



STAKEHOLDERS

First EU-wide stakeholder debate of the Equity Action

“Together for health equity from the start”

8–9 May 2012

Budapest, Hungary

Documentation




EQUITY*ACTION*

TOOLS • REGIONS • KNOWLEDGE • STAKEHOLDERS •



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*It should be emphasized that the “**Together for health equity from the start**” event held in Budapest, Hungary on 8–9 May 2012 was attended by a diverse audience of participants united by a common interest in stakeholder engagement in pursuit of the aims of Work Package 7 of the Equity Action. The views expressed were therefore those of the participants, and may not represent views held more widely.*

It must also be emphasized that the points of view expressed at the event, many of which are reported here, were made in a spirit of free and unhindered expression of opinion and belong to the participants. The ideas and views expressed by participants and summarized in this report do not necessarily reflect the views of the European Union, the Federal Centre for Health Education, Germany, or the National Institute for Health Development, Hungary.

It is not possible to present in the report all the diverse views and ideas expressed at the event, and an element of selection and analysis has been adopted in its preparation.



Contents

Introduction	4
Work Package 7 of the EU-funded Joint Action on Health Inequalities (Equity Action).....	5
WP 7 leaders and partners.....	5
Posters.....	6
Day 1	7
Opening session	7
Opening, <i>Dr Zoltán Vokó, OEFI and Helene Reemann, BZgA</i>	7
Welcoming address, <i>Dr Hanna Páva, Deputy Secretary of State for Coordination and International Health Affairs of the Ministry of National Resources, Hungary</i>	8
Session 2. The EU-funded Equity Action and WP7 on “Stakeholder Engagement”	9
Equity Action – the Joint Action on Health Inequalities, <i>Mark Gamsu, Health Action Partnership International</i>	9
WP7 of the Equity Action, <i>Ágnes Taller, OEFI and Caren Wiegand, BZgA</i>	10
Session 3. Health equity from the start and stakeholder engagement	12
Health equity from the start and stakeholder engagement, <i>Dr Piroska Östlin, WHO Regional Office for Europe</i>	12
What is stakeholder engagement: concepts and relevance, <i>John Griffiths, work2health</i>	14
Session 4: Panel discussion: Good practices in stakeholder engagement and health equity from the start, moderated by Clive Needle, EuroHealthNet	16
Introductory presentations to the panel discussion: (Health) inequalities among children in Europe, <i>Dr Mária Herczog, Eurochild</i>	16
The importance of stakeholder engagement in achieving health equity from the start, <i>Dr Ray Earwicker, Department of Health, England</i>	17
Short panel presentations.....	19
Moderated panel discussion.....	24
Day 2	27
Session 5. How does stakeholder engagement practically work?	27
Methods and steps in stakeholder engagement, <i>John Griffiths, work2health</i>	27
Stakeholder engagement workshop: Feedback from groups	29
National scenario.....	29
Regional scenario.....	30
Annex 1. Agenda	32
Annex 2. Participants	35
Annex 3. Workshop case studies	38



Introduction

Many of the major public health challenges faced by adults have their roots in the early years of life. Action to tackle health inequalities should therefore start in early childhood and should continue through the later years of education.

Tackling health inequalities and ensuring health equity from the start is an ambitious and complex task that requires cooperation and action from a wide range of stakeholders. This goal cannot be achieved by the health sector alone, but calls for shared responsibility across sectors. It is therefore crucial to involve stakeholders from sectors such as health, education, social welfare, transport and urban planning in actions to tackle health inequalities.

The first European Union (EU)-wide stakeholder debate, “Together for Health Equity from the Start”, held 8–9 May 2012 in Budapest, Hungary (see debate agenda at Annex 1), was organized within the scope of the EU-funded Joint Action on Health Inequalities (Equity Action). A second debate will be held in Berlin, Germany, on 14–15 November 2012.

The Equity Action (February 2011–February 2014) is coordinated by the National Heart Forum in England and involves 24 partners from 16 Member States. It focuses on developing capability across Member States to tackle socioeconomic health inequalities through different actions. Joint Actions are activities carried out by the EU and the Member States.

Four participants (core stakeholders) from each Member State involved in Work Package (WP) 7 of the Equity Action, “Stakeholder engagement”, were chosen to take part in the debate. Core stakeholders came from national, regional and local level and worked in different sectors. A full list of participants is shown at Annex 2.

Some core stakeholders had previous experience in stakeholder engagement, while others had none. They shared their experiences, gathered new insights and hopefully will now use their new knowledge to develop and/or improve processes of stakeholder engagement in their own countries. The fact that Member States have signed up to the Joint Action gives core stakeholders authority to promote equity actions when they go back to their countries and regions.

The aim of the first EU-wide stakeholder debate was to discuss stakeholder engagement processes in relation to health equity from the start. The debate allowed exchange of experiences and mutual learning and identified good practice examples, but problems and barriers to effective stakeholder engagement were also discussed.



The first debate aimed to provide:

- knowledge (on health equity from the start, stakeholder engagement processes and good practice examples);
- skills (methods and steps of stakeholder engagement); and
- a first draft of recommendations on stakeholder engagement for health equity from the start (resulting from presentations and discussions during the debate).

Work Package 7 of the EU-funded Joint Action on Health Inequalities (Equity Action)

WP7 aims to develop and/or improve stakeholder engagement processes in Member States and at EU level in the priority area of “Equity from the start”. It is taking this forward through two EU-wide stakeholder debates held during 2012 that aim to allow core stakeholders from partner countries to share experience, good practice and concrete scenarios of stakeholder engagement for health equity from the start.

Evidence of the mutual benefits of cross-policy engagement has been produced in factsheets developed by WP7, and partners are organizing national workshops to engage stakeholders at national, regional and/or local level. Based on the results of the above activities, WP7 aims to develop a guide on how to identify, engage and support stakeholders in tackling health inequalities to promote health equity from the start.

WP 7 leaders and partners

Leaders

- Federal Centre for Health Education (BZgA), **Germany**
- National Institute for Health Development (OEFI), **Hungary**

Partners

- Federal Public Service Health, Food Chain Safety and Environment (FPS), **Belgium**
- National Institute of Public Health (SZU), **Czech Republic**
- **EuroHealthNet (EHN)**, Belgium
- National Centre for Social Research (EKKE), **Greece**
- Local Health T03, Piemonte Region (ASL-T03), **Italy**
- Norwegian Directorate of Health (NDOH), **Norway**
- National Institute of Public Health, National Institute of Hygiene (NIZP), **Poland**
- Ministry of Health and Social Policy (MSPS), **Spain**



Posters

The success of debates at the meeting depended largely on all participants contributing and sharing their work and experiences. To enhance opportunities for all participants to present their work, they were encouraged to produce posters of good practice examples in stakeholder engagement/intersectoral work in relation to health equity from the start.

Informal poster displays were exhibited during lunch breaks on both days of the meeting. Participants were provided with a basic PowerPoint template to use as a basis for developing their poster but were free to choose their own design. Eleven posters were exhibited during the stakeholder debate. These can be accessed at the Equity Action website at: http://www.health-inequalities.com/HEALTHEQUITY/EN/projects/equity_action/wp7/

The following posters were presented.

Belgium

- Equity from the start – coordination of perinatal and childhood well-being agencies to tackle health inequalities in Belgium
- How do Belgian actors tackle social determinants of health inequalities in childhood?

