



ACTION-FOR-HEALTH



Action plans in practice

Implementation of strategic objectives



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Foreword

National Institute of Public Health in Slovenia with the acronym NIJZ has been operating from the 1st January 2014 continuing a 90-year long tradition of institutionalised public health in Slovenia. A part of continuity is our work in the field of reducing health inequalities in Slovenia performed by the Institute of public health Murska Sobota which became part of the NIJZ in January this year. We are particularly proud of the project ACTION-FOR-HEALTH because of two main reasons. It connects 10 European countries with the same goal- to reduce health inequalities, a topic which is increasingly important and an overreaching issue in today's world. The second reason is that we share our experience, knowledge and our approach to reducing health inequalities with other partner countries in the process of mutual learning and by that we are giving our contribution to reduce the inequalities also in international level.

This publication is a crown of all 10 project partners' hard work. Let it be an inspiration or even a guide to all who are working on reducing health inequality and inequity.

Ivan Eržen, MD, PhD

Director

National Institute of Public Health

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I Introduction

Strategies to tackle health inequalities

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It is well established that socioeconomic status (SES) is a strong correlate of health. Between and within countries throughout the world, a social gradient in health exists whereby people with a lower education, a lower occupational class or a lower income have a significantly lower life expectancy, more often suffer from physical and psychological problems, and present a higher prevalence of health problems (Wilkinson & Pickett, 2006). These differences are also visible in Europe, despite the well-established social security systems in all EU Member States giving access to health care to all citizens. When healthy life expectancy is used as an indicator, educational differences in the number of years lived in good health over the entire life course amount to more than 10 years in many European countries (EC, 2009). Moreover, over the past decades the inequalities in health have increased, rather than decreased.

Strategies to tackle health inequalities

According to the WHO Commission on Social Determinants of Health (2008), the causes of these health inequalities are mainly

social in nature. They include poor material life conditions, unhealthy lifestyles, psychosocial stress, and limited access to appropriate care. All of these so-called “social determinants” are related to health outcomes in a circular way: health can affect a person’s socio-economic status, in the sense that individuals with a poorer health condition are more likely to move down and less likely to move up the social ladder, but socio-economic status also has an impact on health. This impact can be direct, in the sense that an individual’s physical and mental health is determined by his or her material living conditions, but also indirect through behaviour. It has been demonstrated that people in less favourable socioeconomic situations often adopt less healthy lifestyles, such as smoking, unhealthy diet and lack of physical exercise, and participate less in preventive behaviours such as medical check-ups or breast screening. Moreover, health is also strongly influenced by psychosocial factors, in the sense that people in lower social strata suffer more often from continuing anxiety, insecurity, low self-esteem, social isolation and stress, all of which have powerful effects on health. Finally, health inequalities are also linked to the access to health care. As the access to both clinical and preventive



services is related to socio-economic status, differences in access and use of preventive and curative health care often contribute to health inequalities.

In view of the above, the reduction of social inequalities in health has become a priority for health policy makers across Europe. Given the multiple causes of health inequalities, their reduction requires targeted policies and interventions that aim to improve the material living conditions, enhance health-related lifestyles, and improve the access, uptake and adherence to clinical and preventive health services for people in less favourable socio-economic conditions. In the past years, many attempts have been made to develop and implement such strategies and interventions, both on national and international level. While interventions vary depending on the specific context, there are three major approaches to reduce health inequalities: (1) targeting the most disadvantaged groups to improve their health; (2) narrowing the health gap between the better-off and worse-off groups; and (3) levelling the social gradient in health inequalities across the whole population (Davies and Sherriff, 2011).

A specific variant of the latter is “proportionate universalism”, which involves universal action, but at a scale and with an intensity that is proportionate to the level of disadvantage (Marmot, 2010). Ideally, all three strategies would be combined in a multi-level and integrated approach, involving a variety of interventions and policies (Dahlgren and Whitehead, 2006), but in reality the majority of interventions follow the first two strategies, as the third one involves complex interventions

with multiple levels, stages of operation and time lags that require structural instruments with a focus on differential distribution effects within the population (Graham, 2004; Graham and Kelly, 2004).

Whereas the strategies to tackle health inequalities are clearly mapped out, it is difficult to find effective policies and related interventions that actually reduce inequalities. Despite efforts to identify examples of good policies and practices (Stegeman et al, 2010), the evidence for the effectiveness of these interventions is scarce (Arblaster et al, 1996; Michie et al, 2009; Stronks&Mackenbach, 2006).

The strategy to tackle health inequalities in the Pomurje Region, Slovenia

One example of an intervention that proved to be successful was the development and implementation of a Health Promotion Strategy and Action Plan to tackle health inequalities in the Pomurje Region in Slovenia. This intervention, developed by the Institute of Public Health Murska Sobota in Slovenia with the assistance of the Flemish Institute for Health Promotion in Belgium, aimed to strengthen the capacity of the local health promotion workers and create a policy environment to reduce health inequalities through health promotion. To that effect, it developed a strategic plan for an encompassing strategy to reduce health inequalities, setting clear aims and objectives for the government and other stakeholders as well as the strategies to reach these objectives and indicators to monitor progress.

The plan was based on an integration of the policy recommendations to tackle health inequalities from previous research and the participative input of health professionals in the region. Specifically, it involved a systematic analysis of the current state of the policy environment in Slovenia with regard to tackling health inequalities, identifying the strengths, weaknesses, opportunities and threats with regard to 8 policy mechanisms that are internationally regarded as effective to tackle health inequalities: setting health inequality targets, performing health impact assessment, enhancing intersectoral cooperation, community development approaches, providing better access to health services, and improving the evidence base on effective actions to tackle health inequalities. Based on this analysis, regional priorities for action and specific target groups were identified in participation with the health workers. A core planning team transformed these priorities into aims, objectives and targets and identified activities to implement the goals and indicators to measure the progress in the implementation. Thus, the content of the plan took the regional context into account and was therefore more realistic. A number of activities had also been planned to implement the plan, such as teaching the elderly home care skills and teaching school dropouts to raise their self-esteem.

While the strategic plan itself was considered of great value for addressing health inequalities in the Pomurje region, the innovative bottom-up approach that was followed to develop the plan also represents a good example of a participative capacity building process at the regional level. The approach was

implemented successfully in other regions of Slovenia and incorporated in the national plan to tackle health inequalities, and can be inspiring for other countries as well. However, given the bottom-up nature of the approach that was followed to develop the Health Promotion Strategy and Action Plan in Pomurje and the emphasis on participative capacity building, the approach cannot be simply implemented in the exact same way elsewhere. Adopters should be allowed to reinvent or change the program to meet their own needs and derive a sense of ownership.

Empowerment and implementation

Drawing on the principles of community based health promotion, which emphasizes the participation of the community in program planning, implementation, evaluation and dissemination, the implementation of an intervention that has been successful elsewhere should not imply that the intervention is faithfully adopted. Instead, the adaptation of the intervention should be encouraged to make it fit in better with local needs and context and to derive ownership. This adaptation is not necessarily contradictory to remaining faithful to the original program. In fact, fidelity and adaptation are *both* essential elements of preventive interventions (Castro et al., 2004; Weisberg, 1990). Moreover, both are best addressed by a planned, organized, and structured approach (Backer, 2001; Van Daele et al, 2012). Castro et al. (2004) have suggested that an innovative program design strategy



is to develop hybrid programs that ‘build in’ adaptation to enhance program fit with the context, while also maximizing fidelity of the implementation with the original program as well as program effectiveness.

