

**“Implementation of the Public Health Act
in a Norwegian municipality with regard to
Health in All Policies and Health Inequity”**

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ABBREVIATIONS

HiAP	- Health in All Policies
SIH	- Social inequities in Health
SDH	- Social Determinants in Health
WHO	- World Health Organization
CSDH	- Commission on Social Determinants of Health
EU	- European Union
NIBR	- Institute for Urban and Regional Research

“Health 2020 acknowledges and celebrates the wise diversity of health systems and approaches across the European region. It aims not to make national and local health systems uniform but to make them uniformly better. In adopting Health 2020, all countries agreed on two common objectives: the need to improve health for all and reduce health divide and the need to strengthen leadership and participatory governance for health.

In outlining ways to address these objectives, Health 2020 proposes new forms of governance for health, in which health and well-being are seen as the responsibility of the whole society and of the whole of government, and encourages active public participation in policy-making.”

Zsuzanna Jakab

WHO Regional Director for Europe

Excerpt from her foreword in Health 2020: A European policy framework and strategy for the 21st century (2013)

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ABSTRACT

Background

In Norway, as in the rest of Europe, people live on average longer and healthier lives than previous generations but are faced with increasing health inequities revealing socio-ecological factors as the main reason. There still remains a gap in the knowledge of how to tackle social inequity in health (SIH). The Public Health Act, adopted in 2012 imposes Norwegian government to implement health in all policies (HiAP) and reduce SIH. The act is important for implementing health promotion in a long term perspective as a cross-sectoral assignment. Responding to the knowledge gap the research project SODEMIFA¹ was established in 2013. This study seeks to contribute to the project by providing knowledge to a broader understanding about how HiAP and SIH are addressed at municipal level.

Objectives The main objective of this study is to investigate how a municipality implements the principle of HiAP and how SIH is handled in a structure of multilevel governance. How do different types of policies work together to reduce the health gap? What measures are taken? Is there any collaboration between and within sectors? These objectives will be examined by pursuing these research questions; 1) What kind of policies are in place at the municipal level concerning health promotion and social inequities? 2) How are social determinants of health (SDH) a subject to

¹ The SODEMIFA project is lead by the Department of Health Promotion and Development (Hemil-senteret). Partners are: Norwegian Institute for Urban and Regional Research (NIBR), University College of Vestfold (HiVe), The University of Brighton and the University of Mälardalen in Sweden.

governance at the municipal level? 3) What interventions are made to reduce inequities in health? 4) Is there any collaboration in development of policies and actions between sectors?

Theoretical framework The social determinants of the health model of Dahlgren and Whitehead provides the theoretical framework for this study.

Methods The research questions were answered within the frames of a case study design, combining document content analyse and qualitative face to face interviews. Documents were municipal policy documents, while the interview respondents were the Mayor, the Councillor, the public health coordinator and heads of all sectors.

Results and discussion The HiAP principle is anchored in the planning system and health promotion has a comprehensive and holistic cross-sectoral approach in the municipality. Structural, long-term programs, understood as health promotion policies aiming at combating SIH, are implemented in ordinary services instead of short-term projects led by contemporary employees from outside services. Both universal measures aimed at the whole population and measures targeting disadvantaged groups seem to be the chosen strategic policy. To facilitate for physical activity for all is a cross-sectoral mission. The child and adolescent sector where everyone can be reached in an early stage in life, is regarded as the most important sector, not the health sector.

There seems to be a high level of collaboration between and within sectors. Health promotion was a prioritised concern in the municipality prior to the

Public Health Act, but the act has made their effort stronger. Supportive leadership and long-term work with support from national networks and the county partnership seem to be important.

The public health coordinator is perceived to play an important role. The position is located in staff close to the top-level, but a clear mandate and job description seems to be missing. There also seems to be a lack of a leader-group at top level.

Conclusions The municipal policy is coordinated and comprehensive and in line with the HiAP approach and the SDH perspective. Health promotion is implemented in the municipality politically and administratively. The concept of SIH is addressed through universal initiative aimed at the whole population and prioritised groups in line with the concept of proportionate universalism targeting the health gap and the gradient and the socio-economic concept. Prioritised groups are children and youth, which are reached through cultural activities, class management, preventive drop-out programs in kindergarten and school and integration into the labour market. Early intervention and the life-span perspective are important strategies. The municipality moves clearly in the direction of HIAP being concerned with SIH. The work seems to be in line with the requirements of the Public Health Act through a high level of cross-sectoral collaboration and support from the Councillor and leaders' engagement. However, a cross-sectoral group of leaders at top-level, in addition to a mandate and descriptions of the working area for the public health coordinator, seems to be important to further anchor, development and to execute health promotion.