Germany

- National Centre on Early Prevention
- The partner process “Healthy Growing up for All!” of the cooperation network “Health Promotion among the Socially Disadvantaged”

Greece

- Prevention and early intervention service in Greece
- Equity Action network of Greek stakeholders
- NGO NOSTOS – Organization for Social Integration

Italy

- The Italian Council for Economics and Labour: the experience of the BES (Sustainable and Fair Well-being)
- How the Turin College tackles health inequalities
- The results of EUROGBD-SE projects – definition of priorities and engagement of stakeholders in European countries

Spain

- Experience of stakeholder engagement in the process of elaboration of the 2nd National Strategic Plan for Childhood and Adolescence (PENIA II)



Day 1

Opening session

Opening, *Dr. Zoltán Vokó, OEFI and Helene Reemann, BZgA*

Dr Zoltán Vokó welcomed participants on behalf of OEFI and BZgA.

OEFI is a government-based agency that plans, coordinates and evaluates public health and health promotion at national level. It was established in 1958 and has been a partner in previous EU health equity projects such as “Closing the gap” and “Determine”.

The Equity Action programme offers OEFI a great opportunity to enrich its experience in the field of health inequities and to gain new knowledge as a leader of WP7 on stakeholder engagement in partnership with BZgA.

The Equity Action focuses on developing capability across EU Member States to tackle socioeconomic health inequalities through different actions. Tackling health inequalities and ensuring equity from the start is an ambitious and complex task that requires coordinated action from a wide range of stakeholders. The goal cannot be achieved by the health sector alone: it requires shared responsibilities across sectors. Health, education, social welfare, transport and urban planning sectors all need to be involved in the process.

Many of the major public health challenges facing adults have their roots in the early years of life. Action to tackle health inequalities should therefore start in early childhood and should continue through to the later years of school. The scientific basis underpinning the need for action is strong: the challenge is to find a way of translating scientific research findings into action on the ground.

Helene Reemann added a welcome on behalf of BZgA.

Building on the work of the WHO Commission on the Social Determinants of Health and the former EU projects “Closing the gap” and “Determine”, the current Equity Action project aims to create greater awareness of health inequalities within and beyond the health sector, focusing on stakeholders, decision-makers and practitioners at different levels. It aspires to develop active interventions, policies and programmes.

The BZgA is a national institute for health promotion and disease prevention within the portfolio of the Federal Ministry of Health of Germany. It was established in 1967 and is responsible for national programmes and campaigns in areas such as HIV prevention, tobacco prevention, sex education, family planning and other public health issues.



A main cross-cutting issue is tackling health inequalities. This is pursued through nationwide cooperation involving over 50 partners throughout Germany (National Cooperation Network on Work with Socially Disadvantaged People). A second major programme is the National Centre of Early Prevention of child neglect and abuse, which is led by BZgA in partnership with the German Youth Institute and involves intersectoral collaboration. Like OEFI in Hungary, BZgA has been involved in EU health equity projects such as “Closing the gap” and “Determine”.

The meeting aims to discuss how stakeholders could best be integrated in the effort to achieve a healthy growing-up process for children and young people in all societies by facilitating exchanges of experience and mutual learning among different EU Member States and identifying good practice in transferrable methods of stakeholder engagement. A second debate will take place on 14–15 November 2012 in Berlin, Germany, to which all participants were invited. Both debates will result in concrete recommendations for stakeholder processes for health equity from the start, jointly developed by all participants. The Budapest meeting will lay the foundations for the Berlin meeting.

Welcoming address, Dr. Hanna Páva, Deputy Secretary of State for Coordination and International Health Affairs of the Ministry of National Resources, Hungary

The meeting provides an excellent forum in which stakeholders can mutually exchange knowledge and experiences. It is a privilege for WP7 to be jointly chaired by OEFI and BZgA and excellent work has been carried out so far. When tackling health inequalities it is of the utmost importance to reach all relevant stakeholders, encourage their engagement and facilitate their mutual beneficial cooperation at national and EU level. The meeting will support this and will also aim to support the development of effective actions to fight socioeconomic health inequalities at EU policy level.

WP7 puts particular emphasis on equity from the start, which was one of the recommendations from the WHO report *Closing the gap in a generation*,¹ published in 2008.

This first debate and the following activities within WP7 will lead to the development of a guide on how to identify, engage and support stakeholders’ efforts in combating socioeconomic health inequalities. The Budapest and Berlin debates would undoubtedly contribute to the achievement of such an outstandingly important objective.

¹ Commission on the Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008 (http://www.who.int/social_determinants/thecommission/finalreport/en/index.html, accessed 13 June 2012).



Session 2. The EU-funded Equity Action and WP7 on “Stakeholder Engagement”

Equity Action – the Joint Action on Health Inequalities, Mark Gamsu, Programme Coordinator of the Equity Action, Health Action Partnership International

Austerity measures taken within countries to counteract the economic downturn are likely to heighten inequalities. Even in better economic climates, public health has not been very successful in reducing inequalities. One of the main aims of the Equity Action programme is therefore to support public health workers to be better at what they do.

Participants at the meeting were champions for the Equity Action. The fact that Member States have signed up to the Equity Action gives participants authority when they go back to their countries and regions to promote equity actions with governments and ministries.

The aims of the programme are to:

- identify what works in promoting effective action on the underlying causes of socioeconomic health inequalities; and
- apply learning across the EU through the engagement of 24 partners and 16 Member States in a joint action programme.

The programme has a number of WPs. WPs 1–3 are inward focusing, looking at areas such as evaluation, communication and administration of the programme. The remaining WPs are the following.

- **WP4 Tools:** this is about building capability and improving policy at Member State and EU level. The focus is on health impact assessments, health equity audits and health inequality strategies.
- **WP5 Regions:** this recognizes the importance of working with regional governments and focusing on identifying and supporting regional approaches to address health inequalities. It includes influencing the EU Structural Fund programme starting in 2014.
- **WP6 Knowledge:** WP6 is about engaging scientific experts to develop a European research agenda on the effectiveness of intersectoral action to support policy-makers.
- **WP7 Stakeholders:** WP7 focuses on developing lessons for building alliances and networks with key stakeholders at Member State and EU level to promote and embed the social determinants of health agenda.

WPs 4–6 are what public health has traditionally been good at – tools, evidence and research. Public health is less good at developing relationships with others who have a responsibility within the wider determinants of health, such as nongovernmental organizations (NGOs) and other government ministries. WP7 is therefore very important: through its work with stakeholders, it is central to promoting the multisectoral approach that is needed to make a difference.



WP7 of the Equity Action, Ágnes Taller, OEFI, Hungary and Caren Wiegand, BZgA, Germany

Ágnes Taller commenced by offering a brief overview of the aims, tools and expected outcomes of WP7.

Healthy equity from the start is a priority area, based on recommendations from the Marmot review. The aims of WP7 are to:

- develop a process to engage wider stakeholders to achieve “health equity from the start”;
- demonstrate to stakeholders the mutual benefits of cross-policy engagement and their potential contribution to health equity;
- facilitate stakeholder engagement at Member State and EU level; and
- develop proposals for future collaboration.

The following tools have been devised to help WP7 to achieve its aims.

