



ACTION-FOR-HEALTH



Reducing Health Inequalities through Health Promotion and Structural Funds



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Reducing Health Inequalities through Health Promotion and Structural Funds**

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Prepared by **Centre for Health Research, University of Brighton**

Editors **Dr Nigel Sherriff, Dr Lisa Gugglberger, Professor John Kenneth Davies**

Authors **Centre for Health Research, University of Brighton
Dr Nigel Sherriff, Dr Lisa Gugglberger, and Professor John Kenneth Davies**

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Contact **Tatjana Krajnc-Nikolić, project co-ordinator;
tatjana.krajnc-nikolic@zzv-ms.si
Zavod za zdravstveno varstvo Murska Sobota,
Arh. Novaka 2b, 9000 Murska Sobota, Slovenia
www.action-for-health.eu**

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Preface

This publication is the second in a series of publications within the ACTION-FOR-HEALTH project which is coordinated by the Institute of Public Health in Murska Sobota (Slovenia). ACTION-FOR-HEALTH is a European Union (EU) co-funded project within the framework of its Public Health Programme (2008-2013). It builds on the previous experiences gained from a successful Slovenian health promotion project aimed at reducing inequalities at regional level carried out by the Institute of Public Health in Murska Sobota in collaboration with the Flemish Institute for Health Promotion (Belgium; see Belović *et al.*, 2005). ACTION-FOR-HEALTH aims ultimately to improve the health and quality of life of EU citizens by tackling health inequalities through health promotion. Over the duration of the two-year project, this will be achieved (*inter alia*) by strengthening the capacity of health promotion and public health workers in their regions to tackle health inequalities using health promotion principles and practice. This is being facilitated by the development of action plans within seven regions in seven European countries: Bulgaria, Croatia, Estonia, Hungary, Lithuania, Slovakia and Spain.

In general, citizens of the EU now live, on average, longer and healthier lives than previous generations. Yet despite this, although

the average level of health in the EU has continued to improve, differences in health between people living in different parts of the EU and between the most advantaged and most disadvantaged sections of the population remain substantial and in some instances have increased (European Commission, 2009). Reducing health inequalities within and between European Member States is crucial at local, national, regional, and international levels. This is because health inequalities are unjust as they are not always the result of individual behavioural choices, genetic factors, or lifestyle factors. Inequalities in health are thus preventable and ultimately inequitable and unfair. To this end, it is now well established that health promotion can play a major role in efforts designed to tackle health inequalities.

This publication builds specifically on the work developed by Work Package 5 (WP5) of the ACTION-FOR-HEALTH project. WP5 aims to increase the capacity of stakeholders (e.g. public health professionals, policy makers etc.) within appropriate European regions to use health promotion interventions to effectively tackle health inequalities as a core part of strategic action plans that can access European Structural Funds. Building practical capacity and competency is essential to enable stakeholders to understand and use

effectively health promotion actions to reduce health inequalities and maintain and promote health. The first part of this publication explains the underlying concepts and principles of health promotion on which effective practice is based and how health inequalities can be tackled using such actions, in particular by accessing European Structural Funds. The second part of the publication highlights methods

developed by the ACTION-FOR-HEALTH project, which form a bespoke training strategy that facilitates health promotion capacity building into practice.

**Dr Nigel Sherriff, Dr Lisa Gugglberger,
and Professor John Kenneth Davies**

Leaders of Work Package 3 & 5
for the ACTION-FOR-HEALTH project
University of Brighton, November 2013.



I Health and health inequalities in the EU

Setting the scene: health and health inequalities in the EU

There are established and growing inequalities in health both between, and within most European Member States, even though their populations are healthier than at any time in their history (e.g. Mackenbach *et al.*, 2007). These inequalities form a systematically patterned 'gradient' between health and social circumstance across their entire populations which can affect all individuals, with substantive evidence demonstrating that health

becomes worse as you move down the socio-economic scale (Davies & Sherriff, 2011, 2012; Graham, 2001). The reasons for these health inequalities are complex and involve a wide range of factors which relate to the wider social determinants of health including living conditions, health related behaviours, education, occupation and income, disease prevention and health promotion services, health care systems, health policy, and so on (Figure 1).

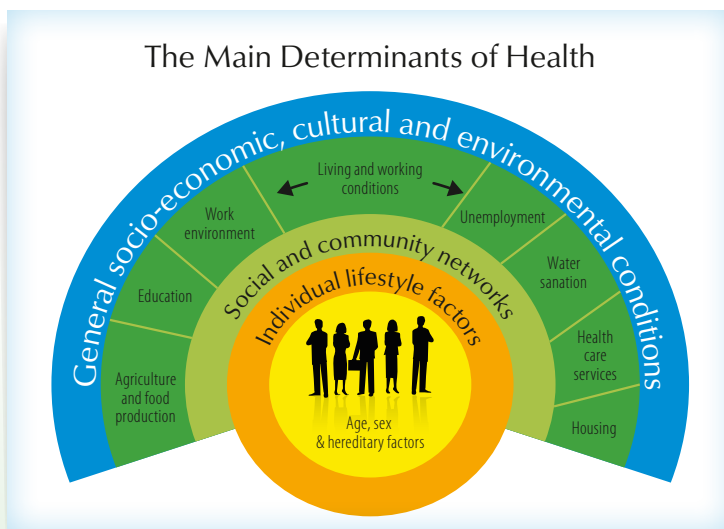


Figure 1: *Determinants of health (Dahlgren & Whitehead, 1991)*

Health inequalities persist along the life-course starting at birth and continuing into old age. Health inequalities are unjust because they are not always the result of individual behavioural choices, genetic factors, or lifestyle factors and are thus deemed inequitable. This is important as whilst inequality can apply to any variation in health; inequity is only applied to those variations which are deemed to be unjust and therefore preventable.

Although this is an important distinction, in our experience the literature (academic and ‘grey’) is often inconsistent in differentiating between health inequalities and health inequities. However, while we acknowledge this distinction, throughout this document we adopt the broader term ‘health inequalities’ synonymously with health inequities both for convenience and brevity (Davies & Sherriff, 2012; Davies & Sherriff, in press).

Health inequalities are unjust because they are not always the result of individual behavioural choices, genetic factors, or lifestyle factors and are thus inequitable.

In addition to the ‘moral case’ for addressing health inequalities, there is also a considerable economic case for the EU and its Member States. For example, Mackenbach *et al.*, (2011) estimate that when health is valued as a ‘capital good’, inequalities related losses have been estimated to cost around €141 billion or 1.4% of GDP. However, when health is valued as a ‘consumption good’ this rises substantially to 1,000 billion or 9.5% of GDP. Although Mackenbach and his colleagues acknowledge that these estimates require confirmation through additional studies, clearly the

economic as well as the moral implications of health inequalities warrant considerable attention and investment in policies and interventions to reduce them.

Indeed, reducing health inequalities (and inequities) is regarded as one of the most important public health challenges facing the EU and its Member States (EC, 2009). It is also a major policy focus at global level with the Global Commission on the Social Determinants of Health (CSDH) advocating to the World Health Organisation (WHO) and all governments that:

“...Achieving health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it.” (WHO, 2008, p.22)

Addressing health inequalities is also a key action of the current EU Health Strategy (2008-2013) which identifies equity in health

as a fundamental value and has led to an orientation towards addressing health inequalities in areas such as mental health, tobacco,



youth, cancer, and HIV/AIDS. The EU Public Health Programme (DGSANCO) has also supported the identification and development of activities to address health inequalities including a portal of European directory

of good practices (see www.health-inequalities.eu). Table 1 gives an overview of examples of projects designed to tackle the social determinants of health inequalities funded by the EU Public Health Programme.

