# EPHE Operational Board

## Position Paper

The **EPHE Operational Board** (EOB) included representatives from each of the 7 national coordination teams and, throughout the implementation of the project, was in charge of supervising, monitoring and offering the tools needed for effective development of the project in the field. The main objective of the EOB was to assist the programmes in the practical implementation of the EPHE project, while sharing experiences from each programme on the 4 different themes approached by EPHE.

EOB role was to:

- review the choice of the intervention communities and the evaluation framework established, in collaboration with the EPHE Scientific Advisory Board;
- design action sheets together with local stakeholders according to the recommendations from the EPHE Scientific Board and the EPHE Guidebook. These action sheets were tailored to reach the disadvantaged families;
- monitor on-going activities for the project evaluation and discuss how to overcome possible challenges;
- ensure the effective implementation and monitoring of actions.

The EPHE Operational Board was chaired by a coordinator, chosen from one of the participating national coordination teams, who contributed to all of the functions and operational aspects associated with the EPHE activities.

In order to ensure a good communication between members and have updates on the project's implementation, the EOB had regular meetings and briefings, online or during special events. The topic of each meeting was defined according to the stage of the project and the next steps to be implemented. During the 3-year project, the

EOB members met 6 times, participated in 2 webinars, and had regular communication sessions with the coordination team.

During the project, tools were put at the disposal of the national project management teams in order to help and guide the implementation process. The EPHE Guidebook (a practical guide describing the EPHE project elaborately), the framework for evaluation designed by the EPHE Scientific Board, together with a portfolio of activity sheets developed during the intervention period, communication and PR tools (press releases, video, newsletters), and the WHO Appraisal Tool (for the evaluation of the programmes) were accessible to the national coordinators and their teams.

The EOB worked closely with the EPHE Scientific Board in order to make sure that the evaluation of the project would be carried out accordingly, and the results then used to design interventions that would address the factors determined by the evaluation process.

The work of the EOB was concentrated in the first six months of the project on the selection of the towns for the implementation of EPHE, on determining best motivational tools to be used in the field, and on the preparation and implementation of the baseline evaluation. Partnerships were established in every country by each local organization in order to ensure the entire community's involvement in the EPHE project. Different stakeholders came together and collaborated throughout the implementation of the project in order to ensure the success of EPHE.

**The bottom up approach used in establishing partnerships, doubled by the stakeholders' empowerment during implementation and their long term commitment to the project, stand as evidence of the EPHE project's success in the field.**

When they chose the EPHE towns, the countries had to follow a standardized protocol defined by the EPHE Scientific Board, discussed and agreed with the members of the EOB. To ensure the comparability amongst the participant communities, the national coordination teams provided a description of the city they selected before the baseline measurements were conducted. The description included socio-economic information and health promotion programmes/campaigns conducted in the city, along with general information about the selected schools, including infrastructure. This information was gathered from all the EOB members using a template document and sent to the EPHE Scientific Board for analyse and review.

After the EPHE towns were selected and the target public identified, the members of the **EOB analysed the different approaches they could use to ensure a good participation rate for the baseline evaluation. Motivation tools were different in each country because of difference in contexts and habits.**

The countries were offered multiple options during one of the EOB meetings. The details about the motivational tools used by each country were also gathered by the EOB to ensure best reporting on the project.

The central coordination team further guided the national project managers into the preparation of the baseline evaluation's implementation: translating the questionnaires into the national language of the country, offering guidelines for the dissemination of the questionnaires, and processing the documents collected from the respondents.

**The EOB and the Scientific Board closely collaborated to ensure that every step was being followed, that the national coordination teams had all the necessary information and that the first evaluation unrolled at best standards**.

**A first proof of the success of the joint work of the two EPHE boards and the national coordination teams was the *high response rate* registered during the baseline evaluation in most of the countries (over 85%).** The high response rate was maintained over the next two evaluation periods, demonstrating the willingness to collaborate from the parents of the children involved in the project, as well as their interest for nutrition and health related issues.

