



JAHEE

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HEALTH EQUITY EUROPE**

**Work Package 6 – Healthy Living Environments
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Policy Framework for Action**

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Abbreviations

CA	Country Assessment
CHRODIS	EU Joint Action Chronic Diseases and Promoting Healthy Ageing across the Life Cycle
CTC	Programme Communities That Care
HI	Health inequalities
HiAP	Health in all Policies
EQUIHP	European Quality Instrument for Health Promotion
INHERIT	Horizon2020 Project Intersectoral Health and Environment Research for Innovation
JAHEE	Joint Action Health Equity Europe
JANPA	EU Joint Action on Nutrition and Physical Activity
PFA	Policy Framework for Action
PHAC	Public Health Action Cycle
RCT	Randomized controlled trial
SDG	Sustainable Development Goals
SMART	Guide to goal-setting: S=Specific, M=Measurable, A=Achievable, R=Relevant, T=Time-bound
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WP	Work package

Key messages

1. This Policy Framework for Action (PFA) focuses on the influence of the living environmental context on health and health behaviour. Socioeconomically deprived communities are more likely to have social and environmental risks to health like poor housing, safety from traffic, fewer green spaces, poorer air quality and higher rates of crime (Marmot 2010). They are associated with worse health outcomes. The environment can have an impact through biological mechanisms and psychosocial mechanisms (Morello-Frosch et al. 2011, ncb 2012).
2. The approach of healthy living environments prevents social problems resulting from social inequalities from being individualized. The creation of healthy living environments is supposed to strengthening individual health in two ways. Firstly, healthy behaviours are improved irrespective of income, origin and educational background (e.g. Swinburn, Egger & Razza 1999) and, secondly, health is promoted by strengthening resilience factors and reducing environmental risk factors. As a result, through the participatory orientation of such measures, people are enabled to influence their living conditions and living environments themselves.
3. The conceptual basis in JAHEE WP6 of how to create healthy living environments follows a settings approach in a broad community-oriented understanding that is steered from the municipal level. A municipality can be regarded as an 'umbrella setting' for a cross-setting strategy. Healthy living environments can only be created if sectors other than the health sector are involved. Capacity-building, structural development, planning and networking are central approaches. The fundamental basis is the willingness to prioritise the issue of health on the local political agenda and to create a broad awareness of the multifactorial conditions of health. Measures to create healthy living environments require a solid database for the implementation of concrete measures. The aim here is to develop integrated monitoring at the local level that systematically combines socio-spatial data from originally different sectors.
4. The municipal context offers comprehensive entry points for action. Municipalities seek to provide education throughout the life course, create appropriate conditions for housing as well as for physical activity and healthy eating. Municipalities can also promote the creation of a stable ecosystem. Moreover, a focus on municipalities addresses the local political context, local political regulations and urban or rural planning and development, which are important contributions to improving living conditions ('upstreaming').
5. An explicit equity dimension in municipal approaches to create healthy living environments can be pursued by focussing on deprived urban quarters or communities, on vulnerable population groups as children or elderly people, or by programmes and efforts that improve the health within the municipality as a whole, with benefits increasing through the gradient.
6. Approaches and measures to create healthy living environments in municipalities should follow a process-oriented and quality-supported approach. In this PFA, 16 quality criteria are presented. They apply to the individual phases and to a lesser extent to the overall process of the so-called Public Health Action Cycle.
7. Although the focus for WP6 is on local healthy living environments, it is a serious concern that municipalities might be left on their own to manage this huge task. There are many possibilities to support and create supportive structures from the regional and national level to enable municipalities to create healthy living environments, including capacity building, funding, training, networking or research.
8. It is difficult to provide sufficient empirical evidence due to the complexity of the approaches and the addressed outcomes, which often aim at long-term changes. And there are still challenges in the evaluation designs and methodologies. Evidence of the effect of risk and protection factors provides important entry points for changing the contexts within and outside of settings at the local level. Compared to the epidemiological body of evidence, there is limited but growing evidence for the impact of environmental interventions. For example, promoting equigenic environments 'may disrupt the usual conversion of socioeconomic inequalities to inequalities in mental well-being' (Mitchell et al. 2015, p. 80). Intervention studies show that strategies such as capacity building are of great importance in this context. Also concepts as Walkability have already proven to be effective.

1. Introduction

This Policy Framework for Action (PFA) – Healthy Living Environments was developed in the framework of the EU Joint Action Health Equity Europe (JAHEE, 2018 – 2021) as one of the project deliverables in Work Package 6 (WP6) - Healthy Living Environments. The overall objective of JAHEE is to contribute to achieving greater equity in health outcomes across all groups in society in all participating countries and in Europe at large.

1.1 Purpose and scope of this Policy Framework for Action

The aim of this specific PFA is to provide the partners with the best available knowledge on why and how to create healthy living environments while reducing health inequalities. The theoretical background described in this PFA serves to promote a common understanding of what we mean in WP6 when we speak of healthy living environments. As a working basis for the participating countries in WP6, this PFA aims to ensure a consistent approach for all actions implemented under WP6. The framework described in chapter 3 is intended to facilitate country assessments conducted in the project process and to enable countries to select tailored actions to be implemented.

Actions and their objectives will be selected and defined by participating countries based on the needs they identify and on their political context. All actions have to be adapted to each country's specific context. This is why the focus of the PFA is on an ideal process and quality criteria. It does not identify specific topics or target groups.

There are many different possible approaches to creating healthy living environments. As was agreed upon among the WP6 partners, the specific focus of WP6 is a broad community approach towards health promotion and disease prevention that is steered from the municipal level and therefore called “municipal health promotion”. This approach will be explained and theoretically supported in this PFA.

The following approaches and strategies are not considered in WP6 unless they are part of a comprehensive strategy:

- Legislative measures
- Fiscal measures
- Isolated marketing or advertisement measures
- Disease-specific strategies
- Target group-specific strategies
- Workplace health promotion interventions and approaches
- Isolated behavioural interventions or measures providing information and education
- Migration and health (covered in WP 7 in JAHEE)
- Health care and social services (covered in WP 8 in JAHEE).

1.2 Methodology

The PFA is a consensus document of the Work Package 6 partners. The first PFA version was based on the results and decisions of the first WP6 meeting in September 2018 and drafted by the WP6 leader. It was then circulated among the WP6 Project Group Members, WP6 Experts and the JAHEE Steering Committee in two feedback rounds from November 2018 to January 2019. The common working philosophy is characterized by a participatory approach. A further evolution of the document in the course of JAHEE is probable.

The PFA development was supported by a group of German experts in the field of public health. The expertise of the six German experts comprises social inequality and health, environment and health, setting-based health promotion, including quality assurance and evaluation, as well as the implementation of large spectrum of interventions to create healthy living environments. The expert group is interdisciplinary.

To draw up a catalogue of criteria to identify promising practice projects, a number of existing quality assurance instruments for health promotion and prevention focusing on reducing health inequalities were examined and central aspects of the various instruments were identified. The resulting synthesis comprises 16 quality criteria, which are formulated in Section 3.3. The catalogue of criteria suggested here is based on good practice as defined by German and European experience. Essentially they are those of the European Quality Instrument for Health Promotion (EQUIHP), the good practice criteria of the German network Equity in Health, the EU Joint Action on Nutrition and Physical Activity (JANPA), the EU Joint Action Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (CHRODIS) and the findings on good practice in the Horizon2020 project Intersectoral Health and Environment Research for Innovation (INHERIT).

1.3 Intended users

This Policy Framework for Action is mainly intended for the members and partners of WP6 within the Joint Action Health Equity Europe.

2. Healthy living environments for health equity: towards a common understanding

‘Why treat people and send them back to the conditions that made them sick?’ This question raised by Marmot (2015) highlights the need to deal with and positively influence various health-related factors stemming from the social and physical environment.

The major reference model of this PFA is based on the model of health determinants by Dahlgren & Whitehead (1991, shown in annex 1), which includes the natural, social and human-made environment. Another major reference model is the model of mechanisms for the generation of health inequalities by Diderichsen et al. (2012, shown in annex 2), particularly in its description of how the context and conditions in which people live contribute to generating health inequalities. The conceptual basis of how to create healthy living environments follows a settings approach in a broad community-oriented under-

standing. The settings approach is one of the key strategies for health promotion and is also seen as one of the main strategies to tackle health inequalities (Dahlgren & Whitehead 2006).

