J Public Health
DOI 10.1007/s10389-015-0699-y

ORIGINAL ARTICLE

Building capacity to reduce health inequalities through health promotion in Europe

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Received: 4 August 2015 / Accepted: 16 November 2015

Abstract
Aim Whilst considerable attention has been paid to describing and measuring health inequalities, relatively little attention has been paid to ways to effectively reduce health inequalities within and among populations. This article presents a conceptual framework for capacity building to assist stakeholders at the regional level within Europe to maximise the potential of healthy public policies and practices to reduce these inequalities as a core part of strategic action plans to access European Structural Funds.
Subject and methods Within the ACTION-FOR-HEALTH (A4H) project co-funded by the European Commission (EC), a conceptual framework for capacity building to reduce health inequalities was developed and evaluated. The evaluation design adopted mixed methods involving a series of focus groups (n=22), interviews (n=14) and questionnaires (n=34) involving the project partners.
Results We present the A4H conceptual framework, which is based on a series of capacity-building actions comprising three key areas: (1) developing knowledge and skills; (2) building partnerships; (3) creating action plans. The evaluation data show that the project contributed to enhancing capacities in all three of these areas, at the regional, organisational, and individual levels.
Conclusion Focussing mostly on building capacities, the A4H project has the potential to have several sustainable outcomes. Our results underscore the importance of the capacity-building approach for the reduction of health inequalities in Europe.

Keywords Health inequalities · Capacity building · Health promotion · Structural funds

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Introduction

Over the last few decades the average level of health in the EU has continued to improve to the point that citizens now live, on average, longer and healthier lives than previous generations. Yet despite this improvement, the differences in health status between people living in the most advantaged and most disadvantaged sections of the population remain substantial or have in some instances increased (European Commission [EC] 2009). These inequalities in health, both between and within European Member States, are well documented (e.g., Mackenbach et al. 2011). They form a systematically patterned 'gradient' between health and social circumstances across populations with substantive evidence demonstrating that health becomes worse as you move down the socio-economic scale (Graham 2009; Marmot 2010).

The reasons for these health inequalities are complex and involve a wide range of factors that relate to the wider social determinants of health, including living conditions, education, and occupation/income as well as health policies, in particular disease prevention and health promotion services and health care systems (Dahlgren and Whitehead 1991). Health inequalities, which concern differences in health status and health

Published online: 26 November 2015

service use as well as health-related behaviours, persist throughout the life course, starting at birth and continuing into old age. As most of these inequalities are in principle preventable, inequitable and ultimately unfair, reducing health inequalities is regarded as one of the most important public health challenges facing the EU and its Member States (EC 2009). Indeed, reducing health inequalities was a key priority of the EU Health Strategy (2008–2013) and is prominent in other current EU policies.

To implement these policies, designated programmes and financial mechanisms have been put in place, which contribute directly or indirectly to tackling health inequalities. These mechanisms (*inter alia*) include the Cohesion Policy and the Structural Funds; the European Agricultural Fund for Rural Development; the new Health Programme "Together for Health" (2014–2020); the Research Framework programme "Horizon 2020"; the employment and social solidarity programme (PROGRESS); the Sustainable Development Strategy; and the environment and market policies under the Common Agricultural Policy (CAP) (Sherriff et al. 2014).

Health promotion and health inequalities

The Ottawa Charter for Health Promotion (WHO 1986) implies a fundamental shift away from an exclusive focus on individuals to consider the social and wider determinants of health. This also includes addressing 'the causes of the causes'——in this case, the causes of health inequities. Since it is widely acknowledged that most health inequalities are avoidable, it has become generally accepted that health promotion can play a major role in tackling these inequalities. However, what remains less clear is *which* health promotion approaches are most effective to reduce health inequalities (Davies and Sherriff 2011; Sherriff et al. 2014). While it is clear that it is necessary to move away from an exclusive focus on pathogenic (disease-based) approaches, salutogenic health promotion approaches (focussing on factors that support health and well-being rather than on factors that cause disease) that are more effective in addressing health inequalities must be identified and tested out to help identify what works, for whom, and under which circumstances (Davies and Sherriff 2014).

