change community structures. In order to do this work effectively, community engagement is essential; all members of the community should be representing and have voice in the process of decision making and implementing any strategy to improve health status (Wallerstein & Duran, 2010).

Health and health inequalities at national level

Life expectancy at birth in Spain is 82.5 years, 79.4 years for males and 85.4 years for females (Instituto Canario de Estadística. ISTAC, 2012). Life expectancy in the Canary Islands is similar to that of Spain (Instituto Canario de Estadística. ISTAC, 2012). The score of healthy life years indicator for males is 65.4 years and for female 65.8 years, meaning that women have about 20 unhealthy life years, although their life expectancy is rather high.

Total life expectancy on the Canary Islands is slightly lower at 81.43 years (78.5 years for males; 84.3 years for females) while the total number of healthy years is 54.5 years (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2008) .

With respect to mortality rates in Spain, according to the National Statistical Institute (2010) the three major health problems are: cardiovascular diseases (31.2%), cancer (28.1%) and respiratory diseases (10.5%) (Instituto Nacional de Estadística. INE, 2010). With respect to cardiovascular diseases, women are more often affected than men, and with respect to cancer men are more affected than women. All these diseases have a higher prevalence on the mainland in the regions of Cataluña, Madrid and Andalucía. The 3 major health problems in the Canary Islands region based on mortality rates are cancer (differing from the mainland where CVD are the first cause of death), (2) cardiovascular diseases and (3) respiratory diseases (Instituto Nacional de Estadística. INE, 2010).

Except for heart attacks, women are more affected by cardiovascular diseases than men.

Smoking is the leading avoidable risk factor related to cardiovascular diseases in Spain comprising 21.5% of the women and 31.5% of the men over 16 years of age who are daily smokers. But in terms of age groups, this pattern changes and the prevalence of smokers is higher among women in the 16-24 age group: 28.8% of women compared to 25.0% of men.

Alcohol consumption in the last 12 months before the survey was 68.6% (80.2% of males and 57.5% of females).

A total of 37.1% of the population displayed slight obesity and 15.4% signs of serious obesity. Men are more often overweight than woman (45.1% of men versus 30.4% of women) and obesity is more or less comparable in both sexes (10). Almost half the population of Spanish children (45.2%) is overweight, with 26.1% overweight and 19.1% obese. A total of 54.1% of children have a healthy weight and 0.7% are considered thin in relation to their age and size. If the results are analysed by gender, little difference in terms of overweight among children are seen (boys 26.3% and girls 25.9%), while the obesity rate shows a six-point higher frequency rate in boys compared to girls (22% and 16%, respectively) (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2011).

Obesity and severe obesity are a serious health problem in the Canary Islands and the rates of prevalence are higher than in mainland and are still growing.

Smoking and obesity are important risk factor for numerous diseases. Health professionals attempt to discover the reasons for the increasing tendency in

overweight of 36.8% of the adult population (42.1% of males and 31.7% of females) and obesity (18.5% of the adult population). The percentage of women who are obese (19.24%) is higher than the percentage men (17.92%), in contrast to the percentages of overweight men and women (Instituto Canario de Estadística. ISTAC, 2012). Special attention is needed for children as the prevalence of overweight and obese children is higher in the Canary Islands than on mainland Spain.

Being aware of these data and the need for special attention for children with respect to the prevention of obesity, the focus of the action plan in Tenerife will be on this health problem. The prevention of obesity depends significantly on the policy agenda, however, effective evaluation of the existing health promotion programs and interventions is lacking, so the effectiveness of those actions is unknown (S. Darias Curvo, 2008; S. Darias Curvo, 2009).

Gender and socioeconomic status are key social determinants for obesity in Spain and, consequently, need to be addressed when developing preventive activities (Ortiz-Moncada et al., 2011).

Factors influencing obesity in the Canary Islands are education, lifestyle, religion, cultural beliefs and family environment {{8411 Rodríguez Pérez, M.C. 2006}}. Another problem is access to quality food. Food is expensive on the islands as most of it needs to be imported.

Determinants to be tackled first are diet (increased knowledge), physical activity and behaviour & attitudes.