1. Introduction and Study Objective

1.1 Problem Statement

In Europe, people live on average longer and healthier lives than previous generations. However, the European countries, as the rest of the world, are faced with health inequities revealing socio-ecological factors as the main reason (Graham, 2009; Mackenbach, 2006; Whitehead & Dahlgren, 2006). During the latest decades there has been an increasing awareness and acknowledgement of that health inequities have become an important challenge in European countries. By the constitution of the World Health Organization (WHO), drafted in 1946, a commitment to addressing the inequities was enshrined (WHO, 1946). This was further developed and repeated in the charter for “Health for All 2000” (WHO, 1985). In the Ottawa Charter (WHO, 1986) the key determinants of health were identified, steering health promotion away from a dominant health education model of individual behavioural change, towards a socio-economic concept of health addressing SDH. Further, “Health 2020”, a European policy framework supporting action across government and society for health and well-being sets out a far-sighted agenda for health (WHO, 2013).

In contrast to a levelling policy throughout more than two decades, various studies reveal that health inequities increase within and between European countries. This affects not only the rich and poor but the whole population as each step down the social ladder is correlated with an increased risk of ill-health, like a gradient (Graham, 2009).

Against this background a national strategy to prevent social differences in health in Norway was agreed upon (the Norwegian Ministry of Health and Care department, 2006). Health inequity also increases in Norway (The Norwegian Public Health Institute, 2010) while the knowledge about how to effectively tackle SIH still is missing. Responding to this knowledge gap the research project “Addressing the Social Determinants of Health: Multilevel governance of policies aimed at Families with Children – SODEMIFA” was established in 2013 (Fosse and Helgesen, 2011). The aim of the project is to investigate how municipalities handle the challenges of addressing the SDH and the social gradient. Through the adoption of the Public Health Act in 2012, government at all levels are responsible for implementing HiAP, something which implies the importance of the SDH perspective, in order to reduce SIH. Therefore, the Public Health Act is considered important for implementing health promotion in a long term perspective as a cross-sectoral assignment.

There is little research in Norway today on how municipalities address HiAP and SIH prior to the Public Health act and how the act has affected municipal health promotion approaches. This study will provide knowledge about municipal practice concerning HiAP and SIH after the adoption of the Public Health Act. This study also seeks to contribute to the SODEMIFA project since the focus of this research is social inequities in health. The study’s findings will contribute to the understanding of the field and will demonstrate its significance above and beyond the single study by locating findings to literature, theory and findings of other researchers. This will

contribute to a broader understanding of how HiAP and SIH are addressed at municipal level.

1.2 Study Purpose

Responding to the knowledge gap outlined above, the purpose of this qualitative case study is to investigate how HiAP, SDH and SIH are addressed at the municipal level of government. The key elements of this study are to map how measures for addressing health promotion were communicated politically in the overall plan system in a municipality and how challenges addressing social inequities are handled. How do different types of policies work together to reduce the health gap? What measures are taken in municipal services? This objective will be examined by pursuing these questions.

1.3 Significance and Contribution of the Study

Studies about how the principle of HiAP and the SDH perspective are addressed in Norwegian municipalities in regards to SIH are few and the knowledge gap is significant. Studies performed by Ouff et al. (2010), Hofstad and Vestby (2009) and Kassah, Tingvoll and Kassah (2014) provides some knowledge about municipal health promotion efforts and organisation. Helgesen and Hofstad (2012) conducted a study before the adoption of the Public Health act in 2011 mapping the status of how Norwegian municipalities implemented health promotion activities and policy in different sectors. Their study will to a large extent serve as a baseline for this study.

The Public Health Act represents a shift in the health promotion work. Great responsibility for anchoring and implementing HiAP and SIH is placed at all governmental levels. Little research has been done to reveal how this responsibility is executed. The knowledge gap here is also significant.

2. The Scientific Background of the Study

This chapter starts with presenting the concept of health promotion before highlighting the concepts of SDH and scientific literature about the key concepts and objectives of this study. The principle of HiAP, the social gradient, Norwegian policy and legislation to promote HiAP and reduce SIH are highlighted. Furthermore, planning and inter-sectoral collaboration and partnership will be explored through literature and earlier research. This will provide the basis for the problems of this study.

