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EPODE

for the **Promotion**
of **Health Equity**



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Contents

Editors	5
Contributing authors	9
Foreword	11
Preface	13

Part 1, Preventing Obesity, The Challenge of Health Equity

Chapter 1: Promoting health and striving to reduce health inequities	19
Chapter 2: EPODE: a methodology involving everyone	31
Chapter 3: Social and environmental determinants, household food insecurity	47

Part 2, Epode for the Promotion of Health Equity project

Chapter 4: EPODE for the Promotion of Health Equity **61**

Chapter 5: EPODE Flandre Lys, France **73**

Chapter 6: Healthy Kids, Bulgaria **87**

Chapter 7: JOGG, The Netherlands **99**

Chapter 8: MAIA, Portugal **115**

Chapter 9: PAIDEIATROFI, Greece **125**

Chapter 10: SETS, Romania **139**

Chapter 11: VIASANO, Belgium **151**

Part 3, Evaluation Framework and Results

Chapter 12: Description of the Evaluation Framework **169**

Chapter 13: Baseline and Impact Results **179**

Conclusion and Perspectives **195**

Private Partners Statements **209**



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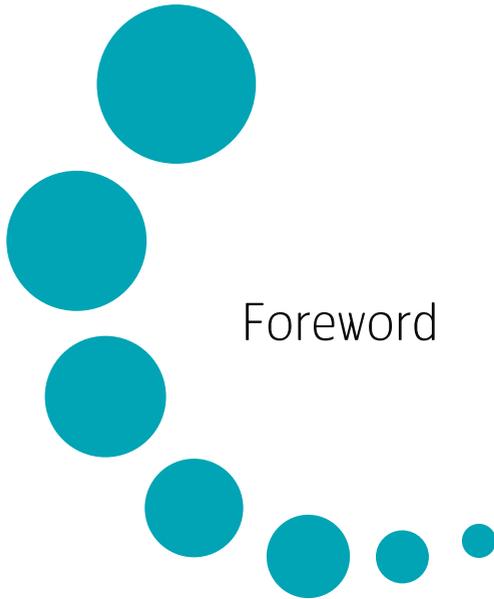
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Foreword

John F. Ryan

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Addressing health inequalities throughout the European Union remains a priority for the European Commission. Health inequalities can to a significant extent be prevented or minimised, both between population groups and between different EU Member States. Action to reduce health inequalities must take a holistic approach and cannot rely solely upon public policy and the health sector. All stakeholders such as individuals, communities, companies and governments, have a significant role to play. Nevertheless, despite efforts in the recent past, health inequalities remain a major challenge. This is also the case in the area of nutrition and physical activity.

Research shows that citizens with lower incomes suffer from higher levels of obesity. Lack of physical activity is also associated with lower socio-economic status. To fight this situation, we have to remember that habits set in early childhood are paramount for obesity's onset.

In fact, children who are overweight or obese are highly likely to remain so into adulthood. Children are often not in a position to evaluate all options or to effectively protect themselves and are also more vulnerable to peer pressure and aggressive advertising and marketing tactics. Obese children are more likely to suffer from bullying, self-confidence issues, depression and underachievement in school. On average, one in three children in the EU are overweight or obese and only 1 in 5 take part in regular moderate-to-vigorous exercise.

The European Commission has been addressing these issues in the framework of the *2007 Strategy for Europe on Nutrition, Overweight and Obesity-related Health Issues* and of the *2014 Action Plan on Childhood Obesity*. Both documents promote healthy lifestyles in general and focus in particular on children and healthy inequalities. They both encourage action involving the Member States and civil society. These priorities were confirmed in the *2014 Council Conclusions on Nutrition and Physical Activity*.

Support for action under this theme has also been happening through the EU Health Programme. The Programme has co-financed, among others, “EPODE for the Promotion of Health Equity”. This project that now reaches its end was aimed precisely at analysing the added value of the implementation of community-based approaches based on the EPODE methodology for the reduction of socio-economic inequalities in health-related diet and physical activity behaviours of families living in 7 different European communities.