Based on the results of the baseline measurements, the members of the EOB designed the local interventions which were implemented during the second year of the project and focused on the energy balance-related behaviours and their associated environmental determinants. **The specially tailored interventions were to be added to the programmes already established actions, and thus cover all the 4 themes addressed by EPHE. The community as a whole was targeted via the different activities, ensuring the non-stigmatization of the deprived population.**

Action plans were put in place by each country coordinator, member of the EOB, indicating the interventions to be implemented and their topic, target group to be reached, tools to be used. Descriptions were provided for all actions and the results were monitored to determine the impact of each intervention. The action plans were shared at the EOB level and with the EPHE Scientific Board. The interventions were different in each country, as the determinants of behaviours to be addressed varied, as shown in the results of the baseline evaluation. The actions were established through a participative process between local stakeholders. **This co-creation type of approach in designing the interventions ensured a good mobilization amongst stakeholders and offered a local ownership over the project's activities.**

To support the development of actions that would have a real impact in the community, activity sheets were developed by the members of the EOB during dedicated workshops on the project's themes, like sleep of physical activities. Programme coordinators shared their best practices from the field on the specific themes, inspiring the others on what tools they could use and adapt for their own communities.

The local and international communication on the projects' activities was also a good motivational factor. For example, the coordinated actions that were organized for the World Water Day in almost all of the EPHE communities and the communication campaign developed around the interventions ensured a good visibility of the project in the participating countries, leveraging the international aspect of the activity.

The results gathered for each intervention demonstrated the good level of involvement from the target public in each of the EPHE activities developed within the communities.

The last phase of the EPHE project was dedicated to implementing regular activities in the communities, and giving the possibility to organise a series of special events as part of the joint actions approach, in order to have coordinated interventions in all of the countries at a specific moment. Only a few programmes could develop joint actions, however, as most of them encountered barriers due to social or political context in their country, as well as budgetary constraints. In doing so, they kept empowering the local political leaders.

A last evaluation was organized at the end of the project to determine whether the gaps in health related issued between different socio-economical groups were reduced by the delivery of tailored interventions implemented throughout the three years of the project.

At the end of the implementation period, the final overview of the operational aspects of EPHE done by the members of the EOB determined that there is clear evidence of the success of the project.

The operational aspects of EPHE were well developed and implemented, thanks to the hard work and dedication of the national coordination teams, who succeeded in:

- **creating and developing long term, sustainable partnerships;**
- **empowering the communities and the local stakeholders;**
- **tailoring interventions based on local realities and the input received from the Scientific Board of the project;**
- **gathering communities around the health related themes and mobilizing the target public by its active and direct involvement in the project activities.**

The long term approach of EPHE offered continuity in the interventions and ensured brand recognition. The local programmes used the logos of their national campaigns in association with the EPHE logo in order to offer credibility and a good endorsement of the project. EPHE became a part of the community activities and a recognized source of information and actions on health related issues. The interventions developed throughout the project inspired the local stakeholders in taking the initiative and design other related actions which addressed the same issues as EPHE.

**The practice in the field demonstrated that awareness-raising and motivation campaigns are essential for the success of community-based programmes on health related issues. They insure the involvement of the local stakeholders and encourage the participation of the targeted public in the project, including good results in the evaluation process**.

When dealing with schools, as a main vehicle for disseminating the message and reaching the families, a good motivation campaign has a great importance for the

school staff (coordinators, teachers and educational assistants) as well as for the parents and the entire community. The involvement and motivation of teachers in the project is vital to the successful development of any intervention in this area, as they are the driving factor that can encourage the families and children's participation in the project.

For a successful implementation, the local operational team has to work closely with schools' staff and all the different stakeholders of the community, find out their motivation factors and activate those during the project. Every stakeholder in the community has a roll to play and can contribute to the project, as concluded by the members of the EOB. From the initial brainstorming and planning of an action in the field up to the day of the implementation, it is really important to include all key local actors in the process, according to their specialty and position. **This bottom-up – rather than top-down– approach has proven to be efficient when implementing health related programmes.** When talking about changing behaviours, all the key actors in a community have to be activated and take part in the campaign in order to have a real impact and reduce socio-economic inequalities in the families' health-related diet and physical activity-related behaviours.

As in any project, the EPHE national coordination teams had to deal with and overcome the barriers that arose during the implementation of the project. Challenges varied from **making sure that no stigmatisation was put on the deprived families to ensuring that the different tools and interventions were adapted to the local social context.** Also, the delay in funding and the lack of resources was an issue that the local programmes had to find solutions for in order to secure the continuity of the actions.