Health Promotion

The emergence of health promotion represented a shift from the individual approach to a system approach focusing on equity in health and equal opportunities and resources enabling all people to achieve their fullest health potential (WHO, 1986). It was a response to the need of addressing the environmental as well as the behavioural determinants of health. This becomes clear from the Ottawa Charters' definition of health promotion:

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical

capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Building further on the Ottawa Charter (WHO, 1986) the statement that health is created and lived by people within the settings of their everyday life; where they learn, work, play and love, called for the creation of supportive environments with focus on settings for health (Dooris, 2006).

The charter points at the very basic understanding of health promotion:

The basic conditions for health are peace, housing, education, food, income, a stable eco-system, sustainable environment, social justice and equity. Better health needs to be founded on these basic conditions.

According to this, health promotion is decisively influenced by factors largely determined outside the health sector (Fosse, 2013). Building a healthy public policy in all sectors and at all levels, empowering individuals to be active participants in health decisions, became the framework for health promotion (Scriven and Speller, 2007).

The “Health 2020”, framework (WHO, 2013) builds on the knowledge gained throughout recent years about the role of health: 1) Maximizing health through all stages of life is a fundamental right for all and not a privilege for a few. 2) Good health is an asset and a source of economic and social stability. 3) Health is a key to reducing poverty and both contribute to and benefits from sustainable development. 4) Sustainable and equitable improvements in health as the product of effective policy across all parts of government and collaborative efforts across all parts of society.

“Health promotion” as a term stands for preventive policy and work in all sectors, especially emphasizing sectors outside the health sector. In recent years the term “public health” has been adopted in Norway. This term might be associated with a stronger connection to the health sector. Since this study has a strong health promotion approach, this term will be used in general.

2.1. Theoretical Framework

Addressing the socio-environmental determinants of health is a shift from a medical approach that focuses only on diagnoses and illness, to an approach that acknowledges the importance of the settings and their impact on health and quality of life. The Ecological Model of Health Promotion by Dahlgren and Whitehead (1991) understands health as being determined by a complex interplay of environmental, organisational and personal factors. It represents a holistic view and a shift from illness to health, from individuals to population, from a mechanistic and reductionist focus on single health problems and risk factors to supportive contexts within the places that people live their lives (Dooris, 2005).

Social Determinants of Health – SDH

The model (fig.1) developed by Dahlgren & Whitehead (1991) has different layers indicating that health is influenced by a variety of factors and life circumstances. They describe a socio-ecological theory to health through upstream and downstream determinants affecting individuals and community. This concept may be useful to characterize different approaches

to health promotion policies (Fosse, 2009). It provides a useful framework for this study.

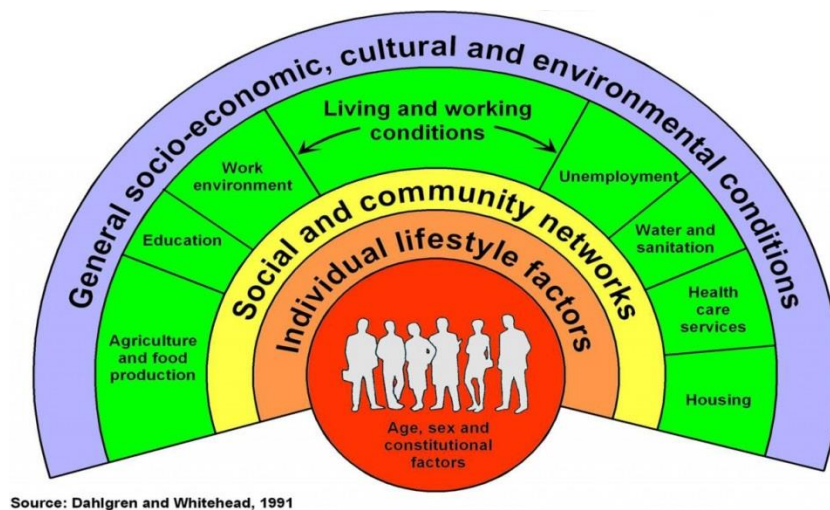


Fig. 1: The Socio Ecological Model of Health of Dahlgren and Whitehead (1991).