Van Daele et al (2012) have elaborated this view by introducing the concept of *empowerment implementation*. The approach has been inspired by community-based participatory research (CBPR), a collaborative approach to research that involves all partners equitably in the research process and recognizes the unique strengths that each brings (Minkler&Wallerstein, 2003; Minkler et al., 2006) and by the principles of empowerment evaluation. The latter provides program stakeholders with the knowledge and tools for self-assessing their program effectiveness, thus building evaluation capacity (Fetterman, 1986; Wandersman et al., 2005). The key aspect of empowerment implementation is to involve community stakeholders in the implementation of a program as equal partners by providing them with the concepts, tools and skills to identify the core components of the intervention, to adapt the intervention to their context and culture, and to assess, monitor

and maintain the implementation quality. This can be achieved by following a series of steps: (1) developing a core component, (2) selecting partners, (3) assessing the fidelity/adaptation concerns with partners, and (4) developing an overall implementation plan. The way in which these steps are executed:the content of each step is defined by the key elements of high fidelity implementation, and by research concerning the balancing of program fidelity and adaptation.

The empowerment implementation approach was followed for rolling out the *Tackling Health Inequalities in the Pomurje Region* project and to implement the program’s learning to seven neighbouring EU Member States in the Action for Health project, funded by the European Commission through its Health Program 2008-2013. The following sections will describe the way in which the strategic bottom-up approach of the Slovenian project was transferred to the other countries to develop action plans using the Slovenian approach as a lead but taking account of the specific context, and then give examples of the way the action plans were implemented in each of the participating countries.

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II Transfer of the strategic bottom-up approach to tackle health inequalities from Slovenia to 7 EU countries

By Tatjana Krajnc-Nikolić and Branislava Belović

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Development of the strategic bottom-up approach to tackle health inequalities in Pomurje region is based on several interconnected principles and approaches (Belović et al., 2005). We started with comprehensive situation analysis and capacity building of health professionals simultaneously. Performing of situation analysis included the use of tools such as SWOT analysis and focus groups. Both analytical tools were used for the first time by health professionals in the context of data collection from marginal target groups and from different stakeholders at national and local level. At the same time, involved public health professionals have increased the capacity in the fields of health inequalities, social determinants of health and strategic planning. The main output was the regional action plan on tackling health inequalities by means of health promotion. The action plan has been adjusted to the actual situation in the region, respecting available resources, balanced between national

and regional priorities, culturally appropriate. The strategic objectives have been defined to the level of activities, including indicators of achievement. The result of all these activities was an action plan, which has been tailored to all important features in local and national environment and can be actually implemented, can reach final target group directly and whose impact can be assessed.

The bottom-up strategic approach in tackling health inequalities has been horizontally transferred from Pomurje region to all other regions in Slovenia. The original approach from Pomurje region has been used in its generic form. Important characteristics of each region, e.g. resources available, particular public health problem or cultural differences have been respected (Krajnc-Nikolić et al., 2013).

We have transferred this approach to 7 EU countries within the project ACTION-FOR-HEALTH, enriched by additional content and activities. The project has two main processes:

capacity building and practical implementation of gained knowledge. The knowledge and skills gained during capacity building have been implemented into creation of project deliverables and vice-versa. The production of project deliverables was actual implementation of gained knowledge in practice.

Capacity building of project partners was approached in systematic and comprehensive manner. It was synchronized with other project activities aimed at the achievement of project deliverables and results. The project partners have performed the situation analysis and needs assessment in their successive countries. They all followed the same approach, used the same tools and criteria (Vervoordeldonk J et al., 2013). After the situation analysis was finished, we prepared the first capacity building event- the training. The training was aimed at increasing of capacity in the field of social determinants of health, strategic planning and using incorporation of health promotion into the process of tackling health inequalities on regional and local level. The basis for the strategic planning was the data and information gained through situation analysis and needs assessment. The knowledge and skills gained at the training have successfully been implemented during the process of the action plan's preparation. After the action plans were prepared in 7 EU countries, the second capacity building event-the summer school took place. It was an opportunity to increase knowledge in particular fields of expertise, to learn particular practical skills and to try the chosen health promoting tools in practice. The summer school was tailored to the project partners and objectives from their action plans. After

the summer school, all partners implemented the activities aimed at achieving one chosen objective from the action plan. The aim of implementing one objective was twofold: to serve as an evidence of implementability of the action plan and to motivate the stakeholders to support and continue with implementation of other objectives.

The approach included participation of different stakeholders and partners on local and regional level, but also the support on national level was in some cases present. The capacity building of stakeholders, such as public health professionals was continuously and simultaneously developed throughout the project activities.

The regional action plan could serve as a model which could be horizontally transferred to other regions within the country and also to other EU countries. This bottom-up approach is based on existing capacities connected in a meaningful way to overcome weaknesses by using strengths. The approach is flexible to changing environment: when a priority rises on the virtual priority ladder because of changed circumstances (e.g. availability of unexpected resources or changes in political priorities), the change is considered. Being flexible and respecting cultural and socio-economic differences are some of the crucial features of the approach and argued also by leading scientists (Wilkinson et al, 2010).

In the next chapter we will introduce the examples of action plans and their implementation in 7 different EU countries. One of the principles of the strategic bottom-up approach is to offer a generic tool and at the same time to enable adjustment to individual situation in



environment. The contributions from 7 partners have the same basic content (experiences from the process of preparation of action plan and implementation on one objective). We wanted to dispose the individual differences between partners; therefore the described examples of implementation differ among themselves.

The countries are from northern and southern Europe, old and new member states. Four

of the countries are neighbours: Slovenia, Croatia, Hungary and Slovakia. This could be a potential for further horizontal transfer of the approach within this broad geographical region. All partners have established new and improved existing partnerships in chosen region. Partner from Hungary already ensured development and sustainability of project results.

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III Examples of implementation of action plans

Preparation of an Action Plan and implementation of one objective in Bulgaria

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Action Plan preparation

The Action Plan of the Pomurje Region, Slovenia and other available materials were used as a baseline for the preparation of the Action Plan for Lovech region, Bulgaria.

A situation analysis and needs assessment were developed both at national level and in a selected region – Lovech Region in view of major socio-economic factors, determinants of health and the existing structural funds plan. The methodology used has been provided by NIGZ together with unified evaluation criteria.

An agreement has been reached at regional level for cooperation on the piloting of the project and subsequent plan implementation with Lovech Municipality and Lovech RHI.

The training of the project partners on how to develop an Action Plan for reducing health inequalities through the usage of the EU structural funds helped to enhance team capacity.

The preliminary development of the Action Plan for tackling health inequalities through

the usage of EU structural funds was supported by the participation of team members in the project working meetings and the Summer School on Health Inequalities and Structural Funds. Achievements were reflected in both interim project reports.

During the meetings with the project partners contacts and cooperation have been established (primarily on future scientific publications), particularly with Estonia, Slovakia and Spain.

Good working contacts at regional level (RHI-Lovech) allowed the collection of more detailed information on the initiatives of forming a good practice and solving problems accompanying them.

The main problem that was identified early on at the stage of the very development of the plan, i.e. the limitation of activities due to the considerable lack of financial and human resources necessary for the plan implementation, has persisted in the second project year as well. The local initiatives gathered within planned tasks as examples of good practice, have been



kept in the form of campaigns, without being further developed into a sustainable process, both owing to financial constraints and expected inertia of the various administrations.