2.1 Social inequities in health and the living environment

Research findings consistently show that there is a social gradient in health. In other words, people with lower social status have poorer health and die earlier. Income, education and occupational class are indicators commonly used to determine individual or family social status and so vertical social inequality and the access to valuable resources in a society. Indicators of vertical social inequality are tied to indicators of horizontal social inequalities, such as gender and ethnicity. And these create specific social inequalities, shape an individual's social position and have an impact on health. This means, for example, that gender inequality can weaken or intensify the emergence of social inequalities linked to gender groups. Accordingly, it is crucial that horizontal dimensions are taken into account when describing vertical social positions. In addition, the influence of these indicators on the social gradient must be considered.

Research has shown that the link between social inequality and health is complex. Although there are numerous explanatory models and extensive evidence, there is still a need for research into the explanatory factors and in particular the underlying mechanisms of this relationship. This research should go beyond a purely quantitative exploration of interactions and causal relationships and should aim at a deeper understanding of pathways and their heterogeneous patterns.

Nonetheless, five central causal mechanisms behind social inequalities in health have been identified: social stratification, differential exposure, differential vulnerability, differential disease consequences, and disease consequences for the individual and for society (Diderichsen et al. 2012). More and more attention is being paid to the life course of individuals and thus to accumulations or critical phases of health risks.

This PFA focuses on the influence of the living environmental context on health and health behaviour, an influence shown in numerous studies, often with reference to social gradient (Landrigan et al. 2017). According to WHO (2017), environmental factors include exposure to hazardous substances in the air, water, soil, and food; natural and technological disasters; climate change; occupational hazards; travel; transport; and the built environment and access to nature. The environment also includes social factors like social cohesion and social support. There is growing evidence that social inequalities may be linked to worse environmental quality, and environmental inequalities may be causally connected with health inequalities (Cushing et al. 2015). Environmental inequalities are defined as 'the unequal impact of environmental influences on health and wellbeing' (ncb 2012, p. 3).

Socioeconomically deprived communities are more likely to have social and environmental risks to health like poor housing, safety from traffic, fewer green spaces, poorer air quality and higher rates of crime (Marmot 2010). They are associated with worse health outcomes. The environment can have an impact through biological mechanisms (e.g. air pollution results in the production of free radicals in the lungs, as well as the inflammatory pathway triggering of visceral fat deposition, leading to a higher risk of obesity) and psychosocial mechanisms (e.g. stress and anxiety resulting from overcrowding and insecurity) (Morello-Frosch et al. 2011, ncb 2012). Nevertheless, the mechanism by which the built environment and community deprivation affects the individual health are not yet fully understood (Chaparro et al. 2018, Schüle & Bolte 2015).

Air and noise pollution in the community, indoors, and at the workplace cause major health problems (Landrigan 2017; WHO 2010, Science for Environment Policy 2016). Several European studies deal with the unequal distribution of environmental burdens like air and noise pollution from the perspective of environmental justice (Köckler et al. 2017). Several instruments implemented through EU directives or by national law aim at reducing noise and air emissions through environmental and urban planning as well as design standards. Although the impact of such burdens is well studied, there is little research into the evaluation of the different environmental instruments from a health perspective, and it is rarely done from a health equity perspective.

Green spaces in the living environment are associated with mental health and all-cause mortality (van den Berg et al. 2015; Rittel et al. 2014). Communities that are characterized as more walkable, either leisure-oriented or destination-driven, are associated with increased physical activity, increased social capital, lower overweight, lower reported depression and less reported alcohol abuse (see the walkability approach for more information, e.g. Buck 2018, Schneider, Frank, Salis, Saelens et al. 2010). Good access to recreational or green areas and the natural environment improves physical and mental health and wellbeing regardless of socioeconomic status (SES) (Mitchell et al. 2015, ncb 2012). Increasing urban green space is one of the very few interventions with the potential to deliver positive health, social and environmental outcomes, especially among lower SES groups (WHO Europe 2017 b).

There is extensive evidence of a social gradient related to poor diet, tobacco, drugs and alcohol consumption as well as to the worldwide challenge of obesity (e.g. Marmot 2010). Experience in tobacco prevention impressively shows that only a coordinated combination of legal regulations and access restrictions leads to sustainable effects at the population level, such as reduced myocardial infarction and achieve positive health effects (LIT).

A decrease in health inequalities can only succeed if all the macro, meso and micro levels are addressed. The macro level deals with society-wide issues, for example, ensuring through legal and normative regulations that social inequalities are lessened, risks reduced and resources strengthened. At the meso level, the emphasis is on institutions and social networks. At the micro level, the focus is on the individual.

However, the influencing factors at the macro and meso levels play a key role as downstream action to tackle risk factors. Accordingly, health inequalities should be seen as a cross-cutting dimension to be taken into account in the development, implementation and evaluation of any activity. This also applies to the social determinants of health (see e.g. the model of Whitehead and Dahlgren 1991). The central question here is whether and to what extent a contribution is made to reducing health inequalities. Benach et al. (2013) describe four scenarios that can contribute to reducing health inequalities:

- Targeted interventions
- Universal policies
- Redistributive policies
- Proportionate universalism (targeted and universal policies)

The approach of healthy living environments prevents social problems resulting from social inequalities from being individualized. The creation of healthy living environments is supposed to strengthen individual health in two ways. Firstly, healthy behaviours are improved irrespective of income, origin and educational background (e.g. Swinburn, Egger & Razza 1999) and, secondly, health is promoted by strengthening resilience factors and reducing environmental risk factors. As a result, through the partic-

ipatory orientation of such measures, people are enabled to influence their living conditions and living environments themselves.

2.2 Implementing healthy living environments: the HiAP approach

Healthy living environments can only be created if sectors other than the health sector are involved. Health in all policies (HiAP) is an approach promoted by WHO since the Ottawa Charter (1986). It acknowledges the need for an integrated approach to health involving different policy fields. The reduction of health inequalities is one core aim. On the global level, the United Nations' 17 Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable Development, which officially came into force in 2016, address global challenges related to, among others, poverty, inequality, climate, environmental degradation, and education. All these topics are central to population health, which is captured in SDG 3 'Ensure healthy lives and promote well-being for all at all ages' as one major goal for sustainable development.

As health inequalities are strongly determined by social inequalities, all policies addressing social cohesion and lessening the social gradient are relevant (CSDH 2008). Labour and social policy, as two policy fields dealing with income inequality, could contribute to health promotion and disease prevention. Education policies, such as fair access regardless of parental income, lead to upward social mobility and improved health literacy. Gender mainstreaming policies aim at reducing all gender gaps, including pay gaps, in society. The discrimination of societal groups based on their ethnic belonging, religious beliefs, sexual orientation or other characteristics impacts mental and even physical health and so strategies and instruments promoting a diverse society can contribute to health promotion and disease prevention.

The relevance of health and the environment was reconfirmed in 2017 in the Ostrava Declaration of the Sixth Ministerial Conference on Environment and Health of WHO. In statement 5 of the declaration, the HiAP approach is mentioned. Several EU regulations include disease prevention and health promotion in their mission, most importantly the European Environmental Noise Directive and the Directive on Ambient Air Quality and Cleaner Air. The latter includes environmental standards that were enforced in a recent court decision to ban the driving of diesel automobiles on specific roads in several German cities. This is one example showing that HiAP is also a multi-level-approach encompassing EU standards, national and federal regulations, as well as local municipal plans.

Another policy field is spatial planning, which has only limited relevance on the EU level as it is regulated on state level. Healthy urban development has a great potential to reduce health inequalities (CSDH 2008; Barton & Grant 2013; Baumgart et al. 2018).

To reduce the impact of different policy fields on health inequalities, population vulnerability has to be rigorously studied. In different policy fields like the environment or urban planning this is not common or even wanted, as all humans are seen to be equal. Neither environmental standards nor noise or air action plans consider population vulnerability. The implementation of a population vulnerability principle as an additional guiding principle for (environmental) politics could support the aim of reducing health inequalities through a HiAP approach (Köckler 2017).

To implement HiAP, experts in the different policy fields need at least a basic knowledge of health promotion and disease prevention. Equally, health experts need policy knowledge of different domains to integrate health in other policy fields.

Environmental impact assessments require determining the environmental impacts of different policies or plans, especially infrastructure projects. One protected good that has to be considered are human beings. In some countries, health impact assessments are being applied. Such an assessment aims to integrate health into different policy fields, such as transport, housing, or industry.