This multifactorial approach differentiates between individual and social factors, presenting the main influences on health as a diagram with layers which can be peeled away. The core of the diagram consists of conditions relating to age, sex and hereditary factors. The influences of genetic inheritance we are born with will also be a part of it, and both age and sex are factors that will influence the impact from the other layers.

The inner layer suggests that health is partly determined by individual lifestyle factors, such as patterns of smoking, physical activity, accidents and diet. Moving outwards, the diagram draws attention to relationships with family, friends and social networks within the local community. These are the downstream determinants of health – the actions of individuals and communities. The next layer focuses on working and living conditions like housing, employment, schools, access to health care services and so on. The

outer layer highlights broader socio-economic, cultural and environmental forces such as economic development, shifts in welfare systems, political change, social forces and structures. These final two layers relate to the upstream determinants of health. Although it is not really shown in the diagram, there is potential for layer-to-layer interaction. For example, cutbacks in welfare services might adversely affect people's access to adequate housing and thus influence their health, and lack of education and work skills will most likely have an impact on social and community networks. If people "win or lose" in life relating to the upper layers, is dependent on their socio-ecological status and how networks and living conditions are created.

Political issues providing different opportunities for individuals depending on their place in the social ladder is the key issue in this model (Dahlgren and Whitehead, 1991). The main focus of this study will be at the two outer layers of the model which represent the political level and the living and working conditions. These factors can be addressed at the municipal level. Addressing the socio-environmental determinants of health is a shift from a medical approach that focuses only on diagnoses and illness, to an approach that acknowledges the importance of the settings and their impact on health and quality of life.

2.2. Literature Review

Health in All Policies (HiAP) and Social Determinants of Health (SDH)

As a consequence of the holistic view on health, all policy sectors representing social determinants are responsible for the promotion of health.

This approach is called Health in All policies. The rationale behind HiAP is that health is influenced by social, environmental and economic factors in all sectors. Such factors and processes act as determinants of health by influencing the underlying conditions to individuals' living conditions (WHO, 2003).

In contrast to biological and health care related determinants there is a common agreement that socio-economic determinants have major influence on health (Commission on Social Determinants of Health, 2008; Regional Office for Europe of the World Health Organisation, 2003; World Health Organization, 2010; Whitehead & Dahlgren, 2006). Socio-economic determinants are explained as “the causes of the causes” by the Commission on Social Determinants of Health (2008) which means an early impact perspective and early health promotion approach. As suggested by the Ottawa charter, important community level strategies are supposed to create supportive environments and strengthen community action:

Health promotion works through concrete and effective community actions in settings priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities – their ownership and control of their own endeavours and destinies. (WHO, 1986)

This means integrating health considerations into a broader range of related policy areas and to engage leaders and policy-makers at all levels of government – local, regional, national and international.

The Understanding and Use of Health Inequalities and Health Inequities

The terms “health inequality” and “health inequity” are used interchangeably in international debates (Graham, 2004). While “health inequality” refers to individuals or groups having different health outcomes, “health inequity” has a more wide understanding of differences between social groups (Marmot, 2001). The term links the health of individuals to the structures of social inequality which shape their lives. Systematic health differences are being associated with individual differences and position in society and by this “health inequity” refers to those inequalities in health that are unacceptable, unfair, systematically produced, and unjust (Whitehead, 1991; Dahlgren 2004; Whitehead & Dahlgren, 2006). With reference to the understanding of both terms given above, this master thesis makes use of the term “health inequities”.

Health Inequities in Europe

In every part of Europe and in every type of political and social system, differences in health have been noted between different social groups in the population and between different geographical areas in the same country. We find consistent evidence that disadvantaged groups have poorer survival chances and are dying at a younger age than more favoured groups. Large gaps in mortality can also be seen between urban and rural populations and between different regions in the same country. Disadvantaged groups not only suffer a heavier burden of illness than others, but also experience the onset of chronic illness and disability at younger ages (Stegeman and

Costongs, 2012; Dahlgren and Whitehead, 2007; Marmot et al, 2011; Dahl et al. 2014; Mackenback, 2007). There are also differences in accessibility and quality of health services, showing in general that those most in need of medical and preventive care are least likely to receive a high standard of service (Whitehead, 1991). Problems also tend to cluster together and reinforce each other, making some groups very vulnerable to ill health.

Reducing social inequities in health is a highly political issue which demands a political agenda that regards social inequities as unfair. It also demands concrete policies and interventions. Social inequities may be defined as a “wicked” problem, first introduced by Rittel and Webber (1973) linking the term to planning. WHO defines that equity in health means that everyone has a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving their potential (Stegeman and Costongs, 2012).

