Equality Analysis

Social Marketing Strategy for Public Health England

Introduction

The Department of Health (DH) is committed to equality, diversity and human rights.

Since the DH is subject to the public sector equality duty, which came into force on 5 April 2011, it must also, in the exercise of its functions, demonstrate due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

In its role, the DH seeks to be an effective champion for all, by:

- Setting national direction and supporting delivery in ways that promote equality and tackle inequalities in health that arise from disadvantage and discrimination
- Taking action to support people to maximise their health, wellbeing, independence, choice and control, and
- Supporting all the people who work in the system and for the Department to deliver these goals, recognising the value of their differences in the contribution they make

Why a change is necessary

As a nation, we are living longer, healthier lives than ever before. However, we know that too many of us damage our health through the choices we make in living our lives. In addition, wider social determinants such as housing and education, impact on health. Professor Sir Michael Marmot's strategic review of health inequalities in England post 2010 (*Fair Society, Healthy Lives*) found that health inequalities result from social inequalities and that the lower a person's social position, the worse his or her health.

Despite people placing a high value on their health and wanting to live healthy lifestyles, the majority (70%) of the adult population has at least one of the major lifestyle risks (smoking, drinking above recommended guidelines, and/or being overweight or obese) that can lead to poor health, increased cost to society and lives cut short. Other lifestyle risks include drug abuse, poor sexual health and mental health conditions.

The majority of health problems fall disproportionately on individuals, families and communities that have lower incomes and lower education levels; some (such as low levels of physical activity) also affect some ethnic groups and others (such as certain cancers) affect men or women disproportionately.

Specifically:

- 21% of the adult population smokes and, while this had reduced by seven percentage points since 1998, the decline has been greater among high income groups, resulting in a widening of health inequalities

- 61% of adults and 28% children are overweight or obese[1]
- 82% of men and 65% of women consume more than the recommended 6g of salt per day.
- Fewer than 40% of adults do the recommended amount of physical activity
- 23% of adults regularly drink more than the Chief Medical Officer's recommended guidelines.
- Around 3.8% of girls under 18 become pregnant each year (the lowest levels for 30 years)[2]
- The prevalence of sexually transmitted infections continues to increase. Young people under 25 are the most at-risk, with the peak age for women being between 19 and 20 years and for men between 20 and 23 years. Of all the 15-24s diagnosed with an STI, around one in ten currently become re-infected within a year.
- The uptake rate for pre-school immunisations are slowly improving, although there is still considerable regional variation; uptake of the MMR vaccination still lags behind other childhood vaccinations at 82.9% (in 2010);
- Each year, around 70-75% of over 65s take up their flu vaccination, but only around half of clinically at-risk people under 65 do so[3]
- It is estimated that 5,000 lives could be saved each year if England met the European average on cancer survival rates. One requisite for achieving this would be people going to see their doctor sooner with common signs and symptoms of cancer[4]
- About a third of the population admit to taking illicit drugs at some point in their lives[5]

There is also inequality in access to information, support and advice: wealthier, better-educated people with managerial jobs are more likely to already have access to health information (for example via the newspapers they read or via employee wellness programmes), they are also more likely to seek out additional information (for example via websites) and to feel confidence in their own ability to use and act on that information.

While access to new technologies has been growing rapidly, there are still nine million people in the UK who have never accessed the internet. These people are more likely to be older, to have fewer qualifications and lower incomes than those who do use the internet[6]. In addition, there are 4.8 million people living in Great Britain who report that they never read or even glance through a newspaper. Moreover, 4.4 million report that they never watch any television news or current affairs programming. 785,000 people could be termed "information poor" in that they fall into both groups[7].

Reducing health inequalities is a matter of fairness and social justice. In England, there may be people who are currently dying prematurely each year as a result of health inequalities who would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life (39). Inequalities exist across a wide range of domains: age, gender, race ethnicity, religion, language, physical and mental health and sexual orientation. These inequalities interact in complex ways with socio-economic position in shaping people's health status (2).

To help redress this imbalance, this social marketing strategy will target those groups who are poorly served by other information and resource providers and will prioritise the channels these groups prefer. Without social marketing, there is a risk that people will not attempt the substantial efforts required to change their behaviours, or that these efforts will change, in the face of ingrained habits and negative market forces.