- The first draft of a set of factsheets of evidence-based information on how various sectors can contribute to achieving health equity from the start has been prepared (participants were invited to comment on the drafts).
- Two EU-wide stakeholder debates (this meeting in Budapest and the follow-up in November 2012 in Berlin) have been organized to allow a mutual exchange of experiences on stakeholder engagement processes.
- National stakeholder workshops, developed by partners and involving core stakeholders at country level, will commence towards the end of 2012/beginning of 2013.
- A final joint action conference, “Towards a roadmap for health equity for 2020”, will be held in Brussels, Belgium, in October 2013.

Expected outcomes from WP7 are draft recommendations on stakeholder engagement (based on the experiences of the two EU-wide debates) that will inform the final deliverable of the WP, which will be a guide on how to identify, engage and support stakeholders in tackling health inequalities in the field of health equity from the start.

Caren Wiegand discussed how stakeholders can become more engaged through WP7.

Stakeholders can participate in drafting recommendations on stakeholder engagement, and the work on this starts with the Budapest meeting. A first draft of the recommendations will be produced after the meeting and will be taken on for further consideration at the Berlin meeting. Participants will be contacted after the meeting to seek further views on stakeholder engagement and to begin the process of refining the recommendations: this will be done during the summer of 2012.



Participants can help to organize national workshops in their countries to enable wider engagement with stakeholders and identify responses specific to national or regional sensitivities.



Session 3. Health equity from the start and stakeholder engagement

Health equity from the start and stakeholder engagement, *Dr. Pirooska Östlin, Programme Manager, Vulnerability and Health Programme, WHO Regional Office for Europe*

Health equity from the start is very high on the Regional Office agenda. Health equity is enshrined in the WHO constitution and links very closely with human rights and concepts of social justice. The promotion of good health is necessary across the lifespan and cannot be achieved without joint efforts and partnerships with stakeholders.

The WHO European Region has 53 Member States and almost 900 million people. It is an incredibly diverse Region, ranging from countries with some of the most advanced health care systems in the world to those that find it a challenge to provide even the most basic care, and from countries that have enthusiastically adopted the gender equalities agenda to those where women still need to seek their husband's permission to access health care. There is a 16-year difference between countries with the highest (generally western) and lowest (countries of the Commonwealth of Independent States) life expectancy and a 43-fold difference in maternal mortality rates across the Region.

All countries, however, have health inequities to greater or lesser extents. Inequities are seen both within and between countries. The worldwide economic and fiscal crisis is posing severe challenges to some countries, with a real risk that social and economic development and health achievements may be undermined.

The age demographic in the Region is changing, with shrinking numbers of younger people and growing numbers of older. Fortunately, migration into the Region is helping to redress the age balance, but despite the positive effects of migration, antimigration sentiments are present in many European countries.

Supporting children and young people to be healthy is clearly very important. Healthy children tend to become healthy adults, who tend to be more productive. Healthy adults in turn tend to become healthy older people who can continue to make positive contributions to society. The idea that healthy ageing starts at birth is true.

Many factors affect children's ability to be healthy, with education level and family affluence identified as being among the most crucial. Gender and ethnic inequities also play important parts. The Commission on the Social Determinants of Health has stated that investment in child health is a very powerful equalizer – this is one of the most important investments a country can make, contributing positively to social and economic development and also reducing costs to health and social care systems over the longer term. The largest effects of investment are seen among the most deprived children.



Investment patterns vary greatly among countries, but those that have identified investment as a priority use means such as social protection or social transfers to reduce child poverty. There is clear evidence that these kinds of interventions are effective.

Dahlgren and Whitehead's famous model of the social determinants of health² shows that "fixed" factors, such as genetics and sex, are surrounded by layers of factors that can be modified. The model demonstrates how actions in many sectors can influence health, and that health is only one sector among many.

The *Closing the gap in a generation* report³ identified three overarching recommendations for reducing health inequalities:

- improve people's daily living conditions
- tackle the inequitable distribution of power, money and resources
- measure and understand the problem and assess the impact of action.

The new WHO framework for health in Europe, Health 2020, is being developed in partnership with Member States and will be presented at the next meeting of the WHO Regional Committee for Europe in Malta in September 2012. It is hoped that the policy framework will inspire Member States to develop their own policies based on Health 2020's principles and values. In addition to issues such as equity and access to services, the framework will also focus on health governance.

The consultation document states that the vision is for a European Region in which "all people are enabled and supported in achieving their full health potential and well-being and in which countries, individually and jointly, work towards reducing inequities in health within the Region and beyond". The overall goal is to significantly improve health and well-being of populations, reduce health inequities, strengthen public health and ensure sustainable people-centred health systems. Health 2020 has two strategic objectives which must be incorporated within governance actions: working to improve health for all and reducing the health divide; and improving leadership and participatory governance for health.

Stakeholder engagement is very important in addressing the social determinants of health and health inequities. This is a central component of the governance elements within Health 2020, which stress the imperative of collaboration and citizen engagement. Ministers of health and the health sector have a key leadership role in promoting and supporting intersectoral action for health and health in all policies.

² Dahlgren G, Whitehead M. *Policies and strategies to promote social equity in health*. Stockholm, Institute for Future Studies, 1991 (http://ideas.repec.org/p/hhs/ifswps/2007_014.html, accessed 13 June 2012).

³ Commission on the Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008 (http://www.who.int/social_determinants/thecommission/finalreport/en/index.html, accessed 13 June 2012).



The number of countries requesting technical assistance from WHO in the area of social determinants of health and health inequities has increased from 6 in 2006/2007 to 33 in 2012/2013. This is an encouraging sign that more and more countries are addressing this agenda.

What is stakeholder engagement: concepts and relevance, *John Griffiths, Director, work2health*

The fundamental element that needs to be considered when bringing people together to tackle health inequities is that stakeholder engagement is built upon relationships. If there is no sense of relationship, it will be a struggle to achieve stakeholder engagement.

Relationships with stakeholders develop through:

- working towards a common goal or objective
- being collaborative, not competitive, in nature
- promoting openness, transparency and mutual trust and respect
- recognizing the diversity of stakeholders and their needs.

The fundamental question to be asked when considering stakeholder engagement is: “Why should any potential stakeholder wish to become involved in the promotion of health and well-being?” Several answers are possible, and stakeholder involvement may be based on a mixture of some or all of them. They include:

- altruism – they do it because they believe it is the right thing to do irrespective of cost;
- investment – they do it because they perceive that there will be a return on their investment;
- compulsion – they do it because they have been told they have to: the significant risk with this approach is that they are allowed to do the absolute minimum; and
- lost opportunity – they do it because the potential benefits are so great that they cannot afford not to.

Stakeholder influence has been described against two criteria: interest and power. A stakeholder with low interest and low power will probably require low effort. Those with low interest but high power will need to be managed to keep them satisfied. Stakeholders with low power but high interest need to be kept informed and involved. And those with high power and high interest are key players. It is much easier if stakeholders are positive about what the policy or programme is doing, but it is difficult to measure their power and interest.

Other issues that are relevant to this model include the influence of changing events, which can cause stakeholders to change allegiances, and the fact that those with neither power



nor influence could be largely ignored (this does not take into account ethical or moral considerations).

Stakeholders can be categorized under four headings.