Pilot Implementation of an Action Plan Task at Regional Level

The specific objective 1 “Enhancing the capacity of health professionals and non-medical professionals in health promotion” within the aim 2 “Enhancing the capacity of the community in the health field” involving the following activities, have been chosen for the implementation:

- Conducting training courses for medical professionals in schools, educational counsellors and psychologists in order to strengthen their capacity to prevent health risks and promote a healthy lifestyle among students;
- Development and distribution of educational and information materials, programmes for the staff in educational institutions;
- Training public health professionals in methods for evaluating the effectiveness of health promotion initiatives.

These tasks have been chosen in order to increase awareness of the important target groups, such as teachers and health professionals and to raise their capacity in field of health promotion. We have identified following characteristics of the region: the negative demographic and health trends in Lovech Region, the CVDs as a key cause of morbidity

and mortality and the leading role of behavioural factors in the prevalence of NCDs as well as the preparation of health and educational professionals in schools, and the views of the local municipal and educational administration.

Task Implementation

The pilot implementation of the selected Action Plan task in Lovech region started with the working meeting organized and held in April 2013 at NCPHA with the participation of Lovech RHI representatives (project partners) that was focused on:

- Introducing the goals, objectives and project activities;
- Establishing a working group at local level;
- Provision of a project information material;
- Allocation of the tasks.

It was followed by a workshop in Lovech in April 2014 involving representatives of stakeholders concerned with health inequalities issues aimed at strengthening their capacity on project activities.

The project and the results of the situation analysis and needs assessment in the field of health inequalities in Lovech Municipality and the Action Plan for Reducing Health Inequalities in Lovech Municipality were presented at the meeting.

Local media were provided with a project information material as well as information on its goals, objectives and activities.

Key materials in the task implementation were the methodological guides for health and

educational professionals, entitled “Health Promotion in Schools” developed under the project as well as the “Methodological Guide for Medical Professionals in Schools” and “Guide to Good Practices for Medical Professionals on Risk Assessment and Control among Smokers”, which were submitted to the regional partners. They were complemented by three workshop presentations and a series of lectures on various health risk factors provided electronically.

Medical professionals in schools, representatives of RHI, RIE, the municipal and school administration and PHI Association were all involved, with the seminar helping enhance their capacity to tackle inequalities among their target groups.

Access to the target group of health and educational professionals in schools was conducted through the assistance of RIE and on the basis of their traditional cooperation with the team of experts from HPDP Directorate.

Among the difficulties confirmed by local partners in the task implementation remained the uncertain funding, the lack of a

mechanism to include health professionals outside the school, the poor coordination between the institutions as well as the deficit of health mediators by municipalities to assist in the training of the target group of specialists and facilitate its communication with vulnerable social strata.

Administrative and practical support to the Action Plan and the implementation of the selected plan task has been provided by key figures from the Regional Administration and the staff responsible for the activities in the institutions – the Director of RHI and a team of experts at HPDP Directorate.

Contacts have been established with NGOs, particularly with the “Bulgarian Youth Red Cross” and the “Ecomission XXI Century Association”, while direct interaction has been carried out through the “Public Health Initiative Association”.

A partner in the task implementation was the administration of Lovech schools, two of which having predominantly students of Roma descent.



Preparation of an Action Plan and implementation of “Healthy lifestyle programme” in the municipality of Donja Dubrava, Croatia

By *Renata Kutnjak Kiš, Diana Uvodić-Đurić, Marina Payerl-Pal, Berta Bacinger Klobučarić, Renata Tisaj, Marko Klemenčić*
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Situation analysis

The first step in developing the plan was to carry out the situation analysis for health inequalities at national and county levels. The project team of experts at the Institute of Public Health of Međimurje County, in collaboration with other experts from the Institute and elsewhere, conducted a detailed analysis of health determinants. This was based on the data provided by EUROSTAT, National Bureau of Statistics, Croatian Institute of Public Health and other international, national and regional databases and various other sources (expert and scientific publications). Some data were also provided by the Institute of Public Health of Međimurje County (both published and not). Indicators were gathered via online questionnaire prepared by a team of experts at the Dutch Institute for Health Improvement – CBO, in charge of the ACTION-FOR-HEALTH project (Work package 4 - Situation overview, needs assessment and examples of good practice in the field of health inequalities).

Preparation of action plan

Having completed the situation analysis, the attention was turned to carrying out the needs assessment in a participative manner, by a questionnaire prepared by the partners from the Dutch Institute for Health Improvement, based on the Dutch Framework for Health Promotion. In order to assess the needs and possible solutions, six focus groups were organised (together with a meeting of the Health Council members, where one item on the agenda was the project Action for Health and the drafting of the Strategic Plan) for a number of partners from various social sectors. As part of the focus groups the project objectives and the current situation with regard to health inequalities at national and county level were in short presented. This was followed by a discussion to estimate strengths, weaknesses, opportunities and possibilities in the context of reducing health inequalities in the county. In addition, all partners were asked to fill out an open-ended questionnaire so that an insight into the available knowledge, time, and

goodwill, financial, human and other resources could be gained. The existing networks and their way of functioning, as well as their policies, objectives and management, were then assessed. More than 35 people from various county sectors took part in focus groups, and the open-ended questionnaire was filled out by more than 60 people (contacted via email, telephone or in person). Based on the data from the situation analysis and needs assessment, a draft version of the Strategic Plan was made, with aims, objectives, targets and activities clearly defined. This was followed by a process of consultation with the stakeholders from public, private and non-governmental sectors. The Strategic Plan for Tackling Health Inequalities in Međimurje County through Health Promotion was then sent to a wide circle of stakeholders (everyone who took part in the needs assessment, either by participating in a focus group or by filling out a questionnaire - sent to us and to 45 other partner recipients), who were asked to submit their suggestions and comments so that they could be included in the final version of the document.

The final document was then presented in the closing conference to all stakeholders as well as to the public (in a press conference). Also, the Strategic Plan is available to the public on the official website of the Institute of Public Health of Međimurje County. Apart from the electronic version of the document, the most relevant partners received the printed and/or a CD-ROM copy of the Strategic Plan.

Implementation of strategic objective - “Healthy lifestyle programme” in the municipality of Donja Dubrava

In the Strategic Plan for Tackling Health Inequalities in Međimurje County, four aims were selected, and the implementation programme was carried out as part of aim 1 – Improving different aspects of health of the overall population of Međimurje County, through methods of health promotion in different sectors of society and parts of the county with the highest mortality rates of the leading chronic non-communicable diseases. For the implementation we chose objective 2 – Promoting a healthy lifestyle and objective 3 – Improving the prevention, early detection and control of chronic non-communicable diseases. The Institute of Public Health of Međimurje County designed the “Healthy lifestyle programme” implemented in the municipality of Donja Dubrava, with the population of no more than 1,920. In Međimurje County, Donja Dubrava is the second furthest municipality from the City of Čakovec, the county capital, in which the Čakovec County Hospital is situated as well as the specialist services. Apart from that, the situation analysis had shown the mortality rates for cardiovascular diseases in Donja Dubrava in the period 1996 – 2010 to be among the highest in Međimurje County. Moreover, the educational structure is quite unfavourable there compared with the Međimurje County average. According to the



Population Census of 2011, the share of people older than 15 having finished a high education programme was 7.1% for Donja Dubrava and 10.1% for Međimurje County. Apart from that, the municipality of Donja Dubrava was chosen because research had shown that the remoteness from specialist medical care and consequentially the higher costs of commuting can result in the postponed seeking of medical assistance or its avoidance. Also, living in smaller, rural areas presents a considerable risk factor for social exclusion, which endangers health and in this way increases health inequality.