The proposed intervention is to reframe key messages around a person's needs at each stage in life from conception through to early years, at school age, as working age adults and after retirement up to death and bereavement. By making these changes, we would anticipate a positive impact on equality groups by better targeting information

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1 Health Survey of England, 2009 data
2 ONS 2009 data.
3 Winterwatch.dh.gov.uk
4 Richards, M.A. (2009) *The size of the prize for earlier diagnosis of cancer in England.* British Journal of Cancer; 101(suppl. 2): S125–9.
5 Unless otherwise indicated, all data in this section are from *Our Health and Wellbeing Today*, HM Government, 2010
6 45% of people with no formal qualifications have used the internet vs. 97% of people with degrees. Source: National Statistics August 2010.

campaigns and ensuring there is a meaningful and trusted voice delivering relevant messages. There is a commitment to review this policy to understand whether social marketing is contributing to the desired outcomes, set out in the Public Health Outcomes Framework. Each of the four programmes will have its own tailored evaluation plan, including key performance indicators.

The Department of Health's Single Equality Scheme (SES) describes both the commitment and how DH intends to meet the duties placed on it by equality and human rights legislation. The SES covers the policy process within DH and employment related duties. The SES sets out the Department's public commitment and plan for action across the six equality strands of ethnicity, gender, disability, age, sexual orientation and religion or belief. The SES also incorporates the Human Rights programme. This scheme covers the period 2009 – 2012 and is aligned with the DH Business Plan for 2009-2011.

The SES contains the following specific action for social marketing:

DH Single Equality Scheme 2009 - 2012
Policies to Promote Equality [Section 6]
Action: Develop and implement social marketing approaches in priority policy areas
Milestone: The tobacco marketing team will be carrying out an analysis of tobacco use amongst ethnic minority groups to establish the size of the different groups and priorities

Outcome: Programmes of work will be established accordingly in line with the DH tobacco control marketing communications strategy. **–** by end of the 2008/09 financial year
Indicators: Increased levels of engagement with health and social care services amongst BME and disadvantaged groups
Reduced gap in satisfaction rates between diversity groups and average for local population as measured by patient surveys
DG Responsible: Director General, Health Improvement and Protection and Chief Scientist

[7] GB TGI, 2009-10

Equality analysis

Title: Social Marketing Strategy for Public Health England

Relevant line in DH Business Plan 2011-2015**: Action 4.4.** Revise central government public health marketing strategy

What are the intended outcomes of this work? *Include outline of objectives and function aims*

Social marketing will seek to change behaviours that can lead to poor health outcomes, through four discrete programmes:

- The Smokefree programme
- Change4Life (and its sister brand, Start4Life) which will tackle all issues relating to families and middle-aged adults
- One integrated campaign, which will take a more holistic approach to well being in later life. This activity will seek to empower older people (and, where appropriate their carers) to seek prompt diagnosis and medical attention (for example through the cancer signs and symptoms campaign), and will challenge the expectation that loneliness, economic and physical inactivity, mental and physical deterioration and reduced quality of life are an inevitable part of the ageing process
- A new programme, targeting young people, which will seek to influence behaviours, such as smoking, binge drinking, experimenting with drugs and risky sexual behaviours, that form part of a pattern of risk-taking in the transition from the child to adult self.

These four have been prioritised because they address those segments of the population who are greatest users of health services, because there is prior evidence that marketing can have an impact in these areas and/or because a strong case can be made that people's lifestyles are amenable to change.

Each programme will be evaluated in terms of monetised benefits and Quality Adjusted Life Years (QALY)s. To be judged effective, the programmes will need to deliver 733 QALYS in aggregate.

Beyond the life course approach, Government retains an additional responsibility to provide authoritative national information on some topics, such as the health impacts of using illicit drugs or the health harms of regularly drinking above recommended guidelines. This information will be communicated to all individuals and income groups to whom they are relevant, regardless of the stage in the life course they may have reached. Much of this communication will be via help lines and web sites.

Who will be affected? *e.g. staff, patients, service users etc*

Most social marketing engages with the public. Each programme is targeted to those population groups who are most affected and/or have greatest need of information, support and advice to overcome lifestyle risks, specifically:

- Programme 1: Tobacco: low income groups (particularly those engaged in routine and manual jobs), pregnant women, young people (through discouraging uptake), ethnic minority communities (particularly South Asian communities)

- Programme 2: Change4Life: pregnant women, young families and middle-aged adults. There is a discrete strand of activity for ethnic minority communities (particularly black African, Caribbean, Pakistani and Bangladeshi families). Overall, the programme focuses its attention on low income groups, including families with low literacy levels.
- Programme 3: Early Signs and Symptoms: older people and their carers.
- Programme 4: Young people.