1. Internal and external stakeholders: they can be defined in many ways, but generally, “internal” means our own organization and “external” all those outside the organization.
2. Primary and secondary stakeholders: “primary” are those without whose continuing participation the policy or programme cannot survive; “secondary” are not directly depended upon for the immediate survival of the policy or programme.
3. Active and passive stakeholders: “active” are those who seek to participate in the policy or programme, while “passive” generally do not, although this does not mean that they are not interested or are less powerful.
4. Voluntary and involuntary stakeholders: “voluntary” engage willingly while “involuntary” are affected by the policy or programme but are not part of it.

It is necessary to have an understanding of the stakeholders within and outside the health system. There is a need to engage with stakeholders in ways that are appropriate to them, and sound methods of stakeholder identification are essential.

Stakeholders are crucial to the success of policies and programmes and are neglected at our peril. Manage them poorly and they might actively work against us; manage them well and they will promote, resource and support our project. Where there is mutual respect for one another’s goals and an understanding that the achievement of positive outcomes will mean different things for different stakeholders, significant progress can be made in tackling health inequalities. This is the “synergistic impact”.



Session 4: Panel discussion: Good practices in stakeholder engagement and health equity from the start

Clive Needle, Director of EuroHealthNet facilitated this interactive session, which included two plenary and four brief presentations. EuroHealthNet is a not-for-profit network of organizations, agencies and statutory bodies working to promote health and equity by addressing the factors that determine health directly or indirectly. EuroHealthNet offers advice and information for policy-makers, promotes good practice and innovations, and seeks to practice ethical and sustainable methods to achieve the aims and objectives set by its members and partners.

Introductory presentations to the panel discussion

(Health) inequalities among children in Europe, Dr. Mária Herczog, President of Eurochild

Nineteen per cent of children in EU countries live in poverty and one child in five is born into, and grows up in, economic and social deprivation. Children are not only victims of poverty, but are also most likely to suffer from social exclusion and segregation. The extent, seriousness and consequences of the problem are often not well understood by policy-makers and the general public.

Cutbacks in all areas of government spending as a consequence of the financial crisis have a disproportionate effect on the vulnerable groups who need support most, including children. Social exclusion describes the processes that push people to the edge of society, limit their access to resources and opportunities, curtail their participation in social and cultural life and leave them feeling marginalized, powerless and discriminated against. This affects their physical and mental health.

Policies and public health measures for poor children often lead to a continuation of intergenerational inequalities. This is particularly important if countries take a punitive approach against those who do not care for themselves or their children well, instead of supporting them to do better. Lack of capacity in families or among parents should not lead to policies that punish children and deny them future opportunities.

Pre- and postnatal care, birth experience and early childhood have a lifelong impact on all aspects of health and well-being. Poor health among children born and growing up in poverty is preventable as long as comprehensive and cohesive public policies are in place. We know this is the most profitable investment we can make, but we are still not doing it. Maintaining early health equality gains requires a sustained commitment to all children and adolescents, which also includes education and social policy.



A recent roundtable debate in the European Parliament hosted by Mediciens du Monde found:

- poor self-reported health status by representatives of vulnerable groups such as migrants, undocumented asylum seekers and destitute EU nationals in their own and other EU Member States;
- up to half of those with ill health receive no care and treatment;
- a profound lack of access to antenatal care and vaccinations and to primary health care; and
- rises in neglect and violence in health care services towards representatives of vulnerable groups.

All European countries have ratified the United Nations Convention on the Rights of the Child (UNCRC). This is a binding commitment that carries responsibility for action. Part of the UNCRC refers to the right of children to enjoy the highest attainable standard of health and commits countries to facilitate treatment for illness and promotion of good health. As the findings above show, this is not universally the case.

Eurochild believes that it is absolutely crucial to take a child-centred approach based on the principles enshrined in the UNCRC. Such an approach ensures that children's well-being is addressed in a holistic way and that their needs are seen from their perspective. It means that we should empower them and involve them in decision-making processes. It is also important to have intersectoral, interdisciplinary cooperation as part of the holistic approach.

The fight against poverty and social exclusion needs to be a clear priority within the EU budget and appropriate resource allocation has to be ensured to support the European Platform against Poverty. Investing in children and their well-being is not only a moral obligation but also an economic priority. It is probably the most effective route towards sustainable social, economic and political progress in Europe.

The importance of stakeholder engagement in achieving health equity from the start, *Dr. Ray Earwicker, Department of Health (DH), England*

Experience suggests that stakeholder engagement is key to developing effective policy as it promotes ownership among the main players and helps policy implementation. Lack of engagement can result in a failure to connect policy and implementation, however well designed the policy.

The health inequalities strategy developed for England used the best available evidence, set out policy options across government and gained the support of ministers. Its primary aim was to narrow the health inequalities gap in infant mortality and life expectancy in line with two national targets. Despite this aim, the target indicators continued to show a widening of the health gap. It was clear that more needed to be done if the strategy and



the supporting policies were to work and slow, if not narrow, the widening health inequalities gap. New thinking was needed.

A cross-government review was set up to look at how to improve the effectiveness of the infant mortality health inequalities strategy and sharpen up its performance at local level. The infant mortality review considered the available data – including where the incidence of infant mortality was greatest – and the evidence on the most effective interventions – what works. It also explored issues around ownership and stakeholder engagement.

It found that while many agencies had concerns about inequalities in infant and child health, very few people had actually read, or were aware of, the strategy. Local workshops held as part of the review also showed that many participants did not know each other, despite working in the same field and having similar interests.

These findings prompted a new approach that focused on the 43 local areas with the highest numbers of infant deaths and, by implication, the worst infant and child health outcomes. Local agencies and stakeholders were systematically engaged to participate in the health inequalities policy and implementation process. A strategy implementation plan drawing on the results of this engagement was then published.⁴ Broadening the policy focus from tackling health inequalities in infant mortality to addressing inequalities in infant and child health allowed the engagement of a wider range of stakeholders who were concerned with more general issues of deprivation and disadvantage for the under-5s.

This new way forward was underpinned by the establishment of an expert Infant Mortality National Support Team (NST). The NST was set up by the DH to work with a range of agencies and stakeholders to develop local plans and possible measures that would have an impact on child poverty and infant mortality. The content of the plans was important, but the partnership-working and stakeholder engagement process was, perhaps, even more crucial in promoting the shared ownership that is key to successful policy implementation.

Since the review process began, the health inequalities infant mortality gap in England has steadily narrowed and the target has been achieved. This has coincided with the period when the DH stopped developing policy on its own and started working and sharing ideas with stakeholders. That is not the only reason the gap started to narrow, but it offers some support to the idea that working and sharing with others contributes positively to progress.

⁴ Department of Health. *Implementation plan for reducing health inequalities in infant mortality*. London, DH, 2007 (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081337, accessed 13 June 2012).



Short panel presentations

Norway: Free core hours in kindergarten, *Stine Frits Hals, Municipality of Oslo*

In Norway, early childhood education and care (ECEC) is for children under school age (less than six years old). Participation is voluntary. The ECEC sector is regulated by the Kindergarten Act, and children from the age of one year have a legal right to a kindergarten place. Parents are charged a maximum of Nkr 2330 per month (€308). Municipalities provide discounts or free places to families with the lowest incomes.

Since 2006/2007, several Oslo city districts have been part of a project that provides free core hours in kindergarten (four hours per day) for four- and five-year-olds. The districts have high immigrant populations and the project aims to improve integration and social inclusion, particularly for children. It does so by preparing children for starting primary school by improving their Norwegian language competence and social skills. In addition, the project aims to strengthen parental involvement by improving parents' Norwegian language skills and encouraging them to monitor their children's progress at school.