It is important to point out that our institute has always successfully cooperated with the Primary School of Donja Dubrava, which is why we recommended Mihaela Martinčić, professor of pedagogy, an employee of the school and a member of the municipal council of Donja Dubrava, as the local coordinator of the programme. The mayor of Donja Dubrava also offered his support in informing and motivating the target population to participate in the programme. This was done by posting information on municipality websites, putting up posters, distributing leaflets and sending invitations to a number of municipality's associations. We also included the local family doctor and a field nurse in the programme as well as other experts: medical doctors of different specialties, nurses, professors, psychologist, kinesiologists, nutritionists, culinary experts, etc. The target population included middle-aged and elderly people, primarily women, to whom the programme offered lectures, workshops, a demonstration of how to prepare a healthy meal, a demonstration of different forms of physical activity, anthropometric

measurements, individual and group medical counselling and group workouts.

The programme began in January 2014, and ended in April 2014. It comprised 12 lectures/workshops (in 14 meetings) covering different topics, usually carried out once a week for an hour and a half. Each lecture/workshop was followed by a group workout designed and coordinated by a professor of kinesiology for all those who attended. At the end of each lecture/workshop the participants also received educational materials which covered the topics of healthy diet, health-oriented physical activity, stress control as well as prevention and control of the most prominent chronic non-communicable diseases. One objective of the project has been to design an educational brochure titled Healthy Living – a pocket book with tips on how to lead a healthy life (*Živjeti zdravo*), copies of which have been distributed to all participants in the final meeting.

After the initial introduction of the programme, and in order to carry out the final evaluation, the participants were surveyed about their dietary habits, habits related to physical activity, basic knowledge about risk factors and the main symptoms of stroke, heart attack and diabetes. The survey was repeated at the end of the programme.

The programme included 190 participants (157 women and 33 men) of the average age of 59. The number of people attending lectures/workshops was 73 on average. The participants assessed the content and the way the workshops were organised as very successful. A detailed evaluation of the programme is currently being carried out.

Great help and support in creating the Strategic Plan and conducting the pilot implementation were received from prim. mag. Branislava Belović, and asist. mag. Tatjana Krajnc-Nikolić and other project team members from the National Institute of Public

Health – Regional Office Murska Sobota. Their experience in the creation and implementation of the Strategy of Health Promotion and Action Plan for Tackling Health Inequalities, was of immense help to us, for which we are extremely grateful to them.



Figure 1 and 2: *Implementation of strategic objective in Croatia*



Preparation and implementation of Health promotion action plan for reducing health inequalities in Sellye region, Hungary

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Introduction

The National Institute for Health Development (OEFI) developed its action plan within the project „ACTION-FOR-HEALTH” in Sellye region.

The main selecting criteria in choosing the region was the existing partnership we can build on. OEFI initiated a general cooperation with the State Secretariat for Social Inclusion in the Ministry of Human Resources in connection with its on-going projects focusing on health inequalities. The Ministry advised to contact the **Hungarian Maltese Charity Service (MMSZ)**. Based on discussions with the Ministry and MMSZ we have chosen Sellye region which is located in the south-western part of Hungary in Baranya County. The underlying reasons were: available local professional resources, the disadvantaged situation of the region and the existing local partnership provided by MMSZ.

OEFI concluded a contract with MMSZ, given their knowledge of the local situation and experiences in implementing social and health programmes in the region. The partnership with them enabled us to find relevant local experts and made it easier to get into contact with them.

OEFI met with the local experts for the first time at a round table discussion in Sellye.

With the help of MMSZ we have invited local decision makers (mayor, notary, leaders of health care and education institutions) and experts of the local care system (GP, paediatrician, debt counsellor, health visitor, kindergarten teacher, nurse, social worker and regional representative of MMSZ). The aims of the discussions were to present the project, map problems and needs of the local population, get to know the attitudes and problems of local decision makers and experts, collect information on good practices and most importantly to initiate cooperation with local experts.

A working group was formed out of experts participating at the local round table discussion and provided further cooperation. The **working group has six members**, including a representative of MMSZ. The members have the following qualifications: GP, paediatrician, socio-educational instructor, health visitor, social politician, and regional mentor of MMSZ. In the framework of the partnership agreement, members of the working group cooperated in developing the action plan and implemented the selected programmes of the plan. The cooperation was open and was based on a bottom-up approach. The working group was given the chance to act autonomously and OEFI provided professional and methodological support. Members of the working group were provided with an expert fee.

Preparation of the action plan

Three meetings were organized with the working group in Sellye. The aims of the meetings were to develop an action plan which reflects local problems and needs, the social situation, daily life of the population and addresses risky health behaviour with adequate aims and activities. Furthermore, OEFI received methodological support from the Murska Sobota Public Health Institute at a meeting in Budapest.

Within the three meetings, members of the working group submitted proposals for the aim and content of the action plan and the programmes to be implemented. Besides, OEFI kept continuous contact with them by phone and through e-mails.

The aim was to prepare an action plan with various detailed activities which can be implemented in practice. The action plan is in possession of the local community and can be used as a basis to implement further actions after the project period.

Based on the round table discussion and discussions with the working group, three main problems were identified: low health literacy, overloaded health experts at local level and scarce infrastructure resources.

Commonly agreed aims to address the above challenges were:

- Organisation of health promotion programmes, providing information to the

population for decreasing health problems, developing health literacy;

- Capacity development, human resource development;
- Infrastructure development (improving access to health care).

The following issues have been considered in planning the aims and activities of the action plan: the most suitable activities to tackle health inequalities in the current situation, activities preferred by population, activities preferred by the local experts and activities at which the population would most willingly take part.

In reviewing the available local resources and their use, the following issues have been considered: available human resource capacity in the local care system, available infrastructure in the care system, how overloaded are the local experts and how this affects their well-being and what difficulties they face in their daily work.

In order to improve the access to health care the following questions have been discussed: How is the mobility of the disadvantaged population facing social problems? Is the local care system available for the local population regarding public transport (e.g. accessibility, synchronising the consulting and office hours with the public transport time tables)? What kind of impact would public transport development have on the use of services in the care system?



Selecting two programmes of the action plan for implementation

Programmes to be implemented were selected during the working group meetings by discussing their possible implementation and effectiveness. Members of the working group have submitted written programme proposals which were discussed at a meeting. As a result of these discussions, a new, complex programme was designed from the combination of preferred programme proposals, called “Parents’ Club” which was supported by all members of the working group. Furthermore, to directly reach children, soft handball teams were established.

The selection of the above programmes was based on the unanimous agreement of the working group, considering local needs, available resources and professional capacities.

Members of the working group were interwoven with the implementation of programmes. Their active role was inevitable in the implementation. For the programmes to be successful, they contacted local health care, social, education and sport experts, and started cooperating with some of them. OEFI helped the implementation by providing professional advice and documents. Regular and direct communication has enabled good cooperation with the working group. MMSZ provided effective local help and support in the implementation

Implementation of the Parents’ Club

The aim of the programme is to promote a healthier life within families by forming parents’ attitudes towards health, and to help parents to positively influence their life and health and convey the knowledge they gain to their children. The target group were parents of disadvantaged kindergarten and school children.