Resources will also be provided for relevant staff groups (such as general practitioners) and wider influencers on health outcomes (such as schools and voluntary groups).

Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment. For more information, see the current DH Transparency Plan.*

What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.*

Principal sources are listed below, grouped by their relevance to each protected characteristic. In addition, sources are referenced throughout the remainder of this document.

Sources that are relevant to more than one protected characteristic

1. Department of Health: Our Health and Wellbeing Today
2. Marmot, Fair Society, Healthy Lives: A strategic review of health inequalities in England post 2010
3. Healthy Foundations Lifestage Segmentation, Department of Health, 2007
4. Health Survey of England: obesity and physical activity statistics, 2009
5. Health Survey of England: alcohol statistics, 2009
6. National Awareness and Early Diagnosis Initiative: Research for Cancer Research UK and the DH, Research Works, April 2010.

Understanding health inequalities and the role of marketing in addressing these: disability

7. Closing The Gap: The Disability Rights Commission, 2006

Understanding health inequalities and the role of marketing in addressing these: race

8. Tacking Adult Obesity: An Ethnic Minority Perspective: Chandler, J and Macauley, P, COI, 2010
9. Childhood Obesity and Infant Nutrtion/Weaning Practices: Ethnic Minority Communities, COI for the London Social Marketing Unit, April 2009
10. Ethnic Minority Smoking, Research Debrief, Turnstone, 2007
11. Ethnic Minority Masterclass, DH, 2008
12. Smoking Amongst Polish Citizens in the UK, Qualitative Research Debrief, April 2007, Diagnostics South Asian Sexual Health. Ethnic Dimensions, June 2008.
13. Achieving Equality in Health and Social Care: the Afiya Trust, 2010

Understanding health inequalities and the role of marketing in addressing these: age

14. Want Respect Campaign: Qualitative Research Among Looked After Children, Define, June 2007
15. Ethnographic Research Among Low Income Middle Aged Adults, 2CV, 2010
16. Ethnographic Research Among Low Income Families, 2CV, 2010
17. Family Involvement in Weight Control, Weight Maintenance and weight loss interventions: a systematic review of randomised trials: McLean, N, Griffiths, S, Tovey, K and Hardeman, W, International Journal of Obesity (2003), 27, pp 987-1005

18. NHS Information Centre: Statistics on smoking in England (2010)
19. Guidance on the consumption of alcohol by children and young people, CMO report, 2009
20. National Survey of Sexual Attitudes and Lifestyles, 2000
21. Smoking, drinking and drug use among young people in England, 2009, Information Centre for Health and Social Care.

Understanding health inequalities and the role of marketing in addressing these: gender reassignment (including transgender)

22. Engendered Penalties: Transgender and transsexual people's experiences of inequality and discrimination, Whittle, S, Turner, L and Al-Amani, M, Manchester Metropolitan University, 2007.
23. Trans Research Review: Equalities and Human Rights Commission Report 27, Mitchell, M, Howarth, C, 2009

Understanding health inequalities and the role of marketing in addressing these: sexual orientation

24. Department of Health, Reducing health inequalities for lesbian, gay, bisexual and trans people
Nawyn, SJ, Richman, JA, Rospenda KH and Hughes, TL (2000) Sexual Identity and Alcohol Related Outcomes, Journal of Substance Abuse, 11(3): 289-304
25. Department of Health: Healthy Lifestyles for lesbian, gay, bisexual and trans (LGBT) people
26. Integrated Household Survey, ONS 2010

Understanding health inequalities and the role of marketing in addressing these: religion or belief

27. Department of Health, Religion and Belief: A practical guide for the NHS

Understanding health inequalities and the role of marketing in addressing these: pregnancy and maternity

28. Qualitative Research to inform the development of a campaign to promote breastfeeding, Cragg Ross Dawson, March 2007
29. Infant Feeding Survey, 2005, Bolling, K, Grant, C, Hamlyn, B and Thornton, A, ONS 2005
Assessing Learning Needs for Breastfeeding, McFadden, A, Renfrew, MJ, Dykes, F and Burt, S, Maternal and Infant Nutrition, 2006, 2, pp 196-203.
30. Pregnancy and Early Years Message Testing, Define, April 2009
31. Smoking in Pregnancy, Qualitative Research Debrief, Research Works, April 2007