Another aspect that could be improved for future EPHE-like projects is a better coordination of the existing actions in the field and their benchmarking. This will determine the leverages for a successful implementation, and indicate any need to make improvements or adapt specific best practices to raise the impact and maximize the results.

For the further development of actions in the field, it is important to offer online access to already designed tools and best practices models identified within the EPHE project. Having at their disposals information about the actions and the tools to be used to tackle health inequalities, we can ensure the sustainability of the programmes.

When talking about the monitoring and evaluation of the community-based programmes, which is a vital phase in the project's development and sustainability, EPHE has demonstrated that it is important to establish good working processes with the partners involved in the project. Also, the centralization of all the interventions, and the constant review on the actions and the specific results registered can offer a good perspective on the success of the activities and their further development.

As mentioned before, the data collection process in the field must be supported by mobilization and motivation campaigns, which ensure a good involvement in the

programmes' activities and the evaluation process. Indicators like the number of the participants for each intervention, feedback received post event, the response rate for the evaluation stage, are all important aspects that need to be followed for a good overview of the project. Barriers can appear in collecting data when dealing with different socio-economical groups and designing tools that are generally valid. The EPHE questionnaire used in the evaluation process was a complex tool, covering different aspects of the energy balance-related behaviours and their associated environmental determinants. Its translation and wording had to be accessible to both low and high socio-economical groups, so that the former group wouldn't have difficulties in understanding the message. **Finding the perfect wording in its own language was a challenge that each country had to overcome.**

Also, when participating to such a study, the participants want to have access to the results and a delay in the delivery of the information may influence the rate of response for the next evaluation phase of the project. All these aspects have to be dealt with and managed in a proactive manner to ensure the success of the project.

**EPHE, with its operational approach and mix of tools and expertise, has offered a perfect example of how the Community-based Programmes promoting health are a solution when tackling health inequities. The effectiveness of a programme at local level requires a participatory decision-making process, involving all key stakeholders in a community. Only by including everyone in the local area of the project –private and public partners– can we expect to impact and create change, thus influencing the behaviours and habits of families, independent of their socio-economic status.**

The findings of EPHE presented in this book encourage a further exploration of how the community-based interventions can be used in understanding the dynamics of a community when trying to influence and change the behaviours that determine health inequalities.

# EPODE methodology to reduce health inequalities related to diet and physical activity: A personal perspective


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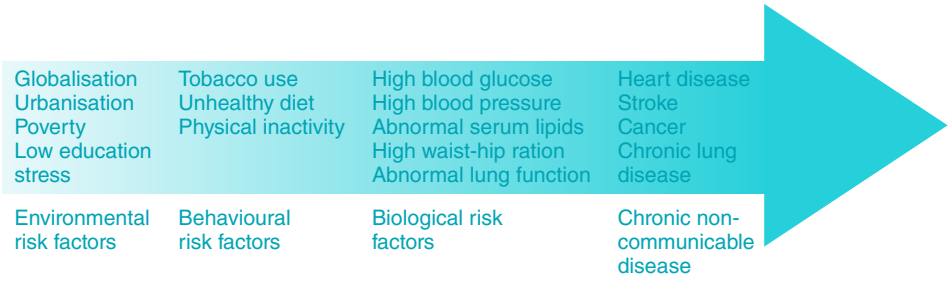
Since the 19th century, inequalities in health have been of a major concern to public health professionals. A milestone is the publication *The Sanitary Conditions of the Labouring Population* (1842) of Edwin Chadwick, a British public health reformer (1). Health inequalities presented themselves by high mortality in deprived populations primarily caused by infectious diseases and malnutrition. These in turn were caused by poor sanitary conditions, unhealthy environments at the workplace and in housing, and poverty.

After the Second World War, most of these conditions rapidly improve in most European countries and cities. Yet, inequalities persist, as described by Jerry Morris in 1979 (2). Outright poverty is much less present. Morris however points out two major issues: poverty and inequality. These overlap but are by no means the same.

Also, in the second half of the 20th century, wealth and income, housing and environment, education and social skills, status and esteem, those major resources and conditions of health, are unequally divided in our society, leading to large social inequalities in health.

In the 20th century, the most important cause of social inequalities in health amongst affluent communities, such as most European countries, is the incidence of chronic non-communicable diseases (see figure below). These in turn are caused by inequalities in biological risk factors. Most of these risk factors are strongly related to behavioural risk factors. Further upstream can be attributed to environmental factors (physical, socio-cultural, economic and political environments).




