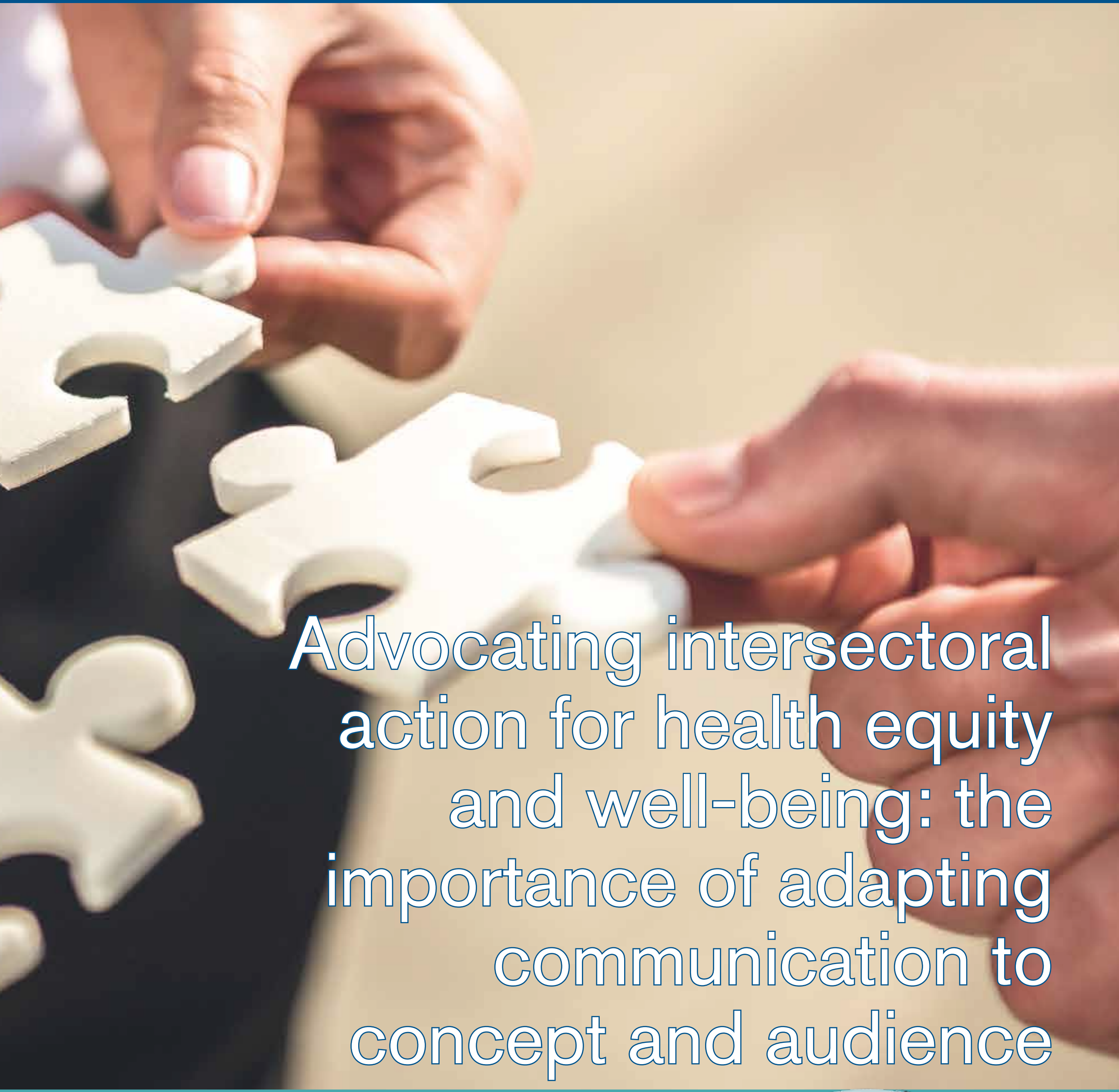
REGIONS FOR HEALTH NETWORK

CENTER ZA ZDRAVJE IN RAZVOJ
CENTRE FOR HEALTH AND DEVELOPMENT
MURSKA SOBOTA

World Health Organization
REGIONAL OFFICE FOR Europe



Advocating intersectoral action for health equity and well-being: the importance of adapting communication to concept and audience

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Abstract

Factors that go beyond the responsibility of the health sector play a role in determining people's health and causing inequities. To improve health and well-being and tackle inequities effectively, more stakeholders and non-health sectors of government need to be involved in the response. Communicating health information requires different approaches and strategies, according to both context and target audience. This is particularly important in advocating, and translating data for, intersectoral action for equity and well-being.

On 6–7 July 2016, the WHO European Office for Investment for Health and Development, Venice, Italy, of the WHO Regional Office for Europe, within the framework of the WHO Regions for Health Network, hosted a summer school in Ljubljana, Slovenia, to facilitate an exchange of experience in the translation and communication of health information and data for different target audiences. The Centre for Health and Development Murska Sobota, Ljubljana, Slovenia, organized the event.

Keywords:

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Foreword

Communicating health information to different audiences, from policy-makers to the wider community, vulnerable subgroups and other actors within the health system, requires different approaches and strategies. At the same time, long-term policy success is dependent on evidence-informed policy-making. Therefore, the Ministry of Health is supportive of capacity-building activity in this area, and welcomed the proposal of the WHO Regional Office for Europe to host the summer school on the importance of communication: advocacy and translation of evidence for different audiences on intersectoral action for health equity and well-being in Ljubljana on 6–7 July 2016.

Health equity and the well-being of the Slovenian population is the goal of the National Health Plan 2016–2025 that prioritizes health-in-all-policies and whole-of-society approaches and sets addressing health inequities, strengthening public health, and promoting health over the life cycle as important targets. The Plan builds on Health 2020 and the Sustainable Development Goals, and feeds into the National Development Strategy until 2030.

I was very glad to see the summer school linked to the 30th anniversary of the Ottawa Charter for Health Promotion, the principles of which are as relevant today as they were in 1986. The Ministry of Health encourages linking the different agendas, activities and events aimed at improving the health and well-being of the population to facilitate the cross-fertilization of ideas, knowledge and experiences, as well as recognition of the benefits of a population-health approach. These benefits span much further than improved population health and include a sustainable and integrated health system, increased national growth and productivity, and strengthened social cohesion and citizen engagement, all of which this report highlights.

Milojka Kolar Celarc
Minister of Health of Slovenia

Foreword

Now, more than ever, health is a political choice. In today's world, there are a number of priority issues relating to population ageing, migration and vulnerable communities that go beyond the health sector and it is crucial that we find new, effective ways of involving different government sectors and civil society in tackling them. It is equally crucial that we focus on accelerating the translation of research, discovery and evidence into sustainable health solutions.

At the WHO Regional Office for Europe, we are very aware of the importance of transforming evidence into meaningful information for different audiences, whether they are politicians, practitioners, or the public. Therefore, the WHO European Office for Investment for Health and Development, Venice, Italy, of the WHO Regional Office for Europe, hosted a summer school in Ljubljana, Slovenia, on 6–7 July 2016, organized by the Centre for Health and Development Murska Sobota, to facilitate an exchange of experiences in the communication of health information and data for different target audiences.

This publication offers a detailed report of the contents and topics covered during the 2-day meeting, providing a uniquely interesting perspective on the specific role of intersectoral solutions in improving public health and developing better conditions for population health. There were many opportunities during the event to remind the participants that the receptivity of the key stakeholders to evidence and data provided forms the basis of transformative change at all levels: international, national and regional. How we communicate public-health messages plays a pivotal role in the progress we make in implementing our guiding policies, Health 2020 and the United Nations 2030 Agenda, and in reaching the Sustainable Development Goals of the latter. In dealing with health risk, disease prevention or health promotion alike, communications thereon can act as game changers on the one hand, and as formative elements for the public on the other.

Initiatives like the summer school held in Ljubljana are praiseworthy as pioneers of actual learning and knowledge sharing. They enhance the commitment we all share in generating quality resources about health, intersectoral action and the valuable translation of evidence into effective, sustainable solutions.

I am confident you will find this publication most thought provoking and am hopeful that other regions and institutions will consider coordinating similar workshops and events in the future. It is important to keep the momentum of the discussion on how to make our evidence-based work more meaningful to all sectors of civil society.

Zsuzsanna Jakab
WHO Regional Director for Europe

Acknowledgments

The outcome of the WHO summer school on the advocacy and translation of evidence for different audiences on intersectoral action for health equity and well-being, held in Ljubljana, Slovenia, on 6–7 July 2016, formed the basis of this report. The WHO European Office for Investment for Health and Development, Venice, Italy, of the WHO Regional Office for Europe, hosted the event within the framework of the WHO Regions for Health Network (RHN). The Centre for Health and Development Murska Sobota, Slovenia, WHO Collaborating Centre for Cross-sectoral Approaches to Health and Development, was responsible for its organization. This report builds on the presentations made and discussions held during the event.