Range of Meanings of Health Inequities

When dealing with social inequities in health there are different approaches that may be seen as a continuum from the approach of improving the health of the disadvantaged groups, through the health gap perspective and on to a systematic relationship between social position and health, which is the gradient.

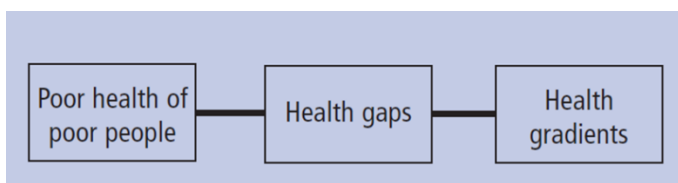


Fig. 2: Range of meanings of health inequalities (Graham and Kelly, 2004)

According to Graham and Kelly (2004) the first perspective, health inequity describes the poor health of poor groups (fig.2). This perspective captures the health consequences of poverty which means the health gap between the best-off and the worst-off. The mid-point of the continuum also focuses on the health of poor groups, but is seen relative to other groups in terms of narrowing the health gap between them. Further along the continuum the systematic relationship between socio-economic position and health, shown as a health gradient, is addressed. The health gap and the health gradient perspectives represent different policy goals which are not mutually exclusive and provide complementary approaches to reduce inequities in the socio-economic distribution of health (Graham, 2004). For the worst-off approach, welfare programs expose only the disadvantaged group which suffers inequity (Graham and Kelly, 2004). However, this approach is not without problems since it turns socio-economic inequity from a structure which impacts all to an impact only on sub-groups and a relatively small portion of the population. This may have a negative effect on the health of other groups, and has been associated with a widening gap in the life expectancy between the bottom and the average and the top of the social class ladder (Graham, 2004).

In terms of health gaps, the approach is not only on the worst-off alone, but also on their health in relation to the better off in society (Graham 2004). There is no attention on groups next to the worst-off, and this is regarded as a moral problem (WHO, 1946; World Health Assembly, 1998). As pointed out by Dahlgren and Whitehead (2006) referring to the WHO policy, it touches on the special position where health holds human rights:

“Everyone has the right to enjoy the highest attainable standard of health in their society”.

The Gradient

Health inequities are not only about health differences between poorer and better-off groups, but the systematic relationship between socio-economic positions and health: the health gradient (Graham, 2004).

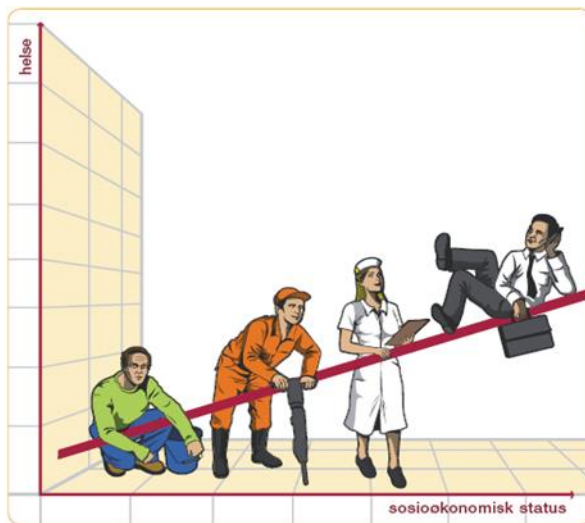


Fig. 3: Social gradient in health by The Ministry of Health in Norway.

The gradient refers to the linear or step-wise decrease in health that comes with decreasing the social position (Marmot, 2005). In whatever way health is measured there tends to be a gradient on which the most socially and economically groups have better health and wellbeing, and lower rates of illness and death than the disadvantaged groups. Over time, the gradient as a whole tends to shift upwards because overall the health of most groups is improving. However, the degree and rate of improving tend to be greater in more advantageous social groupings, and therefore the degree of inequities also tends to increase (Marmot, 2005). These disadvantages tend to

concentrate among the same people, and their negative impacts on health accumulate during life (WHO, 2003). The acceptance of inequities being caused by socio-economic position, has led to increasing pressure in research, practice and policy-making to tackle these wider SDH through the implementation of appropriate interventions (Bambra et al., 2010).