The project involves mainly children from four to five years old as it is difficult for mothers to let their children go to kindergarten earlier than at this age. However, children as young as two years are now coming into the project.

The project in Stovner focuses on:

- recruiting (the city district has a project manager working on recruitment);
- developing and promoting a good learning environment in kindergartens to improve language skills among the children;
- offering training to kindergarten employees to measure and improve the learning environment in kindergarten;
- strengthening collaboration between kindergarten and primary school (the city of Oslo has developed guidelines on this); and
- encouraging parental involvement (Stovner district is taking part in the International Child Development Programme, which aims to promote parental involvement and strengthen the parental role).

The Ministry of Children, Equity and Social Inclusion initiated the project in collaboration with Oslo city authorities and is making annual transfers to it. Some stakeholders, such as primary schools, were not very happy initially that the transfers were made to the kindergartens rather than to them, so have taken a little longer to engage with the project.

Stovner district initially set up an intersectoral working group consisting of the head of the kindergarten unit, a representative from the child health clinic, two representatives from local government and employee representatives. A great effort was made to disseminate information to recruit children to the project through outreach activities (telephone calls,



information by post and posters) and through the child health clinic (parents bring their children to the clinic for free check-ups at ages two and four). Kindergarten administration units in the city districts collaborated with several other bodies such as child health clinics, schools and NGOs to recruit children, but as the project has become better known within the districts, recruitment has increased.

Belgium: Together for health equity from the start in Belgium, Dr. Ingrid Morales, Office de la Naissance et de l'Enfance (ONE)

The child well-being agency of the Flemish part of Belgium realized it was having problems disseminating childcare messages to families facing difficulties with the local language. Authorities consequently worked with a private sector organization to produce a series of flyers and posters that were light on words but rich in images as tools for people working in the field on subjects such as breastfeeding and child development.

The French-speaking part of the country decided to develop similar products using a different approach. ONE worked with partners in the health care field, education, health promotion, communities and users (parents) in developing the products. Parental perspectives and inputs were particularly important, as parents would be the main target audience.

The multisectoral collaboration that underpinned the development of the flyers was very positive. Even though the products can be downloaded for free from the ONE website, ONE is now receiving requests to use the tools from organizations such as the Federal Office of Immigration and from other countries to support production of similar products for their own populations.

The first flyer detailed services offered by ONE to support parents and to promote children's well-being. This flyer was particularly useful for migrant families who did not speak French.

ONE has now produced a DVD governed by the same principle (few words but many images). It is very practical and reflects the reality of parental life in the country in different family situations.

Financial resources are provided by the CERA cooperative but ONE is also using money from its own budget.

Germany: Health equity from the start – opportunities at community level, Dr. Antje Richter-Kornweitz, Association for Health Promotion and Academy for Social Medicine, Lower Saxony

When a new canteen in a Braunschweig school was opened in 2007, it was recognized that many children could not afford the €2.80 cost of the lunch. Consequently, teachers found children wandering around the tables looking for leftovers. The teachers were outraged



and took their concerns to the local media, which prompted action from the city authorities.

The city's investigations found that 25% (10 000) of Braunschweig children and young people under 19 years were living in poverty, with over 50% of those affected residing in one of the five districts of the city. Health data from dental and initial school check-ups showed an accumulation of problems in these areas.

A concerted campaign involving all social services in the city was then set up. Three key priorities were identified:

- every child should be able to eat in school, with subsidies for meals and promotion of healthy nutrition;
- every child should be able to learn, with subsidies provided for school materials; and
- school-based social workers should be in place to support students, parents and the school.

The city had limited funding to support the measures, so funds were also raised from private individuals and foundations.

Systematic cooperation was promoted through the creation of a prevention network overseen by the city. The prevention network is an expert panel formed from associations (such as welfare associations and trade unions) and community initiatives (parent initiatives, advisory foundations, churches and religious communities, job centres, the city parents' council and youth circle). It now has 40 members and an advisory board of 14 individuals. Based on a joint analysis of the situation, the advisory board made general recommendations in consultation with the prevention network. The advisory board has authority to allocate funds to specific measures. Around €1 million from foundations has been spent on measures such as subsidies for school materials, subsidies for school meals and school social workers.

Prevention network activities have included:

- developing a long-term inclusive strategy to deal with poverty that involves all strata of society and the media;
- developing guidelines for the prevention of child and family poverty, including a media strategy; and
- creating recommendations for action focusing on the "prevention chain".

The recommendations for action contain clear statements focusing on specific age groups and have an emphasis on early childhood.

In addition to the specific measures cited above (subsidy for school materials and school meals, provision of social workers), the following actions are currently being implemented:



- day-care facilities are being developed into family centres;
- negotiations with foundations about permanent financing of school-based social workers are being taken forward;
- visits to all newborn babies, informing parents about communal measures and offers for families are being arranged; and
- a welcome letter from the mayor is being given to all newborn babies.

Networking, however, has not been without its obstacles. The competing interests of different institutions and the fear of cutbacks have inhibited cooperation. A plan to set up evaluation bases to identify gaps was found to endanger communication – partners were concerned about the implications for their own institutions and budgets.

It is not normal practice for all these different interests to work together so closely, and this tends to raise concerns. Good, respectful communication within the advisory board is therefore vital.

Through consultation with an external expert, the advisory board managed to overcome concerns and develop concepts and strategies. Gaps were recognized and recommendations produced.

Poland: National Health Programme (NHP) Coordination Team, Rafal Halik, National Institute of Public Health, National Institute of Hygiene

The fundamental objective of the NHP for 2007–2015 is to unify society and public administration with the aim of reducing inequalities in health and improving health and well-being in Poland. The NHP provides the Minister of Health with opportunities to influence activities in other sectors that affect health and is an excellent tool for supporting joint actions in public health.

The NHP is based on:

- involving all sectors in health (“health in all policies”);
- strengthening NGOs and regional governments in activities for tackling public health challenges; and
- focusing on health determinants and vulnerable groups within the population.

The NHP Coordination Team was set up by the Prime Minister after the NHP was adopted by the Council of Ministers in May 2007. The team consists of deputy ministers and representatives from medical organizations, NGOs and institutions responsible for public health. Its main task is to support coordinated cooperation of stakeholders working towards implementation of the NHP.

Four task groups have been set up under the team:



- health of children, youth and older people
- collaboration with the media
- coordination with regional governments
- tackling health inequalities.

The groups work within a framework of coordination, and many opportunities for working together exist. They are not interdependent, but they coordinate well. All the groups have representatives from all ministries.

Hungary: Hungarian network of health visitors (providing preventive and follow-up health care for families with children), *Andrea Odor, National Public Health and Medical Officer Service*

Chief health visitor officers in Hungary have initiated a project to improve cooperation between the health visitor service (HVS) and the children's welfare service (CWS) in the country. Each service works with families to promote child protection (although CWS focuses primarily on disadvantaged families and children) but the structure, culture and methods of HVS and CWS differ. Consequently, role conflicts and misunderstandings have occurred frequently.