Understanding health inequalities and the role of marketing in addressing these: carers

32. Qualitative Research concerning Attitudes to Dementia, Corr Wilbourn, 2009

Understanding health inequalities and the role of marketing in addressing these: other identified groups

33. Variations in Life Expectancy between rural and urban areas in England, 2001-07, ONS Health Statistics Quarterly, Summer 2010
34. Indications of Public Health in the English Regions and Alcohol (2007) by NWPHO for the CMO
35. Qualitative Research with smokers in routine and manual jobs, Cragg Ross Dawson, October, 2007
36. Obesity and Socio-economic Groups in Europe: evidence and implications for action. Robertson, A, Suhr's University College, Denmark, 2007
37. Statistic on usage of the internet : Office of National Statistics August 2010
38. Qualitative research to establish the Role and Reach of the State in the Health and Wellbeing of its Citizens, Define Research, July 2009

Links to previous strategies and other equalities analyses:

39. Equality Impact Assessment for Healthy Lives Healthy People (HM Government, 2010)
40. Equality Impact Screening Assessment for removing the display of tobacco products (HM Government, 2009)
41. Equality Impact Assessment for Cancer Reform Strategy (HM Government, 2007)
42 Equality Impact Assessment for Stroke (HM Government, 2007)

Disability *Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.*
Disability affects length and quality of life and can adversely affect access to services. In the

2001 Census, 18% of people reported a long-term illness or impairment that restricted their daily activities. There is a heterogeneity among disabled people, arising both from variations in impairment and variations in socio-demographic characteristics.
Stroke is the single biggest cause of disability (42) – approximately 300,000 people in England live with a moderate to severe disability as a result of a stroke.
There is considerable evidence that disabled people experience inequalities in health. For example, the Disability Rights Commission 2006 Report Closing the Gap (7) highlighted incidence of obesity and respiratory disease in people with learning disabilities and obesity, smoking and high blood pressure, respiratory disease and stroke among people with long-term mental health conditions.
Uptake of screening among disabled people is also low, for example only 19% of learning disabled women have cervical smears, compared with 77% of the general population (41).

Sex *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).*
There is significant variation in health outcomes. In males, life expectancy in urban areas ranges from 72.3 years in the most deprived quintile to 80.3 years in the least deprived quintile. The variations are much smaller in females, with life expectancy ranging from 78.1 years to 83.6 years in urban areas and 78.4 years to 83.3 years in rural areas (33).
There are some gender-related variations in health outcomes and access to services, for example:

- Some cancers are gender-specific (such as prostate, testicular, ovarian and cervix); others affect one gender more than others (breast, skin, lung); some of this is due to the lifestyle factors, such as smoking, obesity, and sun exposure, that will be tackled by the social marketing programmes contained in this strategy
- Men are less likely to visit their GP than women although the gap between genders narrows as people age (39).
- More women who have strokes die from them by comparison to men (42)

Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.*
The Afiya Trust in *Achieving Equality in Health and Social Care*, Spring 2010, suggests that many minority ethnic communities have poor access to health and social care services for a variety of reasons, including language barriers, lack of information, social isolation, lack of culturally sensitive services and negative attitudes about communities (13).
In addition:

- Some minority ethnic communities have a higher incidence of certain conditions, for example stroke has a 2.2 higher incidence in people of African and Caribbean origin (42)
- In screening pilots for bowel cancer, uptake was lower among minority ethnic groups than the general population (41)

Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*

People can experience poor health outcomes at any time, but tend to have different needs for information, support and advice at different stages, specifically:

Pre-natal and Pre-school:	support relating to the early years, including immunisation, maternal health in pregnancy (27), smoking in pregnancy, smokefree environments, alcohol