The following people contributed to the preparation and revision of the report: Peter Beznec, Director, Centre for Health and Development Murska Sobota, Slovenia; Luca Carra, Consultant, Christoph Hamelmann, Head of Office, and Francesco Zambon, Technical Officer, WHO European Office for Investment for Health and Development; Tanja Kuchenmüller, Technical Officer, Evidence and Intelligence for Policy-making, Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe; and Cory Neudorf, Chief Medical Health Officer, Saskatoon Health Region and Professor, University of Sasktchewan, Canada.

The presentations detailed in the report were made by: Mojca Gabrijelčič Blenkuš, Helena Koprivnikar, and Mircha Poldrugovac, National Institute of Public Health, Ljubljana, Slovenia; John Howie, NHS Health Scotland, Glasgow, United Kingdom; Pania Karnaki, Prolepsis Institute, Athens, Greece; Karin Proper, National Institute of Public Health and the Environment, Bilthoven, The Netherlands; and Marcela Țîrdea, Ministry of Health, Chisinau, Republic of Moldova.

The lead author was Adam Tiliouine, Consultant, WHO European Office for Investment for Health and Development, with substantial input from Peter Beznec, Director, Centre for Health and Development Murska Sobota, Slovenia, who designed and organized the summer school under the supervision of Francesco Zambon, Technical Officer, WHO European Office for Investment for Health and Development.

Executive summary

Effective intersectoral action for health equity and well-being is crucial in addressing today's biggest public-health challenges. Determinants that span a number of domains – politics, culture, society, economy, environment, health systems and commerce – affect health and well-being. Thus, a successful policy response necessitates an approach that is both intersectoral and multidimensional.

In this context, the Pomurje Region of Slovenia, a member of the WHO Regions for Health Network (RHN) *(1)*, hosted a summer school entitled "Advocacy and the translation of evidence for different audiences on intersectoral action for health equity and well-being" in Ljubljana, Slovenia, on 6–7 July 2016. The Centre for Health and Development Murska Sobota *(2)*, Slovenia, WHO Collaborating Centre for Cross-sectoral Approaches to Health and Development, organized the event, which brought together senior civil servants and public-health experts from across the WHO European Region.

The summer school also marked the 30th anniversary of *The Ottawa Charter for Health Promotion*, which was adopted at the First International Conference on Health Promotion held in Ottawa, Canada, in 1986 *(3)*. It focused on the development and evolution of approaches necessary to achieve successful intersectoral action for health and well-being in the contemporary context, highlighting how the values and principles of health promotion outlined in the Ottawa Charter *(3)* are as pertinent today as they were thirty years ago, although the operational context has changed.

The different sections of the report draw on presentations at the summer school (listed in Annex 1), and other relevant material to give the reader an insight into experience gained across the European Region and beyond, as well as lessons learnt, in engaging with different audiences on intersectoral action for health and well-being. These presentations addressed translating evidence into policy effectively; the role of evidence in policy-making, including examples from WHO Member States; the communication of health data and information to different audiences, with a focus on data profiling and social-marketing campaigns; and the communication of health risks to different audiences.

The WHO European Member States are doing a lot already through their commitment to implementing *Health 2020: the European strategy and policy framework for health and well-being* *(4)*, and meeting the goals of the United Nations 2030 Agenda for Sustainable Development *(5)*, as well as their participation in networks, such as RHN *(1)* and EVIPNet Europe *(6)*. All of this will provide a solid foundation for future action to improve health and well-being throughout the Region.

The 2030 Agenda and its 17 Sustainable Development Goals *(5)* are fully aligned with Health 2020 *(4)*, providing the health sector with a unique opportunity to engage with other sectors and stakeholders in building on Health 2020 *(4)* and other existing regional and national commitments to health and well-being.

Effective solutions, however, require evidence-informed decisions. It is, therefore, crucial to ensure that policy-makers are equipped with robust evidence to allow them to make well-informed decisions on how to tackle issues of health equity and well-being, and increase the likelihood of success.

A population approach, that is, focusing on improving the health of a population or subpopulation, as opposed to targeting the individual, not only has a wider-reaching impact but also greater benefits, such as a sustainable and integrated health system, increased national growth and productivity, and stronger social cohesion and citizen engagement.

To obtain a comprehensive picture of a population's health, data from other sectors are also necessary. Reporting on health status is like trying to solve a jigsaw puzzle; many elements are involved, such as data on morbidity, mortality and healthy life expectancy.

Context specificity is crucial to the communication and presentation of data. Factors that play a key role in policy decision-making are, among others: evidence; experience and expertise; political context; public opinion; values and judgements; culture and traditions; available resources (human and physical); budgetary constraints; policy narratives; and non-health stakeholders (for example, pressure groups, lobbyists, industry, and civil society).

In the same way, the characteristics of the target audience (for example, age, gender, ideology, and role) and whether it is in the public or private sector or is a political party/affiliation, must be taken into consideration in deciding the communication approach and data to be used. The message conveyed should be appropriate to both the context and the audience.

The severity of risk perception depends on the target audience. Risk perception comprises two key elements: hazard and outrage. The level of outrage drives perception, not the hazard. Usually, even significant hazards are tolerated when outrage is low, and, conversely, insignificant hazards are usually rejected when outrage is high.

New and emerging forms of communication, such as social media, have made it easier to access different audiences, such as vulnerable groups. Using innovative data visuals and infographics can have a stronger impact than simply presenting statistics.

Introduction

Health 2020: a European policy framework and strategy for the 21st *century (4)* and the United Nations 2030 Agenda for Sustainable Development *(5)* in September 2015 provide a policy platform for the implementation of intersectoral action to tackle health inequity, which is widening across the WHO European Region. Such action, however, requires clear communication among the different sectors, stakeholders and partners involved in the process, and this - in turn - requires strong skills in advocacy and the translation of evidence for the different audiences.

After introducing the current policy context, this publication will focus on three main areas: translating evidence for policy decision-making; communicating health information and data (data-profiling and social-marketing campaigns supporting health-equity and poverty-reduction strategies); and health and risk communication. It is based on presentations made at the WHO RHN summer school, “Advocacy and the translation of evidence for different audiences on intersectoral action for health equity and well-being”, which took place in Ljubljana, Slovenia, on 6–7 July 2016 (Annex 1), and other relevant material.

Current policy context

INTERSECTORAL ACTION FOR HEALTH EQUITY AND WELL-BEING

Promoting intersectoral action for health has long been one of WHO's strategic objectives, as manifested in:

- the *Declaration of Alma-Ata* (1978) *(7)*;
- the health-for-all movement, which started in the 1980s;
- *The Ottawa Charter of Health Promotion* (1986), which pointed to the necessity of working with other sectors to promote health *(3)*; and
- *Health 21: the health-for-all policy framework for the European Region* (1998), which highlighted both equity and intersectoral action *(8)*.

In 2003, the adoption of the *WHO Framework Convention on Tobacco Control* (WHO FCTC), the first international treaty negotiated under the auspices of WHO, reiterated the importance of intersectoral collaboration and action *(9)*. The final report of the WHO Commission on Social Determinants of Health (CSDH), published in 2008, included recommendations that reach beyond the health sector, suggesting that reducing health inequities necessitated "improving daily living conditions" and "tackling the inequitable distribution of power, money and resources" *(10)*. In 2011, intersectoral action was a factor in WHO recommendations on implementing sustainable policies to promote health *(11)*, and, in the same year, the Rio Political Declaration *(12)* called for action to tackle social determinants of health (SDH), involving all sectors of society.

Another approach recommended in implementing intersectoral action for health is the health-in-all-policies (HiAP) approach, which originated under the Finnish Presidency of the Council of the European Union in 2006 *(13)*. This was reinforced through *The Helsinki Statement on Health in All Policies* made at the 8th Global Conference on Health Promotion in Helsinki, Finland, in 2013 *(14)*. In 2014, World Health Assembly resolution WHA67.11 on contributing to social and economic development: sustainable action across sectors to improve health and health equity, adopted by the 67th World Health Assembly, reiterated the need to strengthen intersectoral action across the globe *(15)*.

Most pertinent for the European Region, however, was the adoption in 2012 of *Health 2020: a European policy framework and strategy for the 21st century (4)*, which included governance for health and improved health equity as twin strategic objectives, and marked an invigorated approach to further strengthening intersectoral action in the Region. Subsequently, the WHO Regional Committee for Europe, at its 65th session in 2015, reaffirmed the key role of intersectoral action in the implementation of Health 2020 *(4)* through the adoption of Decision EU/RC65(1) on promoting intersectoral action for health and well-being in the WHO European Region *(16)*). This decision provided WHO with the current mandate to pursue intersectoral action as a means of addressing the complex public health and equity challenges that the European Region is facing today. From a RHN *(1)* perspective, the *Göteborg Manifesto* (2012) *(17)* highlights the commitment of the members of the Network to implementing Health 2020 *(4)*, and emphasizes the role of the subnational level in translating it into practice.

HEALTH 2020 AND THE 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT

As mentioned above, the 53 Member States in the WHO European Region endorsed Health 2020 *(4)* in 2012, health inequity at both the national and subnational levels having been one of the main drivers in its development *(14)*. It has two strategic goals: to improve health for all and reduce the health divide; and to improve leadership and participatory governance for health. These are supported operationally by four common policy priorities:

1. investing in health through a life-course approach and empowering people;
2. tackling the European Region's major health challenges of noncommunicable and communicable diseases;
3. strengthening people-centred health systems, public-health capacity and emergency preparedness, surveillance and response; and
4. creating resilient communities and supportive environments for health and well-being *(4)*.