In his paper, Jerry Morris already points out to these social environmental factors (2). Toba Bryant and others have since proposed a commonly accepted and extensive list of social factors that are currently contributing to health inequalities:

– Income and Income distribution;
– Education;
– Employment and Working conditions;
– Early childhood development;
– Food insecurity;
– Housing;
– Social exclusion;
– Social safety network;
– Health services;
– Aboriginal status;
– Gender;
– Race;
– Disability.

Morris also points out that, in order to diminish these inequalities, a life course approach is needed with great emphasis on early childhood: "creating more equal opportunities for the under-fives through education and day care, expanding child benefit and family endowment, concentrating health services on the socially disadvantaged, and setting an upgraded 'health education' to the task with mothers and children and the whole population" (2).

In the context of the EPHE programme, it was of course not possible to address changes in policy that would lead to the changes in the upstream social factors mentioned above. These policies need to be developed and, at the same time, community-based interventions need to be developed. But the EPODE framework does address upstream factors proximal to inequalities in health-related behaviours in the community (4). In the short time span and with the limited resources granted to EPHE, attention was focused on behavioural determinants in the households of children. These pointed towards shared factors related to parenting, economic factors and the physical environment of the households in various countries. The determination of social determinants of behaviour that posed barriers to healthy choices, particularly in the groups with lower socio-economic position, were instrumental in locally tailored interventions. Based upon this knowledge, the operational board was able to design

interventions within the EPODE framework that theoretically would reduce inequalities in these health-related behaviours. Those, on the short-term, appeared to be beneficial for several behavioural factors but, now, sustainable actions are needed.

A long-term approach towards reducing health inequalities ideally combines structural national and local policies on upstream social factors as well as locally tailored interventions aimed at health promotion targeting the barriers experienced by groups with relatively low social economic positions.

The EPODE methodology, combining political commitment, social marketing, public-private partnerships and evaluation (5), seems to be a valuable element in the strategy to diminish social inequalities in health in children.

## References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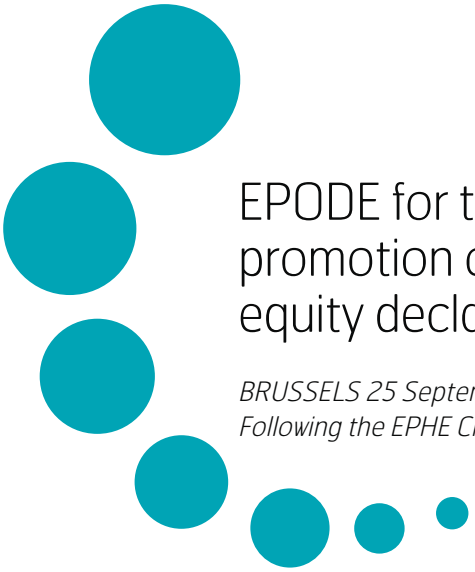

# EPODE for the promotion of health equity declaration

*BRUSSELS 25 September 2015*
*Following the EPHE Closing Event*

Health equity is the absence of systematic differences in health and its determinants between groups of people at different levels of social advantage.

WE, involved in childhood obesity prevention in 20 European countries: politicians, community-based programme coordinators, leading experts, representatives from public health institutions, civil society, corporate sectors, local associations and NGOs:

Declare that community-based programmes (CBPs) are an essential part of a long-term sustainable solution to prevent obesity and to promote healthy active lifestyles. They also have positive effects on environment, economics and enhance social cohesion;

Declare that the community-based approach is able to increase health equity at the local level and has a positive impact on the population health especially for low socio-economic groups;

Declare that we need successful initiatives to be integrated by the communities at the local, regional and national levels.

We act to encourage communities to integrate a multi-stakeholder approach in their local health politics and appoint in every city a local project manager to coordinate this community-based approach.

WE act to integrate health equity in all policies especially at local level.

WE agree that no single intervention creates significant impact to increase health equity; only a comprehensive systemic programme of multiple interventions is likely to be effective.

WE call on representatives from all sectors to become involved, to achieve a sustainable, effective and equitable obesity prevention, to support CBPs and to join the global obesity prevention movement that is beginning here and now.

WE CAN reduce children obesity prevalence and health inequities.