	and drug use in pregnancy, education in PHSE, breastfeeding, weaning and active play (16, 24, 25, 26)
School years:	parents need support on family diet and physical activity, mental wellbeing (tips for raising a happy child), education in PHSE, smokefree environments, strategies for parents to help their children delay initiation into risky behaviours (smoking, sex, alcohol etc.) (16)
Young people:	Young people can be vulnerable to risky lifestyle behaviours, for example: every year 320,000 young people try cigarettes for the first time (18), by 15, the vast majority of young people have had their first alcoholic drink (19), the average age at which young people first have sex is now sixteen (20) and three quarters and 15% of young people reported taking drugs in the last year (21). There is thus a need for a trusted source of information on subjects like alcohol and drugs as well as support and resources to help young people negotiate the transition from their child to their adult selves, including resilience and negotiation skills around smoking, alcohol, drugs and sex (1, 14).
Mid life:	smoking cessation, responsible drinking (5), weight loss, diet and physical activity (4), tackling any poor sexual health issues, health and wellbeing at work, at-risk immunisation, planning for future needs (6, 15)
Retirement:	The prevalence of most acute and chronic diseases increases with age, including cardio-vascular disease, diabetes, suicide and dementia. For most cancers, the risk of developing cancer increases with age, and three quarters of all cancer deaths occur in people over 65. Yet many older people are unaware that they are at increased risk of developing cancer. In addition, older women with breast cancer are more likely to delay seeking help than younger women (41). The proportion of people with a long-term disability that restricts their daily activities increases with age. About 3.5 million people aged 65+ have a limiting longstanding illness or disability (39) There is thus a need for more information on the signs and symptoms of conditions like cancer and dementia (1, 6), advice for living with conditions (including the impact of alcohol consumption upon those conditions), smokefree homes (for at-risk patients), smoking cessation, maintaining mental wellbeing, making best use of service, planning for future needs, such as end of life care.

Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.*

The term “transgender” is used to describe people who have a strong belief that they properly belong to their non-biological gender. Under the Equality Act 2010, trans people who have changed their sex, are in the process of changing their sex or have informed someone that they are planning to change their sex, are given additional protection against discrimination.

Estimates of the number of trans people in the UK vary from as low as 65,000 to 300,000 (22). The absence of a definitive official estimate makes it impossible to establish the level of inequality, discrimination or social exclusion experienced by trans people.
However, Engendered Penalties: transgender and transsexual people’s experiences of inequality and discrimination (18) highlighted that 29% of trans people felt that being trans affected the way they were treated by the health service. The Trans Research Review (23) argued that negative experiences of the healthcare system place trans people at risk of alcohol abuse, depression, suicide, self-harm, violence, substance abuse and HIV.

Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*

Lesbian, gay, bixesual and trans (LGBT) people experience a number of health inequalities, which are often unrecognised in health and social care settings. Research (22) suggests that discrimination has a negative impact on the healthy of LGBT people in terms of lifestyles, mental health and other risks. LGBT people have higher levels of alcohol consumption, are more likely to smoke and more likely to misuse drugs than heterosexual people.
There is some suggestion that lesbians may be at increased risk of breast cancer, since they may be less likely to have children (41).

Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.*

Religion or belief can impact upon lifestyle risks (particularly alcohol consumption or smoking), and should be given due consideration when providing advice for others (particularly dietary advice) (27).

However, it should not be assumed that an individual belonging to a specific religion or belief system necessarily complies with or fully observes all the practices or traditions of that belief system. (27)

Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*

Pregnancy and maternity are both times when women can need additional information, support and advice on both their own health and that of their new baby (28, 29, 30, 31).

Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.*

Carers provide unpaid care and support to ill, frail or disabled friends or family members. People from all walks of life and backgrounds are carers – three in five people will become

carers at some point in their lives. Caring can be a rewarding experience but many carers face isolation, poverty, discrimination and ill health (39)
Carers can be highly influential in noticing negative changes in the health and wellbeing of those for whom they care. This is particularly the case for conditions that affect older people (such as the onset of dementia). They therefore need to have access to information, support and advice on a range of conditions (32). Carers UK suggest that lack of information (together with lack of appropriate support, isolation and financial stress) can contribute to ill health experienced by carers themselves (39).

Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*

The majority of health problems fall disproportionately on individuals, families and communities that have lower incomes and lower education levels (2,3)
For example, lung cancer incidence is significantly higher in deprived than more affluent groups and while breast cancer incidence is higher in affluent groups, outcomes are worse in more deprived groups (41) in part due to the fact that awareness of the symptoms of cancer is poorer in more deprived groups (41), leading to late presentation and diagnosis.

There is also inequality in access to information, support and advice: wealthier, better-educated people with managerial jobs are more likely to already have access to health information (for example via the newspapers they read or via employee wellness programmes), they are also more likely to seek out additional information (for example via websites) and to feel confidence in their own ability to use and act on that information.
For example 45% of people with no formal qualifications have used the internet vs. 97% of people with degrees (37).