Intersectoral action is crucial not only to the success of Health 2020 *(4)*, but also in affording the health sector the possibility of contributing maximally to sustainable development, including economic development *(18)*. It is, therefore, a vital element of the 2030 Agenda and its Sustainable Development Goals (SDGs), not simply as a goal in itself (SDG3), but also as a contributor to, and beneficiary of, action to achieve the other SDGs *(5)*.

The 2030 Agenda has 17 SDGs that apply to every United Nations Member State. Progress towards achieving them will be monitored through 169 targets, of which 9 are linked to SDG3: "ensure healthy lives and promote well-being for all at all ages". The SDGs are fully in line with Health 2020, providing the European Region with a unique opportunity to build on its policy framework for, and other regional and national commitments to, improving health and well-being, by strengthening intersectoral action and building new transformative partnerships *(4,5)*.

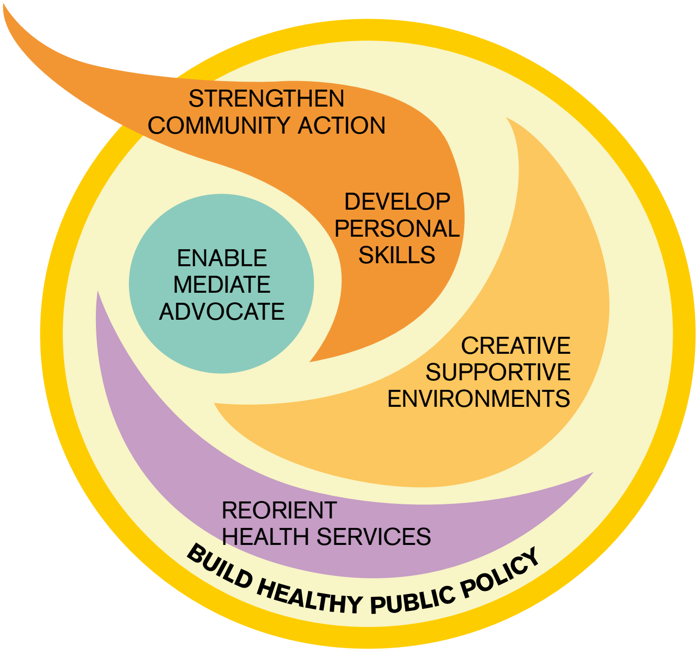
As the operationalization and implementation of the 2030 Agenda *(5)* progress, the scaling up of intersectoral work will lead to new partnership models, and the greater involvement of a diverse range of actors will contribute to achieving global, regional and national goals and targets in addressing today's complex global challenges.

THE OTTAWA CHARTER FOR HEALTH PROMOTION

Signed at the First International Conference on Health Promotion in Ottawa, Canada, in 1986, the Ottawa Charter defines health promotion as it is understood today, underpinning the values and practice of promoting health, and influencing action to this end *(3)*.

The Charter identifies three basic strategies for health promotion: to advocate to decision-makers; to enable people by empowering them; and to mediate through collaboration among sectors and organizations (Fig. 1). It has significantly enhanced the notion that values, such as equity, social justice and women's rights, drive health promotion, distinguishing public-health approaches from the more traditional technical and biomedical approaches. This has rendered the health sector more accessible as a partner in intersectoral action and better placed to tackle the multitude of issues affecting health and well-being (Fig. 1) *(3)*.

Fig. 1. The Ottawa Charter for Health Promotion



Source: The Ottawa Charter for Health Promotion *(3)*.

The summer school in Ljubljana was a celebration of the thirtieth anniversary of the Ottawa Charter *(3)*. Although the development and evolution of approaches needed to achieve successful intersectoral action for health and well-being in the future were the focus of the event, the values and principles of health promotion outlined in the Charter *(3)* thirty years ago were highlighted as being as pertinent today as they were then. However, their operational context of has changed to encompass a more globalized world, involving new social, political and cultural dynamics, digital health technology, big data and the ethical questions accompanying them, a divide in digital literacy, more types of media and new means of communication, such as social media, and greater access to information. In addition, the participation of new actors and stakeholders in public health has increased and the private sector is now one of the major driving forces behind environmental, economic and social change at the global level (which are all areas related to SDH), and is constantly expanding its venture into traditional health promotion.

In translating policy commitments and intentions into action, context is key.

To ensure effective implementation, it is necessary to be aware of the resource structures and power relationships within the environment, and to adapt to the context they create.

New and different contexts, stakeholders and audiences require new and different methods of translating and communicating data and information relating to health and risk. However, just as methods of successfully communicating about and advocating intersectoral action for health must vary according to the target audience, the type of data used should also differ. Thus, the health sector needs to take new approaches to data and information sharing, for example, by collecting various types of data, effectively reporting and following up on them, reviewing activities in the light of the information gained from them, and using them in combination with data from other sectors.

Through their commitment to implementing Health 2020 *(4)* and meeting the SDGs *(5)*, as well as their participation in networks, such as RHN *(1)* and EVIPNet Europe *(6)*, the WHO European Member States – in the true spirit of the Ottawa Charter *(3)* – are currently working towards improving health and well-being throughout the European Region. Countries throughout the Region have implemented, or are implementing, health-promotion strategies, policies, programmes and initiatives involving health equity at all levels of government. Examples of such activities in Greece, the Netherlands, Slovenia and the United Kingdom follow.

Greece. Program on Food Aid and Promotion of Healthy Nutrition (DIATROFI)

DIATROFI *(19)* has been running since April 2012 under the auspices of the Ministry of Education, Research and Religious Affairs of Greece. It provides daily meals, free of charge, to pupils in primary and secondary schools throughout the country, selected according to certain socioeconomic criteria in line with the fundamental principles of the Ottawa Charter *(3)*. The Program provided over 11 million meals between April 2012 and July 2016.

Through its education element, the Program organizes events in the participating schools, such as lectures on healthy nutrition and demonstrations of healthy cooking, and develops educational and informative material for students and the local community.

Intersectorality

DIATROFI targets schools that are most in need, basing selection on average net-taxable-income data by postal code, provided by the Ministry of Finance, and regional unemployment rates. The education sector is a partner in implementing the Program, in particular the informative events organized in the schools. It also supplies: data and reports submitted by school principals on estimated numbers of students facing food insecurity; information from school records on, for example, percentages of students from single-parent or Roma families; and other health data collected by schools, such as those on fainting episodes.

The local community is also engaged for example, through personal interviews with teachers, parents and other personnel to assess the level of food insecurity among schoolchildren, and by encouraging the public to participate in the school events organized by the Program *(19)*.

Impact

Through its commitment to the health-promotion principles outlined in the Ottawa Charter *(3)*, and its intersectoral approach from the development phase to implementation, the Program has achieved notable success. Since its start in April 2012, 887 fewer students have experienced hunger, and the food-insecurity scores for the participating schools and students have dropped by 10% and 20%, respectively.

Greece. E capacity8: strengthening the capacities of occupational health professionals to improve the health of the ageing workforce

The E capacity8 Programme (which started in 2013) is co-funded by the Institute of Preventive Medicine, Environmental and Occupational Health (Prolepsis) Institute, Athens, Greece, and the Health Programme of the European Union (EU). With 14 partners in 13 countries, the aim of E capacity8 Programme is “to strengthen the capacities of European occupational health professionals (OHPs) so that they can facilitate the process of workers’ ageing”.

The Programme has four specific objectives, namely to: (i) analyse and review European OHP training curricula; (ii) continuously identify and enroll the largest possible number of stakeholders throughout the duration of the Programme; (iii) develop training material for use through a learning platform; and (iv) launch a functional e-version of the platform and enroll active users.

The Programme has found that:

- in the majority of the EU Member States, training programmes in occupational safety and health (OHS) do not address the ageing workforce;
- OHS skills related to healthy ageing are acquired basically through experience;
- OHS professionals are willing to tackle the specific needs of an ageing workforce if they are provided with the relevant tools.

To address these issues, the Programme created the relevant training materials and delivered them through an e-learning platform, which was the most cost-effective and flexible way of reaching OHPs with busy schedules.

The Programme has experienced success and is still running *(20)*.

The Netherlands. "Gezond in ...": an example of good practice in reducing health inequities

The Centre for Healthy Living (CGL) falls under the National Institute for Public Health and the Environment (RIVM), Bilthoven. The aim of the Centre is to contribute to the health of the population by supporting health-promotion professionals, primarily through information. It has an innovative communication strategy, which includes: a website with infographics and online communication; daily tweets on best practice (#ErkendGezond); online manuals targeting different settings (including healthy schools and healthy neighbourhoods/municipalities), which list best practice (recommended interventions); and an e-magazine destined for all municipalities.

One of the recognized interventions registered in CGL's database for health promotion is the programme called "Gezond in …" ("Healthy in …"), which was designed to help municipalities strengthen their approach to addressing health inequities. Funded by the Ministry of Health, the programme offers targeted assistance to 164 municipalities based on social-status scores (education, income, and distance to labour market) *(21)*.