Capacity-building to reduce health inequalities

An important precondition to successfully tackling health inequalities through health promotion is to ensure that the system has sufficient capacity to do so. The concept of 'capacity' was introduced to the field of public health and health promotion in the late 1990s to highlight the requirements for successful and sustainable implementation of health promotion programmes and/or interventions (Aluttis et al. 2014; Hawe et al. 1997). It is closely linked to the notion of *capacity building*, which in a health promotion context can be understood as an approach to the development of sustainable skills, organisational structures, resources and commitment to improvement in health and other sectors to prolong and multiply health gains many times over (Hawe et al. 1997). Capacity building can thus be understood broadly as any action that aims to develop the resources, skills, and requirements needed to implement effective health promotion activities.

Capacity building can be applied at various levels, ranging from the national and/or regional level, through local organisations and communities down to the individual level, and can be pursued with a wide range of different measures and instruments (Gugglberger and Dür 2011). Ideally, capacity building should aim at sustainability in terms of producing fundamental and lasting changes, and it entails an on-going process, which is both multi-dimensional and multi-sectorial, in the sense that changes and interventions happen in different areas and across different sectors (Crisp et al. 2000). Building capacity and competency is essential to enable stakeholders to understand and effectively use health promotion actions to reduce health inequalities and to maintain and promote health.

An important component of capacity building is to develop the health promotion workforce by increasing the knowledge and skills of individual health workers. Although capacity building is a broader construct, which involves a variety of strategies to develop resources and create suitable environments, training and professional development of individual health workers are evidently key components of health promotion capacity building (Aluttis et al. 2014; Potter and Brough 2004). In that regard, there is a growing consensus internationally regarding the core competency domains for health promotion professionals (Davies et al. 2008; Loureiro et al. 2009; Battel-Kirk et al. 2009). Various initiatives funded by the EC, including EUMAHP (Davies et al. 2000), PHETICE (Davies et al. 2008), CEIHPAL (Sherriff et al. 2012), TEP (Davies et al. 2012), and ComPH (Battel-Kirk et al. 2009), have aimed at building a competent health promotion workforce with the necessary knowledge and skills to develop, implement, evaluate, and sustain effective health promotion policies and practices. More recently, the EC co-funded ACTION-FOR-HEALTH project (Krajnc-Nikolić 2014) has also focussed on capacity building in health promotion, with a specific focus on reducing health inequalities. This is achieved through the use of strategic action plans to access EU Structural Funds at the regional level.

Action-for-health

ACTION-FOR-HEALTH (A4H) was a project co-funded by the European Commission, which ran from 2012 to 2014 through the Second Programme of Community Action in the

Field of Health (2008–2013). At the time of its implementation, prior to the launch of the Third Programme for the Union's Action in the Field of Health in March 2014, this Programme was the main financial instrument the EC used to implement the current EU Health Strategy: *Europe 2020-Together for Health*. Set within this European healthy policy, the A4H project builds on the experiences gained from an innovative health promotion project aimed at reducing health inequalities at the regional level carried out by the Institute of Public Health in Murska Sobota (Slovenia) in collaboration with the Flemish Institute for Health Promotion, Belgium (Belović et al. 2005). This project used a strategic planning approach at the regional level to set priorities and select actions to tackle health inequalities through health promotion. A4H aimed to build on this approach in order to facilitate the development and pilot implementation of strategic action plans to tackle health inequalities through health promotion approaches at the regional level in seven European countries, making use of European Structural Funds. The seven European regions were: Donja Dubrava (Croatia), Sellye (Hungary), Rokiškis (Lithuania), Trnava (Slovakia), Rapla (Estonia), and Canary Islands (Spain). Additional partners that did not work on a regional level were from Slovenia, the Netherlands and the UK. Project partners included public health and health promotion professionals, policy makers, and practitioners.

In the remainder of this article, we draw upon primary evaluation data and learning from the A4H project to present a conceptual framework for capacity building to assist project partners within European regions, to maximise the potential of healthy public policies and practices to contribute more effectively to the reduction of health inequalities, as a core part of strategic action plans to access European Structural Funds.

Methods

The A4H project was delivered through six work packages (WPs): WP1 coordination, WP2 dissemination, WP3 evaluation, WP4 situational overview and needs assessment, WP5 capacity building in the field of health inequalities and structural funds, and WP6 transfer of innovative bottom-up approaches to tackling health inequalities. This article draws primarily on data generated from WP3 and WP5.

WP5 (capacity building in the field of health inequalities and structural funds) was responsible for developing all training and learning material. The most important outcomes of this work package were the training event, the summer school, and a distance learning tool, as well as one of the project publications (Authors withheld for peer review). Together with WP3 (evaluation), the framework for capacity building presented in this article was developed.