2.3 Creating healthy living environments from a health promotion perspective

From a health promotion perspective, the equity focus is implicitly and explicitly included in the Ottawa Charter (1986), which describes the preconditions for health as follows: 'Basic conditions and constituent moments of health are peace, adequate housing, education, nutrition, income, a stable ecosystem, careful use of available natural resources, social justice and equal opportunities. Any improvement in health is inevitably linked to these basic conditions' (WHO 1986). The Charter also stresses that 'health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources' (*ibid.*). Furthermore, health is understood as an essential part of everyday life. This broad understanding of health shows how many linked environmental factors affect health equity. The Ottawa Charter describes the support of communities and municipalities as the central hub of health promotion in strengthening citizen autonomy and control over the determinants of their own health. For this reason, this PFA focuses on the creation of healthy living environments in municipalities and pursues health equity through the settings approach.

With the adoption of the Ottawa Charter in 1986, settings have been identified as appropriate venues for the promotion of health and the prevention of disease. The charter states that 'health is created and lived by people within the settings of their everyday life; where they learn, work, play and love'. Strengthened by follow-up conferences and their policy statements (e.g. Sundsvall Statement or the Jakarta Declaration), settings are defined as 'places or social contexts in which people engage in daily activities in which environmental, organizational, and personal factors interact to affect health and well-being' (WHO, 1998, p. 19).

In a broad understanding, settings are defined as social contexts characterized by their geographical situation (e.g. municipality), same life situation (e.g. pensioners), common values or preferences (e.g. religion) or by a combination of these features (Hartung & Rosenbrock, 2015). Despite the heterogeneous nature of the term, the settings approach is based on at least three key assumptions (Dooris, 2009):

1. Health is, in accordance with socioecological theory, not merely the result of individual-level (risk) factors but is determined by a complex interplay of individual, social, environmental and economic influences.
2. Settings are complex and dynamic systems whose elements (e.g. people, values, physical structure, framework conditions) are interrelated and reciprocally influence each other.
3. Various methods of organizational development (e.g. organizational diagnosis, capacity building) In an organizational context (e.g. school, day-care centre, hospital), the settings approach makes use of.

The settings approach uses a broad range of strategies aimed at individual level determinants (e.g. literacy, attitudes or behaviour) and at environmental conditions and structures (spatial conditions, organizational culture or climate). The focus on the latter is of particular relevance for health inequalities as socially disadvantaged individuals are more often affected by unfavourable living conditions. So-called ‘downstreaming’ (e.g. settings-based) intervention strategies directly address these living conditions to influence individual lifestyles. This requires that settings are not only considered as access points to the target group (health promotion in settings), but are the subject of health-promoting activities themselves (health-promoting settings). Moreover, as people move between different settings, transitions between settings (e.g. school, home, sports club) and cross-setting activities are increasingly relevant. Thus, as individual attitudes, health behaviours and health outcomes can be regarded as the product of a variety of influences from different settings, the settings approach requires that isolated measures in single settings be merged into a cross-setting strategy (Dadaczynki, Quilling & Walter, 2018).

A municipality can be regarded as an ‘umbrella setting’ for a cross-setting strategy. Strategies with a focus on multiple settings are also referred to as ‘supersetting strategies’. These can be defined as an ‘intervention strategy whereby coordinated activities targeting a common overall goal such as improved health in a population group are carried out in a variety of different settings and involving a variety of different stakeholders within a local community.’ (Bloch et al., 2014, p. 3). One advantage is that these approaches strive to attain synergistic effects through coordinated measures in multiple settings. The municipal context offers comprehensive entry points for action. Municipalities seek to provide education throughout the life course, create appropriate conditions for housing as well as for physical activity and healthy eating. Municipalities can also promote the creation of a stable ecosystem. Moreover, a focus on municipalities addresses the local political context, local political regulations and urban or rural planning and development, which are important contributions to improving living conditions (‘upstreaming’).

2.4 Evidence-based action for healthy living environments

Although the creation of healthy living environments is widely considered beneficial, it is difficult to provide sufficient empirical evidence of their efficacy (Nutbeam, 1998). This is due to the complexity of the approach and the addressed outcomes, which often aim at long-term changes. And there are still challenges in the evaluation designs and methodologies.

Evidence of the effect of risk and protection factors provides important entry points for changing the contexts within and outside of settings at the local level. Compared to the epidemiological body of evidence, there is limited but growing evidence for the impact of environmental interventions. For example, promoting equigenic environments ‘may disrupt the usual conversion of socioeconomic inequalities to inequalities in mental well-being’ (Mitchell et al. 2015, p. 80).

Intervention studies show that strategies such as capacity building are of great importance in this context. Some potentially effective strategies and programmes are listed here:

- **Capacity building**

Inter-sectoral cooperation, e.g. in a broad-based alliance, and the promotion of capacity building play a central role in the creation of healthy living environments. In a scoping review on models and

evidence of municipal health promotion, capacity building was one of the core strategies in all publications analysed (Quilling & Kruse 2018). Evidence on the relevance of capacity building is for instance very well shown by the programme Communities That Care (CTC), where capacity building is both one of the main goals and one of the main effects of the interventions. An integral part of the CTC programme is an individual tailoring of measures based on municipal data on specific health problems and risk factors for citizens. In addition, the training of actors and the provision of supporting materials play a central role for capacity-building effects (Shapiro, Oesterle & Hawkins 2015). Fundamental to intersectoral networking and planned project management are specially created forums for planning and the exchange of ideas and challenges. In this kind of round-table conference all relevant actors meet regularly. The importance and evidence of those round-table meetings for capacity building effects is documented in many publications, e.g. the German long-term project Lenzgesund (Trojan et al. 2013).

- **Transport and walkability**

Transport accounts for 29% of CO₂ emissions. Promoting public transport, road safety and active mobility infrastructures (cycling, walking) can reduce accidents, increase physical activity and facilitate access to community facilities. Closely linked to this is the walkability concept. Walkability is understood to mean the ‘movement-friendly and movement-promoting design of a residential quarter’ (Bucksch & Schneider, 2014). Here, not only leisure and recreation areas and sports centres are considered, but also the accessibility of services and shops of daily life. These include the existence of good walking, cycling and hiking paths, safety in road traffic, playgrounds and residential areas, good accessibility to sports facilities, usable green spaces and a stimulating aesthetics of the surroundings (Galvez, Pearl & Yen, 2010).

- **Green spaces**

Green environments create the health benefits of staying in the countryside, in nature or in parks and the countryside (Poland and Dooris, 2010). Proven benefits include improved human health, physical activity, self-esteem and reduced short-term sleep duration (associated with obesity) (Astell-Burt et al., 2013). Green school grounds with open playgrounds, trees and shrubs also improve the quality and quantity of the children’s physical activity (Dyment et al., 2009; Larson et al., 2011). As financially and materially deprived people spend disproportionate periods of time in their neighbourhood and have less access to outside green environments, it is important to have green environments of high quality with low noise levels and diverse options for use within walking distances (Rittel et al. 2014). Green space interventions are long-term-investments and need to be integrated into local development strategies and frameworks. Green space interventions were most effective in a dual approach combining physical improvement with social engagement and participation to reach new target groups (WHO Europe 2017 b).

- **Healthy schools and kindergartens**

The WHO settings approach in kindergarten and school plays a central role in promoting healthy living environments and strengthening resilience.

- **Municipal planning and control**

This strategy addresses health inequalities through city administration and planning, including investment in active traffic, environmental and regulatory controls (e.g. alcohol outlet density in deprived communities) (CSDH, 2008, Baumgart et al. 2018). In the field of environmental planning, there are a number of environmental standards developed to protect human health.

- **Urban planning measures**

Examples of urban development projects that promote the health of their residents include the redesign of infrastructure to meet the needs of the elderly (Age-Friendly City, City of Unley, Australia,

2011), of children (Bendigo in Victoria, Australia, UNICEF City, St Lukes Anglicare, 2011) and women (the Women Work City housing complex in Vienna) (Foran, 2013). Furthermore, there are several programmes targeted at deprived communities. One German example is the Social City programme, which has the goal of improving the built environment in the most deprived areas in a given city. The programme is evaluated by several different instruments, and focuses on aspects relevant for the reduction of health inequity (Quelle: Soziale Stadt. https://www.soziale-stadt.nrw.de/kooperation_steuierung/evaluation.php).