The programme also assists local authorities in the development and implementation of their targeted approaches, thereby maintaining the municipalities' engagement in and ownership of the programme. It has five tracks to addressing health inequities: (i) lifestyle and health literacy; (ii) social environment; (iii) physical environment; (iv) prevention and health care; and (v) participation *(21)*.

The overall success of the programme is defined by 8 pillars of success: involvement of (political) authorities; involvement of citizens as key players; recognition that differentiation is essential; monitoring of process and results; use of a process-targeted approach; involvement of public and private partners; use of social marketing at all levels; and establishment of synergy circuits *(21)*.

Slovenia. Active and healthy ageing in Slovenia – AHA.SI

The project, Active healthy ageing in Slovenia – AHA.SI *(22)*, which ran from 1 March 2014 to 28 February 2016, was co-ordinated by the National Institute of Public Health of Slovenia. The European Commission General Directorate for Employment, Social Affairs and Equal Opportunities and (jointly) the Ministry of Labour, Family, Social Affairs and Equal Opportunities and the Ministry of Health of Slovenia provided funding. The project was linked to the European Commission's country-specific recommendations for Slovenia for 2013–2016, and to ongoing national reforms relating to health, long-term care, pensions and the employment market (with a focus on older workers), which ensured its topicality and political relevance.

The project had four aims, namely to:

1. interconnect stakeholders in the field of active and healthy ageing in Slovenia;
2. increase public awareness of the importance of demographic change and the need to prepare and adopt intervention measures;

3. prepare proposals of intervention measures for inclusion in an ageing strategy for Slovenia (including timeframe, responsibility for implementation and indicators); and
4. contribute to reducing inequity among the elderly.

The project had an innovative approach to engaging with stakeholders. After a comprehensive mapping exercise of existing relationships with all possible stakeholders, the project organized dynamic stakeholder consultations, including over 60 meetings with individual stakeholders. It used future scenarios to maintain stakeholders' interest and build relationships and developed a sustainability plan to ensure stakeholder participation in the future and lasting project impact.

The project held workshops to build multidisciplinary capacity among project partners, with a view to collaborating on future projects, building relationships and ensuring sustainability.

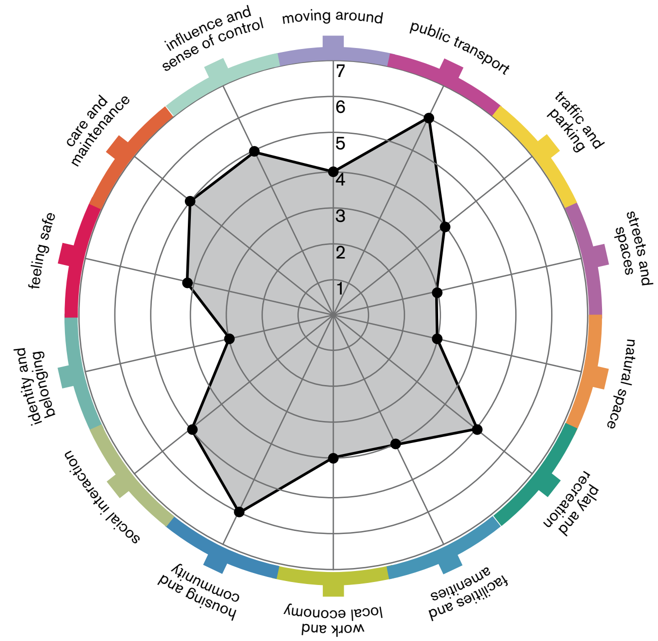
Due to its overall success, the project has been transferred to the nine regional units of the National Institute of Public Health (three in 2015 and six in 2016). The Ministry of Health finances project activities through its annual regular funding programme.

United Kingdom (Scotland). The Place Standard tool

The Cabinet for Social Justice, Communities and Pensioners Rights of Scotland launched the Place Standard tool *(23)* in December 2015. Developed in the light of evidence that positive places play a role in reducing inequity, this assessment tool provides a simple framework for structuring discussion about a particular place and the interaction of the people living there. Its purpose is to support the delivery of high-quality places throughout Scotland and maximize us of their potential for promoting health, well-being and quality of life. Supported by a national plan, a number of areas piloted the tool and it is now in use across Scotland.

By means of 14 questions about a place, the tool produces a simple diagram of the results (Fig. 2), providing information on its physical elements (for example, buildings, spaces, transport links) and social elements (for example, people's views on whether they have a say in decision-making). These details, as well as possible information about the assets of and challenges faced by the place in question, provide a basis for structured discussion on its development.

Fig. 2. The Place Standard tool: example of graphic output



Source: Place Standard *(23)*.

The results of a pilot study in South Queensferry, a town to the west of Edinburgh, highlight the diverse uses of the tool's graphic output. The results of the study informed the drafting of a new town plan and the local housing-development plans; they will also shape future considerations by the Council Services of South Queensferry in the areas of asset management, parks and environment, economic development, and education and housing.

The success of the tool was enabled by a strong policy foundation, the alignment of strategic and delivery goals across organizations, and effective leadership, partnerships and investment. Challenges met in using the tool were: difficulties encountered by the architectural and health agencies in understanding each other's language and terminology; reaching agreement on what the tool should measure in the light of diverse stakeholder needs; managing resources and tasks across organizations; and the scale of ambition in designing a multipurpose tool. The dedication, creativity and passion of the project team, extensive stakeholder involvement, the generation and application of evidence, the appointment of a designated project manager, and regular communication among those concerned all contributed to meeting these challenges.

Translating evidence for policy decision-making

What is evidence?

Evidence is widely accepted as concerning "facts (actual or asserted) intended for use in support of a conclusion" *(24)*. A fact is "something that is known through experience or observation". The importance of separating and clarifying these understandings is based on the implication that evidence can be used to support a conclusion, but is not the same as a conclusion *(25)*.

There are various types of evidence, which include context-free scientific evidence, context-sensitive scientific evidence, expertise and views of stakeholders (tacit evidence), and knowledge derived from data analyses (research evidence). Not all types of evidence are equally valuable or convincing *(6)*.

Research evidence has been defined as "the results of a systematic study of materials and sources in order to establish facts and reach new conclusions" *(26)*. This type of evidence is generally the most robust because the methods used in collecting and analysing it were systematic. The research behind evidence can differ in quality, depending on study design and execution, and this - in turn – can affect the quality of the evidence.

The role of evidence in health policy-making

Evidence-informed decisions are more likely to be successful than those based on opinion and other factors. Evidence is instrumental in supporting the entire policy cycle, from agenda setting through choosing services to implementation, and gives an indication of what resources are necessary. Poorly informed decisions can be the reason that services or programmes fail to reach their targets, or even address the issue in question. However, there are situations where action based on lower-quality evidence is better than no action at all. In such cases, it is important to measure the impact of the action taken, learn from it, and share the experience in building an evidence base instead of waiting for robust evidence that might not become available.

However, although robust evidence will help policy-makers to make well-informed decisions on tackling health equity and well-being, it is only one of the factors influencing them. Others that play a key role, especially at the local, regional, national and international levels include: experience and expertise; political context; public opinion; values and judgements; culture and traditions; available resources (human and physical); budgetary constraints; policy narratives; and other stakeholders (pressure groups, lobbyists, industry, civil society, public servants) (Fig. 3). Strengthening the evidence base will allow policy-makers to better judge the importance of these factors to the policy process.

Fig. 3. Factors involved in policy-making

Source: based on “Is evidence-based government possible?” *(27)*.

In evidence-*informed* policy-making, the best available research is considered; this can include not only scientific evidence but also other influential factors, such as stakeholders’ views, which are not necessarily linked to evidence *(25)*. In evidence-*based* policy-making, on the other hand, only scientific evidence is taken into account. This hardly ever occurs, however, owing to the complex nature of the process and the diversity of factors that intervene. The increasingly recognized term, “evidence-*informed* policy-making”, takes account of this. It also points to the more nuanced picture of evidence *use*, whereby different kinds of research, resulting in different points of view, all feed into the policy-development process, which contrasts with the idea of basing decisions solely on a single piece of research.

A number of challenges to evidence-informed policy-making exist in the European Region where countries struggle with similar problems; hence, the importance of sharing experiences both in best practice and in overcoming obstacles and barriers. The key challenges are as follows.

1. The evidence base is often lacking, or too old to use in evidence-informed decision-making. This is especially true at the local and regional levels. To monitor the impact of longer-term policies, such as Health 2020 *(4)*, solid and timely trend data, or significant national development plans, are needed *(28)*. Because the maturity of health-information systems across the Region varies, evidence is not always available for every context.
2. The evidence base is often contested. If the evidence base is weak, it means that the evidence cannot be verified, and interested stakeholders can easily contest it *(29)*. This often happens when the evidence is of low quality, or only based on a limited number of studies. In addition, it is easy to manipulate evidence.
3. Often, the evidence does not fit with the local context. Context specificity is crucial to the success of evidence-informed decision-making *(30)*. If the evidence base is lacking, and the evidence available matched to different contexts without regard to suitability, it is less likely that the policy will succeed.
4. The use of health information is inconsistent, varying vastly throughout the Region. Sometimes the information is not used at all, sometimes only partially, and sometimes simply to justify decisions taken – and in narrow, instrumental ways *(29)*. Incentives and structures are necessary to ensure the routine use of health evidence in decision-making, and facilitate communication among policy-makers, researchers and other stakeholders to narrow the divide between research and policy.
5. The most successful mechanisms of knowledge sharing are not widely used. Packaging (for example, evidence briefs for policy *(31)*)[1] and interactive approaches (such as, policy dialogues and networks) are the best methods of translating knowledge *(32,33)* and should be used more frequently throughout the Region.