Health System in Spain

The statutory National Health System is universal coverage-wise (including irregular immigrants), funded from taxes and predominantly operates within the public sector. Provision is free of charge at the point of delivery with the exception of the pharmaceuticals prescribed to people under 65 years old, which entail a 40% co-payment with some exceptions. Health competences were totally devolved to the regional level (ACs) as from the end of 2002; this devolution resulted in 17 regional health ministries with primary jurisdiction over the organization and delivery of health services within their territory. The ACs' financing scheme promotes regional autonomy both in expenditure and in revenue rising. The national Ministry of Health and Social Policy (MSPS) holds authority over certain strategic areas, such as pharmaceuticals' legislation and as guarantor of the equitable functioning of health services across the country.

The typical structure of regional health systems consists of a regional ministry (Consejería de Salud) holding health policy and health care regulation and planning responsibilities, and a regional health service performing as provider.

The regional ministry of health is responsible for the territorial organization of health services within its jurisdiction: the design of the health care areas and basic health zones, and the degree of decentralization to the managerial structures in charge of each. The most frequent model consists of two separate executive organizations, one for primary and one for specialist care (ambulatory and hospitals), at the health area level. Nevertheless, regional health services are increasingly creating single-area management structures integrating primary care and specialist care. Basic health zones are the smallest units of the organizational structure of health care. They are usually organized around a single primary care team (PCT) which exercises the gatekeeper function.

Public health responsibilities tend to be centralized in the regional department of health, though functionally following the basic health areas structure. Each health area should cover a population of no less than 200.000 inhabitants and no more than 250.000 {{8239 García-Armesto 2010;}}.

PLANNING METHOD

In order to effectively reduce inequalities in health, a strategic plan is required, which would identify the key aims and objectives for politicians (on the local, regional and national levels) and other stakeholders to contribute to the reduction of health inequalities as well as strategies for achieving those objectives and indicators to monitor progress.

The process of develop an action plan includes different phases interconnected between them. Each step is necessary to success in the implementation of the action plan. The successive steps in the process were a situation analysis and experts inputs through several meetings.

Situation analysis

The first step in the strategic planning process is to analyse the current situation, including the assessment of the health status of the population.

We have used data from the Spanish Statistical Office, Canarian Statistical Office and Ministry of Health, Social Affairs and Equality. A number of health factors have been

identified as contributors to cause health inequalities in the population of Canary Islands.

The results of the situation analysis are mentioned in the previous sections of this document.

Methods for goal and target setting

Based on the information from the situation analysis, strategic issues and target groups were identified.

Using existing information, knowledge and experience, aims and objectives have been identified as well as specific targets and activities to realise the aims.

We have not settle a time line to develop the full action plan as it may continue in a long term and some parts of it needs to be developed intersectorial partnership with other stakeholders.

THE CONTENT OF THE ACTION PLAN

This action plan is based on the analysis of the current situation and on the priorities identified in our region (Tenerife, Canary Islands).

The strategy is divided in three main parts. The first one describes general ideas about health status in the Canary Islands, health inequalities at national and regional level, and characteristics of the National Health System. The second one explains the planning method and the third one describe the content of the action plan.

MAIN GOAL: REDUCTION OF INTRAREGIONAL AND INTERREGIONAL HEALTH INEQUALITIES IN TENERIFE

We have observed interregional and intraregional health inequalities in the Canary Islands.

Interregional health inequalities refer to differences in the health status of the population in different regions. Canary Islands for their characteristic can be considered in general as a poor region together with Extremadura and Andalusia. The health status of our population is less favourable if we compare using socioeconomic data.