The WP3 evaluation design for the A4H project consisted primarily of formative and some summative evaluation, focussing on achievements of the project and its immediate outcomes. Formative evaluation aimed to monitor, document, and evaluate the processes of the project; summative evaluation monitored the output and outcomes, such as project milestones and deliverables. A mix of qualitative and quantitative research methods was used including: focus groups; qualitative (telephone) interviews; short questionnaires; monitoring of different indices (e.g., the number of distributed publications, 'hits' on the project website, etc.). General evaluation results concerned partners' satisfaction with the project, the project leader, communication within the project, their perceptions on their project outcomes, and their knowledge gain, as well as monitoring of project output, dissemination, and building of partnerships. These were regularly fed back to the project leader and project consortium in order to include communicative validation and to support the coordination of the project and all project partners by ensuring that objectives, deliverables, and milestones were met efficiently according to the project proposal (Gugglberger and Sherriff 2014).

In this article, we draw particularly on the evaluation data generated through the 'partner reviews' (questionnaires and interviews) and focus groups with project partners to illustrate findings from the capacity-building framework.

Partner reviews

As part of the process evaluation and ongoing monitoring to feed into the project coordination (WP1), a series of 'partner reviews' were conducted with project partners representing each of the ten countries involved in the project consortium. These reviews included a semi-structured questionnaire of mainly open questions sent out by email to the ten project partners at four specific moments during the project. The questionnaire consisted of a general section, which remained the same for all four time sequences, and a more specific part, which was adapted at each time sequence to the particular phase of the project. A total of 34 partner review questionnaires were completed (see Table 1).

Each review period was followed up by telephone/Skype interviews ($n=14$). Of the ten participating project partners, five were interviewed twice, four were interviewed once, and one partner did not want to be interviewed at all. The reasons why some partners did not want to participate were probably primarily language barriers (interviews were only conducted in English) as well as partners' belief that they have provided all information in the short questionnaire.

The purpose of these follow-up interviews was to generate more in-depth information about the partners' responses in the review questionnaires, as well as to explore their views on other aspects of the project identified as important (e.g.,

Table 1 Summary of partner reviews (questionnaires and interviews)

Evaluation phases	Date conducted	Questionnaires returned	Interviews completed
Partner reviews: round 1	December 2012	8	4
Partner reviews: round 2	March/April 2013	9	3
Partner reviews: round 3	September 2013	10	4
Partner reviews: round 4	February 2014	7	3
Total		34	14

opportunities for dissemination activities, institutional capacity building regarding health inequalities, and sustainability issues relating to the longer-term use of strategic action plans at the regional level). For the WP leaders, interviews covered the same areas as for other partners but also included questions on their leadership role in the project, as well as on the progress made towards achieving milestones and deliverables, and the synergy with other WPs activities.

Focus groups

Focus groups were used as an additional method of generating evaluation data, given that the group setting can potentially generate data that might not be accessible through other means (Robinson 1999). In total, four focus groups (n=22) were facilitated at two strategic moments in the project: the first two groups (n=13) immediately followed a consortium capacity-building training event early on in the project; the second two focus groups (n=9) immediately following the final project conference. The former focus groups (March 2013) reflected specifically on partners' knowledge gain as an immediate outcome of two project activities, notably the completion of the situational analyses (WP4) and participation in the training event. The latter focus groups (June 2014) reflected on partners' experiences and gains from participating in the project summer school (September 2013). They also focussed on the process of pilot implementation of strategic action plans to reduce health inequalities, including issues of future sustainability through intersectoral collaboration with regional (and in some cases national) stakeholders. All the focus groups also included more general reflections on broader project activities and outputs/outcomes, such as the quality and usefulness of publications and reports produced by the project, the overall evaluation of the project implementation process (e.g., coordination), partnership development, capacity-building activities (individual, organisational, community, regional, national, international/global), and project milestones and deliverables.

Ethics and data analysis

Ethical approval for WP3 (evaluation) and WP5 (capacity-building) activities was provided by the Faculty of Health and Social Science's Research Ethics and Governance Committee (FREGC) at the University of Brighton prior to any data generation taking place. The interviews and focus groups were recorded with the participants' consent and transcribed verbatim.