European Project Acronym and Title	Main Objective (s)	Website/Source
Correlation II - European Network Social Inclusion and Health	The overall aim of Correlation II is to tackle health inequalities in Europe and to improve prevention, care and treatment services, targeting blood-borne infectious diseases (BBID), in particular Hepatitis C and HIV/AIDS among vulnerable and high risk populations (e.g. drug users and young people at risk)	www.correlation-net.org/
DETERMINE - An EU Consortium for Action on Socio-Economic Determinants of Health	To apply the EU and its Member State's shared policy competences to act on the socio-economic determinants of health, to ensure greater awareness of the responsibility that all policy sectors, beyond the health sector, have with respect to maintaining and improving the health of EU citizens, and to gather the evidence of the benefits of greater collective investment in health.	www.health-inequalities.eu
ENWHP - Networking Workplace Health in Europe	To contribute to the reduction of health inequalities, to the development of a European health information system and to improving important health determinants with impacts on all relevant settings in working and non-working life.	www.enwhp.org
EUROREGIO III - Health investments in Structural Funds 2000-2006: learning lessons to inform regions in the 2007-2013 period	To extend the results of EUREGIO to identify & share best actions for the effective use of Structural Funds for health & help reduce health inequalities among EU regions. It is a key resource to help Member States, regional & local authorities and actors to develop, apply & implement Structural Funds (SF) projects for health gain.	www.euregio3.eu
EUROTHINE - Tackling health inequalities in Europe: an integrated approach	To develop health inequalities indicators, and to provide bench-marking data; to assess evidence on the effectiveness of policies and interventions to tackle the determinants of health inequalities, and to make recommendations on strategies for reducing health inequalities in participating countries; to disseminate the results, and to develop a proposal for a permanent European clearing house on tackling health inequalities.	http://ec.europa.eu/health/ph_projects/2003/action1/docs/2003_1_16_frep_en.pdf

European Project Acronym and Title	Main Objective (s)	Website/Source
GRADIENT - Applying Public Health Policies to Effectively Reduce Health Inequalities among Families and Children	The GRADIENT project had the overall goal of identifying what measures could be taken to level-up the socio-economic gradients in health among children and young people in the EU. The main objectives were to develop a consensus based European Framework to monitor and evaluate public health policies, to assess if and why children and families from different socio-economic groups respond and act differently to public policy interventions, to make a review of protective factors for the health of children and young people and their families focusing on social capital, and to analyse different welfare regimes and general policies in different EU countries and compare the impact for families and children.	http://health-gradient.eu/about/other-research/gradient
I2SARE - Health inequalities indicators in the region of Europe	To assist European, national, regional and local decision makers in developing their health policy, through a better understanding of the health status of the population and of health inequalities at regional and sub-regional level.	www.i2sare.eu
NowHereland - Improving services for undocumented migrants in the EU	To improve the level of health protection for the people of Europe by addressing migrants' and immigrants' access, quality and appropriateness of health and social services as important wider determinants for health. Focusing on healthcare services for undocumented migrants (UDMs) as an especially vulnerable group, an increasing public health risk and as a group providing difficulties for healthcare providers and health policy.	www.nowhereland.info
ROMA-HEALTH - Health and the Roma community: analysis of the situation in Europe	To contribute to the reduction of health inequalities affecting the Roma community in Europe; obtain reliable and objective data about the social/health situation of the Roma population and the use made of healthcare resources available for the mainstream society; identify factors considered vital in improving the Roma situation and promote equity; promote synergies between public/private sphere (health centres, hospitals, social organisations, public administrations, etc.).	www.gitanos.org/european_programmes/health
TEENAGE - The prevention of socioeconomic inequalities in health behaviour in adolescents in Europe	To formulate policy recommendations to prevent socioeconomic inequalities linked to the health behaviour of European adolescents.	http://ec.europa.eu/eabc/projects/database.html?prjno=2006323

Table 1: A selection of projects on the social determinants of health inequalities funded by the EU public health programme

Other EU policies and financial mechanisms also contribute both directly and indirectly to tackling health inequalities including Cohesion Policy and Structural Funds;

the European Agricultural Fund for Rural Development; the forthcoming Together for Health Programme (2014-2020); the Research Framework Programmes (currently FP7);



the forthcoming Horizon 2020; the employment and social solidarity programme (PROGRESS); the Sustainable Development

Strategy; and the environment and market policies under the Common Agricultural Policy (CAP).

Health promotion: foundations and principles

“Health promotion is the process of enabling people to increase control over, and to improve their health.” (WHO, 1986)

It is globally accepted that health and social wellbeing are determined by many complex factors interacting outside the health system including demographic patterns, socio-economic conditions, employment, and housing, for example. This is why health knowledge and practice are closely related to the cultural, socio-economic and political structures of the society in which they are formed. It is therefore important to analyse the socio-cultural processes and contexts in which health occurs. Health-related behaviour and the social and environmental conditions that influence health therefore need to be understood within the social, cultural, economic, and political context in which they occur. In order to address health issues, a more complex and holistic approach is thus required that moves beyond the traditional bio-medical model of health. This traditional and dominant model

reflects the individual professionally driven and biological paradigm of health, which is based on natural and medical science, whose origins lay in pathogenesis, that is, the origins of illness.

In order to take account of the ecological dimensions of health and act as a challenge to the bio-medical model, a socio-ecological paradigm based on a salutogenic perspective with the origins of health, has been proposed to take account of the above contexts in which health occurs. Within such a paradigm, health promotion, based on the concepts and principles of the WHO Health for All Strategy (WHO, 1981) was developed to facilitate a holistic approach by empowering individuals and communities to take action for their health, fostering leadership for public health, promoting intersectoral action to build healthy public policies in all sectors and creating sustainable health systems.

“Health promotion aims to empower people to control their own health by gaining control over the underlying factors that influence health. The main determinants of health are people’s cultural, social, economic and environmental living conditions, and the social and personal behaviours that are strongly influenced by those conditions.” (IUHPE, 2007).

Although not a new concept, health promotion received an impetus following the WHO Alma-Ata declaration (WHO, 1978). Over the last three decades, health promotion has received international attention and acclaim. The WHO has been the driving force in this process by establishing a vision, framework and agenda through a series of international conferences in an attempt to formulate new ways of understanding and promoting health with the first conference in Canada producing the pivotal Ottawa Charter for Health Promotion (WHO, 1986; Figure 2).

The Ottawa Charter identifies three basic strategies for health promotion. These are advocacy to create the essential conditions for health; enabling all people to achieve their full health potential; and mediating between the different interests in society in the pursuit of health. These strategies are supported by five

priority action areas including: Build healthy public policy; create supportive environments for health; strengthen community action for health; develop personal skills, and; re-orient health services (Figure 2).

This cornerstone declaration and international conference for health promotion was subsequently followed by others which explored the major themes of the Ottawa Charter including for example, the Adelaide recommendations on healthy public policy (WHO, 1988); the Sundsvall Statement on creating supportive environments for health (WHO, 1991); the Jakarta Declaration on leading health promotion into the 21st Century (WHO, 1997); and the Bangkok Charter for Health Promotion (WHO, 2005; For a list of all key WHO milestones from the Global conferences on health promotion see Table 2).