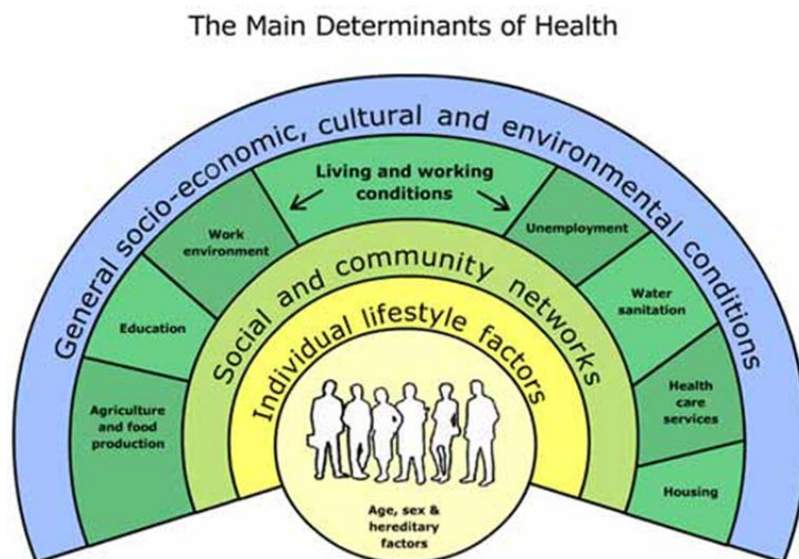
Intraregional health inequalities refer to differences in health status within the population of Canary Islands. We find differences if we compare each of the seven

islands where the smaller ones do not have for example the same access to health care services. Between islands we find great differences among educational status, unemployment rate, income and elderly people.

Our main goal is to improve the health status and reduce health inequalities in the Canary Islands (focus on this first step in Tenerife) by means of health promotion.

AIM 1: Place health inequalities in the attention of communities and individuals

As we have mentioned health inequalities are influenced by a variety of factors. The main determinants of health are shown in figure 1.



Whitehead M and Dahlgren C, in “What can be done about inequities and health? The Lancet, 338, 8774, 26 October 1991, 1059-1063.

A portion of those factors, such as sex, age and genetic factors cannot be influenced. Others, such as life style factors and socio-economic factors (education, poverty, employment) can be influenced, for example, by public policies.

According to the European Health Report 2012, the social determinants of health contribute to 50% of all health inequalities and comprise political, socioeconomic and environmental factors.

Another influencing determinant on health inequalities is, according to this report, access to effective health services. At least 25% of health inequalities (differences found within a country's population) are associated with a lack of access to effective health services. This percentage increases if differential access to basic public health interventions such as access to safe water is included.

Health inequalities that can be avoided should be tackled as should interregional health inequalities and differences in the health status of populations in different regions. Not only because inequalities are unjust and unfair, but because they place an economic burden on society. Poor health leads to high health care costs. Additionally, people in poor health are less able to work and learn, affecting the human capital's ability to contribute to the economy.

To identify health inequalities and health needs we might have a good evidence base database.

Objective 1.1

Increase awareness and responsibility of regional stakeholders about health inequalities in Tenerife.

Activities

- Identify potential network members.
- Establish communication with local stakeholders.
- Develop knowledge information about health inequalities and implement awareness-raising activities with potential stakeholders.

Indicators

- Number of stakeholders identified.
- Communication activities.
- Type of information produced: leaflets, courses, presentation, reports, etc.

Objective 1.2

Create a network of partners to enable intersectorial partnership.

Activities

- Establish cooperation with Regional Institute of Public Health, Regional Ministry of Education, local schools, AMPAS (fathers and mother representatives of

- parents with children at school. Currently they have great influences in decision making).
- Build alliances and networking.

Indicator

- Number of people within those organizations who participate in the network.
- Number of networking.

Objective 1.3

Increase the awareness and responsibility of local population regarding their health and give rise to participate in local activities.

Activities

- Organize local health promotion activities within the primary health care centre in each municipality.
- To communicate widely local health promotion activities so people can know when and where they will take place.
- Give written information through health professional to the population about those activities.

Indicators

- Participation level in local health promotion activities.

Objective 1.4

Support the evidence base on health inequalities and health promotion.

Activities

- Establish health inequality indicators.
- Contact with the Canarian Statistical Institute to include indicators of health inequalities in the periodical research.
- To promote research projects in the field of health inequalities and health promotion.

Indicators

- Presence of health inequality indicators in the regional health survey.
- Establish a regional and national database.
- Create a regional database on health promotion interventions.
- Number of research projects on health inequalities and health promotion.