All data were analysed consecutively throughout the project, resulting in a number of individual evaluation reports. For the purpose of this article, the analyses were revisited to identify the most important themes relating to capacity building. Thematic analysis was applied to examine the interview and focus group transcripts and open questions from the partner review forms, following the steps outlined by Braun and Clarke (2006). Following familiarisation with the data, codes were developed deductively and inductively: deductively, focussing on the main capacity-building activities (e.g., knowledge and skills, action plans, and regional work), and inductively, identifying further codes within the data. These codes were then collated into potential themes, which were checked in relation to the codes. Building on the conceptual underpinnings of A4H from the work of Belović and colleagues (2005), these themes resulted in the three actions highlighted in the capacity-building model: development of knowledge and skills, building of partnerships, and creation of strategic action plans (see Fig. 1). Capacity building involving those three actions was established on different levels, focussing particularly on the regional, organisational, and individual. All these activities are, in the long term, aimed at accessing Structural Funds.

Results

Action 1: development of knowledge and skills

Action 1 focussed on developing particular knowledge and skills. This was accomplished in two ways: first, through workshops where participants learned about principles and foundations of health promotion, the European dimension of health promotion and public health, the social and wider determinants of health inequalities and the health gradient, and strategies to tackle health inequalities; second, by creating a comprehensive overview of the current situation in each partner region/country (e.g., in terms of health status, health inequalities, public health policy environment, etc.), together

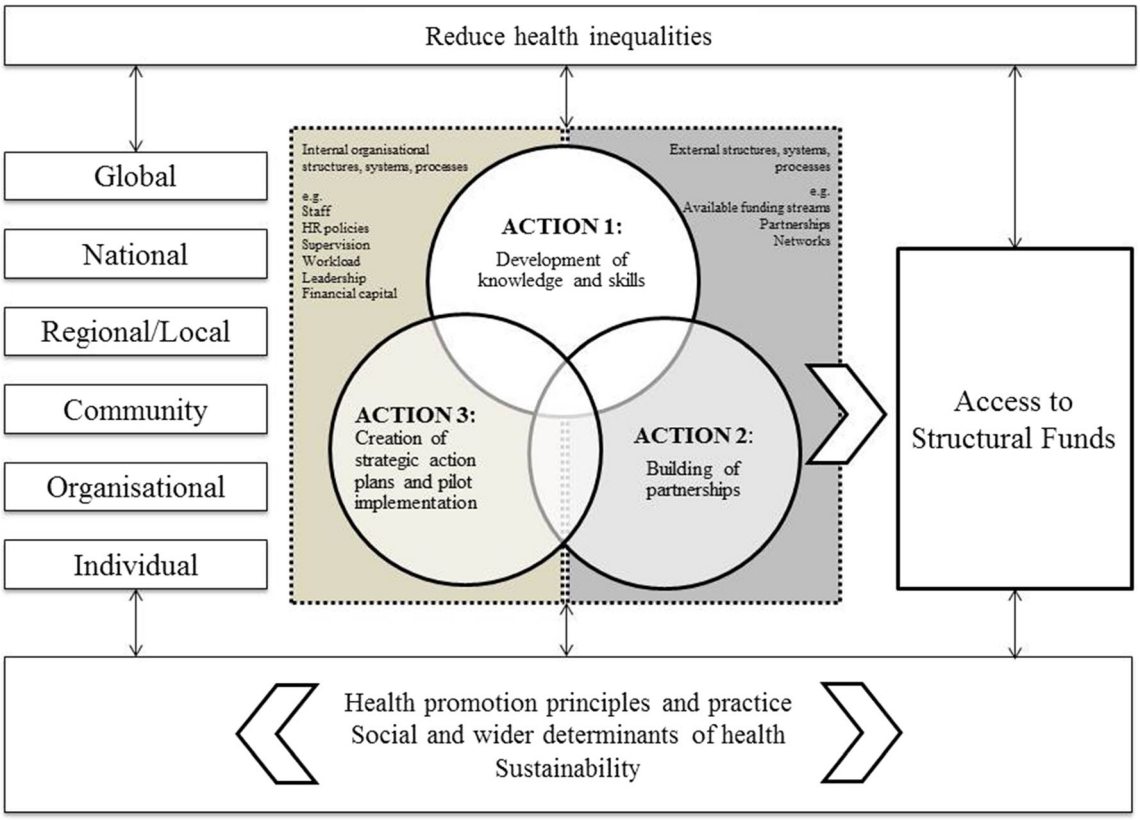

Fig. 1 ACTION-FOR-HEALTH conceptual framework for capacity building to reduce health inequalities

with a comprehensive needs analysis (Vervoordeldonk et al. 2013).

