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Taking action in schools to reduce social inequalities in health

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What do we mean by "social inequalities in health"?

Social inequalities in health (SIH) can be defined as preventable health disparities between various groups in the population, particularly based on socioeconomic status, gender, ethnicity or territory. Social inequality impacts the population's health on several levels, including: life expectancy, quality of life, adoption of behaviours conducive to health, youth development and well-being and use of health professionals and services (Pampalon et al, 2008).

Social inequalities stem from factors that influence the circumstances in which people are born, grow up, live, work and age (education, income, job) (WHO, 2008). They are linked to an unequal distribution of power, money and resources. The reduction of social inequality is possible by acting upon the sources of inequality in society's social, political and economic organization. This requires the implementation of intersectoral policies and initiatives that are beyond the health network's scope.

How can we take action in schools?

The education sector is called upon to reduce social inequalities in health for a number of reasons. Education is recognized as a major health determinant. Individuals with higher education are better equipped to maintain or improve their health (Martin and Arcand, 2005). Equal access to education in a school that provides quality services gives children an equal opportunity to achieve success, health and well-being. Schools must therefore promote values of inclusion, openness and tolerance.

Taking global action

Education is recognized as a major health determinant

A global approach to health promotion acting on key determinants of success, health and well-being at various levels (youth, school, family, community) has great potential to help reduce SIH (Ridde, 2007). An approach such as the Healthy Schools approach in Quebec will help reduce SIH if it includes the following essential factors (Martin and Arcand, 2005; Palluy et al, 2010):

- it is developed in support of the school's mission: based on the school reality;
- it is the result of a collaboration between stakeholders, including school staff, health care professionals, youth, parents, community partners, etc.;
- it is based on strategies set forth in the Ottawa Charter for Health Promotion (WHO, 1986): development of cognitive, social and adaptive skills by promoting the active engagement and empowerment of youth; creation of favourable and equitable environments at the academic, social and physical levels; services for youth and their families; school, family and community partnerships;
- it combines interventions that have been deemed effective (through evaluations) or promising because they are based on theoretical models that have demonstrated their effectiveness;
- it combines interventions that are intense (frequency complying with expert recommendations) and continuous (sufficient duration);
- it offers interventions geared to the developmental stages of youth from kindergarten to grade 11.

Reflecting on practices

However, closer reflection is required to reduce SIH. Stakeholders in schools must reflect on their practices to ensure their interventions contribute to reducing inequalities or, at the very least, that they don't play a part in increasing them.

- Do the interventions implemented take targeted youths' different needs into account such as socioeconomic and cultural situation, ethnicity, gender effect and health representation? How do they avoid stigmatization? How do they ensure the intervention will be as beneficial to all students knowing that certain interventions have greater impact among more advantaged social groups?
- When an intervention is centred on a single health promotion strategy such as individual skills development, and has limited impact, how is it combined to actions that address other social and structural determinants? For example, in disadvantaged areas, are in-school educational activities on healthy lifestyles complemented with food safety measures, equipment, the opportunity to be physically active, community kitchens, trade counters for sports and leisure equipment, purchasing cooperatives, support services for parents, etc.?
- The consensus is that it is important to involve stakeholders in decisions that involve them. How do care providers ensure that all stakeholders are consulted and represent various cultural and socioeconomic situations?
- Mixed messages and inconsistencies are counterproductive and must be avoided. How does public policy support the actions implemented? Do we make sure cultural and socioeconomic diversity are taken into account?
- Do we assess the intervention's implementation? Do we adopt a participatory approach that gives a say to stakeholders representing all cultural and socioeconomic diversities?

Disadvantaged areas require added vigilance to ensure actions are taken to make external resources available and accessible

In general terms, youth cannot effectively deal with various life situations they encounter unless they have the necessary personal resources (e.g. knowledge or experience, know-how, life skills, qualities) and external resources (e.g. parents, care givers, teachers, equipment, healthy foods, condoms). They must also be able to mobilize and combine these resources efficiently when required. Disadvantaged areas require added vigilance to ensure actions are taken to make external resources available (present) and accessible (easy to find, affordable, close). We must develop youths' ability to transform these health resources into interventions appropriate to their social and economic contexts.

Conclusion

In short, we must have a stated objective for taking action on reducing social inequalities in health (Niwiadomski and Aïach, 2008; Ridde, 2007). Educational and environmental interventions in schools must be developed so that all youth benefit equally. Then they can equip themselves to deal with life's challenges in a healthy manner.

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