AIM 2: INCREASE COMMUNITY CAPACITY AND PARTICIPATION-COMMUNITY EMPOWERMENT

Community can be defined in various ways. Community health literature offers a variety of definitions. Behringer and Richards describe community as a web of people shaped by relationship, interdependence, mutual interest, and patterns of interaction (Behringer & Richards, 1996). It is an open social system that is characterized by people in a place over time that has common goals. To make this happen we need to engage community in common goals and make an open participations community empowerment.

Objective 2.1

Enforce the community to participate in needs assessment and decision making process.

Activities

- Engage community representatives to take part in the task force.
- Organize meetings involving community representatives, health professionals, social workers and policy makers to set priorities.
- Prepare a draft of an action plan to reduce health inequalities and promote health promotion activities.

Indicators

- Number of representative's participant in the task force.
- Number of meetings.
- Document prepared with needs assessment, aims and objectives in first step.
- Document prepared with activities, indicators, time frame, resources needed and evaluation activities.

Objective 2.2

Encourage the use of existing resources of the community.

Activities

- Identifications of existing resources in the community.
- To establish a guide of resources in the community.

Indicators

- Number of people working in all government and sectors to identify existing resources in the community.

- Guide

Objective 2.3

Promote the knowledge of professionals in health promotion.

Activities

- Provide education and training on health promotion.
- Organize a series of theoretical and practical courses to professionals involved in health care (health promotion).
- Create a web site with information available on health promotion strategies.
- Training on evaluation of interventions in health promotion.

Indicators

- Number of people involved in education.
- Number of courses.
- Web site.
- Number of evaluations taken.

AIM 3: IMPROVE HEALTHY BEHAVIOURS THROUGH HEALTH PROMOTION ACTIVITIES

Investing in prevention and improved control of noncommunicable diseases (NCD) will reduce premature death and preventable morbidity and disability, and improve quality of life and well-being of people and societies {{8413 World 2012;}}.

Prevention through life course is effective. It is an investment in health and development.

Objective 3.1

To improve health and well-being by making school and workplace settings more supportive of healthy lifestyles

Target 1: Reduce childhood overweight and obesity-Nutrition

Activities

- Improve nutritional knowledge to children at school.
- Improve nutritional knowledge to population level (parents, teachers).
- Develop training materials at schools for children, teachers and families.
- Organize workshops with children, teacher and families in schools located in deprived areas.

Indicators

- Number of activities developed at school level.
- Number of activities developed at community level related to overweight and obesity.
- Number and quality of materials produced.
- Number of workshops within children, teachers and families.

Objective 3.2

Promote physical activity

Target 2: Reduce childhood overweight and obesity-Physical activity

Activities

- Motivate children to participate actively in physical activity at school.
- Promote sports activities out the school schedule.
- Facilitate public and safety spaces to practice physical activity for children and families.
- Include physical activities into diverse events.

Indicators

- Number of children involved in activities.
- Number of children involved in extra-curricular activities.
- Determine how many public places the community have to facilitate exercise.
- Number of people attending events.

Objective 3.3

Promote healthy lifestyle behaviours in Tenerife population

Activities

- Promote knowledge and training skills about healthy lifestyles.
- Implement existing policies and intervention to promote healthy lifestyles in all settings: work, schools, leisure places, sport training centres.
- Engage media to promote healthy habits (produce under supervision of experts).

Indicators

- Number of training courses, seminars, workshops.

- Evaluation of those activities.
- Number of people attended.
- Number and quality of advertising on TV and radio.

AIM 4: REDUCE INTRA-REGIONAL HEALTH INEQUALITIES BY SUPPORTING VULNERABLE GROUPS

The literature suggests a strong relation between health and social exclusion, and demonstrate that the health field can play an important role in promoting social inclusion {{8416 Stegeman 2004;}}.

There is limited awareness of the contributions that public health, health promotion and health care sectors can make to tackle social exclusion.

We consider as vulnerable group in our context of Canary Islands, children and youth, singles parents families with young children, people in poverty, unemployment, elderly people, migrants and ethnic minorities. In this action plan we will establish some objectives and actions referred to children and youth, single parents with young children, unemployment, elderly people and migrants.

Objective 4.1

Provide access to quality food for children at school.