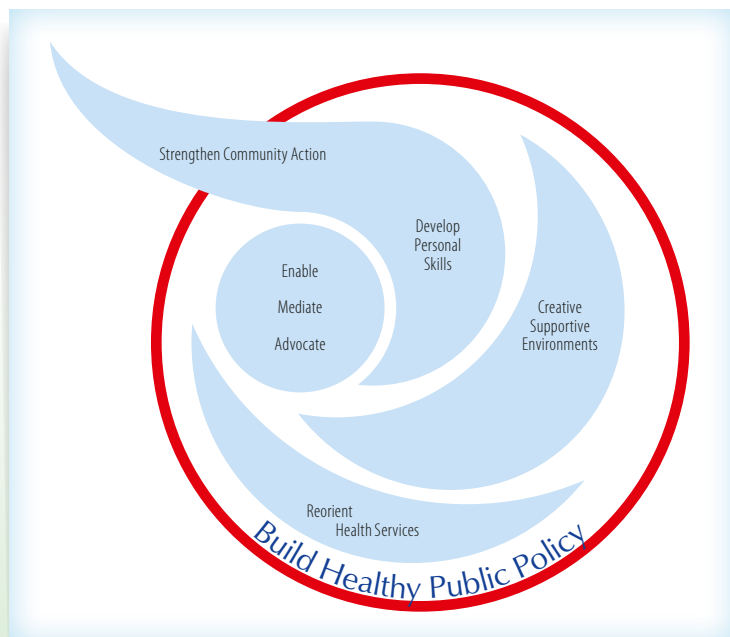


Figure 2: *The Ottawa Charter for Health Promotion (WHO, 1986)*



Global Conference	Outcome
First International Conference on Health Promotion, Ottawa 1986	Ottawa Charter for Health Promotion
Second International Conference on Healthy Public Policy Adelaide, 1988	Adelaide Recommendations on Healthy Public Policy
Third International Conference on Supportive Environments for Health, Sundvall, 1991	Sundvall Statement on Supportive Environments for Health
Fourth International Conference on Leading Health Promotion into the 21st Century, Jakarta, 1997	Jakarta Declaration on Leading Health Promotion into the 21st Century
Fifth Global Conference on Health Promotion: Bridging the Equity Gap, Mexico, 2000	Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action
Sixth Global Conference on Health Promotion, Bangkok, 2005	Bangkok Charter for Health Promotion
Seventh Global Conference on Health Promotion, Nairobi, 2009	Nairobi Call to Action
Eighth Global Conference on Health Promotion, Helsinki, 2013	Helsinki Statement on Health in all Policies

Table 2: Key WHO global conferences on health promotion 1986–2013.

Together, these conferences have contributed considerably to our collective understandings of health promotion, its strategies, and its

practical application, as well as more fully accounting for issues of relevance to developing countries (WHO, 1998).

Addressing health inequalities through health promotion

Health promotion can play a major role in efforts designed to tackle health inequalities.

The acceptance of health promotion as a central issue in public health policy has steadily gained momentum in most Western European countries over the last three decades. Building upon the principles and strategies advocated by the WHO such as the Global

Strategy for Health for All (WHO, 1981), the Ottawa Charter for Health Promotion (WHO, 1986; see also Table 2), the Health 21 strategy (WHO, 1999), and more recently, Health 2020 (the new European health policy framework; WHO, 2012) and the Helsinki

Statement on Health in All Policies (WHO, 2013) policy-makers at the local, regional, national and international levels have introduced a range of measures to improve the healthy life years of populations by addressing lifestyles (e.g. smoking, diet, physical activity etc.) and health-damaging aspects of the socio-ecological environment (e.g. hazards, environmental tobacco smoke, pollution and so on).

Whilst one of the main underpinning principles of health promotion is to involve the population as a whole rather than focusing, say, on more reductionist approaches to individual risk factors for particular diseases, linear causal pathways, and so on; health promotion also focuses explicitly on inequalities in health. Indeed the Ottawa Charter for Health Promotion (WHO, 1986) represented a fundamental shift away from individuals to the social and wider determinants of health or the 'cause of causes' - in other words, the causes of health inequalities or to be more precise, health inequities.

Since it is now widely acknowledged that inequalities in health are avoidable, and that their reduction can also have a considerable economic advantage, it has also become generally accepted that health promotion can play a major role in efforts designed to tackle health inequalities.

However, what remains less clear is which health promotion and public health efforts (e.g. policies, programmes, strategies, interventions etc.) are effective in reducing social inequalities in health. Davies & Sherriff (2011, p.2; see also Davies & Sherriff, in press) have noted that although there is extensive evidence demonstrating the presence and

causes of health inequalities, including the existence of a social gradient, little attention has actually been paid to developing solutions on how to actually reduce or tackle health inequalities. Moreover, the authors argue that there has been scant attention to both the policy process involved in developing such solutions and to the evaluation of relevant interventions. Where evaluative evidence does exist, it tends to be based on downstream initiatives rather than on upstream initiatives (e.g. income and employment policies) which influence the wider, social determinants of health and thus health inequalities (Davies & Sherriff, 2011).

This challenge of demonstrable evidence of 'what works' in health promotion (and public health) initiatives including those designed and/or implemented to reduce health inequalities is not a new one. Moreover the issue is exacerbated in part by the fact that the measurement and monitoring of inequalities in health is neither standardised nor common across all countries and over time (Davies & Sherriff, 2012). This is perhaps not surprising given that the choice of measure(s) is dependent on the particular country/region in question, as well as the availability of data, on the specific determinant chosen to be assessed, and so on. However, it does mean that greater attention is required in order to move away from focusing almost entirely on pathogenic health indicators and look to identify more salutogenic (health promotion) indicators relevant to addressing the health inequalities (Davies & Sherriff, in press). Furthermore health promotion approaches and interventions and/or initiatives to reduce health inequalities need to



be analysed more appropriately in terms of social and political processes rather than relying

on traditional epidemiological frameworks of 'evidence'.

Reducing health inequalities

Whilst lots of attention has been paid to describing and measuring... health inequalities, relatively little attention has been paid to how to most effectively reduce health inequalities in populations

Whilst lots of attention has been paid to describing and measuring the problem of health inequalities, relatively little attention has been paid to how to most effectively reduce health inequalities in populations – and that this

situation is aggravated by the lack of evaluative evidence regarding what does and what does not work in practice. Nevertheless two key frameworks and/or approaches have been proposed which are presented below.

1) A typology of actions to tackle social inequalities in health

Margaret Whitehead (2007) has developed a typology of actions to tackle social inequalities in health, referring to inequalities among different socioeconomic groups within a society. She differentiates between initiatives

that strengthen individuals, strengthen communities, improve living and working conditions, and promote healthy macro policies (see Table 3).

Category 1: Strengthening individuals in disadvantaged circumstances

These types of interventions use a person-based strategy and frame the inequality mainly in terms of a perceived personal deficit (e.g. deficiency in an individual's knowledge, beliefs, self-esteem etc.), practical competence in life skills or powerlessness. Such interventions theorise the problem in terms of an individual's personal characteristics, and the solution in terms of personal education and development to make up for these deficiencies.

Examples: health information campaigns, counselling/support, life skill training, delivered through mass media campaigns, school curriculum problems, clinics, etc.

Category 2: Strengthening communities

Interventions to strengthen communities define inequalities as related to greater social exclusion/isolation and powerlessness in hard-pressed communities, excluding people from taking part in society. There is a wide spectrum of interventions that aim to strengthen communities through building social cohesion and mutual support.

Examples: (1) initiatives that foster horizontal social interactions: community development initiatives, like the creation of meeting places; (2) initiatives that foster vertical social interaction on a societal-wide basis, like social welfare systems and initiatives to strengthen the democratic process.

Category 3: Improving living and working conditions

Interventions within this category are based on the belief that health inequalities are a result of greater exposure to health-damaging environments, both at home and at work, coupled with poorer access to essential goods and services (e.g. food supplies, education, healthcare).