Workshops: the training event and the summer school

At the start of the project, a 1-day training event was held followed by a 2-day summer school 6 months later. These events aimed to increase the knowledge and skills of project partners through a series of lectures, practical workshops, and the creation of opportunities for detailed knowledge exchange (e.g., facilitated networking during breaks including joint activities such as 'health walks'). The formal evaluation of these two events showed that partners appreciated these different types, and combinations, of activities:

> "*[The summer school] was a new experience because there was not just theoretical information but also practical activities, workshops and we could see the other partners' best practice and work*" (Partner review 3).

Partners clearly highlighted the opportunity the events created to learn from each other and often reported how sharing those experiences not only helped them to develop their knowledge, but also to compare and contrast their work with colleagues from other European regions and/or countries.

The contents of the training and summer school events were disseminated widely to project partners and other stakeholders through a dedicated distance learning tool, which incorporated lectures, presentation slides, and further material (Albreht et al. 2014). Furthermore, a series of project publications focussed on the same contents (e.g., Belović et al. 2014; Sherriff et al. 2014).

Situational analysis

A situational analysis, including a needs analysis and identification of promising practices, was conducted in seven countries/regions (Vervoordeldonk et al. 2013). Conducted in the first few months of the project, this activity helped partners obtain an overview of the key issues regarding health inequalities in their own countries/regions, to gain knowledge and insight into what was needed regionally and/or nationally (i.e., needs assessment), and to discover what already exists (e.g., policies on health inequalities, health indicators, specific projects and programmes, etc.). The primary feedback from partners was that they felt the process had been more time-consuming and difficult than they had

anticipated, but that it had nevertheless been very helpful to contextualise their activities regarding the project:

> "*Personally, it was really good to make this situation analysis because I learned a lot in collecting data and summarising all this—so it gives me a good picture about the country and also about the region we have chosen*" (Interview respondent).

Many of the project partners reported that they had not participated in an EU project before, nor had they participated in such data collection prior to their involvement in A4H. Hence, for some, engaging in such activities early on in the project timeline provided a considerable challenge both personally (e.g., concern and worry regarding individual capacities to develop the appropriate new competencies and acquire the relevant new knowledge and skills) and professionally (e.g., existence of organisational capacities to complete the task such as partnerships, workload, leadership, and so on).

Several partners considered engaging in the situational analysis activities as empowering, as it encouraged them to seek out relevant information and make first contact with important (often newly recognised) stakeholders and in doing so directly supported Action 1, Action 2 (building partnerships) and Action 3 (creation of action plans; see Fig. 1). This is also something that partners realised towards the end of the project:

> "*We needed much time for the situation analysis and needs assessment and in that time we didn't realise that we will need all of this data now, when we are developing the action plan. We (realised) that this process has been very important for the development of our action plan*" (Interview respondent).

Overall, evaluation data for the first year of the project indicated that partners felt that their knowledge and skills had improved in line with the project objectives.

Action 2: building partnerships

Partners were encouraged to strengthen existing partnerships and to make contact with new public health professionals, health promotion practitioners, and policy makers in order to create a network of experts with whom they could consult and exchange knowledge and practice. This was an important feature of the project and model as it strengthens the capacity-building approach.

Partnerships within the project

Networking and knowledge and/or practice exchange mainly took place at the four project meetings and workshops, which were attended by between 15 and 28 project partners and their colleagues. However, evaluation data revealed that some partners experienced challenges in terms of communicating with other partners, especially at the beginning of the project. Indeed, a lack of effective communication between project partners was apparent in all partner review feedback reports, where partners stated that they primarily, or only, communicated with the coordinator and work package leaders.

During the partner review interviews, some partners reported that these challenges were partly related to a lack of confidence of participating in a European project for the first time and to a lack of confidence working in English. However, towards the end of the first year, data showed that partners grew more confident that the partnerships they were forming during the project meetings would be sustainable and continue after the project:

> "*I would like to [continue working with project partners] because I have been working with people that otherwise would have been impossible to reach. How it is going to work out in the future, I really don't know, but I think we are quite a nice group. I really hope that at least we can keep some kind of contact*" (Interview respondent).