The current social and economic situation in the Canary Islands is complicated. About 6,160 children do not have access to quality food. Last summer 2103, 162 schools opened their canteens to give at least one food to children of disadvantage groups.

The total poverty risk in Canary Islands for the year 2011 was 33,8% (INE). That is the highest level of all Spain.

The population at risk of poverty under 16 is 25.9% (INE).

The risk of poverty rate differs depending on the level of training of the individual. Thus the 28.9% of the population that has attained an educational level equivalent to education primary or less is at risk of poverty. When the education level is reached higher, the rate stands at 10.0%.

Activities

- Sign an agreement with the local authorities to provide food at school for children under 12 (primary schools).
- Implement whole school approach to healthy eating in the school setting.

Indicators

- Number of signed agreements with local town council.
- Number of produced activities to implement whole approach to healthy eating.

Objective 4.2

Provide information about drugs consumption and their effects in health.

Activities

- Provide information at primary and secondary schools about the effects of drug consumption.
- Select a person who has been drug consumer to participate in the talks.

Indicators

- Number of school participating in the talks.
- Number of events.
- Evaluation from the children and adolescents of all the activities that will be implemented.

Objective 4.3

Encourage smoke-free environment for children at home.

Activities

- Supporting smoking cessation programmes for families.
- Provide information on noxiousness of smoking and second hand smoking in childhood.

Indicators

- Range of smoking cessation programmes.
- Level of awareness on noxiousness of smoking by filling a questionnaire during the sessions.

Objective 4.4

Encourage self-esteem and healthy behaviours of school drop-outs {{8417 Belovic, B. 2005;}}.

Activities

- Enhance the partnership to implement intersectorial programmes for drop-outs.
- Develop appropriate training programme to strengthen positive self-image and healthy behaviour.
- Implement a training programme.

Indicators

- Appropriate training programme.
- Numbers of participants in the training sessions.
- Level of self-esteem after training.

Objective 4.5

Encourage single parents to take part at school and community activities.

Activities

- Provide information on available resources for them and their children at the community.
- To establish relationships among members of the community.

Indicators

- Report from social workers about how many single parents have consulted them.
- Number of social activities developed at community level and number of participants (single parents).

Objective 4.6

Increase social and coping skills of unemployed.

Research has shown that unemployed people are more likely to have poor health habits, characterized by excess drinking, smoking, lack of exercise, and a sedentary lifestyle (Benach, J., Muntaner, O., Solar, I., Santana, V., Quinlan, M. and the Emconet Network., 2010).

Unemployment is associated with a range of increased health problems (Dooley, Fielding, & Levi, 1996).

A widespread conviction in psychology is that the response to stressful events, such as unemployment, takes the form of a progression through stages. Shock tends to characterize the initial phase, during which the individual is still optimistic and unbroken. As unemployment advances, the individual becomes pessimistic and suffers

active distress, and ultimately becomes fatalistic about their situation and adapts unenthusiastically to their new state. Thus, the unemployed are expected to exhibit poorer mental health due to elevated levels of anxiety, frustration, disappointment, alienation and depression. Moreover, these feelings are likely to be more pronounced among those who shoulder greater financial responsibilities and persons with a greater sense of self efficacy fostered by prior success in a host of domains including school and work. Thus, the highly educated and parents are particularly vulnerable to the debilitating emotional consequences of unemployment. A host of factors may buffer the adverse psychological impact of involuntary joblessness including an understanding spouse, parents, siblings, adult children and friends {{8417 Belovic, B. 2005; 8418 Goldsmith 2012;}}.

Activities

- Training of social skills.
- Increase knowledge and skills on healthy lifestyles.
- Increase stress management capacity through workshops.
- Give information on existing resources in the community to job search.

Indicators

- Number of participants in training and workshops.
- Number of people using resources at community level.

Objective 4.7

Support healthy lifestyles and social contact to elderly people.

Activities

- Promote appropriate physical activity.
- Promote healthy nutrition.
- Involve elderly people in different activities at community level.
- Promote safe environments at home, care centres and streets.

Indicators

- Number of activities to promote physical activity.
- Number of people attending activities.
- Number of activities developed at community level to engage elderly people.
- Research on the current state of safety at home, care centres and streets.