Practical and interactive clubs were organized in five topics defined by the working group. The clubs were organized by the members of the working group and in some cases other speakers or professionals took part in the implementation, as well. The clubs were organized around the five topics in three settlements, namely in Magyarmecske, Sellye and Vajszló.

Based on the problems of the local population, especially of the multiply disadvantaged, the following 5 topics were identified:

- Basic healthcare information, prevention and treatment of pulmonary problems;
- Dietary, oral hygiene information;
- Parenting problems, advices;
- “Smart financial management” (consequences of substance abuse);
- Orthopaedic deformities, teaching preventive exercises.

The clubs took approximately two hours. The most difficult task has been reaching

the target group and making them participate. Based on the experiences of the local experts, the most disadvantaged people are the most passive and hard to engage. To facilitate participation, members of the working group have placed invitations in public places of Magyarmecseke, Selye and Vajszló and in nearby settlements. When possible, they invited people personally.

Thematic presents linked to the topic of the clubs were given to the participants in each club (e.g. tooth brush, tooth paste, diary, parLOUR games, thermometer etc.). Participants also received beverages, sandwiches and cookies. Those living in nearby settlements were transported to the venues by the village buses (operated by the village and homestead caretaker services). Based on the local feedback participants enjoyed the clubs, they were active and cooperative and expressed the need for further, similar programmes.

Establishment of soft handball teams for children

The aim of the programme is to enhance physical activity of school children (primarily the age group of 6-14) and orientate them towards team work. In order to reach the target group and properly implement the programme, the Handball Association of Baranya County (BMKSZ) was contacted. OEFI made a partnership agreement with them.

BMKSZ and one member of the working group, with the coordination of OEFI, sent an invitation to all elementary schools in the region. Altogether, 7 elementary

schools applied and established soft handball teams. Based on the partnership agreement, BMKSZ provided one regional coordinator and trainers who held demonstration trainings for teachers of physical education. Based on the demonstration trainings, teachers for physical education held trainings for children after school hours (in some cases within school hours).

The newly formed soft handball team would compete at a final regional soft handball championship at the end of the programme.

Based on the local feedback, the children are enthusiastic, enjoy trainings and expressed the need for regular trainings.

Sustainability of project results

Based on the positive experiences of the joint work in the project, members of the working group decided to set up a civil association which will enable them to continue the joint work on reducing health inequalities.

There is a possibility to continue the soft handball team initiative, as well. The Selye Sport Association informed the working group that they have won an application which includes organizing a regional two-stage soft handball championship. BMKSZ and the Selye Sport Association agreed to harmonize their programmes. Furthermore, the Croatian Minority Government and the Győri ETO Handball Club also expressed interest in continuing the initiative.

We can conclude that a new, community-based capacity building was implemented as a result of the project. Local experts of different



sectors (health, social, education) contacted each other, mobilized their own professional contacts to build a wider network, and to tackle health inequalities.

The implemented programmes are being evaluated by external experts. Results of the external evaluation will be available before the project ends.



Figure 3 and 4: *Workshops for the parents within the programme “Parent’s club”, Hungary*

Preparation of an Action Plan, implementation of one objective and evaluation of the pilot implementation

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The pilot implementation of chosen objective at Rokiskis district municipality

According to the action plan, we have chosen two main activities: Nordic walking sessions and the lecture on promotion of healthy nutrition. Nordic walking is widely used as a form of therapy and is effective in treating respiratory and circulatory disorders, spinal diseases, osteoporosis, Parkinson and Alzheimer diseases. It is suitable for older people and those who are overweight.

The Nordic Walking sessions were conducted in collaboration with Rokiskis public health bureau. Public health bureau had all the necessary equipment for Nordic Walking: all participants received walking sticks, a bottle of water and a leaflet "Take care of your heart and health". This leaflet was prepared in collaboration with the public health bureau of Rokiskis district municipality and Institute of Hygiene. Nordic Walking sessions were held twice a week. When needed, sessions were held more frequently. Nordic walking activities were held outside (e. g. in parks), so the number of participants depended on weather conditions. In April and May, we expect

more participants because weather conditions will be better and more suitable for walking outside. Nordic Walking sessions consisted of two parts: theoretical and practical. In the theoretical part the information about the prevention of the cardiovascular diseases was provided; also, the benefits of Nordic walking and clothes needed for this activity were introduced.

And then the practical part - Nordic walking activity in the park - followed. The residents of Rokiskis district municipality could find out about this activity on billboards of medical institutions, in local newspapers and on the website of the public health bureau. Seeking to raise awareness of healthy life style, members of the local community were invited to the lecture on healthy nutrition "Healthy diet according to Ayurvedic principles". About 50 residents participated in the event. Also, a healthy morning activity was organized. Whoever wished (there were over fifty volunteers) was able to check their level of blood glucose, blood pressure, to try and perform an analysis of body mass (fat, muscle, fluid, BMI). The participants could also find out information about healthy nutrition. 54 people tried these procedures.



Evaluation of the pilot implementation

To evaluate the implemented activities a quantitative survey has been made. The questionnaire consisted of two parts – pre-test and post-test. The pre-test included a subjective evaluation of importance of physical activity and estimation of the Nordic walking sessions. The participants had to fill the first part of the questionnaire during the first session of the Nordic walking. At first they had to express their general opinion on physical activity indicating their approval of the following statements “Physically active people feel better”, “Physical activity contributes to the prevention of diseases”, “Healthy minds - healthy bodies” and so on. Then they were asked to agree or disagree with the statements about their personal physical activity (e. g. “I am a physically active person”, “My life-style provides sufficient physical activity”, “I like being engaged in physical activity” and so on). Also, we asked the participants how much they knew about Nordic Walking technique, what have they expected from this activity, etc.

The second part of the questionnaire was given to the participants who have participated in the Nordic Walking activities more than 3-4 times. In this part they had to estimate the Nordic Walking sessions, indicate positive and negative impressions of it and so on. Also, they had to indicate if they would recommend this kind of sport to their friends, etc. To that point in time 231 participants have attended the Nordic walking sessions. 53 participants have participated in this activity more than three times. The survey data has been analyzed

using a specialized program for statistical analysis SPSS 17.

Ethical background of the evaluation

We tried to ensure that all participants understand the goal of the survey and voluntarily agree to participate in it. Also, the questionnaire was anonymous, there was no name or surname or other personal information about the participants. With accordance to voluntary participation we had a smaller number of the filled questionnaires.

The main evaluation results

The results of the survey showed that the participants realized the importance of physical activity for health. The respondents commonly agreed with the following statements: physically active people feel better (\bar{x} – 9,06; n = 99), „Healthy mind – healthy body” (\bar{x} – 8,81; n = 99), physical activity contributes to the prevention of diseases (\bar{x} – 8,71; n = 99). The participants more rarely replied that they were physically active (\bar{x} – 7,53; n = 99, Table 2). About 10 % of the participants noted that they are physically inactive.

Only one-tenth of the respondents claimed that they had no knowledge about Nordic Walking before this activity; and half of the participants noted that their knowledge was insufficient. Half of participants noted that they had tried the Nordic Walking technique before. More than half of the participants

expected to find out more about this kind of sport through this activity, and to have a good time. During the reinvestigation we asked the participants if their expectations regarding Nordic walking sessions had been fulfilled. The majority of participants said that the activity had met their expectation to find out more about the Nordic walking technique and that they had had a good time. The majority of the participants said that The Nordic walking sessions were a great way to spend leisure time, an effective way to improve health. The respondents also noted that it hadn't been boring to engage in the physical activity. More than two thirds of participants evaluated The Nordic walking sessions as very good or good.