3. Framework for municipal health promotion

As Whitehead & Dahlgren (2006) state from their perspective of health equity, ‘there is a risk of relying mainly (or only) on a community-oriented approach for health development, when wider policies are also required’. They fear that there is a risk that ‘the health-equity perspective will be limited within community-oriented programmes, when the interests of more affluent groups differ from the needs of less-active and less-articulate disadvantaged individuals and families’. If this is to be avoided, it is important ‘to ensure that the community-oriented approach becomes a programme that benefits all in such a way that inequities in health are reduced as efforts are made to improve the health within the community as a whole’. The equity-in-health dimension could also be integrated with urban renewal programmes in deprived areas (p. 102f).

Although health promotion and disease prevention programmes have the goal of reaching all population groups, they do not reach their target groups to the same extent. In particular, those groups that are socially disadvantaged and particularly vulnerable are often not reached through conventional intervention strategies that rely on behavioural elements and use the setting merely as an access point to the target group. It has to be taken into account that health promotion and other interventions could generate unintended inequalities (Lorenc et al. 2013; Frohlich, Potvin 2008). Consequently, people with low socio-economic status must be involved in health promoting and preventive measures. This is all the more important since the vulnerability of numerous people living in poverty and on lower incomes is constantly increasing. Current health reporting shows that the greatest need is among vulnerable target groups. One option to reduce health inequalities is therefore to focus on activities that address groups of people and phases of life that are considered vulnerable. Socially disadvantaged children and young people, older people as well as those moving from one phase of life to another (life transitions) are particularly vulnerable. The life phase model serves as a basis for orientation and encompasses both children and adolescents as well as older people (see also UN Sustainable Development Strategy Agenda 2030 and WHO Europe Framework Concept Health 2020). The term ‘life phases’ refers to defined age phases in the life course as well as to specific transition phases.

Focusing on specific target groups is one of a number of different strategies. And there is no generally agreed best method. Regarding the various environmental determinants of health, it is more relevant to address particular areas or communities in the municipality. It is important that the municipality does not implement undifferentiated interventions throughout the entire municipality, but that it implements packages of measures specially tailored to the needs of selected areas. To avoid stigmatisation, in all planning and implementation decisions for creating healthy living environments in the municipality as an umbrella setting, preference should be given to interventions that look at the entire living environment and do not focus on individual behavioural prevention activities.

Chapter 3 deals with the basics and principles, target groups and quality criteria for the development of healthy living environments in the municipality.

3.1 Municipal health promotion through an equity lens

Focus on deprived urban quarters or communities

When implementing health promotion in a municipal context, it is important to address in particular those persons who may not participate in health-promoting environments and services. For example, the focus for planning healthy living environments is primarily on multiple deprived communities as subsystems of the municipality's umbrella setting. The various local design options in a particular urban area or community mean that communities represent their own umbrella setting. In accordance with the HiAP approach, healthy urban areas and communities must also aim at a policy mix that sees health promotion as a multi-dimensional strategy and addresses various possibilities for change. So-called 'problem zones' are characterised by an accumulation of health-relevant problems affecting the people living there (immigration background, low income or state welfare recipients, long-term unemployment, dependency and mental illnesses, etc.), who are also disadvantaged by an unfavourable institutional infrastructure (poorly developed childcare and education system, limited health care at the place of residence, inadequate or no leisure and recreation facilities) in combination with often unfavourable housing conditions. In this context, the creation of healthy living environments in urban areas and communities with multiple burdens is brought about through measures based on joint analysis, planning and a lifeworld-oriented approach. Although measures can also target individual settings such as day-care centres, schools or living spaces, there must be a coordinated bundle of interventions based on an overall strategy of creating healthy living environments on multiple levels.

Children and adolescents

In early childhood, psychobiological influences on health are conveyed epigenetically through parental behaviour, internalized learning experiences and other environmental factors, often reaching into adulthood (RKI 2008). Adolescence is also a major and particularly vulnerable phase of life. Adolescents are particularly exposed to social norms and media pressure, affecting their changing identity and self-esteem. Resource-oriented health promotion that inherently strengthens resilience must therefore begin in the living environments of families, daycare centres and kindergartens, schools and municipalities. In particular, programmes must enable children and young people from deprived urban communities and communities to grow up healthy, and so make a long-term difference to their health in adulthood. Overall, the exposure to poor diet, tobacco, drugs and alcohol can be reduced through the implementation of existing recommendations (e.g. tobacco convention control, EU Obesity; in e.g. Dądaczynski, Quilling, Walter, 2018) to achieve the WHO goal 'to make the healthier choice the easier choice'.

Elderly people

The people in the life phase of old age are considered to be particularly vulnerable to numerous health risks such as the chronification of diseases, multimorbidity, the thinning out of social contacts and other factors (Scheidt-Nave, Richter, Fuchs & Kuhlmey 2010). With increasing age, the immediate social space of the elderly becomes more significant (Hollbach-Grömgig & Fröhlich von Bodelschwingh 2015), the municipality and the community have a special responsibility for the design of the living environments of this vulnerable target group. The focus is on measures such as accessibility or road safety (which are also

important for young families). Demographic change affects European countries to approximately the same extent, with the number of older and very old people rising disproportionately (WHO 2015; RKI 2015). To ensure that health inequality and its consequences do not continue to grow, special attention should be paid to the target group of the elderly.

Other vulnerable target groups

In principle, it is necessary to develop a perspective that is sensitive to gender and life situations to address inequality and thus be able to develop target group-oriented programmes. All measures should be developed along the major axes of inequality (Marmot 2010): age, gender, income and social class, ethical membership and housing quality.

3.2 Priorities and guiding principles

This framework focuses on the municipality, as this living environment – as described above – is of central importance to the reduction of health inequalities in the context of health promotion and prevention. The municipality is understood here as an umbrella setting and thus as a comprehensive system in which kindergartens, schools and businesses, but also service and leisure facilities are anchored and organised (e.g. Fischer, Geene & Gerigk 2017 or Müller & Quilling 2017). This makes cross-sector action, the connection to civil society and the joint development of appropriate strategies inevitable. For the implementation of comprehensive municipal strategies, planning and networking are crucial.

Health promotion as a cross-sectional task

Health promotion and disease prevention must be understood as cross-cutting tasks to reduce and strategically shape health inequalities. In such an understanding, a broad municipal alliance should be established that aligns its activities across specialist government departments and agencies with stakeholders from civil society with the goal of improving health equity. Special opportunities lie in a broad anchoring of measures addressing the context and settings through which vulnerable target groups can be integrated without stigmatising them with specific programmes.

Capacity building, structural development, planning and networking

Capacity-building, structural development, planning and networking are central approaches in the implementation of municipal health promotion projects (Quilling & Kruse, 2018). They are particularly important for combined intervention approaches in behavioural and relational prevention to reduce health inequalities (*ibid.*). These aspects of the implementation of health promotion and disease prevention in the municipality also underline the necessity of the HiAP approach to promote health equity, since the success of the measures seems to be essentially linked to the joint activity of different sectors.

The fundamental basis for creating healthy living environments in the municipality is the willingness to prioritise the issue of health on the local political agenda and to create a broad awareness of the multi-factorial conditions of health. The aim of such a discourse on the relevance and interdependence of health-related issues for the quality of life in urban communities must be to sensitise sectors outside the health sector to the issue of health and to awaken the recognition of their co-responsibility for reducing health inequalities. For example, authorities such as the department for green spaces or waste disposal must realise that the decisions they make may have a direct influence on health. In their case report

from Minnesota Bliss, Ayers, Mishra and Lupi (2016) refer to the trend-setting development of a new narrative among participating municipal cooperation partners in which each recognises their own part in the promotion of healthy living environments and thus creates the basis for new intervention approaches. Such a health narrative is reflected in changed values toward the topic of health and new perspectives on the multifactorial conditions of development. Such a fundamental discourse addresses the motives and value for engagement in health-related fields and is thus a fundamental prerequisite for openness and the willingness to commit oneself sustainably to the creation of healthy living environments. Consequently, this leads to binding cooperation between relevant sectors, such as the public health service, youth and social welfare, education, the elderly, migration and integration, sport, culture, and urban planning as an alliance for healthy living environments.

In addition to sensitizing and activating stakeholders and cross-sector alliances, the central basis for creating healthy living environments is a binding and lasting anchoring of the health issue as a key objective of municipal policy and its agenda. The corresponding political decisions should be prepared and adopted accordingly (Landschaftsverband Rheinland 2017, Quilling et al. 2013).