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[1] Evidence briefs for policy (EBPs) are research syntheses presented in a user-friendly format, offering evidence–informed policy options. Their purpose is to convince the target audience of the urgency of the current problem and the need to adopt the preferred alternatives or strategies of intervention. This type of policy brief involves systematic and transparent efforts to contextualize the results of systematic reviews and to integrate them with setting-specific research results to support well-informed policy decisions *(31)*.

6. There is insufficient support of knowledge brokers, and a lack of incentives to use health information. This could stem from a lack of researchers, knowledge brokers and policy-makers, the wrong use of incentives by funding agencies, a weak infrastructure or a poor evidence-informed policy-making culture *(26)*.

The Evidence-Informed Policy Network (EVIPNet)

WHO launched the global network, EVIPNet *(34)*, in response to World Health Assembly resolution WHA58.34 (Ministerial Summit on Health Research) in 2005 *(35)*. Present at both the regional and global levels in all regions of WHO, the Network promotes the systematic use of health-research evidence in policy-making. It plays a critical role in facilitating the sharing of best practice, allowing countries to learn from and support each other in the process *(36)*. EVIPNet Europe *(6)*, launched in October 2012, is in line with the European Health Information Initiative *(37)* and supports the implementation of Health 2020 *(4)*.

Focusing on low- and middle-income countries, EVIPNet *(34)* encourages the development of country-level teams (knowledge-transfer platforms), comprising policy-makers, researchers and representatives of civil society. These teams facilitate the development and implementation of policy, using the best global and local evidence available. The Network also helps countries build national capacity to develop policy briefs and establish mechanisms to translate evidence into policy, supporting the vision of the WHO Regional Office for Europe in this connection *(38)*.

EVIPNet responds to Member States' needs to strengthen the use of research evidence in health-system policy- and decision-making *(34)*. In fostering a culture of evidence-informed policy-making, EVIPNet Europe *(6)* promotes: (1) a more transparent, participatory decision-making culture, thus increasing citizens' trust in government; and (2) the development of policies that lead to better population-health outcomes *(36)*.

Case studies on evidence-informed policy processes

The following case studies, presented during the summer school, provide examples of different country processes to foster evidence-informed policy.

Evidence-informed policy, example 1. Slovenija brez tobaka. Kdaj? (Tobacco-free Slovenia. When?)

In Slovenia, the prevalence of smoking among adults (aged 18+) has remained at around 25% since 2000; every fourth adult in Slovenia smokes. In recent years, as shown in the Tobacco Control Scale (2013) *(39)*, Slovenia has been lagging behind other European countries (EU and non-EU) in the field of tobacco control. The Restriction of the Use of Tobacco Products Act *(40)* was one of the most progressive acts in Europe at the time of its adoption in Slovenia in 1996; however, it has since only been updated three times: in 2002, 2003 and 2007, and there is currently no definite plan to change the legislation. When the EU introduced the revised Directive (2014/40/EU) on tobacco products *(41)*, Slovenia saw the task of aligning the Restriction of the Use of Tobacco Products Act *(40)* with the Directive *(41)* as an opportunity to introduce other important measures at the same time.

In order to convince policy-makers about the serious consequences of tobacco use and the need for new effective tobacco-control measures, the National Institute of Public Health prepared an evidence-informed proposal of effective measures to decrease the prevalence of smoking and its consequences: *Slovenija brez tobaka. Kdaj? (Tobacco-free Slovenia. When?)* (2013). The main purpose was to present policy-makers with an evidence-informed proposal of effective and necessary tobacco-control measures for introduction in Slovenia, which could be the basis of "simpler" publications, for example, policy briefs targeting particular groups, such as policy- and decision-makers.

The main challenge encountered during the production of the report was time pressure. It was necessary to publish the report within the timeline of the policy cycle; the document was large, only one author was involved in writing it, and the time required to do so was underestimated. Identifying the evidence and arguments contained in this large document, and translating this information for use by different audiences, proved to be the biggest challenge. This process culminated in a 52-page policy brief, including evidence-informed recommendations, as well as case studies on similar experiences in other countries.

A future challenge related to this publication will be updating the report in the light of new evidence, and translating the evidence into simple, accessible recommendations for policy-makers in a language, which they will understand.

Evidence-informed policy, example 2. EBP on alcohol legislation (Republic of Moldova)

Alcohol consumption is a major health issue in the Republic of Moldova. With a rate of 16.8 L of pure alcohol per capita, it ranks second highest worldwide. About half of all alcohol consumed in the country, most of which is homemade wine, is unrecorded; in 2015, 77% of all grapes were produced by individual farmers and householders. There was a vast reduction, however, in the proportion of total export accounted for by alcohol between 2005 and 2015: from 29% to approximately 8%.

A consultation between two deputy health ministers and representatives of the key departments of the Ministry of Health resulted in the selection of alcohol legislation as the topic of an EBP, reflecting one of the priorities of the Government Activity Programme 2015–2018. The EVIPNet team that drafted the EBP included the coordinator who was from the Ministry of Health and representatives of the National Centre for Public Health, the National Centre for Health Management, the School of Public Health Management, and the State University of Medicine and Pharmacy.

In developing the EBP, the team considered the following context-specific challenges to improving evidence-informed policy-making in alcohol legislation:

- political instability (in 2015, the Republic of Moldova experienced three acting governments, which generated the movement of key personnel);
- weak institutional capacity for evidence-informed policy-making and information exchange;
- difficulties in engaging other authorities;
- limited reliable national sources of evidence;
- a strong alcohol industry (especially beer companies).

Direct outcomes of the EBP included the establishment of a multisectoral working group led by the Analysis, Monitoring and Evaluation Division of the Ministry of Health. The working group met frequently and started a dialogue to generate and share new sources of evidence, experiences and viewpoints. It also requested additional training for members of the working group on the use of the WHO Access to Research for Health Programme (HINARI) *(42)* with the aim of improving evidence-informed policy-making.

Communication among all stakeholders in alcohol legislation has vastly improved thanks to the EBP, and has resulted in opening channels for discussion with the alcohol industry. It has also enhanced the awareness of policy-makers about the possibilities of accessing new evidence sources at both the local and the international levels through the HINARI Programme *(42)*, thus improving the prospects for future evidence-informed policy-making. This was apparent during the development of the national cancer and diabetes programmes.

Evidence-informed policy, example 3. EBP on primary health care: how to improve the purchasing mechanism to incentivize quality of services (Slovenia)

In March 2015, Slovenia initiated the development of an EBP on primary health care (PHC). The EBP team selected this topic, bearing in mind that: (i) the topic needed to be relevant to policy-makers; (ii) the contribution of a systematic review of the literature should be evident; and (iii) it was necessary to adhere to the WHO recommendations included in the Supporting the Use of Research Evidence (SURE) *(43)* guides and the SUPPORT tools *(44)*.

The team selected PHC for three reasons: (i) it was high on the national policy agenda; (ii) action in the area of PHC in the National Health Care Plan 2016–2025 (which was due to be presented in December 2015) was foreseen; and (iii) a national strategy specifically on PHC was under development.

A number of challenges ensued:

- the topic was too broad, making it necessary to specific PHC issues to tackle in the EBP;

- the team would have to be careful not merely to duplicate the work being carried out for the Slovenian health system review *(45)*, which was ongoing at the time;
- it was difficult to maintain the focus on addressing the original problem (how to improve the quality of services) and not on finding solutions to problems that arose in developing the EBP (for example, how to change the purchasing mechanism);
- there was an ongoing public political debate about a capitation payment system in PHC, which needed to be addressed, and this resulted in its becoming an alternative topic for the EBP.

An iterative process began during which external reviewers provided new input into framing the problem, a broad stakeholder workshop on financing and purchasing PHC services was held, and discussions with experts from the Ministry of Health and the Health Insurance Institute of Slovenia were initiated. As a result, the EBP team decided that the theme of the EBP would be "how to improve the purchasing mechanism to incentivize quality services".

An evaluation of the EBP process identified three key lessons learnt, namely that:

- for logistical reasons, it is more effective to commission 1 team member to write an EBP with guidance and feedback from the other members;
- it is crucial to ensure that the topic of the EBP is easy to research so that enough information can be gathered;
- a realistic timeframe must be set at the beginning of the process, and strictly adhered to.

Health information and communication of data

HEALTH EQUITY

Although average life expectancy is increasing in all countries of the WHO European Region, and the difference between the countries with the lowest and highest life expectancies has decreased, there are significant and persistent inequities in avoidable health risks, exposure to health-harming conditions, and levels of preventable illness and premature death. These inequities exist in and between all countries in the Region *(46)*.