Action to Tackle the Social Gradient in Health

Tackling health disadvantages, health gaps and health gradients represent different and distinct policy goals. A focus on socio-economic differentials rather than on social disadvantages widens the frame of health inequity policy. It represents a change from not searching for circumstances that cause illness in disadvantaged groups, but in the systematic differences in life chances, living standards and lifestyle for all (Graham, 2004). Reducing the health gradients needs complementary approaches improving the health of poor groups and strengthening their position in relation to other groups which also need to improve at a faster rate than in the highest socio-economic group (Graham, 2004). National Collaborating Centre for Determinants of Health (2013) states that organisations often create mixed approaches with both universal and targeted interventions which address both the health gap and the health gradient.

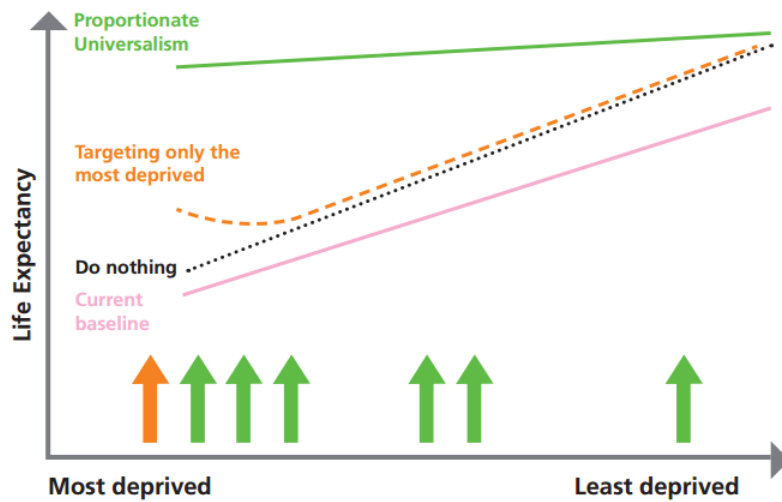


Fig.4: The effect from different approaches to reduce health inequities after Marmot. Adopted from Health Inequalities Commissioning Framework, NHS Kensington and Chelsea

According to Marmot (2013) actions must be universal to some degree to all people rather than applied solely to the most disadvantaged, and with a scale and intensity that is proportionate to the level of disadvantage to reduce the steepness of the social gradient in health. Key to success is therefore “proportionate universalism” (Marmot, 2010). The model (fig.4) shows the effect that proportionate strategies will have on the gradient compared to targeted strategies and doing nothing. While “target universalism” is becoming a renowned framework in Canada and the United States, Marmot’s approach gains more and more acceptance in Europe and the United Kingdom (National Collaborating Centre for Determinants of Health, 2013). Proportionate strategies demands structural measures, and are therefore also a highly political issue (Fosse, 2011).

The Policy in Europe and Norway

Inequities in health exist in all countries across Europe, and the trend is increasing which represents a challenge to the world (Marmot, 2005). This concern is shared by the European Union (EU) as they see a large and growing gap in health between and within EU Member States (COM, 2009).

In recent years several countries have implemented programs aimed at improving the health by creating good lives for citizens and to improve economy of society (Vallgård, 2007). In the UK, great efforts have been made to reduce health inequities. Through assembled evidence and experts' judgements on areas suitable for policy development, a plan of action was formed (Marmot, 2005). Sweden and Denmark aim at improving the general health of the population by reducing mortality, morbidity and social inequities in health (Vallgård, 2007). Even though the perspective of the social gradient is adopted in both national and international studies and reports, Judge et al (2006) states that no EU member country has yet made a concerted effort to implement the most radical approach to health inequities, namely the gradient. This appears to be in line with the findings of Povlsen et al. (2014) that Norway is the only country among the Nordic countries that have implemented concrete policies to address the gradient in order to promote equity in health.

Despite the fact that the Norwegian welfare model is based on an egalitarian ideology (Public Health Institute Norway, 2007; Dahl et al., 2014; Mackenback, 2012; Strand et al, 2010), inequities in health increases in Norway as for all European countries. Significant differences in mortality

among socio-economic classes have been revealed in recent studies concluding that groups with higher education and income benefit the most from the decrease of the mortality rate (Public Health Institute Norway, 2007; Strand et al., 2010). According to the Ministry of Health and Care Services in Norway (2006) there are up to 12 years differences in average life expectancy between different urban districts in Oslo.