Participation

Particularly vulnerable groups are considered difficult to reach, making it difficult to implement health promotion and disease prevention measures to the desired extent. One of the central reasons for this is the prevalence of top-down intervention planning, which does not take sufficient account of the living conditions and needs of people with multiple burdens and difficult access to resources (WHO Europe, 2017 a). This failure illustrates the outstanding importance of participatory processes for the development of healthy living environments in urban communities with multiple needs. The development of alternative forms of participation that help to involve people who are mostly unfamiliar with formal participation procedures is another challenge. To remove obstacles to the participation of these groups, planning should involve professional groups familiar with the challenges of addressing and accessing hard-to-reach target groups. Social workers in the community are therefore particularly important stakeholders and should be involved in planning processes. In addition, those citizens in a community holding key positions must be addressed at an early stage. They serve as opinion leaders and information providers and can assist in determining the views and needs of other residents, which can then be taken into account when developing concepts tailored to the target group. The participation of vulnerable groups requires the strengthening of those population groups that are particularly in need of protection as well as of institutions and interest representatives who want to develop participation procedures or create space for them in their work (Quilling & Köckler 2018).

Database, monitoring and assessment tools

In addition, measures to create healthy living environments require a solid database for the implementation of concrete measures. The aim here is to develop integrated monitoring at the local level that systematically combines socio-spatial data from originally different sectors. If, for example, data on environmental quality, social structure and health burdens are recorded in several dimensions, areas with multiple burdens can be identified for targeted action planning (Flacke et al. 2016; Böhme, Bunge & Preuss 2016). For the planning of healthy living environments, instruments for recording and classifying interventions must also be further developed, especially with regard to the limited resources available for implementing measures in a targeted manner. Larsen and colleagues (2013) have developed an assessment tool to record existing municipal health-related measures to arrive at needs-based planning (Larsen, Pedersen, Davies & Gulies 2013). A similar objective was pursued by Storm et al. (2014) with

their maturity model for local HiAP strategies. This maturity model is also seen as a basis for targeted planning and progress measurement in local HiAP strategies (Storm, Harting, Stronks & Schuit 2014).

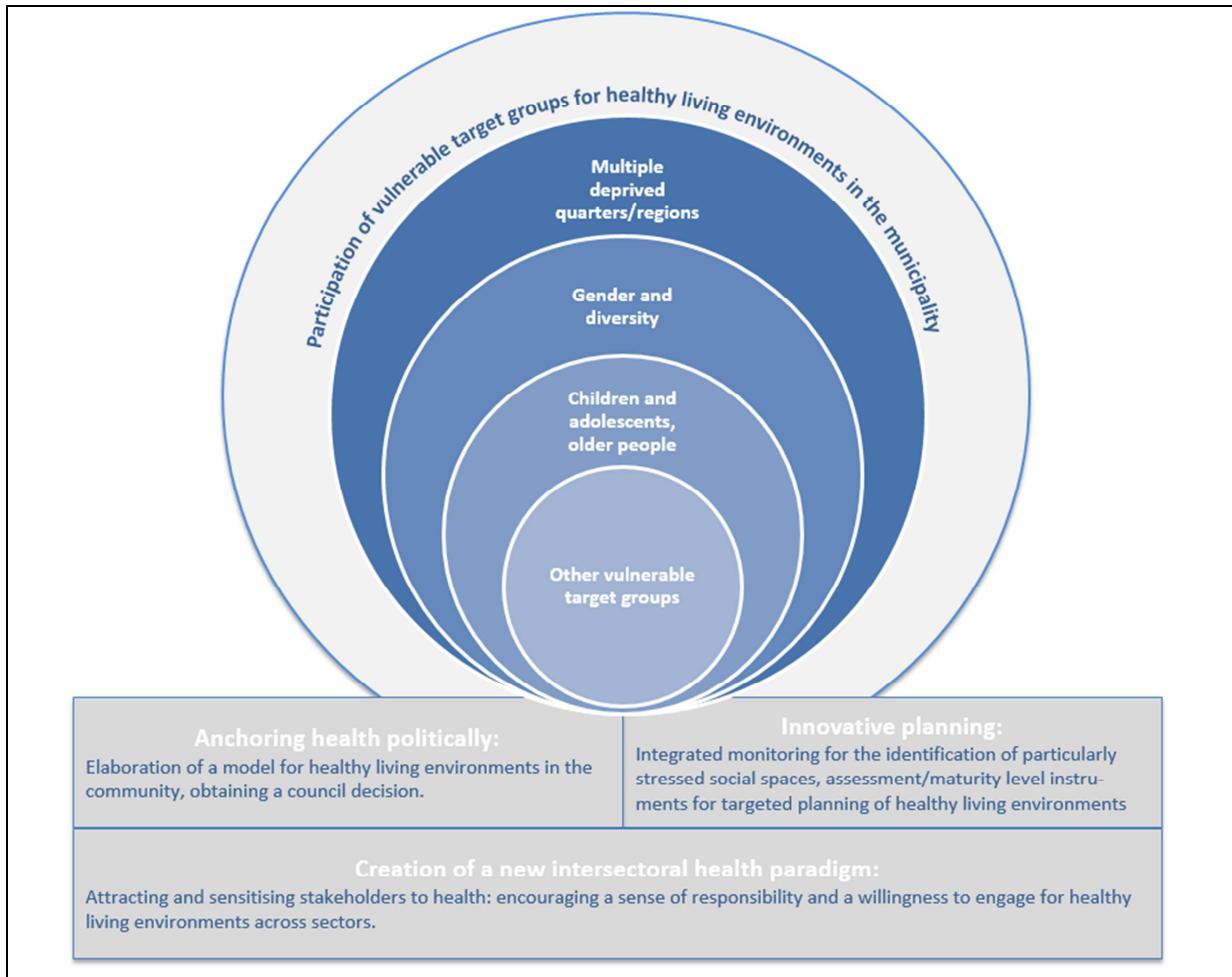


Fig. 1: Summary of basic principles and target groups for the creation of healthy living environments in the municipality (own figure)

3.3 Good practice: quality criteria and process of implementation

Projects and measures to create healthy living environments in municipalities should follow a quality-supported approach. As described in chapter 1.2, a review of existing national and international quality criteria, which was also the basis for the quality criteria presented below (EQUIHP, Good Practice Criteria, JAPNA, CHRODIS & INHERIT), was carried out for the elaboration of this WP. These criteria were selectively supplemented by particularly relevant references from current literature. Before the synthesis of the quality criteria for a ‘good practice’ of promoting healthy living environments will be presented in the following, the term good practice will first be defined in more detail:

‘A *good practice* is an initiative that has been proven to work well (i.e. process evaluation) and produce good results (i.e. output and outcome evaluation), and is therefore recommended as a model. It is a sustainable and efficient experience, with clear objectives and clearly defined target groups [...] to be empowered. Its activities use existing structures and it has a broad support amongst the target population, thus deserves to be shared so that a greater number of people can adopt it.’ (OGYEI 2015)

The literature review yielded 16 quality criteria. They apply to the individual phases and to a lesser extent to the overall process of the so-called Public Health Action Cycle (PHAC) (see Figure 2). The PHAC action cycle originated in political science and was adapted and further developed for health policy actions and processes (Rosenbrock 1995, Rosenbrock & Gerlinger 2014). The PHAC is suitable for measures of varying scope and can be used on projects at the micro, meso and macro levels. The action cycle differentiates a health-related intervention into four individual process categories: (1) identification of the fundamental problem to be addressed by the intervention, (2) strategy development in which an intervention suitable for treatment is developed, (3) implementation of the intervention and (4) evaluation of the activities carried out.

Depending on the type of intervention and the duration of the measures, PHAC can also be used in an iterative (and more spiral-shaped) process.

The PHAC represents an ideal process flow and is therefore not always transferable in all points of a concrete measure or intervention. Nevertheless, the value of this model lies in the necessity and significance of its individual process steps and its use in comparing different health promotion measures. The PHAC can be used to identify and analyse different patterns of dealing with health problems, and then evaluate their effectiveness and impact on the health equity dimension (cf. Rosenbrock & Gerlinger 2014). Figure 2 shows the PHAC with the 16 quality criteria applied to the individual phases of the cycle or spanning all phases.