I believe that the results of EPODE for the Promotion of Health Equity will provide important input to the discussions on how to address health inequalities and reduce childhood obesity. This is crucial if we wish to avoid personal suffering, control national health care costs and prevent negative impacts on the working force and on the economy.

I congratulate all those involved in the EPODE for the Promotion of Health Equity project and I hope that this book and its guidelines can serve as an inspiration.

John F. Ryan



Preface

Jean-Michel Borys

Health inequalities are defined as “differences in health status between individuals or groups, as measured by for example life expectancy, mortality or disease” (1).”

An increasing social gradient in health is found in all European countries (2, 3), making differences in life expectancy at birth possibly reach 10 years for men and 7 years for women between the lowest and highest socioeconomic groups. It is considered that inequalities in mortality from cardiovascular diseases account for about half the excess mortality in lower socioeconomic groups (4).

As indicated by the WHO in the European Charter on counteracting obesity (2007), “overweight and obesity most affect people in lower socioeconomic groups, and this in turn contributes to a widening of health and other inequalities.”

The European Commission Communication “Solidarity in health: Reducing health inequalities in the EU” emphasises the variations in health-related behaviours such as quality of nutrition and level physical activity and in obesity prevalence according to socioeconomic factors within and across countries.

In fact, surveys conducted in some EU member states suggests that over 20% of the obesity found amongst men in Europe, and over 40% of the obesity found in women, would be attributable to inequalities in SES. Evidence also shows that childhood overweight and obesity in Europe is also associated with the socio-economic status of parents, especially mothers. Moreover comparing across countries, it also appears that childhood overweight is linked to a Member State’s degree of income inequality or relative poverty (5). OECD (6) confirmed that poorly educated women are 2 to 3 times more likely to be overweight than those with high levels of education, while almost no

disparities are found for men. The lower socioeconomic groups are more likely to show a greater risk of positive energy balance, lower density of micronutrients in their diet, lower consumption of fruits and vegetables and lower levels of physical activity.

This has to be considered in a broader perspective where important factors such as gender, income, education, ethnicity, social support, and the living environment can play a role in this social gradient. This leads to conclude on the importance of integrated and targeted prevention measures at an early age with a clear focus on lower socioeconomic groups, in addition to prevention campaigns addressed to the general population.

It appears that interventions that only target vulnerable populations tend to present difficulties in tailoring actions according to social diversity, show less participation rates and often short durations (7). Actually, mass public health communication campaigns are sometimes criticized as potentially reinforcing health inequalities. It has been demonstrated in some cases that disadvantaged groups of population (less educated and less integrated) are more anxious and suspicious in front of health prevention messages (8). Even if they perceive the messages as reliable, this may not be sufficient in fostering the desire to change or to adopt healthier habits.

An example of community-based intervention having demonstrated a reduction in health inequalities is the EPODE Pilot Study (FLVS), a long-term intervention pilot program conducted between 1992 and 2004 in 2 North of France communities, and from which the EPODE methodology originates. The results showed a significant decrease in the obesity prevalence during the first 8 years, a clear trend to decrease was observed in both towns including a decrease by more than 50% of health inequities related to nutrition and physical activity behaviours in the case population compared to a control population (9).

In 2008, EPODE received the support of the European Directorate-General for Health and Consumers (DG SANCO) for the implementation of the EPODE European Network project (EEN, Grant Agreement. 2007327, www.epode-european-network.com, 2008-2011). The EEN project aimed at facilitating the implementation of community-based interventions using the EPODE methodology (10).

Based on these results and EPODE's experiences, the EPHE project (EPODE for the Promotion of Health Equity) aims to analyse from 2012 to 2015 the added value of the implementation of an adapted EPODE methodology in the reduction of socio-economic inequalities in health-related diet and physical activity behaviours of families with children aged 6 to 12, living in 7 different European communities.

This book aims to present EPHE's overall outcomes and to develop guidelines to be disseminated amongst EU member states. We give great emphasis to the work of the local teams and the original pragmatic organization, which has led to rapid implementation and an achievement of the objectives in a short amount of time.

We thank all the authors and contributors for this outstanding work, which will bring an added value to reducing health inequities according to the initial objective.

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