None of the respondents noted that they did not like the trainings at all.

Almost all the participants (98 %) indicated positive impressions of their participation in this activity, and stated that it was a good method to engage in physical activity, to gain more knowledge about this technique. A negative feedback was only because

of bad weather during the walking outside. More than half of the respondents two thirds who had participated in the sessions more than three times noticed that these trainings raised their mood, increased physical activity, helped to lose some weight.

All the participants noted that it is necessary to promote Nordic Walking in their living area.

Conclusions

The evaluation of the chosen activities gave a very valuable experience income bating health inequalities. Firstly they strengthen the collaboration between different organizations working for the same goal – reduction of health inequalities in the region. The interest of the people who participated in the activities showed that this kind of a healthy life promotion is necessary. Also, the implementation of the project activities provided the opportunity to improve skills that are required in the process of reducing health inequalities and promoting a healthy life style.



Figure 5 and 6: Nordic Walking training and workshop, Lithuania



Preparation of an action plan and implementation of one objective in Slovakia

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Preparation of the action plan

When preparing the Action Plan we used the concept provided by the coordinator of the project ACTION-FOR-HEALTH. The first step in the creation of the Action Plan was the situation analysis and needs assessment. From the available data, we first assessed the health status of the Slovak population, and then we assessed in more detail the health status of the population of the Trnava region and the Trnava town. The desired output of these steps was to identify the priority health problem of the Trnava inhabitants, which is consistent with the health situation in the Slovak Republic. The priority public health problems are cardiovascular diseases.

Based on the workshop with the representatives of medical, educational and political sector in Trnava and based on meetings with community groups, strategic issues and target groups have been identified and incorporated into the plan. As the Action plan is to be the instrument of tackling health inequalities through health support, we decided to focus it on all population and social groups of the Trnava town.

Implementation of the chosen objectives

Due to the fact that our team is part of the Faculty of Health Sciences and Social Work, we have first implemented Aim 2, in which we were pursuing individual objectives, especially of the group of students from the Faculty, but the afforded activities have affected the staff as well. The Aim 2 targets at improving behaviours of Trnava inhabitants as to tackle health inequalities within supportive environments.

Within the Days of the Faculty (17 – 21 March 2014), every day in the morning, we carried out risk factors measurements- measurement of blood pressure, cholesterol, triglycerides, glucose, anthropometric measurements (waist and hips circumference, height, weight, waist to hip ratio, BMI, percentage of body fat), spirometry and measurement of carbon monoxide in exhaled air in smokers. The results of these tests were recorded into students' and staff's medical records followed by professional advice carried out by the students of the last year of Public Health programme. Due to this action we met the Objective 2.3 - Support healthy lifestyle behaviours with in

Trnava population. A total of 104 students and Faculty members participated in this action.

On Wednesday 19 March 2014 we spent all day at events aimed at health support and health education. We organized lectures on prevention of cardiovascular diseases and cancers, on the impact of physical activity on health and also to raise awareness of health inequalities. Thus, in addition to the Objective 2.3 also the Objective 2.2 –Encourage more physical activity and the Objective 2.4 - Raise awareness amongst people about the early signs of the disease and encourage people to seek advice and further information. Students and Faculty staff also had the opportunity to taste food and beverages healthily prepared (food and beverages low in sugar). The end of the day was dedicated to amass physical activity with a professional Zumba trainer and to lectures on Tai Chi and Judo, so that we aroused the students' interest in exercise.

We experienced no barriers with the implementation of activities at the Faculty. On the contrary, the students and staff had shown great interest in healthy lifestyle. A regional TV channel Mestská televízia Trnava, also interested in this action, made reportage on Health Days and thus Trnava inhabitants were regularly informed about our event and the Action plan. Furthermore, the interest was shown by a representative of a private sector (a food company), which is planning to hold a similar event in their organization.

When organizing these activities, we cooperated with Regional Office of Public Health in Trnava and its representative participated in lecture sections. As part of a partnership building the Regional Office of Public Health

appears to be a promising partner in organizing future events. Building partnerships with the representatives of the Trnava town is our challenge for the future period. However, cooperation with the Healthy City Office Trnava is shaping in order to implement further objective aimed at Trnava inhabitants within the Health Days which will be held on the 19 and the 20 June 2014.

Besides participating in Health Days of the Trnava town we are planning to implement another priority of the Action plan, namely Aim 3 -Improving behaviours so as to tackle health inequalities of the Trnava inhabitants within vulnerable groups with a focus on the Objective 3.3– Senior citizens (elderly population). The activity will reside in the organization of a healthy picnic for seniors in the Trnava town, where they will have the opportunity to taste healthy prepared meals made by the students of a secondary vocational school. Aim 4 of the Action plan – Support a clean and healthy physical environment, namely the Objective 4.2 - Support positive behaviour and ownership of the Trnava inhabitants towards their physical environment will be pursued through cooperation with the civic association Better Trnava, which aims at improving the quality of life in Trnava for the benefit of its citizens.

Conclusions

We evaluate all the implemented activities by monitoring participation and satisfaction, whilst for some we implement a questionnaire on lifestyle. In cooperation with a regional TV



channel Mestská televízia Trnava a video of all the activities within the implementation of particular aims of the Action plan and it will result in a short video clip aimed at promoting the Action plan to the Trnava town officials, as well as to all interest groups that have shown interest in the Action plan and which will also serve as an educational tool for the students of Public Health programme with a focus on

tackling health inequalities and health support. The video clip can be a part of an application to obtain structural funds to implement the Action plan in practice and to ensure sustainability of activities aimed at health support of the Trnava population. All the previous activities have been and continue to be presented at domestic and international conferences, as well as in print and electronic media.



Figure 7 and 8: *Measurement of risk factors for CVDs, Trnava, Slovakia*

Pilot implementation of “Suicide prevention and mental health promotion in schools - love is the best ‘kick’”

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Introduction

Health at childhood and adolescence exerts a big influence on health in adulthood so that it is very important to create a healthy lifestyle and a healthy environment for sustainably favourable health in childhood and adolescence (1). Estonian Population Policy 2009-2013 proposed three priorities of actions of improving health of children and adolescents: 1) promotion of the physical and mental health and social development; 2) prevention of injuries and violence; 3) prevention of chronic diseases and their risk factors (2). These principles become very firm base of our action plan for children and adolescents.

Rapla County is a rural area and located in the north-western part of Estonia. Due to the geographical closeness to Tallinn, the country's capital, Rapla County has been called the 'bedroom' of Tallinn. Building, transport and agriculture are the primary industries there (3). Moreover, public administration, schools, health and social service play an important role.

Preparation of action plan

During the period of action plan preparation, in order to do a thorough situation analysis and needs assessments, the stakeholders

from the Rapla County were invited to have focus group meetings. Based on the information collected from the focus group with specialists and stakeholders of Rapla County (4), it was known that Rapla County is lacking of sufficient knowledge and other resources for implementing situation analyses and evaluating the effectiveness of programs, especially the impact assessment of mental health as a determinant of injuries (e.g. stress, mental health problems, suicide and related alcohol and drug consumption). Moreover, unstable financing support and legislations that don't encourage 'grass' level health promotion will be obstacles for building a network organization on this level (4). Therefore, the capacity for recognizing and solving mental health problems/disorders and suicide attempts and sustainable political and financial support from the national government should be taken into account in our action plan for tackling health inequalities in Rapla County (5).