Partnerships with local stakeholders

The development of partnerships with local stakeholders, including regional government, regional public health organisations, charities, and non-governmental organisations (NGOs), was mentioned as an important benefit of the project. Partners began establishing partnerships during the early situational analysis activities in preparation for the pilot implementation of their regional strategic action plans. During the final focus group discussions, some partners reported that these partnerships would be sustained beyond the life of the project activities and in one case had led directly to the creation of a new association for health education, thus empowering its members to 'own' and respond to their local health priorities:

> "*The spark from the A4H project created a sustainable flame in our local community. Stakeholders who we worked with went on to form an association for health education (an NGO)—they are dedicated and they decided to conduct the activities and apply for grants. So the local ownership of the health priorities is now there and has developed as a direct result of this project*" (Focus group respondent).

Although not always easy to establish, new partnerships and collaborations with local stakeholders were considered as helpful in terms of assisting with data collection to inform the project actions, such as the completion of the situational

analysis (Action 1). Moreover, the development of partnerships was also considered as crucial for developing and piloting strategic action plans to reduce health inequalities through health promotion in the respective regions (Action 3). During one of the focus group discussions, partners reflected on the issue of developing partnerships with local stakeholders, and in one case a partner highlighted the need to have relevant data available (e.g., from a situational analysis) to approach local partners and facilitate their interest and participation in the project:

> *A: Especially when you don't have that data available […]*
> *B: Yes, I think it's important as we said yesterday that we have this data for arguments. And therefore we need it when we go to the local place and then we have to (…?) suggest to work on certain problems.*
> *A: make certain choices*
> *B: yeah* (Focus group participants).

Action 3: creation of action plans

The third core area of capacity building, and the main result of the first year of the project (2012–2013), was the creation of strategic action plans to reduce health inequalities and the piloting of one objective from this action plan in practice (see Fig. 1; see also Belović et al. 2014). An action plan, in this context, is a strategic plan based on the situational analysis and needs assessment of a chosen region, with the general aim to reduce health inequalities. The creation of action plans incorporated several capacity-building measures, as it was necessary to work in close partnerships with multiple stakeholders because of the variety of expertise required. Therefore, the partnerships that were established as part of Action 2 became relevant again:

> "*Developing the action plan, we really formulated the aims on what we heard from them [local stakeholders] and developing the concrete activities we also relied on our ideas and also their own ideas so it's a mix of our proposal and their ideas. Of course, we wrote together with them, so it's a common product with them. And most important, they are very interested in the implementation phase, so there's a very strong focus on what will happen the next year*" (Interview respondent).

Collaborative working with local partners ensured that the action plans were tailored to the specific needs of the respective regions and began the process of developing shared ownership and commitment within the group of stakeholders. Furthermore, the creation of action plans enabled partners to put Action 1 into practice by applying their newly gained knowledge and skills concerning health promotion principles, health inequalities, and the situation and needs in the respective regions. Moreover, the way in which the action plans interlinked with the situational analyses in each country was reported by some partners as being helpful in highlighting the urgent need to address health inequalities and to empower other relevant stakeholders to take action:

> "*All the work is about developing an action plan and I think it's necessary in these regions to do something about health, if you see the situation analyses and the results, it shows the importance to set up an action plan and to inform partners*" (Interview respondent).

While during the early stages of data generation, partners were "*not very hopeful that the information would be used after the project*", in the final stage of the project, when the action plans were piloted in practice, most of the partners expressed their hope to be able to use the action plans in the future, if resources would be available.

Similarly, the question as to whether they were satisfied with their action plan was generally answered positively:

> "*Yes, very. It is realistic; it encompasses health promotion approaches, and is also generic enough to be useful for years to come*" (Partner review 2).

Discussion

Reducing health inequalities requires capacities of public health professionals that comprise the development of knowledge and skills, the building of partnerships, and the creation of action plans. The findings presented in this article give an indication that the A4H project contributed to enhancing capacities in all three areas, at the regional, organisational, and individual levels.

Based on their review of national and regional capacity-building frameworks, Aluttis et al. (2014) identified seven key domains of public health capacity within the 11 publications they analysed: organisational structure, financial resources, partnerships, workforce, knowledge development, leadership and governance, and country-specific context with relevance for public health. All of these domains can be found within the present A4H conceptual framework for capacity building to reduce health inequalities (Fig. 1), yet with different emphases.