Engagement and involvement

Was this work subject to the requirements of the cross-government Code of Practice on Consultation? (N)

How have you engaged stakeholders in gathering evidence or testing the evidence available?

Many of our evidence sources were commissioned in partnership with stakeholder groups. For example, the early signs and symptoms campaign for cancer (which will be the core element of one of the four programmes) was developed as a result of a major research programme developed in conjunction with Cancer Research UK. This research included, ethnic minorities (both settled communities and recent migrants) and with lesbian and gay people.

Similarly much of the evidence for the dementia early signs and symptoms work was developed by Age UK

How have you engaged stakeholders in testing the policy or programme proposals?

The consultation for Healthy Lives, Healthy People (39), the public health white paper, included feedback that has shaped (and will continue to shape) the development of the social marketing strategy, specifically:

- The National Childbirth Trust (NCT) called for support for parents in the transition to parenthood, to help parents get off to the right start. This will be addressed via the

Start4Life component of the Change4Life programme.

- Age UK noted that a significant factor for older people was the prevalence of multiple conditions and frailty. The older people strand of the social marketing strategy will seek to build linkages between common conditions affecting older people (with the aspiration that the programme will challenge the assumption that mental and physical deterioration are an inevitable part of the ageing process and seek to empower older people to seek prompt diagnosis and medical attention across a range of conditions).
- The Afiya Trust commented that they felt it was not possible to achieve better health and wellbeing for all without addressing the specific needs of our diverse, minority ethnic communities. This reminds us to ensure that each of the four programme strands contains appropriate materials for ethnic minority communities.

In addition, each of the four programmes engages (and will continue to engage) with stakeholder groups through stakeholder consultations (for example, the Change4Life programme was included within the stakeholder engagement programme for the development of the obesity strategy. This programme included representation from the medical profession (general practice, midwifery), charities and NGOs (CRUK, NHF, Weight Concern, DIPEx, Which?) and ALBs (Youth Sport Trust).

Many of our campaigns are delivered in partnership with NGOs (e.g. Age UK for dementia, CRUK, BHF and Stroke Association for alcohol health harms).

All our messaging is tested with the intended target audiences before it is made public.

All our digital channels are accredited at least AA for digital accessibility.

See annex for more detail

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

(see annex)

Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

The social marketing strategy aims to positively impact those groups in society who disproportionately experience poor health outcomes or who disproportionately exhibit those risk factors (such as poor diet, low activity levels, drinking above recommended guidelines, smoking and late access to services) that result in those poor outcomes.

In particular, the evidence from the tobacco control campaign (which has historically targeted low income and low education groups) has contributed to a decrease in smoking levels among people working in routine and manual jobs. The strategy will extend targeted interventions to other groups (including pregnant women and preventing youth uptake).

Targeted interventions among low income families have resulted in over 500,000 families signing up to the Change4Life programme (healthier diet and better physical activity levels).

Targeted interventions in dementia, stroke and cancer have shown improvements in the way older people (and their carers) access services.

The new youth-targeted strand of activity will seek to impact on young people, particularly those who are most at risk of poor health outcomes.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

The strategy aims to make services more accessible (and appropriate for) groups who were previously disengaged from their health and wellbeing.
For example, by providing services that can be accessed remotely (via the internet, telephone or the post) such as the tobacco control Quit Kit or the FRANK drugs help line, we are tackling indirect discrimination

Advance equality of opportunity *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

The strategy of migrating information, support, advice and other products and service to digital channels makes them increasingly accessible to groups who might avoid direct interaction with health services. Increasing use of social media enables people with protected characteristics to share information and ideas. At its best, technology can empower citizens to make better decisions about their wellbeing for themselves (and their dependents), based on their own individual circumstances

Technology also facilitates individual tailoring of information and presentation of choice based on personal circumstances.

For example, Engendered Penalties (22) found that trans people, who may be geographically isolated, are in the foreground of information technology and internet development.
Developing our use of social media will be especially important for the youth programme and for families. Recent ethnographic research (16) with low-income families found that children were significant drivers of new technology within households and researchers witnessed children as young as three using their own laptop computers.