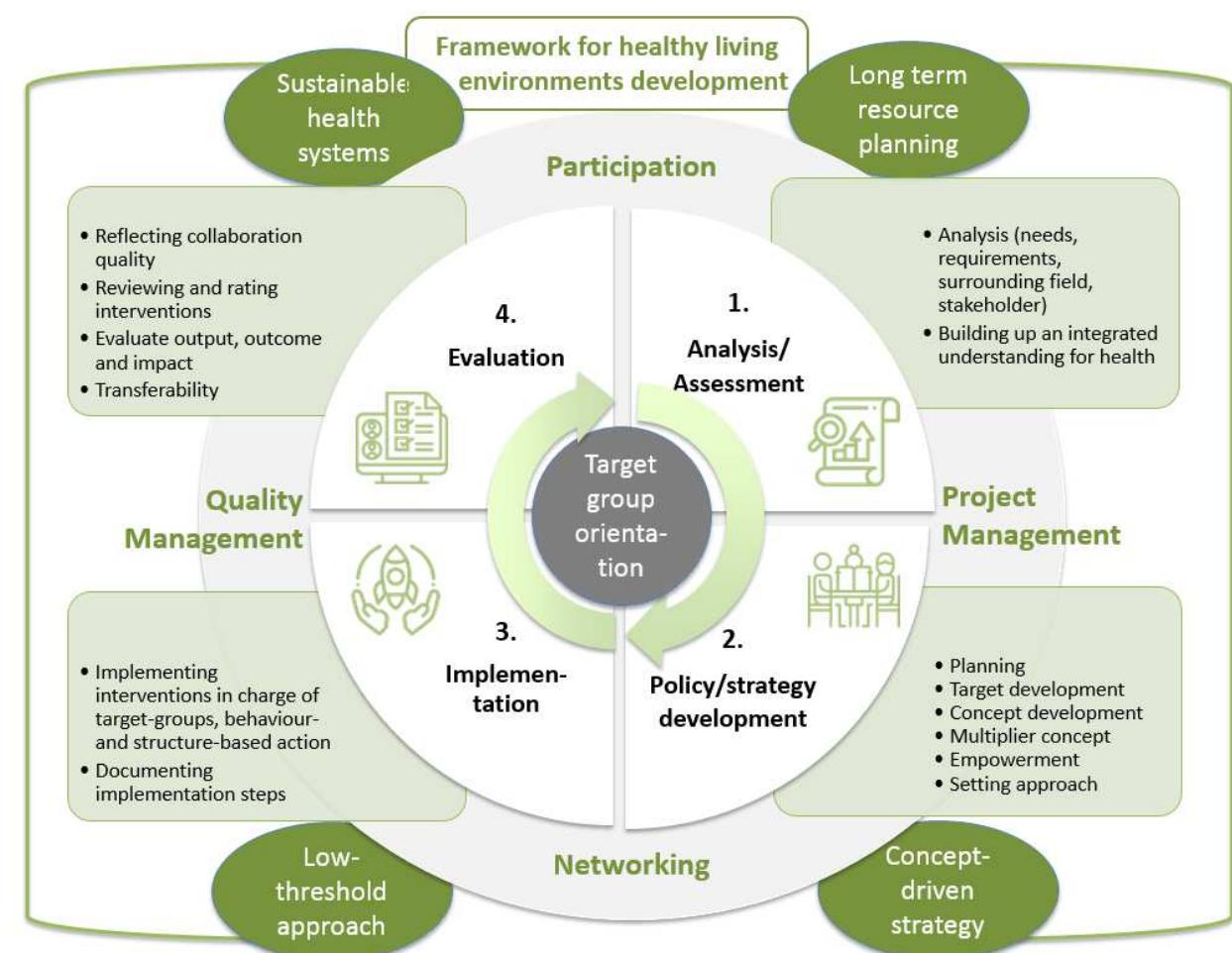


Fig. 2: Framework for healthy living environments development: quality criteria identified and applied to the PHAC

The 16 central quality criteria for good practice are divided into three categories: (A) fundamental quality criteria for the creation of healthy living environments; (B) process criteria applying to individual PHAC phases; and (C) general criteria covering the PHAC. Projects representing the use of each quality criterion are found in brackets.

A. Fundamental quality criteria for the creation of healthy living environments in the municipality and its settings

A.1 Target group orientation

Based on analysis of the social space and the needs of the people in the target group, measures are tailored precisely for vulnerable groups to achieve health equity. Projects and measures can be differentiated according to income, education, employment, age, sex, ethnicity, neighborhood and other social determinants of health. This allows programmes to be created that reach target groups by accounting for their individual lifeworld needs. The concept of lifeworld is characterized by multiple, overlapping and complementary individual settings affecting health. Accordingly, interventions promoting healthy living environments should always be understood as cross-setting, complementary and coordinated. (*Equity in Health/Good Practice, JAPNA, CHRODIS, EQUIPH*)

A.2 Long-term resource planning

Adequate funding appropriate to the objectives and planned measures is fundamental to the successful development of health-promoting municipalities. Financial resources must be reliable and long-term to develop healthy living environments in the municipality. Funding bodies should make stable commitments to providing the resources to facilitate sound and comprehensive planning. (*JAPNA, CHRODIS, EQUIPH*)

A.3 Concept-driven strategy

The development of healthy municipal living environments involves a demanding and complex approach whose implementation requires an integrated overall strategy. It is essential to develop a multi-layered concept that takes all quality criteria and implementation phases into account. Criteria such as empowerment, the setting approach and low-threshold working methods are particularly important as well as the scientific evidence-base of an intervention. The concept for the planned interventions must be based on fundamental attitudes and the formulated goals. A comprehensive written concept allows health-promoting packages of measures to be bundled and responsibilities to be distributed in coordination with all actors. In addition, a written concept is a good prerequisite for the transferability of the measures. (*Equity in Health/Good Practice, JAPNA, CHRODIS, EQUIPH*)

A.4 Low-threshold approach

Offers for the development of municipal, health-promoting living environments must be easily accessible, especially for hard-to-reach target groups. This means anchoring them in people's everyday lives and making them accessible at places they frequent regularly. Such an approach differs markedly from formats that are associated with formal registration procedures in institutions, for example. Low-threshold health promotion measures address people in their immediate everyday lives and can be implemented there. Examples include the common room in a school, jointly prepared, healthy lunches in

the homes for the elderly, or the lay helper who visits other mothers in the community and advises them on health issues. (*Equity in Health/Good Practice*)

A.5 Sustainable health systems

For measures to promote municipal health promotion to be sustainable, there must be a high level of support for the planned activities among both policymakers and target groups. At the same time, sustainability means assuming responsibility at an institutional level to establish or consolidate structures in the long term. (*Equity in Health/Good Practice, JAPNA, CHRODIS, EQUIPH*)

B. Phase-specific process criteria

B.1 Analysis and assessment

The basis for the planning and implementation of health-promoting measures to promote equal health opportunities is an individual needs analysis at municipal level. The analysis must cover concrete, social-spatial and population-specific problems in the community. An early step towards establishing communal health promotion and prevention is to carry out a comprehensive stakeholder analysis to systematically identify as many interest groups as possible and win them over for cooperation. An important step in the analysis phase is to develop a common understanding of health, health promotion, and a sector-specific and shared responsibility for health. (*EQUIHP, Equity in Health/Good Practice, JAPNA, CHRODIS & INHERIT*)

B.2 Planning, concept and target development

The planning, concept and goal development for healthy living environments is a strategic process that should be linked to political decisions or recommendations. The planning is based on the settings approach and focuses on determinants for the reduction of health inequalities. To this end, the objectives of the intervention must be clearly defined (e.g. SMART rule). For the development of municipal health promotion, a concept must be formulated that combines goals and measures in a matrix. The concept provides an overview of the objectives, milestones and implementation planning. In the local context, it is important to ensure a high level of participation right from the start. (*EQUIHP, Equity in Health/Good Practice, JAPNA, CHRODIS & INHERIT*)

B.2.1 Multiplier concept

The commitment to healthy living environments must be adopted by many actors. This means that not only healthcare professionals, but also as many multipliers as possible must be involved in the work. This is where local associations and work alliances as well as cultural and religious communities come into focus. As professionals, they often have good access to the citizens of a community and often also fulfil control functions. Especially when designing programmes for hard to reach target groups, non-experts may also have to be involved. For example, peers in comparable life situations can be recruited and trained as multipliers to advocate preventive and health-promoting interventions in the community or region. (*Equity in Health/Good Practice, CHRODIS*)

B.2.2 Empowerment

At its core, health promotion is a process of promoting self-responsible action about the concerns of one's own life and health. For this reason, the development of health-promoting living environments also aims at empowering people. By enhancing their knowledge and competence, the target group

should be enabled to make autonomous decisions about health-promoting lifestyles. Accordingly, the goal of empowerment must be rigorously pursued in the creation of healthy living environments. Resources, autonomy and self-efficacy of the individuals should be strengthened and conceptually anchored. (*Equity in Health/Good Practice, JAPNA, CHRODIS, EQUIPH*)