An underlying assumption of the population-health approach is that reductions in health inequities require reductions in material and social inequities. The definition of health equity implies that all people can reach their full health potential and should not be disadvantaged from attaining it because of race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstances *(47)*.

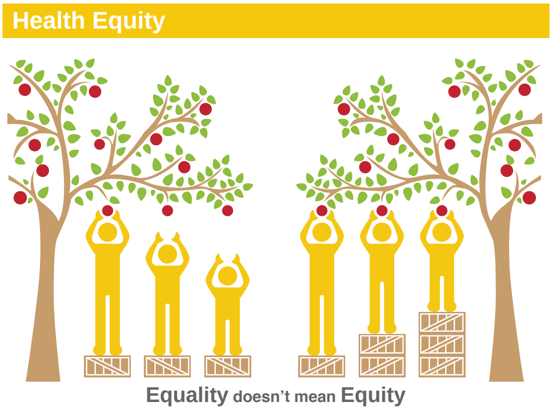
Different groups within society are deprived, and suffer from poor access to education and increased levels of unemployment. These subgroups, often minorities, subsequently rank worst in terms of mental-health issues, health inequities, and access to services. This can be a result of certain policies, societal values, or infrastructure. It is, therefore, important to ensure that policy actions do not inadvertently contribute to increasing inequities through interventions that are not sensitive enough to equity *(48)*. This necessitates the use of proportionate universalism, an approach according to which "to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage" (Fig. 4) *(49)*.

COMMUNICATING THE POPULATION-HEALTH APPROACH

The implementation of a population-health approach is a key aim in public health and crucial to the reduction of health inequities and poverty. According to the Public Health Agency of Canada:

> *A population-health approach focuses on improving the health status of a population or sub-population, rather than individuals. … Focusing on the health of populations also necessitates the reduction of health inequalities in health status between population groups. … The outcomes or benefits of a population-health approach, … extend beyond improved population health outcomes to include a sustainable and integrated health system, increased national growth and productivity, and strengthened social cohesion and citizen engagement (51).*

Fig. 4. Proportionate universalism



Source: Better health for all. Health Status Reporting Series 3. Advancing health equity in health care (50).

These outcomes or benefits underline the intersectoral nature of the approach and its potential for impact across society *(51)*.

In communicating a population-health approach, it is important for the public-health sector to: adopt a population-health approach; apply a sector-wide focus on health equity and population health in working with the rest of the health system; and, in its role as a catalyst and convener, or leader, pursue this approach with other sectors.

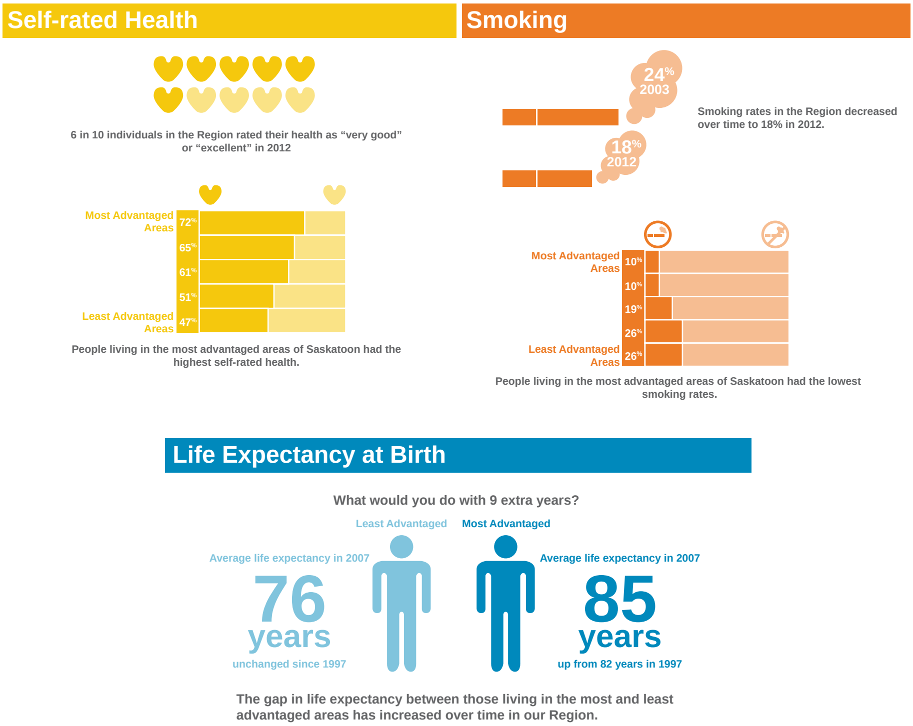
A review carried out by the Regional Health Authorities (RHAs) in Canada in 2007 showed that most organizations are struggling to operationalize these concepts, concluding that an "inability to adopt a population health approach may be due as much to government directives to spend new monies elsewhere rather than the particular failings of RHAs" *(52)*. The European Region faces similar challenges. As already mentioned, many factors influence policy decisions. Therefore, to engage the policy- or decision-maker in pursuing the desired approach, the health sector must communicate information and data effectively. This requires presenting and packaging them innovatively, and tailoring the means of communication to the context created by all factors influencing the policy process. It also necessitates adapting these means to the target audience.

Due to the global economic crisis, budgetary limitations remain a reality, both globally and in the European Region. Health sectors throughout the Region are suffering from budgetary cuts because of political priorities and reduced government spending *(53)*. While public health tends to receive only a small percentage of the overall health budget *(54)*, the focus of public-health officials should not simply be on increasing the size of the budget. Rather, they should work towards systemic change, including shifting the mindset of those responsible for the remainder of the budget in order to follow a population-health approach. This would have a greater impact on the health and well-being of society as a whole, and for the same amount of resources.

The question for the health sector, therefore, is how to communicate numbers, data, and information in a way that speaks to different audiences, be they policy- and decision-makers, the media, managers in the health sector, or certain groups in society and the community. This requires new ways of presenting epidemiological data, using visual technology to make them more accessible. Fig. 5 depicts examples of infographics created by the Saskatoon Health Region in Saskatchewan, Canada, to communicate health-equity data on self-related health and smoking in a visual way.

The images in Fig. 5 have a strong visual impact and reinforce the message told by the epidemiological data in a way that enables the target audience to create a conscious or subconscious response. The question, “What would you do with 9 extra years?” personalizes the issue of discrepancy in life expectancy between the least and most disadvantaged groups. This is crucial when attempting to make an impact on your audience, people working in policy in particular, and the time available is brief. Infographics constitute a more effective tool than graphs and charts, and are easier to interpret quickly.

Fig. 5. Examples of infographics to communicate health-equity data on self-related health, smoking and life expectancy at birth



Source: Saskatoon Health Region, Saskatchewan, Canada.

The health system uses health-equity data:

- at the programme/department level for planning and monitoring disease-prevention and health-promotion programmes and services;
- at the system-planning/quality-improvement level for planning and monitoring quality of treatment and rehabilitative programmes and services; and
- at the leadership/strategic level for planning and prioritizing health-system programmes and services (*55*).

Whether to target the different levels individually or jointly would depend on the context or issue on hand and would require a different method of communication in each case. In targeting policy-makers (most likely at the senior-leadership/strategic level), presenting them with a "menu" of evidence-informed recommendations, rather than simply providing them with data for others to interpret, would increase the probability of their choosing an option to implement.

Continuous dialogue with health-system leaders and managers by, for example, hosting consultation sessions, is a good way to increase engagement in, and ownership of, the policy at the target-audience level. The following are some example of questions asked during a consultation with health-system leaders and managers in the Saskatoon Health Region in Canada.

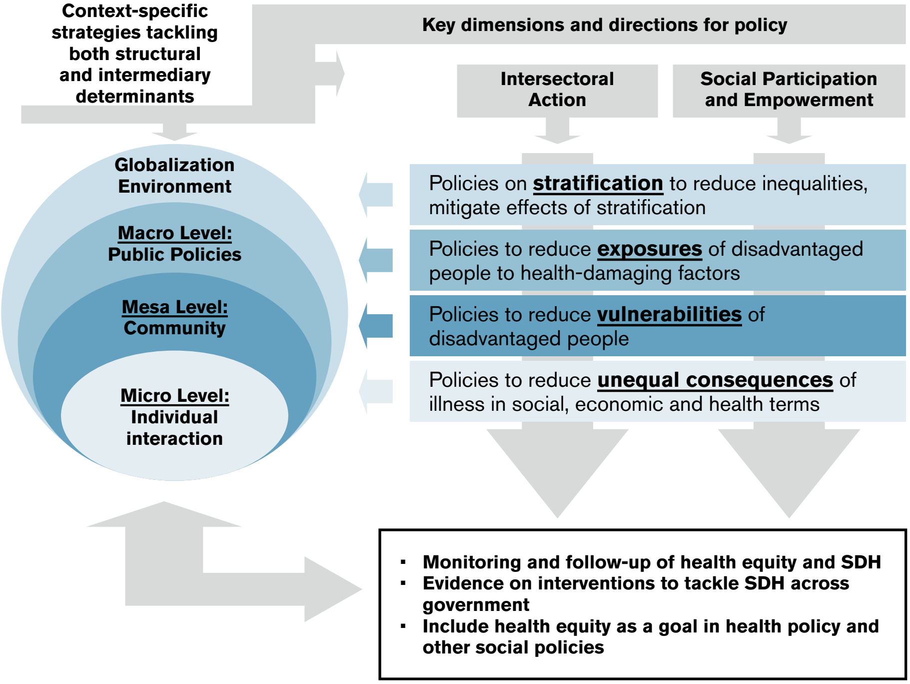
- Are there any barriers to accessing or using services and facilities that any particular population group frequently encounters?
- Are there any already existing priorities for action that would contribute to improving health equity?
- What programmes, services, approaches/practices already exist in your area, which might help to reduce equity gaps?
- What further action is required of existing services or structures to address equity gaps?
- In which way can existing work incorporate the principles of health equity?
- Is more action targeting specific groups and areas required?
- Does the system have the support and resources required to address health inequities in your area adequately? What other resources would be helpful?