Examples: Improving access to adequate housing, sanitation, safer workplaces, and better access to health care.

Category 4: Promoting healthy macro-policies

Such interventions locate the causes of health inequalities in macro-economic, cultural and environmental conditions of a country or region, which influence the standard of living experienced by different sections of the population. Interventions therefore aim at improving the macroeconomic or cultural environment to reduce poverty and the wider impacts of inequality on society.

Examples: Measures to ensure human rights, changes of labour market policies, and the promotion of equal opportunities.

Table 3: A typology of actions to tackle social inequalities in health (Whitehead, 2007)

2) Health inequalities and social determinants: a policy framework

Hilary Graham (2009) has developed a matrix which gives an outline of determinants-oriented approaches to reducing health inequalities (Table 4). This matrix can be used to map policies claiming an engagement with health

equity and social determinants, and provides a helpful overview of different approaches. In the vertical axis, goals of health inequalities are listed; the horizontal axis displays approaches to tackling social determinants.



		In broader determinants	In individual risk factors
Tackling health inequalities	Reducing gradients	(1) Increase in level of determinants in all groups to match that in most advantaged group	(2) Reduction in prevalence in all groups to match that in most advantaged group
	Narrowing health gaps	(3) Faster rate of improvement in determinants in poorest group than comparator group	(4) Faster rate of reduction in risk factors in poorest group than comparator group
	Improving health of the poorest groups	(5) Improvement in determinants in poorest group	(6) Reduction in risk factors in poorest group

Table 4: *Determinants-oriented approaches to tackling health inequalities (Graham, 2009)*

Further information on reducing health inequalities

It is beyond the scope of this publication to provide a comprehensive list of resources and information on reducing health inequalities. However, as noted previously, other useful sources include the searchable projects

database of the EC Public Health Programme (see <http://ec.europa.eu/eahc/projects/database.html>) and the Seventh Framework Programme (FP7; Figure 3):

The screenshot displays the 'EXECUTIVE AGENCY FOR HEALTH AND CONSUMERS' website. The main content area is titled 'Project database' and includes a description of the database's scope. Below this, there are filters for 'Quick lists' and 'All proposals'. A list of 30 records is shown, with the first two projects highlighted. The first project is 'NPDR - An EU rare diseases registry for Niemann-Pick Disease type A, B and C', and the second is 'ICARE4EU - Innovating care for people with multiple chronic conditions in Europe'.

Figure 3: *Projects database of the EC Public Health Programme and Seventh Framework Programme*

II European Structural and Cohesion Funds

European Structural and Cohesion Funds 2007-2013

A variety of EU policies and financial mechanisms contribute directly and indirectly to tackling health inequalities including Cohesion Policy and Structural Funds.

Structural Funds are essentially the European Union's financial instrument to implement the EU Cohesion Policy. They are also referred to as the 'Regional Policy' of the EU.

All European regions are eligible for funding, but the poorer regions receive most of the support.

For the current Structural Funding Framework for 2007-2013, there are three funding instruments that together, are worth €347 billion or 35.7% of the total EU budget (DG Regional Policy, 2013). All European regions are eligible for funding, but the poorer regions receive most of the support. Structural funds are invested to achieve the objectives of the Cohesion Policy, i.e. to reduce the economic, social and territorial disparities that exist between different regions in Europe. More specifically, these financial instruments or mechanisms are used to meet the three funding objectives:

1. Convergence–solidarity among regions (€283 billion) - The aim is to reduce regional disparities in Europe by helping those regions whose per capita gross domestic product (GDP) is less than 75% of the EU to catch up with the ones which are better off. Types of projects funded include improving infrastructure, helping businesses, training, high-speed internet infrastructure etc.
2. Regional competitiveness & employment (€55 billion) - The aim is to create jobs by promoting competitiveness and making the regions concerned more attractive to businesses and investors. This objective covers all regions in Europe not covered by the convergence objective. In other words, it is intended to help the richer regions perform even better with a view to creating an knock-on effect for the whole of the EU to encourage more balanced development in these regions by eliminating any remaining pockets of poverty. Types of projects funded include cleaner transport, support for research centres and universities, job creation, training, small business start-ups etc.
3. European territorial cooperation (€9 billion) - The aim is to encourage cooperation across borders between countries or regions



that would not happen without help from the cohesion policy. Types of projects funded include improving transport links,

creation of networks of universities and research centres, shared management of natural resources, risk protection, and so on.

The different types of Structural Funds

The EU Cohesion Policy as a whole is thus designed to support measures that will boost economic growth in Member States thereby reducing the differences in their respective levels of development (including health disparities). To meet these funding objectives, the

Cohesion policy is financed by three main funds (see Figure 4):

1. European Regional Development Fund
2. European Social Fund
3. Cohesion Fund

Objectives	Structural Funds and instruments		
Convergence	ERDF	ESF	Cohesion Fund
Regional Competitiveness and Employment	ERDF	ESF	
European Territorial Cooperation	ERDF		

Figure 4: Cohesion policy objectives and financial mechanisms

1. European Regional Development Fund (ERDF)

The ERDF (Budget: €201 billion) covers all three Cohesion Policy objectives (Figure 4) and supports major (often structural) projects addressing regional development, economic change, enhanced competitiveness (e.g. by

direct aid to investments in companies, particularly, small and medium enterprises to create sustainable jobs) and territorial co-operation. All EU regions can access the ERDF.

2. European Social Fund (ESF)

The ESF (Budget: €76 billion) covers the convergence and regional competitiveness and employment objectives of Cohesion Policy (Figure 4). The ESF seeks to improve education, training, and employment in the EU and focuses on four key areas: 1) the adaptability of workers and enterprises (lifelong learning schemes, designing and spreading innovative

working organisations); 2) access to employment for job seekers, the unemployed, women, and migrants; 3) social integration of disadvantaged people and combating discrimination in the job market, and; 4) strengthening human capital by reforming education systems and setting up a networks of teaching institutions. All EU regions can access the ESF.

3. Cohesion Fund (CF)

The Cohesion Fund (Budget: €70 billion) contributes to projects and activities in two main areas 1) Trans-European transport networks and 2) environment. The CF is specifically aimed at poorer EU regions or those with

a Gross National Income of less than 90% of the EU average. The aim is to reduce Member States' economic shortfall and to stabilise their economy.

Why Structural and Cohesion Funds to reduce health inequalities?

It is beyond the scope of this publication to present in detail the case for why and how Structural Funds can be used to reduce health inequalities in the EU. However for an excellent and detailed perspective, see WHO (2010). In short, the Structural Funds (SF) and the Cohesion Fund (CF) are an investment policy allocated by the EU as part of its regional or Cohesion policy. The funds aim to reduce regional disparities in terms of income, wealth [our emphasis] and opportunities. In the Cohesion Policy funding framework for 2007–2013, a health priority was included with an estimated €11 billion allocated from the ERDF to support direct health system investments

which includes approximately €6 billion for ageing and e-services priorities including e-health (WHO 2010). Moreover, the ESF is also used to support employment policies in regions categorised under both the Convergence and regional Competitiveness and Employment objectives (see Figure 4). In this way, the ESF can provide funding for activities aiming to improve human capacity, to support healthy population and workforce, such as health promotion and disease prevention programmes, training of the health workforce, and health and safety at work measures. In other words, Structural Funds can be used to help Member States reduce health inequalities.

Structural Funds can be used to help Member States reduce health inequalities.