B.3 Implementation

As a central element of the settings approach, projects and measures for the establishment of municipal health promotion and prevention must combine behavioural and relational preventive approaches. Other principles of the settings approach – such as low-threshold methods, tailoring programmes to the special needs of the target group, and sensitivity in gender and diversity – have already been described in the other criteria. (*Equity in health/Good practice, CHRODIS, EQUIPH*)

B.4 Documentation and evaluation

The basis of effective quality management is the systematic documentation of processes and results. Structures must also be in place for this, with easy-to-use evaluation and documentation tools. The collected data is also the basis for the evaluation. The evaluation measures the output, outcome and impact of measures for the development of health-promoting municipalities. Data from existing monitoring tools must be regularly compared with the specific data collected during the evaluation. This requires broad agreement and support from all parties that evaluations are indispensable components of interventions. Evaluation concepts try to capture complex cause-effect relationships of success as precisely as possible and to make the findings useful for adjustments to implementation. Ultimately, the evaluation must show whether target groups have been reached, goals have been achieved and whether the measures implemented have actually led to an improvement in health opportunities. (*Equity in health/Good practice, JAPHA, CHRODIS, INHERIT*)

B.5 Transferability

Successful measures should become good practice and find imitators. Therefore, interventions for healthy living environments should be planned and implemented in such a way that they are easily transferable. To this end, recommendations for action, strategic plans and other materials should be made available to help with the transfer to other municipalities. This also includes concepts of knowledge management, which facilitate the systematic transmission of knowledge and competence to partners in the process. This helps to achieve capacity building and transferability. All key points for a transfer have to be considered (required resources, personnel, barriers, experiences to target groups and compliance, key persons, processes etc.). Since professional knowledge transfer requires transparency and communication, appropriate time frameworks must be planned. (*INHERIT, CHRODIS*)

C. General process criteria

C.1 Participation

Participation procedures are a key factor in the successful development of health-promoting services. Acceptance by the population and target groups can be increased if they are tailored to the needs of the users. The participation-oriented development of measures is regarded as a trend-setting strategy to create services that fit well into the existing environment. To this end, the capacities and strengths of the institutional partners must be integrated. In addition, the users themselves must also be involved, as this is the only way to design tailor-made programmes acceptable (identification with interventions).

This presupposes that inclusive participation is realised in all phases of developing a health-promoting community. (*Equity in Health/Good Practice, CHRODIS, EQUIPH*)

C.2 Project management

The promotion of healthy living environments is a management task. This applies in particular to the establishment of health-promoting municipalities, as administrative responsibilities for health promotion are either not clearly defined or they are located in other sectors than health (e.g. air quality, noise protection). Accordingly, a competent project manager with decision-making powers should be appointed as soon as possible. Project management must ensure inter-professional cooperation and, in the course of this, ensure continuous and intensive communication and transparency across sectors with regard to planning, objectives and implementation. This specially appointed project manager is responsible for project management, including resource planning and administration as well as communication strategy and processes. (*EQUIHP, Equity in Health/Good Practice, JAPNA, CHRODIS & INHERIT*)

C.3 Networking

Municipal health promotion can only succeed in joint and cross-sector efforts. To this end, existing local partnerships and cooperation networks should be reviewed. The aim of this work step is to integrate existing networks into the newly established alliance for healthy living environments and to avoid creating parallel structures (Landschaftsverband Rheinland 2017, Quilling et al. 2013). However, existing municipal development structures can, if necessary, be used to establish healthy living environments, as synergy effects are to be expected (Reimann & Böhme 2015). Such networking must be an integral part of the concept and serve as a guideline for project management. (*Equity in Health/Good Practice, JAPNA, CHRODIS*)

C.4 Quality management

The development of healthy living environments in the municipality is a continuous improvement process. The dimensions of planning, structure, process, and result quality are fundamental to formative evaluation taking place during the phases of the Public Health Action Cycle. Quality management requires its own personnel resources as well as materials suitable for the measurement and assessment of quality. Comprehensive quality management requires acceptance by the actors involved. (*Equity in Health/Good Practice, JAPNA*)

3.4 Conclusion

Reducing health inequalities is a public health priority. Health is a cross-sectional task that needs to be addressed in all policy areas. The HiAP approach provides an important framework and thus sets the preconditions to promote health equity. The settings approach is one core strategy of health promotion that can be used to achieve this aim. In this context, it is of particularly importance to strengthen healthy living environments, which compared to behavioural measures have not received full attention in practice and research. Health equity not only requires a commitment by society (e.g. political action such as binding intersectoral norms as well as structural and procedural (political) frameworks), but also the willingness and ability (e.g. competencies) of all stakeholders acting on different political levels and in policy areas according to their scope of decision-making.

Although the focus for WP6 of the Joint Action Health Equity Europe is on municipal health promotion, it is a serious concern that municipalities might be left on their own to manage this huge task. There are many possibilities to support and create supportive structures from the regional and national level to enable municipalities to create healthy living environments, including capacity building, funding, training, networking or research.

In principle, the Public Health Action Cycle is a reference point for the implementation of all interventions to improve the health situation in a setting. The more thoroughly and comprehensively the steps of the PHAC are implemented and the more quality criteria are considered, the more likely an intervention will achieve promising practice and good results. Especially for complex actions, it is essential to consider the fundamental quality criteria (see 3.3, category A) to the same extent as the process-related quality criteria of the PHAC (see 3.3, category B) and the phase-independent criteria (see 3.3, category C).

The goal of achieving more health equity in the municipality depends on political will and decision-making. It is therefore necessary to develop a very well planned and multi-layered strategy that leads to sustainable health equity change. Once this ambitious goal is defined, it is advisable to include not only the 16 quality criteria for good practice but also the priorities and guiding principles described in chapter 3.2 to lay a good foundation for interventions.

The creation of healthy living environments should be accompanied by a cultural change in the organisations and institutions in the municipality. For this reason, a change in political attitudes must be accompanied by a new awareness of the importance of health and recognition of the responsibility of local government and sectors beyond the health sector.

Nevertheless, isolated measures can also serve to promote healthy living environments and represent important steps that can have positive effects for the target groups involved. The local context of each municipality must be taken into account to determine what are the possibilities and necessities of implementation. An important role is played by local needs, which are dependent on the population profile and its age structure, on the specific institutional infrastructure, on geographical, economic and other characteristics which, taken together, mark the needs and requirements for healthy living environments in a municipality.

This municipal need must be accompanied by a willingness on the part of local institutions to play an active part in promoting a healthy living environment. Therefore, both the perspective of the municipality and the perspectives of local stakeholders must be taken into account to decide which measures are appropriate and feasible as first steps.

The desire for evidence-based complex interventions is understandable, yet it faces health promotion with enormous challenges. Best practice in evidence-based medicine is the randomized controlled trial (RCT) used in clinical research to prove the efficacy of a new therapy. However, RCT is rarely suitable in the case of health promotion because of the significant difference between medical interventions and health promotion interventions. Medical interventions (e.g. through medication or surgical interventions) are intended to have a direct, and often visible, effect on physical and psychological illnesses.

In health promotion, an intervention is viewed from a fundamentally holistic perspective: ‘Health is the state of complete physical, mental and social well-being’ (WHO, 1948) and thus encompasses much more than just an absence of disease and infirmity. Health promotion interventions and primary disease

prevention attempt, in a complex way, to influence the health of individuals indirectly through their behaviour and the conditions surrounding them.

The fact that successful approaches to health promotion and prevention are often implemented in a community environment – a complex structure of interwoven individual settings – makes it difficult to measure these approaches in a controlled study design as required by RCT. The complexity of the intervening factors affecting the inhabitants in the local community makes it almost impossible to isolate the effects of individual behavioural interventions, since these usually have an indirect effect and not a direct one.

Measuring the success of interventions becomes all the more difficult with the increasing complexity of the intervention, as the impact often only becomes apparent in the long term and the project duration often ends after just one year. In the meantime, individuals are exposed to many other social and environmental factors that can moderate the health-promoting effects. A straight forward causal attribution between the health-promoting interventions and the effects on individual health is therefore often not possible. Nevertheless, there is a growing evidence-base available for interventions, as is the case, for example, with the implementation of walkability approaches.

4. Implementing actions in WP6: from assessment to evaluation

The focus and core work of JAHEE is about implementing actions that contribute to reduce health inequalities in the participating countries. This chapter provides an overview of the project requirements and a template for the envisaged project process for these implementations in WP6.