In order to successfully carry out the implementation of one objective of action plan, Estonian-Swedish Mental Health and Suicidology Institute (ERSI) took the key role with the cooperation of the stakeholders in Rapla County. The stakeholders were Ülle Riiüson - local health promotion specialist from Education and Social Department of Rapla County Government, Liivia Vacht



- academic counselling coordinator from Rapla County Information and Counselling Centre, and Urve Uusberg – Psychologist from Rapla County Hospital.

One report ‘Mental Health Promotion and mental disorder prevention: a policy for Europe’ (7) listed out five common principles in the work of mental health promotion as follows: expand the knowledge base for mental health, support effective implementation, build capacity and train the workforce, engage different actors and evaluate policy and program impact.

Thus, in the preliminary draft of action plan, the awareness and knowledge base for mental health promotion and suicide prevention would be increased through offering training courses to the different actors in schools, with the topic of preventing depression and suicide, preventing violence and harmful substance use, and building capacity of relevant actors to support the groups at risk, e.g. children and adolescents.

After proposing the preliminary draft of action plan based on the above-mentioned

principles, two more focus group meetings with stakeholders were held: one in Rapla County Government and the other in Estonian-Swedish Mental Health and Suicidology Institute (ERSI). Under the agreement between ERSI and the stakeholders in Rapla County, the objective 2 (To increase early identification of mental disorders and signs of suicidal behaviour among children and adolescents) of Aim 3 (Reducing health inequalities in the region by supporting groups at risk) in action plan was chosen for pilot implementation in Rapla County.

Implementation of the chosen objective

The announcement of training courses was posted onto the official webpage of Rapla County Government (see below) by Ülle Rüüson, the local health promotion specialist from Education and Social Department, Rapla County Government.



Figure 9 and 10: Implementation of strategic objective in Rapla County

Liivia Vacht, the academic counselling coordinator from Rapla County Information and Counselling Centre was the local coordinator and took responsibility of dissemination of training courses announcement, registration of participants, and organization of locations for training course. ERSI invited researcher and project manager, Airi Mitendorf, experienced expert, to undertake three training courses. The main topic of training courses was “Suicide prevention and mental health promotion in schools - love is the best kick”.

The first training course was held in Kohila Gymnasium, the second training course was held in Märjamaa Gymnasium and the third training course was held in Rapla Joint Gymnasium. The participants were teachers, special education teachers, children protection specialists, social pedagogues, social workers, social counsellors, career counsellors, psychologists, parents, nurses, and doctors etc.

During the training courses, the lecturer gave a brief overview of the characteristics of mental problems (e.g. depression), substance abuse (e.g. alcohol consumption, drug abuse, etc.), and suicide among children and adolescents. The theoretical knowledge was followed by the presentation of the teaching films which presented different life stories of adolescents who attempted suicide in the past. With the lecturer’s help, participants were divided into different groups to have specific discussions related to the films and the topic.

Evaluation of implemented activities

After the training courses, the participants were asked to fill in the feedback sheet to evaluate the output of training courses. According to the feedback from 48 participants, 87% have strongly agreed that the topic which the lecturer provided was explicit and understandable; almost 98% have agreed that training was well structured and goal-oriented; 77% have strongly agreed that selected training methods (e.g. cases presentation, teaching film, etc.) were appropriate; almost 90% mentioned that training course improved their knowledge; and 87% thought that training course has fulfilled their expectations.

During the training courses, besides a PowerPoint slides print-out, additional materials were disseminated to participants, e.g. practical booklets/guidelines for teachers, psychologists, social workers, primary health care workers, and other school staff, etc. to recognize mental disorders and prevent suicides of school children and adolescents. Almost 98% of participants agreed that these materials were interesting and up-to-date.

According to participants’ answers to two open-ended questions in feedback sheet, most of them pointed out that ‘it is a very important topic’ and they appreciated that the lecturer showed a very general yet comprehensive overview of this topic in a short time.



Conclusions

Since the objective 2 of action plan – to increase early identification of mental disorders and signs of suicidal behaviour among children and adolescents- has been the main focus in the pilot implementing of the action plan, a relatively high evaluation from participants to some extent demonstrated that the expected goal has been achieved. In the long run, with the reasonable utility of Structural Funds, the training course could be sustainably carried out in neighbouring regions, or even at national level of Estonia. In terms of the second open-ended question, some of participants suggested that more time should be spent for more

specific topics, especially to learn the practical skills to intervene with the suicide cases or cope with similar situations, for instance, when the children and adolescents showed their suicidal signs, thoughts and even took suicidal behaviours during study time at school. In the future, the other objectives of action plan, e.g. to promote mental health and then decrease prevalence of suicidal ideation and behaviours of children and adolescents, and to increase early identification of mental disorders and signs of suicidal behaviour among working-age population and older people etc. could be taken into consideration for continuous implementation of action plan not only in Rapla County but also in other regions.

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Tackling childhood obesity at Canary Island, Spain

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Introduction

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

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

Being aware of these data and the need for special attention to children regarding the prevention of obesity, the focus of the action plan in Tenerife has been on this health problem.

The prevention of obesity depends significantly on the policy agenda, however, effective evaluation of the existing health promotion programs and interventions are lacking, so the effectiveness of these actions is unknown (S. Darias Curvo, 2008; S. Darias Curvo, 2009).

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

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

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

The General Directorate of Public Health of the Canary Government has elaborated an intervention programme to prevent childhood obesity following the WHO Strategy and the Ministry of Health of Spain. The main objective of this strategy is to promote a healthy diet and physical activity among children and adolescents and to reduce the prevalence of overweight and obesity.



Preparation of the strategic action plan and identification of one objective for implementation

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

We used data from the Spanish Statistical Office, Canarian Statistical Office and Ministry of Health, Social Affairs and Equality. A number of health factors have been identified as contributors to cause health inequalities in the population of Canary Islands.

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

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

We have decided to implement the activities aimed at improving healthy behaviour.

Implementation of strategic objective

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

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

To improve health and well-being by making school and workplace settings more supportive of healthy lifestyles, Target 1: Reduce childhood overweight and obesity-Nutrition.

The theoretical framework has been based on the study and contributions of many professional associations, such as “Paediatric guide of healthy diet and physical activity for 0 to 18 year olds” or “Healthy menus for 4 to 18 year olds”. More information can be found at www.programapipo.com.

The General Directorate of Public Health, the Education Department of the Canary Government and the University of La Laguna have developed a health promotion intervention which has been implemented in six schools in Adeje (Tenerife) among 6 and 7 year olds. Some of the materials used are:

- “In search of the lost nutrition”, (“En busca de la alimentación perdida”).
- “The Pyramid of healthy nutrition”.

We have had several meetings with partners and stakeholders, organised workshops and produced printed materials. We have organised *the workshop* “healthy nutrition for 6 and 7 year olds” for teachers, parents and health authorities. A workshop entitled “Workshop of healthy nutrition” has been implemented among 300 freshmen in primary school.

The general goal has been to promote a healthy diet and physical activity in childhood and to prevent overweight and obesity among children. More specific goals have been to increase the participants’ knowledge of all the different types of food and their precedence and to introduce the health pyramid rules in healthy nutrition, e.g. learning more about the

frequency of consumption and the distribution of food on the food pyramid. At the same time a workshop on physical activity has been developed.