Accessing Structural Funds

Accessing Structural Funds can be challenging and complicated and it's often best to work with someone or an organisation that already has experience in the process of applying and implementing a Structural Funds project. Moreover, it is important to note that projects funded by Structural Funds are co-financed. That is, in addition to the European

Commission's contribution, additional 'matched' funds are required. For the CF the EU contribution can be up to 85% but for the ESF and ERDF EU contribution ranges between 50-75%. For an overview of the 'who', 'how', 'when', 'which' and 'where' of applying for Structural Funds, see Table 5:

WHO can apply for Structural Funds?	Generally, there are few restrictions meaning a wide range of organisations can apply and benefit from Structural Funds include public bodies, some private sector organisations (especially small businesses), universities, associations, NGOs and voluntary organisations. If you are unsure, you can contact the appropriate managing authority in your country. see: http://ec.europa.eu/regional_policy/manage/authority/authority_en.cfm
HOW do I apply for co-financing from Structural Funds?	The detailed management of programmes/projects that receive support from the Structural Funds is the responsibility of the individual Member State. For every programme, a managing authority (at national, regional or another level) is designated who is then responsible for informing potential beneficiaries, selecting and evaluating projects and monitoring implementation. In most cases, funding is granted to projects, so you need to develop a project to be eligible for funding. So the first step in applying for SF is to contact the national managing authority in your country/region to ensure your idea/project fits with the national, regional or 'other' level priorities. Contact details for managing authorities in each Member State (and programme objectives and/or priorities) can be found here: http://ec.europa.eu/regional_policy/manage/authority/authority_en.cfm
WHEN can I apply for Structural Funds?	You will need to follow the particular application procedure for your relevant managing authority – some follow a rolling application process whilst others use specific calls at certain times of the year.
WHICH projects can be funded?	In each Member State, the Operational Programmes (OP) sets out the selection criteria and investment priorities for each region they cover. So before applying for funds you should thus check the OP(s) that is/are covering your region. You can find the OP for your country/region here for ERDF: http://ec.europa.eu/regional_policy/country/prordn/index_en.cfm and here for ESF: http://ec.europa.eu/esf/main.jsp?catId=45&langId=en
WHERE can I find examples of projects already co-financed by Structural Funds?	The EC holds a large searchable online database of projects that have benefited from the EU Cohesion Policy between 2007-2013. See http://ec.europa.eu/regional_policy/projects/stories/index_en.cfm

Table 5: *The who, how, when, which and where of Structural and Cohesion Funds 2007-2013*

Preparing a project for structural funding

Although a rather simplistic representation, a project submitted to access structural funding typically comprises six key steps which approximate those for submitting any other kind of project for potential funding:

1. Identification of the idea and preliminary design
2. Preparation
3. Appraisal
4. Proposal approval and financing
5. Implementation and monitoring
6. Evaluation.

To increase your chances of success in gaining structural funds:

1. Design projects that correspond to the relevant EU and national/regional priorities. Make contact early on in the process with the managing authority for your country/region;
2. Try to see that Structural Funds are not just a financing tool to fund projects, rather they are a strategic development instrument with long-term goals in mind;
3. Ensure you consider what the EU-added value of your project might be;
4. Highlight any potential economic benefits from reducing the health problem;
5. Seek synergies between cohesion policy and the Lisbon Agenda, or if applying in the 2014-2020 period, the Europe 2020 strategy.

Structural Funds 2014-2020

EU Cohesion Policy has been a considerable force for change during the current funding framework 2007-2013. To continue this work in the future and to strengthen the focus on European economic priorities, the EC (at the time of writing) is in the process of finalising the new Cohesion Policy for 2014-2020. The new framework is specifically intended to reinforce the strategic dimension of the policy and to ensure that EU investment is targeted on Europe's long-term goals for growth and

jobs (Europe 2020 strategy of smart, sustainable, inclusive growth). Other changes include a greater focus on results (e.g. the use of common indicators, reporting, monitoring, and evaluation, and so on), and a focus on maximising the impact of EU funding (e.g. more coherent use of funds, harmonising and simplifying funding rules etc.).

For the purposes of the ACTION-FOR-HEALTH project, the impact these changes may have for project partners is unclear.



However, it is likely that the foreseen project outcomes for ACTION-FOR-HEALTH (particularly the increased capacity of project partners and/or public health professionals in the areas of health inequalities, health promotion, and Structural Funds; and the preparation and testing of an action plan for tackling health inequalities) will remain relevant and valuable

for the forthcoming 2014-2020 framework. Indeed, it is likely that the ACTION-FOR-HEALTH outcomes will provide important EU added value and considerable opportunities for accessing Structural Funds to reduce health inequalities in their respective regions and/or countries.

Further information on Structural Funds

The European Portal for Action on Health Inequalities was launched by the European Commission during 2011 (see www.health-inequalities.eu). Developed by EuroHealthNet, on behalf of the 'Equity Action' Programme (part of the Joint Action on Health Inequalities which is a collaboration between DGSANCO of the European Commission and National governments of 12 EU Member States), this portal aims to provide a source of information on health inequalities, social determinants of health, and Health in All Policies.

Of relevance to ACTION-FOR-HEALTH is that one of the work strands of this programme (coordinated by EuroHealthNet) has brought together a network of 29 regions to capture and share regional approaches to reduce health inequalities, and to strengthen understanding on how to influence and use Structural Funds to address Regional health equity issues. The outcomes of this work are the basis for the content of a useful and up-to-date guidance tool on European Structural Funds (Figure 5).

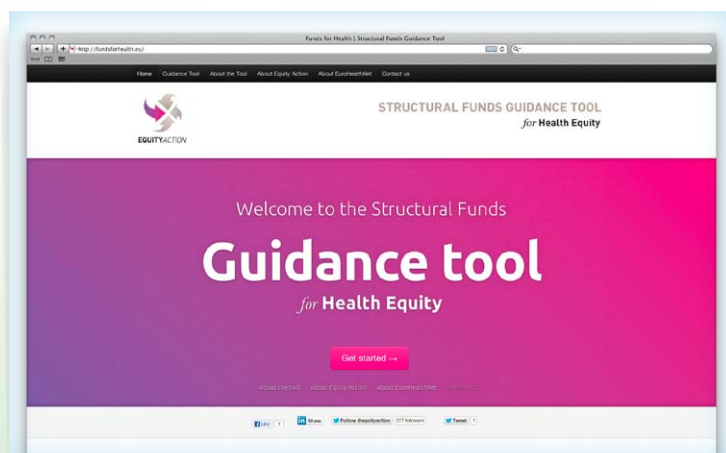


Figure 5: *Structural Funds guidance tool for health equity (<http://fundsforhealth.eu>)*

III Building Capacity in ACTION-FOR-HEALTH

Over the last three decades the concept of 'capacity building' has been introduced into the field of health promotion as a (relative-ly new) focus on the requirements for suc-cessful implementation of health promotion

programmes and/or interventions. Capacity building can be described broadly as any ac-tion that aims at developing resources, skills, and requirements that are needed in order to implement health promotion activities.

"The rationale for capacity-building is simple. By building sustainable skills, resources and commitments to health promotion in health [care] settings, community settings and in other sectors, health promotion workers prolong and multiply health gains many times over."
(Hawe et al., 2000, p.2).

Capacity building to reduce health inequali-ties through Structural Funds needs to be nest-ed in a broader capacity-building approach that ensures sustainable capacity is achieved at various levels including system, organisa-tion, team and individual levels (WHO, 2010). Ideally, capacity building should aim at being sustainable in terms of producing fundamental and lasting changes, and needs to be viewed as an on-going process, multi-dimensional, and

multi-sectorial, meaning that changes and in-terventions occur in different areas and across different sectors (Crisp *et al.*, 2000).