First, knowledge development is a central dimension in Action 1. While we agree that capacity building should not be reduced to training and professional development of individual health workers (Aluttis et al. 2014; Potter and Brough

2004), a large part of the capacity-building activities in the A4H project needed to centre on this aspect, as this development was crucial at the beginning of the project.

Second, the domain of partnership is prominently represented within Action 2 as it played an important role throughout the project. Indeed, building partnerships and networks are inherent concepts for building (public health and health promotion) capacities, since partnerships have the potential to create something new and valuable by merging perspectives, knowledge and skills and creating synergies (Weiss et al. 2002).

The A4H framework places less emphasis on organisational structure, financial recourses, workforce, and leadership and governance, which can all be seen as part of the internal organisational structures box (see Fig. 1, left box). However, it can be argued that the project had an influence on all of these capacity domains, despite the lack of means within the project to fully exploit them.

Finally, although the country-specific context is less prominently represented in the external structures box (see Fig. 1, right box), the regional and national structures played an important role in the delivery of Actions 1, 2 and 3: Knowledge and skills (action 1) were built by creating a comprehensive overview of the key issues regarding health inequalities in the country or region concerned, local partnerships (action 2) were built, and action plans (action 3) were tailored to the specific needs of the region.

The A4H framework additionally incorporates an eighth, project-specific dimension of creating and piloting strategic action plans to reduce health inequalities (Action 3). This dimension was one of the central outcomes of the project and an emanation of a stronger capacity in itself. Indeed, the creation of these action plans is a key element of both the A4H project and framework as it builds on all previous capacity-building measures and was framed as a first step towards applying for Structural Funds.

To discuss the A4H project, we would also like to highlight the issue of sustainability, which is often problematic in European projects, for which funding is only available for a specific time. By focussing mostly on building capacities, the A4H project has the potential to generate sustainable outcomes (Hawe et al. 1997). Moreover, A4H aimed at building the capacity of public health professionals to access Structural Funds, which would help them to access the means to (further) implement the action plans in their regions. Although some partners have already indicated readiness to apply for Structural Funds, it would go beyond the scope of our data to say whether the project has succeeded in reaching this aim in the long run. However, in the medium term, we found that the project has already created some potentially sustainable outcomes, such as partnerships with local stakeholders as well as with project partners (including the possibility for follow-up projects), the implementation of the action plans within the regions, and the knowledge and skills that have been developed through the project. As the capacity-building actions displayed in the A4H framework were crucial for these outcomes, our results point towards the importance of the capacity-building approach for the reduction of health inequalities in Europe.

It should be acknowledged that the project and A4H capacity-building approach have some limitations, connected mostly to the project's very tight time schedule of only 2 years and also the restricted budget for WP3. First, the A4H framework has not been validated empirically. Instead, it was developed on the basis of theoretical and empirical work tailored towards the A4H approach. Data were generated only from ten project partners, which leads to limited generalisability and representativity of the results. However, it would be interesting to explore whether and how the model could also work in other projects and other contexts. A second limitation lies in the fact that resources were not available to include local stakeholders in the evaluation. However, the views of some local stakeholders were captured, to a limited extent, through the partners' evaluations of pilot testing of their strategic action plans, which have also been a part of the project. Finally, long-term effects could not be evaluated within the short time frame of the project.

Acknowledgments The research leading to these results was carried out within the framework of the ACTION-FOR-HEALTH project (www.action-for-health.eu) coordinated by the Institute of Public Health in Murska Sobota, Slovenia funding from the European Commission's Public Health Programme under grant agreement no. 20111205. The authors would like to thank Tatjana Krajnc-Nikolic, coordinator of the project, and the other members of the A4H Consortium: Monika Kuzma, Mihaela Törnar, Jing Wu, Laura Narkauskaite, Rasa Varvuoliene, Ágnes Taller, Tamás Koós, Plamen Dimitrov, Renata Kutnjak Kiš, Diana Uvodid-Đurid, Sara Darias-Curvo, Janine Vervoordeldonk, Eva Nemčovská, and Mària Kvaková.

Compliance with ethical standards

Ethical approval Ethical approval for WP3 and WP5 activities was received (details of approval removed for peer review).

Conflict of interest The authors declare that they have no conflict of interest.

Funding This work was supported by co-funding from the European Commission's Second Programme of Community Action in the Field of Health 2008–2013 under grant agreement no. 20111205 awarded to the Institute of Public Health Murska Sobota.

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