National Policy and Strategies

Health promotion has been high on the Norwegian political agenda for over three decades, shifting from strategies aimed at individuals to structural and universal strategies. The “Health for all 2000” strategies of WHO was followed up in the government White paper no 41 “*The health policy towards 2000. National Health plan*” (Department on Social Affairs, 1987) where reducing social differences in health was a central aim through partly universal strategies, but mostly by addressing disadvantaged groups. The White paper no 37 “*Challenges in in health promotion and preventive work*” (Ministry of Social and Health Affairs, 1993) was the first government white paper on health promotion. This paper expressed the vision of health promotion policy as a follow up on the Ottawa Charter (Fosse, 2009).

The most important national document seems to be the White paper no 16 *Prescriptions for a Healthier Norway* (Ministry of Health and Care Services, 2002). Investigating the development of Norwegian policy in regards to social inequity in health, Fosse (2009) found that this paper represented a political shift in several ways. First the issue of inequities was

raised in a governmental white paper for the first time. Second a broader perspective on risk to population health was raised and was followed up by an action plan to provide a foundation for the national work on social inequities in health (Fosse, 2009).

In 2005 the action plan, entitled “*The Challenge of the Gradient*” (Directorate of Health and Social Affairs, 2005), was published indicating a shift of focus arguing against a perspective which focuses only on the marginalized groups. This was developed further as the government issued its White paper no 20 *National Strategy to Reduce Social inequalities in Health* (Ministry of Health and Care Services, 2006). This paper emphasizes the gradient strongly, and the society’s responsibility for the health of the population is underlined (Fosse, 2009).

Partnership for Public Health and Health Promotion

The White paper no16 *Prescriptions for a Healthier Norway* (Ministry of Health and Care Services, 2002) also represented another shift in that it points at the importance of a sustainable infrastructure for prevention in Norway. Due to their role as a developing and planning actor, all counties were challenged to establish and operate a sustainable infrastructure for health promotion through partnerships with municipalities, regional actors and volunteers (The Norwegian Ministry of Health and Care Services, 2002; Hofstad and Vestby, 2009). The aim behind this was to foster a shift from prevention being a task for very dedicated people and project-based interventions, to being an integrated responsibility for all governmental sectors (The Directorate of Health, 2003). As a follow up to this challenge

the Directorate of Health introduced a program in 2004 to develop different models contributing to a systematic and obligated partnership (Ministry of Health and Care Services, 2002). Some years later the Department of Health and Social Services (2006) in the White paper no 20 emphasized that this partnership must be strengthened and further developed as a part of developing knowledge and cross-sectoral tools.

Up until 2011, 70 percent of the municipalities in Norway have signed a partnership agreement with its county (The Norwegian Directorate of Health, 2011). An important part of this agreement was the claim from most counties that the municipalities had to develop a new position – a public health coordinator. To mark the significance of the field, it is important that this position is situated in the Councillor's staff and is close to the political leadership (The Norwegian Ministry of Health and Care Services, 2003; Hofstad and Vestby, 2009).

In a study evaluating the partnership Hofstad and Vestby (2009) found that 74 percent of the municipalities responding to the study had a public health coordinator, 20 percent of these had a full time position. They also found that the public health coordinator was central in the integration of the health promotion and planning at municipal level (Hofstad and Vestby, 2009). In a survey investigating the implementation of health promotion in municipalities before the adoption of the Public Health Act in 2012, Helgesen and Hofstad (2011) found that municipalities, even if they had started to pay attention to the determinants of health, their health promotion work still was health sector oriented. The public health coordinator held a

small part time position, often organised in the health department. This corresponds with a new research of Kassah, Tingvoll and Kassah (2014) concluding that the public health coordinators still hold small positions in the health sector. In order to achieve implementation and an understanding of health promotion, the coordinator probably should be situated near the top level in line with the other sector leaders (Kassah, Tingvoll and Kassah, 2014).

Inter-sectoral Collaboration

Inter-sectoral governance facilitating actions that support health in all policies requires strong political or bureaucratic leadership, particularly within the broader policy environment where the concept of HiAP may be unfamiliar (McQueen et al., 2012). Collaboration between governmental levels, sectors and settings are therefore essentially important (Axelsson & Axelsson, 2007; Amdam, 2011, Helgesen & Hofstad, 2012; Fosse 2013). However, an inter-professional and inter-sectoral collaboration is difficult to achieve (Amdam, 2011; Axelsson and Bihari Axelsson, 2007; Fosse, 2013). It seems to be structural and organisational factorial reasons for this, in addition to the increasing professionalism (Fosse, 2013). Overcoming such differences to forge productive collaborations is a key challenge for health promotion (Amdam, 2011; Fosse, 2013).