These became heightened through an investigation carried out by the chief health visitor officers into the death of a four-year-old child in 1997. Proposals to improve cooperation between the HVS and CWS arose as a result, with tighter regulations for child protection work being developed. These and several other significant initiatives over the years led to a recognition of the need to standardize cooperation between the two services at national level.

The county of Veszprém identified good collaboration practice and worked on developing guidelines on child protection for health visitors. The guidelines identify tasks, responsibilities and areas of cooperation across the two services and:

- standardize collaboration, especially in cases involving social problems;
- establish mechanisms for health visitors to provide early warnings to the CWS to initiate appropriate interventions;
- set an upper limit of 15 days for the CWS to register cases and begin interventions; and
- provide unified data on health visitor work in child protection through annual reports for the CWS.

The guidelines were published in 2010. Since then:

- cooperation between the two services has been improving;
- appropriate social interventions with children and families are being initiated quicker;
- health visitor early warning signals are initiating prompt responses from the CWS; and



- annual health visitor reports (currently around 4000 in number) are providing important data on issues such as the numbers of pregnant women and children with special social needs and the quality of cooperation between the two services, with ideas for improvements.

The initial evaluation of the data collected from the health visitor annual reports to CWS is now taking place at national level, and data at county and subregional level are currently ready for publication.

Moderated panel discussion

Clive Needle, Director of EuroHealthNet, facilitated a panel session with the introductory presenters and brief-presentation speakers and asked the panel the following main questions.

Which sectors were easiest to involve in the stakeholder engagement process on health equity from the start?

Stine Frits Hals: child health clinics and kindergartens have very good cooperation as they share the same goal. There has not been any concrete evaluation of health gain through the project, but an evaluation of inequalities impacts is ongoing. A participant who represented the Ministry of Health in Norway confirmed that focusing on children's education was a priority within the Norwegian strategy to overcome health inequalities.

Ingrid Morales: having a common goal is important and tackling health inequalities among children and young people is a field that has many potential stakeholders in Belgium who share common goals. Being able to demonstrate data on health inequalities supports stakeholder participation.

Rafal Halik: organizations that have a history of working in the area and are closer to the people affected are easier to persuade to collaborate as stakeholders. The higher you go within the hierarchy of organizations, the weaker the collaboration becomes. It seems that if stakeholders can actually see the problems or experience them themselves, they are keener to collaborate. Having a framework or system to support stakeholder engagement is essential to motivate stakeholders to collaborate.

General discussion: it is important that health does not "tell" other departments what to do. In relation to this, the title of WP7 may be misleading. It focuses on engaging other stakeholders to tackle health inequalities, which raises the issue of health imperialism, when perhaps the question that needs to be asked is: how can health become engaged with other sectors as a non-imposing stakeholder?

The power of stakeholder indignation and anger about a situation was evident from the Germany presentation, where teachers reacted very strongly to a public health issue



around children's nutrition and poverty. The teachers were so outraged by the situation that they took their concerns to the media, which was an unusual situation. Once the media had the story, they were relentless in pursuing it. Media involvement was also maintained throughout the project, so the project and the media worked together.

The influence of the media as a stakeholder should not be underestimated: repeated media activity tends to attract the attention of politicians, which is very important.

What strategies helped in engaging stakeholders from different sectors?

Ingrid Morales: media presence and publications are vital. They are particularly helpful in alerting populations and politicians to data that show a problem exists or is emerging.

Rafal Halik: the commercial media in Poland is not so interested in health inequalities or in campaigning about them.

General discussion: most participants are currently working with the media in all its guises (commercial, professional and social) and feel the media are important stakeholders, but very few see the media as active partners (rather than as recipients of a press release). While media representatives can offer a means of targeting other stakeholders, particularly political opinion-formers, actually working with them as stakeholders can be more challenging. Many NGOs say they are too busy dealing with the problems they face to develop a media strategy, and health inequalities are not big media issues in all countries, with some preferring to focus on issues such as immigration.

Public health does not tend to have a good relationship with the media, possibly due to a misguided feeling that carrying out research and presenting the evidence is sufficient. Public health needs to take the time to build relationships, develop its arguments and make its message relevant to specific audiences.

Stakeholder engagement is a slow process that takes time to produce results, and stakeholders should be made aware of this. It is important to horizon-scan now to identify opportunities for stakeholder engagement at future dates, taking into account how stakeholders can be engaged on their terms to help them achieve their objectives – that kind of dialogue is likely to have real positive outcomes for them and for health.

Who holds budgets within stakeholder engagement and how are they managed?

Clive Needle: as the example from Germany shows, budgetary restraints can introduce tensions into relationships. But progress can be made even in the absence of money.

Ingrid Morales: this is already happening in Belgium. Local initiatives supported by local champions can produce wonderful results in the absence of money, but if the idea is to sustain or even spread the change, then budgets must come into consideration.



Clive Needle closed the session by remarking that while the pace of change can seem slow, politicians tend to want quick fixes. A way needs to be found of building in quick success stories over the next few years. There is no guarantee that the EU will continue to fund this type of work in the medium-to-long term, so solid, tangible pieces of work are necessary.



Day 2

Session 5. How does stakeholder engagement practically work?

Helene Reemann provided a brief summary of Day 1.

Methods and steps in stakeholder engagement, *John Griffiths, Director, work2health*

The aim is to identify who the most important stakeholders are, recognize what steps are needed to engage and work with them and understand how to sustain their engagement – often, years of stakeholder engagement are necessary.

Many models set out how stakeholders can be engaged. Whatever method is used, it is important to get to know each stakeholder and understand their interests and priorities. It is also necessary to answer the following prequalifying questions about the potential stakeholders.

- What do the stakeholders know, feel, want, believe and value in relation to the problem or issue?
- What are the threats, risks, costs and benefits for the stakeholders?
- Who are the community opinion leaders for groups within our stakeholder network?
- What are stakeholders' main concerns about the issues?
- What are the differences in stakeholders' concerns about the issues, and what happens if the differences are significant?
- What are the areas of common ground and benefits for various stakeholder groups?
- What roles do we want stakeholders to play, or what types of involvement do we want stakeholders to have in the initiative?

“Working with” stakeholders, rather than “on” them, is necessary to secure “buy-in” from the communities with whom we work.

A simple way to identify potential stakeholders is to write down the names of all interested groups, institutions, individuals, organizations and authorities who: are concerned in any way with the project; are located in the region; hold an influential position; and/or may be affected by the problems addressed in the programme. Other issues that could be considered include the following.

- Who cares if the problem is solved or the issue is addressed?
- Who is being impacted by the problem or issue?
- Who can help solve the problem or address the issue?
- Who brings knowledge or skills about the issue?



- Who will benefit if the problem is solved or the issue is addressed?
- Who would bring a diverse viewpoint to the collaboration?

Key prerequisites for successful outcomes in stakeholder engagement and ensuring sustained stakeholder engagement include the “5 Rs”:

- role clarity – stakeholders know why they are there;
- responsibility and accountability – stakeholders know what they are responsible for and can be held to account (formally or informally) for non-delivery;
- reporting mechanisms – complex programmes require clarity about stakeholder activity;
- realistic expectations – stakeholders need to be clear on what can be achieved within the project or programme; and
- recognition of effort – stakeholders derive satisfaction from having their efforts acknowledged and appreciated.

Creating a sense of collaboration and partnership is also important, with a common agenda defined. Disagreement and conflict need to be addressed and dealt with effectively and equitably, with agreement from all stakeholders at the outset, and clear rules of engagement through which the processes of operation are made clear need to be in place. Transparency, communication, trust and respect in all dealings with stakeholders are essential.