Objective 4.8**Encourage healthy behaviours of migrants and ethnical groups.**

In Canary Islands, migrant population come mainly from South America and we speak the same language. In this case this is not a barrier. Another group of migrant are people from England or Germany but they have better socioeconomic status than the people from the Canaries. A small group of Indian people also live in Tenerife and Gran Canaria. They have their own business and also a good socioeconomic position.

A small number of people came from Africa and they keep in an irregular legal situation. This group is really difficult to reach. Some NGO's work with all of them.

Activities

- Get in contact with migrants and ethnical minorities groups.
- Establish a way of communication and dissemination of information.
- Promote healthy activities taking into account their expressed needs.
- Enable accessibility to health care system.
- Empowerment of different groups.

Indicators

- List organizations, locals, places where migrants meet.
- Find an "entrance" person to their community.
- Use churches, health care centre, bars, public places to spread information on activities.
- Facilitate their integration into the health care system.
- Level of partnership within groups.

AIM 5: SUPPORT HEALTHY PHYSICAL ENVIRONMENT

The physical environment has a huge impact on health. This includes not only the study of the direct pathological effects of various chemical, physical, and biological agents, but also the effects on health of the broad physical and social environment, which includes housing, urban development, land-use and transportation, industry, and agriculture {{8414 Kranic-Nikolic, T. 2013;}}.

Objective 5.1**Encourage positive behaviour of people towards the physical environment.****Activities**

- Provide knowledge about healthy environment to increase awareness of population about influence of environment on people's lives.
- Develop programmes and interventions focus on how to improve the environment.
- Involve media in those activities.
- Encourage people to use public transport.
- Encourage people to keep the environment clean.

Indicators

- Range of messages about healthy environment.
- Number of programmes and intervention.
- Evaluation of those programmes and activities.
- Media coverage of activities and information.
- Report on environment cleanness.

RESOURCES

In this action plan we will implement objective 3.1. We have established collaboration with the Regional Institute of Public Health (which depend on The Health Government Department) and the Education Government Department. The preparation of this implementation has been a long negotiation process. Some steps needs to be decided and an effective assessment of all the activities. Health promotion implies a long term outcomes. The focus group will be children from 6 to 12 years old at primary school.

Rationale

Primary education consists of six grades, from 6 to 12 years, and is mandatory. It is divided into three cycles of two years each: an initial cycle (for 6-8 years), medium cycle (from 8-10 years) and an upper (10 to 12 years). This is the first stage of compulsory education system so all children of 6 years old should be incorporated into the education system regardless of whether or not they conducted Childhood Education in nurseries.

It's a free and compulsory education stage.

Its purpose is to promote the socialization of children, promote their incorporation into the culture and contribute to the progressive autonomy of action in their environment.

Objective 3.1

To improve health and well-being by making school and workplace settings more supportive of healthy lifestyles

Target 1: Reduce childhood overweight and obesity-Nutrition

Activities

- Improve nutritional knowledge to children at school.
- Improve nutritional knowledge to population level (parents, teachers).
- Develop training materials at schools for children, teachers and families.
- Organize workshops with children, teacher and families in schools located in deprived areas.

Indicators

- Number of activities developed at school level.
- Number of activities developed at community level related to overweight and obesity.
- Number and quality of materials produced.
- Number of workshops within children, teachers and families.

Objective 3.2

Promote physical activity

Target 2: Reduce childhood overweight and obesity-Physical activity

Activities

- Motivate children at school to participate actively in physical activity at school.
- Promote sports activities out the school schedule.
- Facilitate public and safety spaces to practice physical activity for children and families.
- Include physical activities into diverse events.

Indicators

- Number of children involved in activities.
- Number of children involved in extra-curricular activities.
- Determine how many public places the community have to facilitate exercise.
- Number of people attending events.

Human resources

Regarding to the economic situation we need to be realistic in the human resources we can use. The action plan should be developed in six schools in Tenerife and after that in Gran Canaria. We will evaluate the activities and then make them extensive to other islands (La Gomera, El Hierro, La Palma, Fuerteventura, Lanzarote).