Capacity building can be applied at vari-ous different levels including the national lev-el and/or regional level, organisational level, community level, and individual level, and can be pursued with a wide range of differ-ent measures and instruments (Gugglberger & Dür, 2011).



Different levels of capacity building

National level

At the national level and/or regional level, capacity building is particularly important for many of the EU new Member States, and to a large extent, usually concerns the development of infrastructure. This includes the development of “policies, surveillance systems, research and evaluation capability, a skilled workforce and programme delivery mechanisms” (Catford, 2005, p.2). In relation to tackling health inequalities, the development of policies is particularly important in order to stimulate the implementation and/or development of necessary and relevant structures and mechanisms (Stegeman *et al.*, 2009).

Organisational level

Organisational capacity building concerns, amongst other things, the training of staff, the development of organisational policies, the provision of resources, and the institutionalisation of health promotion (Smith *et al.*, 2006). “The scope of organizational capacity building encompasses the range of policies and partnerships for health promotion that may be necessary to implement specific programs [sic] or to identify and respond to new health needs as they arise” (Smith *et al.*, 2006, p.342). An important part of building organisational capacity is, of course, organisational development, referring to processes that ensure that the policies, structures, procedures and practices of an organisation are in place, and that change is managed effectively (Stegeman *et al.*, 2009). Within the Reviewing Public Health Capacity in the EU project (see Aluttis *et al.*, 2013), a

useful overview of the capacity building concept as it relates to organisations was developed, differentiating between organisational structures, partnerships, resources, workforce, knowledge development, and leadership & governance within organisations and institutions (see Figure 6).

Community level

The community level is important in the context of health promotion as it enables bottom-up approaches, empowerment, and partnership building. The community includes different stakeholders – organisations and individuals. Community capacity building therefore spans over a wide range of activities including supporting the ability of community members to take action to address their needs, increasing health literacy, raising awareness about health risks, facilitating access to resources, and developing structures for community decision-making (Smith *et al.*, 2006, p.342). Furthermore, building capacity for health promotion within a community concerns the development of common goals, visions, and advocacy to generate the willingness and the ability to act. Partnership development and creation of leadership are also crucial to successfully implement health promotion in communities. This concerns improving the possibility of people or organisations to collaborate (Stegeman *et al.*, 2009). Here intersectoral collaboration can be especially important because health promotion and the tackling of health inequalities touches on many different areas, and therefore requires different sectors to work together.

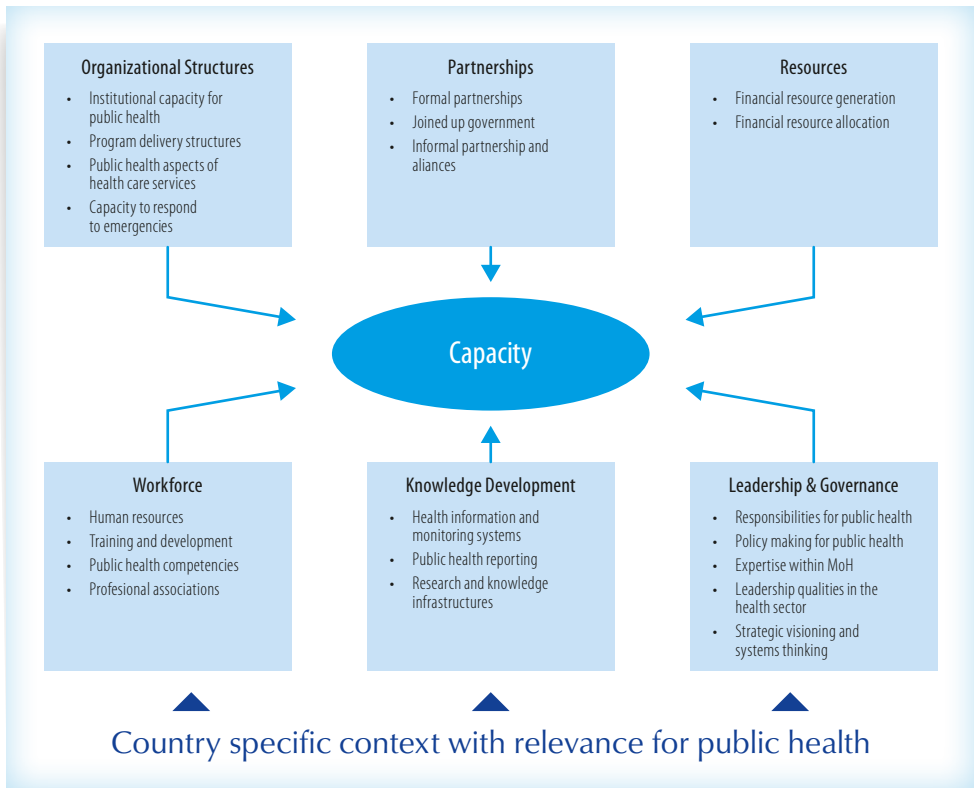


Figure 6: Overview of public health capacities Aluttis et al., (2013)

Individual level

Finally, individual capacity building for health promotion concerns enabling and empowering individuals to take action for their health. Individual capacity building can happen within organisations or communities. A common strategy to build capacity for health promotion concerns the increase of knowledge and skills of individuals, which is why capacity building is often (wrongly) used synonymously with

training and professional development (Potter & Brough, 2004). While training and professional development are of course key components of building individual capacity, other aspects of developing resources and creating suitable environments also need to be incorporated, including strategies such as the empowerment and enabling of staff, building of partnerships and networks, the creation of common visions, and so on.



Building capacity systematically

Capacity building is the objective of many development and interventional programmes including those designed to reduce health inequalities by addressing the social determinants of health. However, Potter & Brough (2004) argue that as a term, it too often becomes merely a euphemism referring to little more than training. The authors argue that when aiming to build capacity, it is important to approach it systematically which can help to identify sectoral shortcomings in specific locations, improve project/programme design and monitoring, and lead to the more effective use of resources.

To this end, Potter & Brough (2004) developed a pyramid of capacity building comprising nine separate but interdependent components that form a four-tier hierarchy of capacity building needs including: 1) structures, systems and roles, 2) staff and facilities, 3) skills, and 4) tools (Figure 7).

According to Potter & Brough (2004), to build capacity certain measures need to come before others to ensure that the foundations

are put in place to enable the effective implementation of further measures.

Important capacities on the first stage include role capacity - concerning authority, responsibility, and decision making power; structural capacity - concerning decision-making forums and inter-sectoral discussions, and; systems capacity - which refers to the abilities and effectiveness of the system, its communication, and ability to change.

On the second stage, support service capacity and facility capacity become important, which concern the facilities and infrastructure, administration, and quality control; furthermore, supervisory capacity is needed, in terms of monitoring systems, accountability, and incentives; as well as workload capacity, concerning human resources and job descriptions.

On the third stage, personal capacity is important, which is the knowledge, skills, and confidence of staff, and finally, on the last stage, performance capacity is needed, which concerns tools, money, equipment, and so on.