Using data from other sectors

Improvements in population health require the use not only of health-sector data but also of those from other sectors. Reporting on health status – which involves many elements, such as morbidity, mortality and healthy-life expectancy – is like doing a jigsaw puzzle. However, if only health data are analysed, the picture of population health will be incomplete. A combination of health-sector data and those of other sectors is required to develop a comprehensive understanding of the situation. Employment data and crime statistics, for example, provide an indication of the status of these SDH, prompting advocacy for an intersectoral approach and intersectoral partnerships that address all the elements of society that affect health and well-being.

An intersectoral approach and intersectoral partnerships require a whole-of-government approach, which integrates the collaborative efforts of the departments and agencies concerned towards a shared goal. While it may be complicated initially to integrate systems and broaden access to sector-specific data, information sharing across the sectors is necessary to provide an understanding of the overall health status of a population, monitor changes at the macro, meso, and micro levels over time, and identify policy entry points (Fig. 6).

Fig. 6. Policy entry points



Source: Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice) *(56)*.

In Canada, the sponsorship of the intersectoral website and data-sharing platform, “CommunityView Collaboration” *(57)*, by the Saskatoon Regional

Intersectoral Committee was vital in enabling the respective government sectors and nongovernmental organizations to access and contribute to the broad community data. This allowed the Saskatoon Health Region to set priorities, goals and targets, and to monitor outcomes over time.

Data-sharing platforms can be instrumental in allowing the health sector to engage with other sectors and access their data. However, difficulties can arise, and the support of an intersectoral team is required. Over 15 years, the Saskatoon Public Health Observatory *(58)*, which created the "CommunityView Collaboration" website *(57)*, gradually increased its human resources to the current 12–14 full-time staff members. These include epidemiologists, geographic-information-system (GIS) analysts, policy analysts, research assistants, knowledge-transfer specialists, and database analysts. To build capacity in the long term and ensure sustainability, the Observatory *(58)* created university partnerships and cross appointments in research on population-health intervention.

The equal management of the platform by all sectors involved is crucial to creating ownership and increasing the likelihood of its being regularly updated and used by all sectors.

Different methods of reporting data: traditional and social media

Reliable and trustworthy collaboration with the media is essential to conveying the message, especially to the political level where reaction to media news tends to be greater than it is to alternatively disseminated information. When launching a campaign, it important to prime the media beforehand, allowing them time to analyse the data and prepare stories for release at a moment most beneficial to the campaign.

Social-marketing campaigns are an effective means of communicating data to the public and influencing policy- and decision-makers. By releasing information, such as the report of a technical meeting, through social- and digital-media outlets (websites and blog sites, such as YouTube and Twitter), it will be seen by a much wider and more diverse audience than if it had been sent out in the form of a traditional report. It is also useful to use a combination of dissemination methods: for example, to spread the results of a meeting, this combination could comprise: a publication for professionals; targeted releases of more accessible, visual data and infographics in the national, regional and local media; letters to politicians and key stakeholders; and presentations to politicians and policy-related committees. Such a strategy can enhance the impact of other ongoing efforts to engage policy- and decision-makers in a certain issue by increasing their awareness of how society, the community, and the wider public view it.

In Canada, the Saskatoon Health Region decided to alter its mode of communicating data. The policy had been to release a single, long-term report on health equity every four years and topical reports in between. They opted instead for a database-related approach that entailed regularly updating the core data and releasing various mini reports on micro topics throughout the year, as well as recommendations for policy- and decision-makers resulting from periodic reviews. They also expanded the indicators to include SDH and held follow-up consultations with stakeholders to assist them in interpreting, analysing and disseminating the data, and improve their uptake and ownership. This was combined with presentations, including infographics, and one-page briefings for relevant stakeholders, government committees, and the media to maximize the reach of the data and optimize their use.

It is also important to develop tools that will allow people impacted by tradition and social-media campaigns, to improve their understanding of the data. The Saskatoon model initiated a change in health-status reporting by introducing a web-based format, using the intersectoral website, “CommunityView Collaboration” *(57)*. The website presents infographics and one-page documents, allowing users to click for more information, including a summary of recommendations for the health and other sectors on improving population health, and links to related work and research. The development of the website *(57)* involved consultations with target audiences to fine tune format and content.

The communication of health data is a key element of health promotion, as outlined in the Ottawa Charter *(3)*, and of improving health literacy *(59)*. Health information is also important for empowering communities and individuals to take ownership of their own health. However, effective methods are not only crucial in communicating data for health promotion and policy-making, but also in sharing information with people in situations of potential health risk.

Health and risk communication

Understanding the target audience is the key to effective communication and involves assessing how the target audience – usually a particular group of people – perceives a particular topic. A message that is consistent with the values of the target audience tends to be more convincing *(60)*. Therefore, it is important, in preparing a health-related communication, to consider the following factors: age; gender; ideology; sector (public or private); political party (affiliation); and role. This is even more pertinent in risk communication.

The way of conveying a message should be appropriate to both audience and context. For example, in an approach on the same issue to three key public-health groups, the elements of the approach used might differ as follows:

- politicians: 2-minute "elevator pitches"; public-opinion polls; briefing notes; small-area data; and constituency-relevant maps;
- health-system decision-makers: detailed health-status reports; infographics; health-equity audits and gauges; a proposal to integrate an issue through quality improvement and performance monitoring; a draft position statement;
- for the public: educational media campaigns on, for example, the effects of poverty and other SDH on health; policy changes that work; the potential cost of maintaining status quo; calls for action.

In addition to adapting the approach to fit the context, it is important that the message is clear. To this end, the Canadian Council on Social Determinants of Health identified a number of pointers to follow in preparing a health communication (Table 1) *(60)*.

Table 1. Guidance on preparing health communications

WHAT TO DO	WHAT TO AVOID
Use **clear, plain language**	**Technical language or jargon**
Make issues **tangible** with analogies and stories	**Abstract concepts** or terms
Break down and round numbers; place numbers in **context**	**Complex numbers,** or large numbers without any context

Table 1 contd

WHAT TO DO	WHAT TO AVOID
Challenge conventional wisdom with **one unexpected fact**	**Exhaustive documentation**
Use **inclusive** language (we, our, us)	**Creating distance** between groups (them, they)
Identify people by **shared experiences**	**Labelling** people by group membership
Prime your audience with a fact, image or story they are likely to believe, based on their values, interests and needs	Facts, images ore stories that audiences may find **too contentious or extreme to be believable** (even if they are true)
Leave the audience with a memorable story or fact that can be easily repeated	Being **forgettable**
Use a **conversational and familiar** tone	A **clinical or academic** tone
Take the time to **understand your audience** – this include **customizing your message** by selecting appropriate tools, approaches and information	Assuming the **same message will work for all the audiences**
Prepare your message content and presentation	Speaking **off the cuff**
Focus on communicating **one thing** at a time	Trying to **do too many things** at once

Source: Canadian Council on Social Determinants of Health, Ottawa, Canada *(60)*

Risk perception

Communicating risk is challenging because the perception of its severity depends on the target audience (gender, value system within the community), the way in which the information presented, and the method of communication *(61)*.

Two key elements form the basis of risk perception: hazard and outrage. According to Sandman *(62)*, outrage, not hazard, drives perception. It is usual that even significant hazards are tolerated when the level of outrage is low, whereas insignificant hazards are usually rejected when it is high.

The greater the sense of outrage is, the stronger the intensity will be with which people perceive a risk (hazard). Reactions to risk depend on risk type: voluntary or involuntary, natural or manmade, or whether it possesses other variable characteristics. To communicate risk effectively, it is important to understand the reasons behind these variations, perceptions and biases, and address them in the communication strategy *(63)*.

KEY FACTORS OF RISK COMMUNICATION

It is important consider the following elements in preparing risk communications *(63)*.

Framing and method of communication appropriate to target audience
The language used in communicating risk and the method of communication must be adapted according to the target audience. Likewise, if certain data are destined for a specific audience, it is important to make them accessible to that audience through media outlets they actually use (newspapers and magazines online sites), as opposed to simply publishing the data in scientific journals.

Quality of information, transparency, simplicity, coherence and timing of message
For a risk communication to be effective, it is essential to consider all of these elements as well as ensure that the communication reflects receptivity to public concerns. Clarity is key; "over assurance" should be avoided at all costs.

Multisectoral and multistakeholder involvement
To ensure comprehensive risk communication, all relevant sectors should be involved in a joint communication strategy, led by a single figurehead.