Adult participants have found the workshop very helpful, particularly the practical information about healthy food and how to use the materials in daily classroom. We are in the process of evaluating the intervention among children.



The second phase has been the project's presentation at all levels of regional government.

This project presents the beginning of a strategy to tackle overweight in children and obesity in the Canary Islands. The strategy has been developed as part of the ACTION FOR HEALTH project. We intend to continue with implementation of other objectives over the next years.



Figure 11 and 12: *Promotion of healthy lifestyle at primary school at Canary Island*



IV ACTION-FOR-HEALTH project evaluation

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The evaluation of the ACTION-FOR-HEALTH (A4H) project was based on an evaluation framework developed from drawing on aspects of the Gradient Evaluation Framework (Davies & Sherriff, 2012). The A4H framework comprised qualitative and quantitative methods to evaluate and monitor project activities, processes, outputs, and immediate outcomes of the project.

Evaluation data was generated primarily from project partners through methods such as partner reviews, individual interviews, focus groups, and short questionnaires. Complementary documentary analysis was also conducted thorough the project. Together these methods generated data allowing the provision of on-going feedback and recommendations to the project coordination team, as well as more summative identification of how well the project objectives were achieved and more broadly, strengths and weaknesses of the project. Of particular value reported by both partners and the coordination team, was the use of the partner reviews (a combination of a short questionnaire with some qualitative follow-up interviews).

In general, ACTION-FOR HEALTH was successful in the achievement of the project

objectives, milestones, and deliverables. Whilst some of the milestones and deliverables had to be extended at due to a variety of reasons in agreement with the EC project officer, this was not detrimental to quality or the overarching project time line. In particular, the project was successful as planned in applying an approach developed previously in Slovenia (Belović et.al, 2005) to a number of other European countries and regions including Bulgaria, Croatia, Estonia, Hungary, Lithuania, Slovakia, and Spain. In doing so, the project has built the capacity of the project partners by increasing their knowledge and skills, by applying these skills in practice, and by building partnerships within the participating countries and within the project consortium. Evaluation data show that partners feel they have benefited from participating in the project both personally (e.g. knowledge and skills) and institutionally (e.g. in terms of organisational capacity).

A key strength of the project reported by partners was the accessibility of the project coordination team throughout the project activities. Project partners appreciated the frequency of communications with the coordinator and felt sufficiently supported in all project phases.

Another key strength was the outputs of the project: All publications and especially the publication trilogy were disseminated widely, both by the project coordinator and by the partners. Furthermore most of the action plans that the partners developed were disseminated within the partners' countries, and the project and project results were presented at several European and local/regional events.

A further strength concerns the successful fulfilment of all milestones and deliverables. This is particularly noteworthy, as there have been several obstacles for project partners such as changes of the (legal) status of their organisations, staff changes, and so on. Furthermore, project partners and the project leaders reported being satisfied with the project outputs and immediate outcomes as well as having enjoyed participation. For instance in terms of the latter, partners reported that the practical approach adopted informed by theory, including the situation analysis and the implementation of one objective of the

action plans, was particularly liked by project partners.

A relatively minor weakness of the project related to the hierarchical project structure whereby only three partners were in charge of leading the project and its work packages. This meant that there was little participation in decision-making by other partners not leading work packages. In future projects, greater diversity in work package leadership is likely to resolve this issue.

Perhaps the largest weakness and challenge of the project was the very short time frame (24 months) which put partners under considerable pressure to carry out the different project phases as quickly as possible. This also meant there was little capacity for additional added value activities that was not set out in the original project proposal.

A detailed explanation of the evaluation methodology, process and results are available in the project's final evaluation report (see Gugglberger & Sherriff, 2014)

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V Conclusions and recommendations

By Stephan Van den Broucke and Tatjana Krajnc-Nikolić

Given the multiple causes of health inequalities, their reduction requires targeted policies and interventions that are preferably embedded in a coherent strategy. Such a strategy to reduce health inequalities has to involve more than improving the health care system: it should also include actions to create equal social opportunities for a good health. As the various processes which lead to or reinforce health inequalities do not work in isolation, but often compound one another, it is necessary to combine measures that address each of the determining factors and mechanisms.

In this regard, health promotion offers a promising approach to tackling health inequalities. Health promotion is defined in the Ottawa charter (1986) as “the process of enabling people and communities to increase control over the determinants of health and thus improve their health”. It represents a comprehensive social and political process, which not only embraces actions directed at strengthening the skills and capabilities of individuals, but also at changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. As such, it entails a mix of midstream and upstream level interventions.

Health promotion strategies targeting health inequalities must go beyond health education and bring about structural or organizational changes to create an environment that enables dis-advantaged groups to take control of their own health. These broad determinants of poorer health cannot be changed by health promotion workers alone. Indeed, health promotion emphasizes the importance of inter-sectoral policies where health determinants are integrated in other policy areas at a national, regional and local level. By involving these other sectors, more effective measures can be taken to reduce health inequalities.

While admittedly the effectiveness of such interventions is difficult to assess, a lot can be learned from examples of good policies and practices. One such example was the Health Promotion Strategy and Action Plan to tackle health inequalities in the Pomurje Region in Slovenia, which involved a systematic process to develop a regional strategic plan to reduce health inequalities, setting clear aims and objectives for the government and other stakeholders as well as the strategies to reach these objectives and indicators to monitor progress. The innovative component of this approach was its participative nature, whereby regional

priorities for action and specific target groups were identified in participation with the health workers, who also identified and proposed specific activities had also been planned to implement the plan.

The Action for Health project rolled out the experience of the Pomurje to implement the program's learnings in seven EU Member States. The present publication presented a description and illustration of this wider implementation process.

While the different examples outlined in the different countries reflect a wide variety of situations, problems, and actions to tackle inequalities, a number of similarities can be detected.

- The co-operation of partners from different sectors led by enthusiastic teams creates an intensive process and results in visible results.
- Involvement at the regional level can be created through various participating opportunities.
- The steps of the approach to strategic planning give structure, while allowing a sufficient degree of freedom for the participants.
- Ownership of the strategic plan can be achieved at the regional level.
- The regional workers involved in the project are more focused on the implementation, and less on a strategic level. This makes the elaboration of a strategic plan at the local level more difficult.

The main outcome of the project was the increase of the capacity to tackle health inequalities in each of the participating countries.

This increase in capacity is not only noticed in the core team working in the project, but also amongst stakeholders at the regional level. To continue this capacity building process in the region, further cooperation on knowledge transfer would be useful.

Moreover, also in the organisations that participated in the project, at the capacities of the health promotion workers were strengthened through the exchange of experience between the project partners, the organisation of workshops, and the involvement of experts. The co-operation of partners from different countries focusing on capacity building and the openness to learn created an intensive process. One of the most important immediate output of the project was the meaningful connection of the existing capacities in achieving synergistic effects. The detailed project plan gave structure and clarity for a difficult and ambitious project. A stronger involvement of the other participants in the preparation of the project plan would be beneficial.

The implementation of the strategic objectives serve as an evidence that the action plan made in the project is realistic and implementable. At the same time, it could be a motivation to stakeholders to continue with addressing health inequalities on local or regional level.

Further training and transfer of the approach of the project to more regions, leading to the development and implementation of national strategies, could secure even more sustainability and increase capacities to address health inequalities in the future.



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