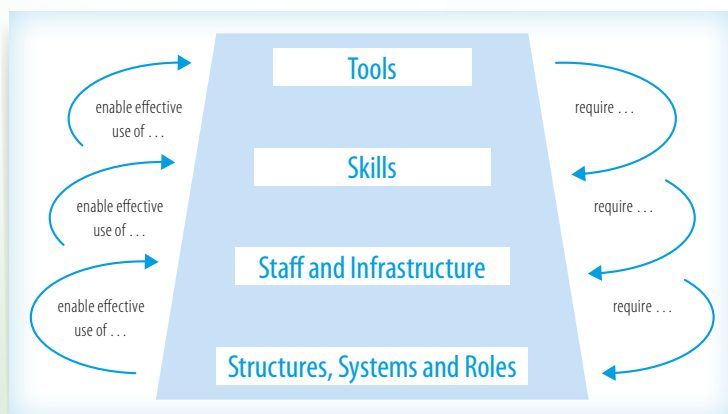


Figure 7: *Capacity pyramid*
(Potter & Brough, 2004)

Putting capacity building into practice in ACTION-FOR-HEALTH

As noted in the Preface to this publication, the ACTION-FOR-HEALTH project and its underpinning principles builds on the previous work of Belović *et al.*, (2005) in a collaboration between the Institute of Public Health Murska Sobota (Slovenia) and the Flemish Institute for Health Promotion (Belgium). The project aims ultimately to improve the health and quality of life of EU citizens by tackling health inequalities through health promotion.

Over the duration of the two-year project, this will be achieved (inter alia) by building the capacity of project partners and other public health professionals, particularly at regional and/or local level.

ACTION-FOR-HEALTH capacity building can be divided in three areas that are closely linked and interrelated with each other (Figure 8).

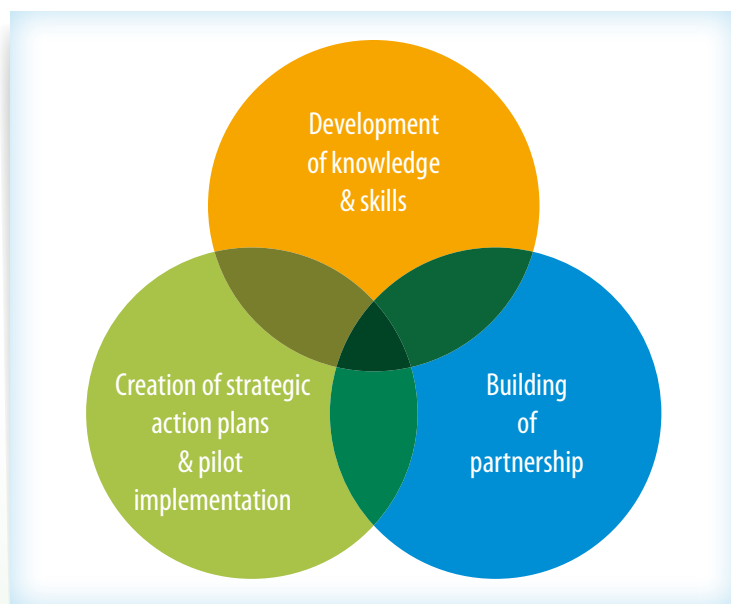


Figure 8: *Capacity building in the ACTION-FOR-HEALTH project*

ACTION 1: Development of knowledge and skills

Reducing health inequalities by public health professionals (including ACTION-FOR-HEALTH project partners) from

different European regions/countries clearly requires the development of particular knowledge and skills. In ACTION-FOR-HEALTH,



the following areas were identified as being centrally important including: a comprehensive overview of the current situation in each partner region/country (e.g. in terms of health status, health inequalities, public health policy environment, needs assessment etc.); principles and foundations of health promotion including the European dimension of health promotion and public health; the social and wider determinants of health inequalities and the health gradient; strategies to tackle health inequalities (including their limitations); public health capacity at regional level (e.g. human, infrastructural, financial); culturally adjusted and tailored health promotion interventions; knowledge of Structural Funds and; an understanding of evaluation and monitoring issues (see Table 6).

Situation and needs analysis

A situation analysis and needs analysis including identification of promising practices was conducted in seven countries/regions by partners as part of WP4 of the ACTION-FOR-HEALTH project. Linked directly to WP5, this activity although very time-consuming and complex, helped partners to get an overview of the issues of health inequalities in their own countries and regions, to gain knowledge of what is needed and what already exists. This activity also helped to empower and encourage partners to proactively seek out relevant information and make first contacts with important stakeholders – in doing so, directly supporting both Action 2 (building partnerships) and Action 3 (creation of action plans and pilot implementation).

Training workshop

Development of the above knowledge and skills to date has been achieved by a one day **Training workshop** held in Murska Sobota (Slovenia) in March 2013 that was designed specifically by the leaders of WP5 in partnership with the project coordinator, to be interactive, flexible, and empowering for partners of the project broadly around health inequalities, health promotion, and Structural Funds. A key aim of this event was to start the process of building the capacity amongst and between partners with respect to reducing health inequalities through health promotion at regional/local level, and to learn about Structural Funds. Part of this process meant exploring a range of different health promotion initiatives as well as the creation of opportunities for partners to think strategically about issues such as priority setting and resource allocation to achieve desired project objectives. In addition, a key aspect of the training workshop was to also create opportunities for project partners to get to know each other, build networks and partnerships, develop confidence, share knowledge expertise and experiences, as well as lay the groundwork for later successes. The agenda, minutes, and documents for this event can be found on the project website (www.action-for-health.eu).

European summer school

The Training Workshop was then followed up by a two day **European summer school** held six months later in Murska Sobota (Slovenia) in September 2013. The main aim of this second event was to build on the gains made during the Training workshop through a mixture

of key learning and interactive sessions (e.g. covering health promotion, healthy literacy, health inequalities, Structural Funds etc.), practical demonstrations, and cultural and social visits (Table 6). The content of the summer school was designed specifically to facilitate both partners' contributions in terms of their

knowledge and expertise, as well as that of externally invited experts - resulting in a comprehensive and synergistic programme offering a combination of theoretical perspectives and applied health promotion (e.g. through demonstrational workshops).

Topic areas for the development of knowledge and skills in ACTION-FOR-HEALTH:

Situation and Needs Analysis (February 2013)

- Health status of relevant region/country
- Overview of public health policy environment
- Early identification and first contact with stakeholders

Training Workshop (March 2013)

- Principles and foundations of health promotion
- The European dimension of health promotion and public health
- Health inequalities and the health gradient
- Monitoring and evaluation I
- Situation analysis, needs assessment, and identification of promising practices in 7 European countries
- Preparing strategic action plans to reduce health inequalities

European Summer School: Tackling Health Inequalities in Practice

(September, 2013)

- Health promotion and health inequalities: from theory to practice
- The role of health promotion in tackling childhood obesity
- Depression, suicidality and mental health promotion
- The promotion of physical activity (including nordic walking)
- Tailored health promotion media activity and awareness raising
- Measurement of health risk indicators
- Local sustainable food production
- Let's live healthily programme
- Environmental aspects of health inequalities
- Using structural funds in the EU and Slovenia
- Building capacity through health literacy
- Cultural and social activities
- Monitoring and evaluation II



Final Conference (estimated June, 2014)

- Content to be confirmed

www.action-for-health.eu/publications/conference

Distance Learning Tool (estimated June, 2014)

- Content to be confirmed

www.action-for-health.eu/publications/distance-learning-toolkit

Table 6: *Topic areas for the development of knowledge and skills in ACTION-FOR-HEALTH*

Distance learning tool

Although not yet available at the time of writing (November, 2013), a distance learning tool will be developed by the end of the project (June, 2014). Generated in part from the learning materials developed directly as a result of the Training Workshop and Summer School, this tool will be available for the public and will provide information on the core issues of ACTION-FOR-HEALTH. It will also enable partners and other stakeholders to revisit the most relevant topics in their own time (Table 6).