Collaboration and partnership with stakeholders is vital if we are to achieve the full potential of policies and programmes. We need to identify the right stakeholders and work with them in the right way if we are to build and sustain effective policies and programmes. Communication and understanding are at the core of what we do in terms of stakeholder engagement.



Stakeholder engagement workshop: feedback from groups

Participants joined designated groups for the workshop sessions. Four of the seven groups looked at a national stakeholder scenario and the other three at a regional issue. Each group was asked to consider a series of questions and note their responses on a feedback form. The list of questions can be found in Annex 3. What follows below is a summary of the feedback provided by group rapporteurs immediately after the workshops closed.

National scenario

Group 1

Group 1 focused on the process rather than the detail of the scenario. Scoping was seen as critical – appropriate scoping makes clear the stakeholders you want to include and those you want to exclude. The group took as its starting point the need to seek organizations with an interest in early years rather than equity, then defined clearly what was meant by “early years”. That decision will determine the organizations involved: for instance, if “early years” covers from conception to age 3, health may be an important stakeholder, while if the age extends to 6 years, then education becomes more prominent. The group also discussed the need for clarity on roles, responsibilities and accountability and the desirability of an ethical code for stakeholder engagement.

Group 2

The group wanted to convey only one message, which was that stakeholder management is a very complex activity that requires a range of skills, including communication, networking, negotiation, participation and conflict management. The big question is, how can this kind of skill and expertise be mobilized within our sector? The group noted that many stakeholders only engage once or twice: it is a dangerous option to believe they can “learn on the job” – they need support.

Group 3

The main focus of discussions was on building capacity for stakeholder engagement. Mapping of stakeholders is a necessary part of this, with analysis of their strengths, weaknesses and resources. The mapping process enables communication and sharing of knowledge and information with stakeholders, but mapping and analysis cannot be done without clear leadership. Networks of stakeholders should then be defined – what kind of links exist and which other stakeholders could be engaged? The group felt that a clear framework for stakeholder collaboration is necessary to reduce any misunderstandings and to define mechanisms for reacting to conflicts of interest.



Group 7

The group agreed that there was a need for strong political will to involve stakeholders, particularly around the social determinants of health. There is also a need to use language that stakeholders from other sectors understand, with benefits for the other sectors being defined in partnership. Tailored data can be used for this purpose, demonstrating how intersectoral action can work. Benefits should be demonstrable not only to the main target group, but also to potential stakeholders: it should be possible to show potential benefits for all sectors. There is a need not to be too health-centred, but to focus on improving living conditions overall by creating sustainability within intersectoral working. Stakeholder training should be linked to common goals and “win-win” mechanisms should be created to encourage stakeholder engagement.

Regional scenario

Group 4

The group members found the exercise very helpful, but because they came from different countries, they had to spend a lot of time identifying common themes and ideas for the discussion. This, they felt, reflected what would happen if a project tried to assemble stakeholders from different sectors within a country – much time would be needed to identify the common ground. A solid infrastructure was required to support this process, with strong coordination and charismatic leadership – this is necessary to make sure that if there is a difference of opinion, stakeholders do not go to the media but can turn to an internal process of conflict resolution. The group asked how far industrial and “risk-producing” stakeholders should be engaged – the literature suggests risk producers are no-go areas as stakeholders, but examples exist of how such stakeholders can contribute positively to the process.

Group 5

The group agreed that different kinds of information were important to different stakeholders and that you had to put out the right messages to commit stakeholders to your project. Stakeholders in different places and positions can be used to bring other stakeholders into the project. The group felt it was important to think “out of the box” in relation to stakeholders: for example, the fire service was identified as a potential stakeholder within the regional scenario. Stakeholders should not be taken for granted, and should be involved early.

Group 6

Clarity of purpose on what the stakeholder group is about is vital for stakeholder engagement – this has to be the starting point. We need to know what stakeholders are trying to achieve through engagement – is it about gaining buy-in to existing policy or to secure help in developing new policy? Ways of managing stakeholders vary, so there has to be complete clarity about what each stakeholder seeks to achieve from the outset. We



want stakeholder engagement, but we want practical outcomes as a result of that engagement.



Annex 1. Agenda

First EU-wide stakeholder debate of the Equity Action

“Together for Health Equity from the Start”

8-9 May 2012

Danubius Hotel Gellért, Szent Gellért tér 1, H-1111 Budapest

PROGRAMME

Chair: Dr Tamás Koós, National Institute for Health Development (OEFI) and Helene Reemann, Federal Centre for Health Education (BZgA)

Tuesday 8 May 2012

12:00 Arrival and lunch and poster exhibition

Welcome and Opening

13:00 Opening, *Dr Zoltán Vokó, OEFI, and Helene Reemann, BZgA*

13:10 Welcoming address, *Dr Hanna Páva, Ministry of National Resources, Hungary*

The EU-funded Equity Action and Work Package 7 on “Stakeholder Engagement”

13:20 Equity Action – the Joint Action on Health Inequalities, *Mark Gamsu, Health Action Partnership International*

13:30 Work Package 7 of the Equity Action, *Ágnes Taller, OEFI, and Caren Wiegand, BZgA*

Health equity from the start and stakeholder engagement

13:40 Health equity from the start and stakeholder engagement, *Dr Pirooska Östlin, WHO Regional Office for Europe*

14:00 What is stakeholder engagement: concepts and relevance, *John Griffiths, work2health*

14:20 Coffee break and poster exhibition



Panel discussion: Good practices in stakeholder engagement and health equity from the start

Moderator: Clive Needle, EuroHealthNet

14:45 **Introductory speeches to the panel discussion**

(Health) inequalities among children in Europe, *Dr Mária Herczog, Eurochild*

The importance of stakeholder engagement in achieving health equity from the start, *Dr Ray Earwicker, Department of Health, England*

15:10 **Moderated panel discussion**

Free core hours in kindergarden, *Stine Frits Hals, Municipality of Oslo (Norway)*

Together for health equity from the start in Belgium, *Dr Ingrid Morales, Office de la Naissance et de l'Enfance (ONE) (Belgium)*

Health Equity from the Start – opportunities at community level, *Dr Antje Richter-Kornweitz, Association for Health Promotion and Academy for Social Medicine, Lower Saxony (Germany)*

National Health Programme Coordination Team, *Rafal Halik, National Institute of Public Health, National Institute of Hygiene (Poland)*

Hungarian network of health visitors (providing preventive and follow-up health care for families with children), *Andrea Odor, National Public Health and Medical Officer Service (Hungary)*

16:00 Coffee break and poster exhibition

16:30 Moderated panel discussion *continued*

17:45 Summary and conclusions of panel discussion, *Clive Needle, EuroHealthNet*

18:00 End of day 1

20:00 Dinner



Wednesday 9 May 2012

Welcome back

9:15 Recap of the previous day, *Helene Reemann, BZgA*

How does stakeholder engagement practically work?