First step in Tenerife we need a team of eight people. Two professional trained in nutrition, two professionals trained in physical activities, two stagiaries, and two teachers.

The estimated cost of the intervention is 15,000 euros. We need to fit the program into this budget for one year. That is the amount of money that the Government will put into the implementation of this objective.

CONCLUSION

The preparation of this action plan is an indicator of the increase capacity to tackle health inequalities in Tenerife. This is a draft proposal of an action plan. One of the important issues about an action plan is the need of continuous assessment in any phase of it. The content of the action plan is based on the regional context.

REFERENCES

- "Marmot, M., & "Wilkinson, R. (2006). *Social determinants of health* (Second Edition ed.). New York: Oxford University Press.
- Barten, F., Mitlin, D., Mulholland, C., Hardoy, A., & Stern, R. (2007). Integrated approaches to address the social determinants of health for reducing health inequity. *Journal of Urban Health*, 84(Suplement, May), 164-173.
- Behringer, B., & Richards, R. W. (1996). The nature of communities. In R. W. Richards (Ed.), *Building partnerships: Educating health professionals from the communities they serve*. (pp. 82-101). San Francisco: Jossey-Boss.
- Benach, J., Muntaner, O., Solar, I., Santana, V., Quinlan, M. and the Emconet Network. (2010). In Benach J., Muntaner O. :, I., Santana V. and Quinlan, M. and the Emconet Network. (Eds.),
- *Employment, work, and health inequalities: A global perspective*. Barcelona: Icaria.
- Campos Esteban, P. y col. (2010). *Hacia la equidad en salud: Monitorización de los determinantes sociales de la salud y reducción de las desigualdades en salud*. Madrid: Ministerio de Sanidad y Política Social.
- CSDH Employment Conditions Knowledge Network (EMCONET). (2006). *A glossary of key concepts*. Geneva: WHO.
- Dahlgren, G., & Whitehead, M. (2006). *Levelling up (part 1): A discussion paper on european strategies for tackling social inequities in health*. EURO: WHO.
- Darias Curvo, S. (2008). Análisis de las desigualdades económicas en la prevalencia de diabetes y obesidad en Canarias. *Revista ENE*, 4, 51-60.
- Darias Curvo, S. (2009). *Determinaciones socioeconómicas y factores de riesgo cardiovascular: Un estudio en canarias*
- Demakakos, P., Nazroo, J., Breeze, E., & Marmot, M. (2008). Socioeconomic status and health: The role of subjective social status. *Social Science & Medicine*, 67(2), 330-340.

Dooley, D., Fielding, J., & Levi, L. (1996). Health and unemployment. *Annual Review of Public Health, 17*, 449-465.

Instituto Canario de Estadística. ISTAC. (2012). Retrieved May, 2013, from <http://www.gobiernodecanarias.org/istac/>

Instituto Nacional de Estadística. INE. (2010). Retrieved May, 2013, from www.ine.es

Ministerio de Sanidad, Servicios Sociales e Igualdad. (2008). *Report of the national health system of Spain*. Madrid: Ministerio de Sanidad, Servicios Sociales e Igualdad.

Ministerio de Sanidad, Servicios Sociales e Igualdad. (2011). *Proyecto ALADINO*. Retrieved May, 2013, from www.naos.aesan.msssi.gob.es/naos/ficheros/investigacion/aladino_final.pdf

Ortiz-Moncada, R., Álvarez-Dardet, C., Miralles-Bueno, J. J., Ruíz-Cantero, M. T., Dal Re-Saavedra, M. A., Villar-Villalba, C., et al. (2011). Determinantes sociales de sobrepeso y obesidad en España 2006. *Medicina Clínica, 137*(15), 678-684.

Wallerstein, N., & Duran, B. (2010). Community based participatory research contributions to intervention research: The intersection of science and practice to improve health equity. *American Journal of Public Health, 100*(1), 40-46.

Whitehead, M., Petticrew, M., Graham, H., Macintyre, S. J., Bambra, C., & Egan, M. (2004). Evidence for public health policy on inequalities: 2: Assembling the evidence jigsaw. *Journal of Epidemiology and Community Health, 58*(10), 817-821.