Clear methodology and impartiality in communicating evidence
A clear methodology is fundamental to effective communication approaches, which should be participatory and integrate social and traditional methods of communication. It is crucial to maintain impartiality in integrating robust evidence with public norms and values.

Advantages of social media
When used correctly, new communication vehicles, such as social media, promote a sharing aspect that creates a sense of active communication. Social

media have a larger outreach than traditional media, and make it possible to communicate quickly and broadly; however, the speed of communication can also cause a rapid spread of false information.

Effect of outrage on risk perception

A sense of outrage can distort risk perception. For this reason, outrage plays an important role in the policy debate. Risk perception is dependent on outrage, not on actual hazard. Thus, it is usually the level of outrage – as opposed to the level of hazard – that determines political action, if any.

Importance of embedding risk communication in scientific evidence

In communicating risk, the target audience should always have access to the scientific research behind the data, even if initially presented in a more accessible form (for example, as infographics).

Need for capacity-building in the area of risk communication

The effective communication of health information and risk is central to public-health agencies in the connected world. It is a specialized task, requiring particular skills; thus, underestimating the task and the skills necessary to carry it out constitutes a real risk. The emergence of new types of social media also reiterates the fact that professionals working in the communication area must adapt to and be receptive of a changing world.

Monitoring as a component of risk management and communication

If the public perceives that a situation, for example, an environmental issue, is being monitored effectively, its trust in those dealing with it will increase. Therefore, monitoring activities (such as, the real-time measurement of air quality in a city or region) are important components of risk management and communication and increase the effectiveness of both by allowing for evidence-based responses and promoting the credibility of the message.

Key messages

The main messages in this publication are as follows.

The principles of the Ottawa Charter *(3)* **are as relevant today as they were in 1986 but the operational context has changed.** Approaches must be adapted to fit their context (existing resource structures and power relationships within the environment) to ensure effective implementation.

The Member States are doing a lot. In striving to meet their commitments to Health 2020 *(4)* and the SDGs(5), and through their participation in networks, such as RHN *(1)* and EVIPNet Europe *(6)*, the countries are currently engaged in many activities in the spirit of the Ottawa Charter *(3)*, building a solid foundation for future work to improve health and well-being throughout the Region.

The 2030 Agenda and its SDGs *(5)* **offer a unique opportunity for intersectoral collaboration on building a better future.** The SDGs *(5)* are in alignment with Health 2020 *(3)*. Working towards them, provides the European Region with a unique opportunity to build on Health 2020 *(3)* and other existing regional and national commitments to health and well-being by strengthening collaboration among the sectors and forming new transformative partnerships.

Effective solutions require evidence-informed decisions. Robust evidence allows policy-makers to make well-informed decisions and increases the likelihood of success in tackling issues of, for example, health equity and well-being.

There are a number of challenges to evidence-informed policy-making in the European Region. These relate to use of the evidence base. EVIPNet Europe *(6)* is working with countries to solve them and improve evidence-informed policy-making in the Region.

Reducing health inequities requires reducing material and social inequities. Determinants that go beyond the health sector affect health and well-being and result in health inequities. To counter this situation it is necessary to address the social determinants.

All policies and interventions must be equity sensitive. It is important to ensure that policy action does not inadvertently contribute to increasing inequities through interventions that are not sensitive enough to equity.

Proportionate universalism is necessary to reduce health inequalities effectively. If action to tackle inequities is to be effective, it must be universal, and both the scale and intensity of the action must be proportionate to the level of disadvantage.

A population-health approach is crucial to reducing health inequities and poverty. Such an approach focuses on improving health at the population or subpopulation level, as opposed to the individual level, and has a wider impact.

A population-health approach has wider benefits than simply improving the health of a population. These include a sustainable and integrated health system, increased national growth and productivity, and strengthened social cohesion and citizen engagement.

To obtain a comprehensive picture of the health of a population, it is necessary to consider data from both the health and other sectors. Reporting on health status is like doing a jigsaw puzzle: many elements are involved, such as morbidity, mortality and healthy life expectancy. An analysis based only on health data does not give an overall picture of the health of a population.

Data-sharing platforms are crucial in encouraging other sectors to become involved. Such platforms require the support of an intersectoral team. In addition, to ensure equal ownership, all sectors involved must be equally responsible for their management.

The different levels of the health system that use health-equity data are unique target audiences. These are the programme/department level, the system-planning/quality-improvement level, and the senior-management/strategy level. Engaging with any of them, either individually, or in conjunction with each other, requires a different approach and strategy.

Context specificity is crucial for the communication and presentation of data. Factors that play a key role in policy decision-making include the following: evidence; experience and expertise; political context; public opinion; values and judgements; culture and traditions; available resources (human and physical); budgetary constraints; policy narratives; and other stakeholders (pressure groups, lobbyists, industry, and civil society, for example). Therefore, adapting the communication method to fit the context is very important.

Communicating with different target audiences requires different approaches. The approach used should take account of a number of factors in relation to the target audience: age; gender; ideology; public or private sector; political party/affiliation; role. The communication method should be appropriate to both the audience and the context.

The type of data used in a communication approach is also dependent on the target audience. In the same way as communication methods need to differ according to the target audience, the data required should also differ. This can be by level (data from the international, national, or subnational levels) or by timescale (elected politicians may be interested in data showing what can be done in an election-cycle, while others may require data for a longer period).

Technology is key in communicating health information. Technology can help mitigate challenges, such as language barriers, issues of anonymity, unfamiliarity with the health system (for example, in the case of migrants), reluctance to engage with the health system for different reasons, and the inability to access the formal health system.

New and emerging forms of media, such as social media, are key tools in communicating health information. The media have made it easier than before to access and communicate with different audiences, such as vulnerable groups.

Visuals can help in communicating data. Presenting data, using innovative visual technology, such as infographics, can have a stronger impact than simply showing statistics, depending on the target audience. Images and visuals make data more accessible and can create a conscious or unconscious response, reinforcing the message communicated by the data.

The severity of risk perception depends on the target audience. Two key elements form the basis of risk perception: hazard and outrage. Outrage, not hazard, drives perception. Usually, significant hazards are tolerated when outrage is low, and insignificant hazards are usually rejected when outrage is high.

Conclusion

The nature of the globalized world is rapidly changing, there is an understanding that the social determinants and the policies of every sector can affect health, and the numbers of actors and stakeholders in public health and health promotion have increased and will continue to do so over the course of the 2030 Agenda. The combination of these facts means that choosing the right approach to advocating and translating evidence for different target audiences has become more important than ever before.

Different strategies are necessary for communicating with different actors. Increased access to data and new forms of communication, such as the social media, has made this easier. If managed appropriately, they have a vast potential for improving health and risk communication and, ultimately, health equity and well-being.

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Annex 1. Presentations[3]

Title of presentation	Presenter
Health and environment: communicating risks	Luca Carra Consultant, WHO European Office for Investment for Health and Development
Active and Healthy Ageing in Slovenia – AHA.SI	Mojca Gabrijelčič Blenkuš National Institute of Public Health, Ljubljana, Slovenia
The Place Standard	John Howie NHS Health Scotland, Glasgow, Scotland
Good practice in intersectoral work	Pania Karnaki Prolepsis Institute, Athens, Greece
Slovenija Brez Tobaka. Kdaj? (Tobacco-free Slovenia. When?)	Helena Koprivnikar National Institute of Public Health, Ljubljuana, Slovenia
EVIPNet Europe: enhancing evidence-informed policy-making	Tanja Kuchenmüller Technical Officer, Evidence and Intelligence for Policy-making Division of Information, Evidence, Research and Innovation WHO Regional Office for Europe
Health information and communication of data: data profiling and social-marketing campaigns supporting health-equity and poverty-reduction strategies	Cory Neudorf Chief Medical Health Officer, Saskatoon Health Region Professor, University of Saskatchewan, Canada
Evidence brief for policy in primary health care: challenges in framing the problem	Mircha Poldrugovac National Institute of Public Health, Ljubljana, Slovenia
Healthy in... Good practice to reduce health inequalities in the Netherlands.	Karin Proper National Institute of Public Health and the Environment Bilthoven, The Netherlands
Justification of the draft law related to alcohol policies in the Republic of Moldova to be promoted and approved	Marcela Ţîrdea Ministry of Health, Chisinau, Republic of Moldova

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[3] All presentations available at: http://czr.si/summer-school-2016.aspx, accessed 14 December 2016.

Factors that go beyond the responsibility of the health sector play a role in determining people's health and causing inequities. To improve health and well-being and tackle inequities effectively, more stakeholders and non-health sectors of government need to be involved in the response. Communicating health information requires different approaches and strategies, according to both context and target audience. This is particularly important in advocating, and translating data for, intersectoral action for equity and well-being.

On 6–7 July 2016, the WHO European Office for Investment for Health and Development, Venice, Italy, of the WHO Regional Office for Europe, within the framework of the WHO Regions for Health Network, hosted a summer school in Ljubljana, Slovenia, to facilitate an exchange of experience in the translation and communication of health information and data for different target audiences. The Centre for Health and Development Murska Sobota, Ljubljana, Slovenia, organized the event.

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