Final conference

Lastly, a final project conference will be organised at the end of the project which will be open to invited experts, public health professionals, and the wider public. It will summarise the project, showcase achievements, and provide insights into the lessons learned and next steps. All documents from the conference will be available on the project website in due course (Table 6).

ACTION 2: Building partnerships

The second area of capacity building in ACTION-FOR-HEALTH, concerns the development of partnerships between the project partners, and perhaps more importantly, of project partners with stakeholders within the seven participating countries and regions. As part of the project, partners have been encouraged to strengthen existing partnerships and to make contact with different public health professionals, health promotion practitioners,

and policy makers, in order to create a network of experts with which they can consult with. This was helpful for various activities within the project including the situation analysis and identification of promising practices (Action 1) which were conducted by project partners within WP4, and necessary for the creation of strategic action plans to reduce health inequalities (Action 3).

ACTION 3: Creation of action plans and pilot implementation

The third core area of ACTION-FOR-HEALTH, and the main result of the first year of the project (2012-2013), is the creation of strategic action plans to reduce health inequalities. An action plan, in this context, is a strategic plan based on the situation analysis and needs assessment of a chosen region, with the general **goal** to reduce health inequalities. It consists of specific **aims and objectives** that define how these aims can be achieved, **activities** that list a number of potential ways to act, and **indicators** by which success of the activities can be evaluated (Belovic *et al.*, 2005). Thereby, the action plans can provide a strategic framework and guidance for public health professionals on how to reduce health inequalities and which inequalities to focus on according to the particular region in question. Furthermore, the action plans that are developed during the project can then provide a basis on which to transfer and adapt to other regions thus potentially multiplying its benefits.

Pilot implementation

In ACTION-FOR-HEALTH, projects partners not only develop strategic action plans to reduce health inequalities through health promotion which are based on the situation and needs assessment of their region, but they are also required to pilot test their action plans by implementing (and evaluating) one of its core objectives. This pilot implementation process is important because it incorporates several capacity building measures. For example, it facilitates partners to synthesize and apply their newly gained knowledge and skills (Action 1), as well as empowering partners to work in close partnerships with different relevant stakeholders (Action 2) to ensure the action plan is tailored to the specific needs of the region, creates shared ownership, and sets the foundations for future collaborative efforts. Finally, the pilot implementation allows partners to also engage in evaluation and monitoring activities (e.g. see Davies & Sherriff, 2012) which is an essential element of any health promotion activity designed to reduce health inequalities.



Further information on capacity building

There are a great many resources available on capacity building in health promotion and it is beyond the scope of this brief publication

to list them here. However some of the more relevant resources are included below:



WHO (2010). *How health systems can address health inequities through improved use of Structural Funds*. Copenhagen, WHO Regional Office for Europe.



Stegeman, I., Costongs, C., Chiotan, C., Jones, C., & Bensaude de Castro Freire, S. (2009). *Menu for capacity building and awareness raising actions to address the social determinants of health and to improve health equity*. Brussels: EuroHealthNet.



Aluttis, C. A., Chiotan, C., Michelsen, M., Costongs, C., & Brand, H. on behalf of the public health capacity consortium (2013). *Review of Public Health Capacity in the EU*. Luxembourg, EAHC.

IV Further information and resources

This section provides an annotated list of resources that may be useful for those interested in finding out more about reducing health inequalities, health promotion, EU Structural Funds, and other related areas (see Table 7). It is not meant to be comprehensive and by featuring them here we are

not necessarily endorsing them as examples of ‘good’ or ‘best’ practice. Rather we hope they will offer some ideas and background information to assist in the development and continuation of valuable work on reducing health inequalities through health promotion and Structural Funds.

Resource/Source	Availability*
Action Plans to tackle health inequalities – Examples of action plans from seven European countries are provided as part of the ACTION-FOR-HEALTH project. The aim of these plans is to reduce health inequalities through health promotion and Structural Funds between regions in one country and between vulnerable groups within one region.	See ACTION-FOR-HEALTH project website: www.action-for-health.eu Download action plans (pdf) – http://www.action-for-health.eu/publications/development-and-implementation-7-action-plans.html
European Portal for Action on Health inequalities – A web resource as part of the Equity Action which is the EU funded Joint Action on Health Inequalities.	See www.health-inequalities.eu
European Projects on health inequalities, health promotion, and Structural Funds – A European Commission database that includes information about projects, joint actions, conferences, and operating grants funded through calls for proposals in the years 2003 to 2013 under the previous EU Public Health Programme and the current EU Health Programme 2008-2013.	Search for relevant EU projects using the EC database: http://ec.europa.eu/eabc/projects/database.html
Gradient Evaluation Framework (GEF) – An excellent European action-oriented policy tool to guide and inform technical experts in public health working at the Member State level. GEF is designed to assist those involved in the development, implementation, and evaluation of policies that aim to reduce health inequalities and level-up the gradient in health and its social determinants among children, young people and their families.	Download the pdf from the University of Brighton’s website: www.brighton.ac.uk/snm/research/areas/health-promotion/projects/gradient.php?PageId=250 Use the online web tool - www.gradient-evaluation.eu Available to download on Android devices from Google Play
Health inequalities toolkit – Developed jointly by the Association of Public Health Observatories and the Department of Health in the UK, it focuses on improving life expectancy and infant mortality rates, especially in disadvantaged areas	Use the online intervention toolkit from Public Health England: www.lho.org.uk/LHO_TopicsAnalytic_Tools/HealthInequalitiesInterventionToolkit.aspx



Resource/Source	Availability*
Healthy schools toolkit – The health of a whole school community can be improved through taking some simple steps and health benefits can support learning and working in schools. This toolkit has been developed by the Health Promotion Agency for Northern Ireland (UK) providing a focus for school staff to develop, implement and monitor a healthy school environment.	Download the pdf from the Health Promotion Agency for Northern Ireland's website: www.healthpromotionagency.org.uk/Work/hpschools/pdfs/HPA_Toolkit.pdf
International Union for Health Promotion and Education (IUHPE) – A global independent and professional association of individuals and organisations committed to improving the health and wellbeing of the people through education, community action and the development of healthy public policy.	See www.iuhpe.org Publisher of Global Health Promotion Journal – see: http://ped.sagepub.com
Structural Funds guidance tool for health equity – This excellent tool has been developed by EuroHealthNet as part of Equity Action, which is the EU funded Joint Action on Health Inequalities. Easy to use, practical, and interactive.	Use on the online webtool: http://fundsforhealth.eu
Tools and approaches for assessing and supporting public health action on the social determinants of health and health equity – A document that provides examples of the tools and approaches that have been adopted or applied by the public health and health sectors, with a focus on regions and authorities in Canada. Examples from outside of Canada have been included in cases where the approaches and tools are 'foundational' or particularly relevant to the Canadian context.	Download the pdf at: www.nchpp.ca/docs/Equity_Tools_NCCDH-NCCHPP.pdf
World Health Organization Health Promotion Unit – The WHO Health Promotion Unit (HPR) is part of the Department of Chronic Diseases and Health Promotion (CHP), within the Noncommunicable Diseases and Mental Health Cluster. The Health Promotion Unit is composed of the following teams: National and community programmes (co-operate with Member States in strengthening their capacity, policies, financial support and evidence for health promotion); school health and youth health promotion; oral health; and physical activity.	Download the WHO Health Promotion Glossary (PDF) - www.ldb.org/vl/top/glossary.pdf Visit WHO (Health Promotion) - www.who.int/topics/health_promotion/en/ Visit WHO (Europe) - www.euro.who.int/en/home
<i>* All web links and resources correct and working at the time of writing (November, 2013)</i>	

Table 7: Further information and resources

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