However, we have committed to the continued production of paper-based products for groups who are not digitally enabled (particularly older people and people on low incomes)
The creation of “white labelled” tools (applications and widgets that can be taken and used by stakeholder organisations) further helps disseminate information.
Targeting partner-funded incentives (such as money-off healthy foods and physical activities) to low income groups enables people who might not otherwise have been able to afford healthy behaviours to trial them. (For example, one million voucher booklets, each with a value of £50 were distributed to low income families through the network of Change4Life local supporters).
Providing information and support to young people may advance equality of opportunity since

the World Health Organisation has identified a link between the right to information and the right to education as contributing to a reduction in vulnerability to ill health (40). In particular, action to reduce smoking uptake in young people should advance equality of opportunity, since there is a relationship between smoking and low educational outcomes, young people who smoke being two and a half times more likely to truant than those who do not smoke (40).

Promote good relations between groups *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

If we are successful in reducing health inequalities, we should promote a more equitable and cohesive society. Research conducted for the Department of Health by Define in 2009 (38) found that the prominence of health inequalities created resentment of groups of people (such as recent migrants or low income parents) perceived as "other". In addition, there was a tendency to blame groups of people who exhibited poor lifestyle behaviours (such as the obese, or smokers) for their health problems and to resent the cost to the health services of treating these people (33, 19).

What is the overall impact? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*

We believe that the social marketing strategy has the potential to make a positive impact on equality groups, through reducing the barriers that currently exist, through bolstering motivation to change/adopt healthier behaviour among less-engaged groups and increasing access to information and other forms of marketing-driven support.
Specifically:

- Improvements to diet and physical activity (via Change4Life) should reduce future incidence of diabetes, musculoskeletal conditions, heart disease and dementia (50% of dementias have a vascular component).
- The tobacco strand aims to generate an additional 1.5m quit attempts and 100,000 successful quits a year, contributing to overall reduced prevalence of smoking. Reduced prevalence will reduce the number of cancers, heart attacks, strokes and incidence of chronic obstructive pulmonary disease (COPD).
- Improving diet, physical activity, alcohol consumption and smoking should contribute to lower incidence of cancer – it is estimated that over half of all cancers could be prevented by lifestyle changes (41).

Addressing the impact on equalities *Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.*

The social marketing strategy will support the approach set out in Healthy Lives, Healthy People and the draft indicators published for consultation in the Public Health Outcomes Framework.
In order to best support these indicators, the
The strategy has the potential to reduce inequalities, since resources have been focused on improving those lifestyle behaviours which are the greatest drivers of health inequalities. The four programmes that have been prioritised were chosen because they:

The four programmes have been

- Reductions in diabetes and dementia would have a positive impact on the quality of life of citizens (particularly older people).
- Reductions in musculoskeletal conditions, heart disease, stroke, diabetes, respiratory diseases and dementia would benefit BME communities (since these are disproportionately affected by these conditions.
- Since smoking accounts for half of all inequalities in health outcomes (40), reducing the number of smokers should have a positive impact on health inequalities. In particular, it should benefit groups in society with higher smoking prevalence (who will be directly targeted by the activity). These include manual workers and some minority ethnic communities (41).
- Since cancer predominantly affects older people, campaigning to raise awareness of the signs and symptoms of cancer, should improve health outcomes and quality of life for older people; since awareness of the signs and symptoms of cancer is lower in low income groups, the marketing activity will target these groups.
- Reducing the number of strokes (through improvements in smoking, diet and activity) and encouraging stroke sufferers to seek immediate medical attention (via the signs and symptoms activity for older people) will reduce the number of people living with disabilities (42)
- Positively impacting the number of citizens living with long-term conditions has the potential to reduce the burden on carers. This would particularly benefit women (since women are more likely to take on caring responsibilities than men)

In addition, we would expect to see positive impacts upon children (through Change4Life), pregnant women (through Start4Life), low income families (Change4Life and Smokefree), ethnic minority groups (Change4Life and smokefree), young people (the new young people's strand) and older people (signs and symptoms).
There is robust cost-benefit evidence (2) that prevention and early intervention can break down cycles of inequality running through generations of families (39).

Action planning for improvement

Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.

The DH has committed to annual reviews of the efficacy of the social marketing strategy. Since reducing health inequality is core to all four programmes, any that fail to achieve their objectives will be reviewed and either amended or curtailed.

For each strand in the programme we will need to design the evaluation criteria so that we can disaggregate the impact on relevant protected characteristics.