9:30 Methods and steps in stakeholder engagement, *John Griffiths, work2health*

10:00 Workshop on stakeholder engagement, *John Griffiths, work2health*

10:45 Coffee break

11:15 Workshop *continued*

12:00 Workshop *reporting back*

Wrap up and closing

12:45 Closing: *Dr Tamás Koós, OEFI, and Helene Reemann, BZgA*

13:00 Lunch and poster exhibition



Annex 2. Participants

Last name	first name	Country	Organization
Alleman	Johan	Belgium	King Baudouin Foundation
Ballesteros	Concepción	Spain	Platform of Childhood Organizations
Broviacné Stallenberger	Anita	Hungary	Health Directorate, Local Authority of Szekszárd Town of Country Rank
Brzková	Martina	Czech Republic	Ministry of Health of the Czech Republic
Castellanos Delgado	Jose Luis	Spain	Ministry of Health, Social Services and Equality
Christakos	Nikolaos	Greece	"Nostos" Organization for Social Integration
Costa	Giuseppe	Italy	Italian Interregional Commission for Equity in Health
Csordás	Ágnes	Hungary	Hungarian Association of Health Visitors
Deliens	Cristine	Belgium	Coordination Education and Santé asbl (Cordes)
Diaz Huertas	Jose Antonio	Spain	Spanish Social Paediatric Association
Eknes	Kjersti	Norway	Directorate of Integration and Diversity
Fabisiak	Magdalena	Poland	Ministry of Labour and Social Policy
Galeone	Daniela	Italy	Ministry of Health
Giustetto	Guido	Italy	College of Physicians and Surgeons
Hadházy	Ágnes	Hungary	Halus Spontán Bt
Hals	Stine Fritz	Norway	Kindergarten in Stovner district in the Municipality of Oslo
Morales	Ingrid	Belgium	Office de la Naissance et de l'Enfance (ONE)
Kammenou	Athina	Greece	Society for the Development and Creative Occupation of Children (EADAP)
Kilian	Holger	Germany	Health Berlin-Brandenburg e.V.
Kowalewski	Mariusz	Poland	Association of Polish Counties
Kristiansen	Marita	Norway	Directorate of Integration and Diversity
Larun	Marianne	Norway	Kindergarten in Stovner district in the Municipality of Oslo
Morales-González	José-Manuel	Spain	Ministry of Health, Social Services and Equality
Mudra	Josef	Czech Republic	Office of the Government
Odor	Andrea	Hungary	National Public Health and Medical Officer Service, Office of the Chief Medical Officer



Last name	first name	Country	Organization
Papaprokopiou	Anastasia	Greece	Society for the Development and Creative Occupation of Children (EADAP)
Reilhof	Charlotte	Belgium	Kind en Gezin
Renner	Ilona	Germany	National Centre on Early Prevention, Federal Centre for Health Education
Réthy	Lajos	Hungary	National Institute for Child Health
Richter-Kornweitz	Antje	Germany	Association for Health Promotion and Academy for Social Medicine, Lower Saxony
Stepniak	Katarzyna	Poland	Centre of Education Development
Zdun	Paweł	Poland	Ministry of Regional Development
Campos	Pilar	Spain	Ministry of Health, Social Services and Equality
Koós	Tamás	Hungary	National Institute for Health Development (OEFI)
Fekécs	Éva	Hungary	National Institute for Health Development (OEFI)
Gamsu	Mark	United Kingdom	Health Action Partnership International
Gerits	Pol	Belgium	Federal Public Service Health, Food Chain Safety and Environment
Halik	Rafal	Poland	National Institute of Public Health, National Institute of Hygiene
Lambrechts	Michel	Belgium	Federal Public Service Health, Food Chain Safety and Environment
Lőrík	Eszter	Hungary	National Institute for Health Development (OEFI)
Marra	Michele	Italy	Epidemiological Service, Aslt03, Regione Piemonte
Reemann	Helene	Germany	Federal Centre for Health Education (BZgA)
Santaolaya	María	Spain	Ministry of Health, Social Services and Equality
Stegeman	Ingrid		EuroHealthNet
Strandrud	Janne	Norway	Norwegian Directorate of Health
Taller	Ágnes	Hungary	National Institute for Health Development (OEFI)
Wiegand	Caren	Germany	Federal Centre for Health Education (BZgA)
Weyers	Simone	Germany	Heinrich-Heine-University, Medical Sociology
Pusztai	Zsófia	Hungary	WHO Country Office, Hungary
Gábor	Edina	Hungary	ELTE PPK ESI



Last name	first name	Country	Organization
Poucet	Thierry	Belgium	Freelance journalist
Tonté	Dóra	Hungary	Ministry of National Resources, State Secretariat for Health Care, Department for Public Health
Wykurz	Geoff	United Kingdom	PHAST
Earwicker	Ray	United Kingdom	Department of Health
Herczog	Mária		Eurochild
Östlin	Piroska		WHO Regional Office for Europe
Páva	Hanna	Hungary	Ministry of National Resources
Griffiths	John	United Kingdom	work2health Ltd
Mathieson	Alex	United Kingdom	Freelance
Needle	Clive	United Kingdom	EuroHealthNet



Annex 3. Workshop case studies

Case Study 1 – National Policy Development

You have been asked to contribute to the development of a national policy which has as its goal the reduction of health inequity in childhood.

Politicians recognize that to achieve this goal, agencies from a wide range of sectors will need to be fully involved.

Your role is to develop a guidance document for stakeholder engagement at the national level.

- What issues will this guidance need to address – and why?
- How might the issues identified in the guidance be dealt with in the implementation of the policy?
- What criteria, if any, would be included in the protocol to determine whether or not a potential stakeholder could be considered to be “fit” (appropriate) to be involved?
- Please identify potential stakeholders (by type/nature rather than name!) who could become involved in the development of the policy and/or its implementation.
- What would you say/write to the potential stakeholders to convince them to participate in the policy development?
- What support, if any, would need to be provided to these stakeholders to optimize (get the most out of) their participation?
- What sort of roles would you expect the stakeholders to play?
- Are there any potential stakeholders you would not wish to involve, and why?
- Part way through the implementation of the policy, one of the key stakeholders with whom you are working informs you that it is reluctantly withdrawing from the project as reducing health inequity in childhood is no longer one of its priorities. What advice would you give to key politicians who are very concerned as this stakeholder receives much of its funding from government and no advance warning of this shift in priorities has been given?



Case Study 2 – Regional Policy Development

You have been asked to chair a working group to develop and implement a city-based child health improvement policy. The aim is to develop the policy and then implement it in three pilot municipalities in an area of known socioeconomic deprivation before the policy is rolled out across the country as a whole.

- At the first meeting of the working group, it is suggested that each municipality should establish a stakeholder group and so capture the experience, views and possible additional resources that such stakeholders might bring. What positive reasons (good) and what negative reasons (bad) might there be for the establishment of such a group in the participating municipalities?
- Make a list (by type/nature rather than name!) of potential stakeholders that you believe could make a valuable and positive contribution to the development and implementation of the policy. What support, if any, would need to be provided to these stakeholders to optimize (get the most out of) their participation?
- What roles would these stakeholders play in the development and implementation of the policy?
- What would you say/write to the potential stakeholders to convince them to participate in the policy development and implementation?
- Are there any potential stakeholders you would not wish to involve, and why?
- Part way through the pilot project you are made aware that following an election, one of the stakeholders, a local council that has previously supported the policy and permitted access to schools and day care centres for the very young, has a changed political allegiance. The new council is not supportive of the policy, as its political ideology is that “health” is a matter for individuals alone. What is your response to this developing situation?