The described background in chapter 2 and the framework for municipal health promotion in chapter 3 are supposed to serve as a technical basis and a measure, and to ensure a consistent approach of implementation in the partner countries of WP6.

In order to select tailored actions and promising practices to be implemented in the partner countries, country assessments (CAs) are being conducted in an early phase of the project process. These CAs identify and describe the country context and the development potentials in the countries. Furthermore, the partners should be able to identify up to max. 4 promising practices with the help of chapter 3 of this PFA. As one of the approaches in JAHEE is to learn from each other, a list of promising practices from all the 13 participating countries will be generated. Participating countries will select their actions to be implemented from this list of promising practices and transfer (parts of) them into their countries.

The goal is for all participating countries in WP6 to implement one feasible action and to initiate one complex action that contributes to creating healthy living environments according to the approach and criteria described in this PFA.

Feasible actions are actions that can be implemented during the course of JAHEE project period.

Complex actions require a more complex and long-term approach, for which preliminary actions can be made during the JAHEE period.

For example, a feasible action would be to organise health days in a municipality in an attempt to transform a particular place in a deprived urban community. The initiation of a complex action could mean obtaining council permission to initiate a network that focuses on health promotion for children and youth or pursuing a long-term strategy to transform all kindergartens and schools into healthy settings.

Quality criteria and the implementation procedure for WP6

For the implementation of WP6, regardless whether a feasible or complex action is chosen, it is recommended to follow the PHAC action cycle (chapter 3.3). For feasible actions, it may be sufficient if the selected interventions meet a number of the 16 quality criteria and follow the PHAC action cycle. For the initiation of a complex action, it would be preferable if as many of the 16 quality criteria as possible (chapter 3.3) were met, and even better if the priorities and guiding principles were also followed (chapter 3.2). The four general phase-independent process criteria – participation, project management, partnerships and networking, and quality management – should always be taken into account when implementing feasible actions or initiating complex actions.

WP6 Implementation Template

A. Analysis and assessment of needs and resources

The Country Assessment and next WP6 meeting are aimed at completing this step.

1. Start with an inventory and use it to identify strengths and resources. Identify and prioritize specific challenges. Focus on unmet needs to identify nation-wide, regional and municipal challenges facing specific target groups.
2. Begin research to find out which interventions promise to address these challenges.
3. Check what resources are available for conducting interventions in JAHEE. How many person-hours are needed? How long will activities take? What are the skills and competence of team members?
4. Identify as many stakeholders as possible by carrying out a thorough analysis of the problem environment. This will be crucial in the next phase of planning and concept development.

Note: Concentrate on the essentials. Decide which problems should be solved. Prioritize, as without focusing all topics appear to be equally important. Ensure that the resources are directed to these most important issues.



B. Intervention planning, policy and strategy development

1. Select promising practices from the list of good practices generated from the country assessments. Each country should choose at least one promising practice. Selection criteria include:
 - a. Needs and resources (from the assessment stage)
 - b. Feasibility
 - c. Transferability
 - d. Evaluability
 - e. Expected impact on health inequalities, structures and stakeholders
2. In planning, look for broad support from authorities and stakeholders. Remember that all interventions require the cooperation of those responsible for the proposed activity. There is no 'one size fits all' solution for success. Partners must build on their specific strengths, use available resources and consider individual needs.
3. A well-founded concept is the crucial to a successful intervention. Take enough time to develop a vision together with your alliance partners, formulate goals according to the SMART rule, align measures with the setting approach, and empower those people in your target group.
4. In concept development, complex tasks are bundled. Individual packages are then distributed to partners in the network, creating appropriate responsibilities for healthy living environments. Develop a multiplier concept and integrate capacity building elements to disseminate the findings of the project and promote sustainability.

Note: Since when implementing promising practices the development phase is omitted, ensure that the objectives of the intervention actually correspond to those of the planned feasible action.



C. Implementation

1. Design interventions combining both behaviour-based and structure-based measures.
2. Ensure cooperation with all partners and shareholders. Cooperation is the central success factor in meaningful and sustainable change. A common vision strengthens group cohesion in networking and intersectoral cooperation projects.
3. Communicate effectively with all stakeholders during each step of the PHAC action cycle. This serves as motivation and improves transparency. It is a key to the successful implementation of projects and programmes.
4. Document each step in implementation carefully. Collecting data and experiences is a basis for quality management and evaluation.

Note: Each municipality is different, and as a result efforts to improve health will be different. Involvement of numerous stakeholders contributes to create commitment. Building and maintaining partnerships aimed at long-term and collaborative development create sustainable health promotion structures.

1. Combine behavioural-based and structure-based interventions

2. Ensure cooperation with all partners

3. Communicate with all stakeholders

4. Document implementation carefully

D. Evaluation

1. Evaluate actions at each phase of the PHAC action cycle. This helps to assess whether the selected interventions are working and whether the desired results are being achieved.
2. Distinguish in evaluation between process, outputs, outcomes and impact. Each requires different procedures regarding time periods, methods and resources.
3. Include social components in evaluation design. Check the quality of cooperation, communication and the participation of target groups and stakeholders.
4. Prepare the evaluation findings to enable transfer to other health projects and interventions.

Note: Facilitate evaluation and working out evaluation tools is time-consuming and demanding. There are many evaluation tools available, which can be slightly modified and adopted for single projects. With regard to JAHEE, projects tools for self-evaluation will be provided by WP6 leader. There will also be support from WP3 as part of the overall evaluation of JAHEE.

1. Evaluate each phase of the action cycle

2. Set clear evaluation goals

3. Evaluate social dimensions

4. Enable transfer of findings

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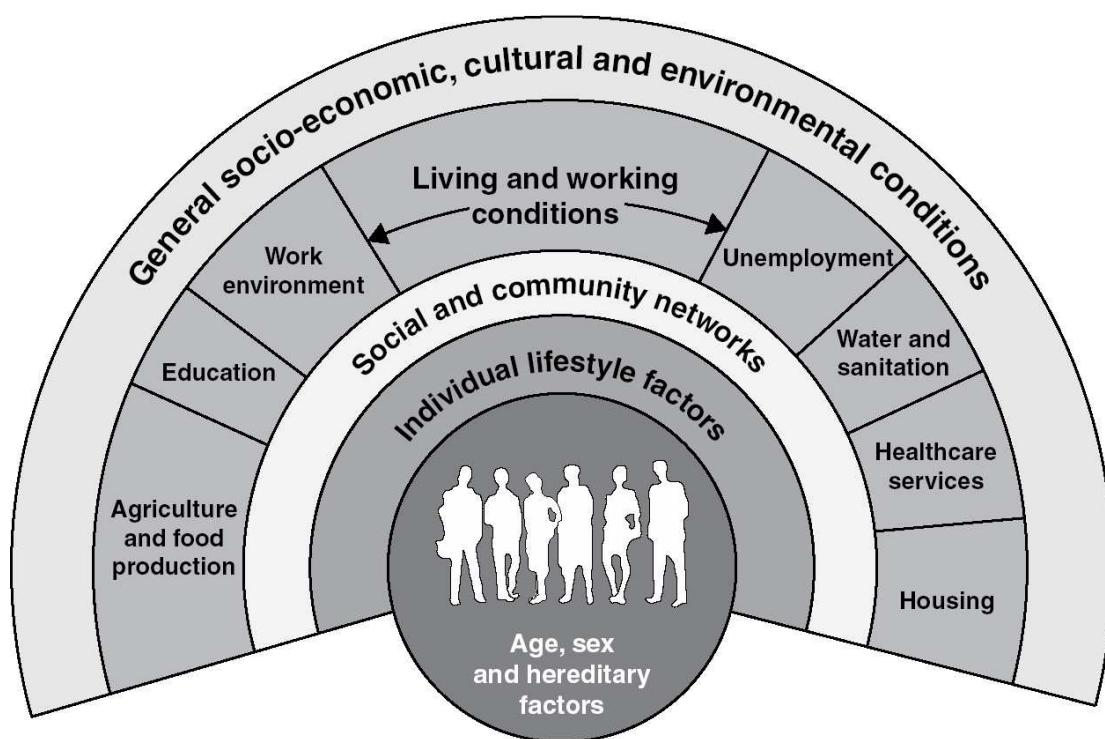
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Annexes

Annex 1: Social determinants of health by Dahlgren & Whitehead 1991



Annex 2: Central mechanisms (I–V) and associated policy entry points (A–D) related to social inequality in health by Diderichsen, Andersen, Celie & Andersen 2012

