



Preface

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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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