Please give an outline of your next steps based on the challenges and opportunities you have identified. *Include here any or all of the following, based on your assessment*

- *Plans already under way or in development to address the **challenges** and **priorities** identified.*
- *Arrangements for continued engagement of stakeholders.*
- *Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)*
- *Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service*

providers and regulatory bodies

- *Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results*
- *Arrangements for making information accessible to staff, patients, service users and the public*
- *Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives.*

The impact of each programme will be evaluated via a combination of tracking studies (nationally representative), survey data (such as Health Survey of England), response data and commercial data.
Each evaluation programme must pay due regard to the impact on protected groups.
All marketing materials are researched with their core target audiences in advance of publication.

For the record

Name of person who carried out this assessment:

Alison Hardy

Date assessment completed:

9/5/2011

Name of responsible Director/Director General:

Sian Jarvis, Director General, Communications

Date assessment was signed:

18/5/2011

Annex: Stakeholder engagement in the four programmes

Tobacco Control

The tobacco control team has an academic reference group, which meets frequently to consult on all aspects of the policy, including marketing. In the past, we have part-funded academic research (through UCL).

We provide campaign information to ASH, who are conducting an analysis of the impact of mass media campaigns on quitting and smoking prevalence (although we do not fund or commission this work).

The following stakeholder organisations are being consulted in the development and delivery of the strategy. This is both via face-to-face engagement (the next meeting is in May) and written comments.

Academics:

- UCL
- University of Edinburgh
- University of Stirling
- The UK Centre for Tobacco Control Studies (specifically the inequalities lead)
- University of Sydney
- Global Dialogue for Effective Stop Smoking Campaigns

Commercial sector stakeholders:

- Boots
- Sainsbury
- GSK

Public sector stakeholders:

- Chartered Institute for Environmental Health
- LGA
- Cabinet Office Behavioural Insights Unit
- NICE

Professional Bodies:

- Royal College of General Practitioners
- British Medical Association
- Royal College of Nurses
- National Association of Primary Care

NGOs/third sector:

- ASH
- Cancer Research UK

- British Heart Foundation
- British Lung Foundation
- Men's Health Forum

Change4Life

The most engaged stakeholders include:

- Cancer Research UK
- Diabetes UK
- British Heart Foundation
- Stroke Association
- MEND programme

Engagement is via partnership in the Change4Life programme (Cancer Research UK, Diabetes UK and BHF are all founding partners of Change4Life and have run co-branded marketing and communication in support of the campaign and have distributed Change4Life vouchers to their members). In addition, Cancer Research UK peer-reviewed the Change4Life marketing strategy (2009) and Change4Life One Year On (2010).

Cancer Research UK, BHF, Diabetes UK and Stroke Association have twice met with Secretary of State to discuss the Change4Life programme in December 2010 and March 2011.

Other stakeholder organisations that have joined as Change4Life partners include:

- National Family Week
- Busy Bees
- National Childminding Association
- National Osteoporosis Association
- Netmums
- The Ramblers

Engagement with partner organisations is via regular newsletter and a dedicated area of our website. We are currently improving this to allow partners to share information and views.

In addition, two meetings were held in March 2011 with the following stakeholders to discuss the development of Change4Life (and the broader obesity policy). Attendees included:

- LGA
- National Obesity Forum
- Which?
- National Heart Forum
- Cancer Research UK
- Weight Concern
- DiPEX
- Mend
- National Obesity Observatory
- Youth Sport Trust

- Sustrans

The following representatives of ethnic minority communities attended a stakeholder event in 2010 to discuss the implications of Change4Life for ethnic minority communities:

- Ethnic Dimension
- Media Moghuls
- Illumina Lifestyle Consulting
- Diabetes UK (equality and diversity manager)
- Rich Visions Marketing Agency
- Ethnos Research and Consultancy
- Afiya Trust
- NHS Tower Hamlets (lead of health trainers in Bangladeshi mental health community)
- Ethnic Health Foundation
- British Heart Foundation (Ethnic Strategy Manager)
- NHS Mid Essex (BME community worker in mental health)

Young People

The young people's strand is at an embryonic phase.

We will consult extensively in the development of the strategy, including:

- Other government departments, particularly DfE, Home Office and Ministry of Justice (for youth offenders)
- Schools, charities and youth workers
- Commercial brands that target youth
- Organisations (such as the Youth Social Enterprise, Rough Hill) run by young people.

Older people

Stakeholder have been engaged in the development of the strategy and in the commissioning of research, for example

Alzheimers' Society: co-commissioned the Attitudes to Dementia research project in November 2011.

Cancer Research UK: co-commissioned the National Awareness and Early Diagnosis Initiative: Research for Cancer Research UK and the DH, Research Works, April 2010.