In an early study, Fosse (1999) revealed that collaboration between important actors in the health promotion work in municipalities is a problematic exercise. Later studies provide proof that this has not changed (Hofstad and Strand, 2009; Helgesen and Hofstad, 2011; Amdam 2011).

However, McQueen et al (2012) state that coordinated approaches are an emerging development that might encompass how different governmental sectors work together at different levels focusing on horizontal collaboration across and within sectors and between governmental levels.

Collaboration in municipal health promotion practice is still difficult to achieve and there is a particular need for cross-sectoral and cross-disciplinary groups (Lillefjell et al., 2013; Kassah, Tingvoll and Kassah 2014). Kassah, Tingvoll and Kassah (2014) argue that a top-level cross-sectoral group is needed and might be a substitute for the public health coordinator position, as they discuss if and how such a group might be a force for collaboration between management and all sector leaders in municipalities.

Planning for Health Promotion Policy

A common focus, a policy framework and institutional involvement at all levels in a long-term perspective, have been emphasized in order to facilitate for HiAP. Implementing such an approach is challenging, especially because SDH are mainly controlled by policies of all sectors, not solely the health sector (WHO, 1986). Planning becomes a vital strategy to achieve the health promotion goals and reduce inequities in a sustainable way. In the Public Health Act, planning is emphasized as a key tool to implement HiAP. The act is therefore closely connected to the Plan and Building Act which shall promote overall plans where sectors, tasks and interests are interconnected as shown in the model

available at the webpage of the Norwegian Directorate of Health:
(<http://www.helsedirektoratet.no/folkehelse/folkehelsearbeid/helse-i-plan/Sider/default.aspx>)

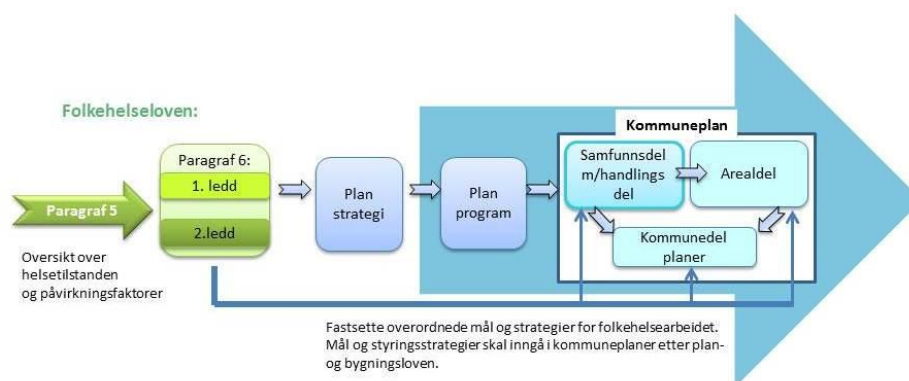


Fig.5: The planning model visualises the synchronization of the Public Health Act and the Plan and Building Act.

However, an act in itself does not mean that health, and health promotion issues, become part of the plan system at local level, at least not in a way that gives it enough legitimacy (Amdam, 2011). Traditionally the local planning system has been concentrated around economic development and land management. There has been little and random understanding about the importance of implementing health promotion in the overall plan system (Fosse, 2009). Lately the health promotion field has been treated more politically extensive in connection with the general plan and decision-making processes of the county and municipal government in line with the Public Health Act. According to Kingdon (1984) policy making is complicated because policy outputs are the results of successful coupling or interaction of problems, policies and politics. There has to be a correct

balance of strategic planning and timely responses to the policy window, which might increase the odds of a policy being adopted.

According to the Plan and Building Act (Norwegian Government, 2009) every municipality in Norway must have an overall plan for their management. This plan sets the overall goals for the municipalities in a long term, and describes the most important issues and concrete tasks that should be carried out during the plan period in the municipality as a whole. In addition to the overall plan they also have several sector plans where these goals and priorities are elaborated and specific actions are described. This is followed up by annual action plans, which should be connected to the municipal budget. Both the Public Health Act and the Plan and Building Act impose the municipality to include health promotion strategies and actions in these documents. The overall policy plan and strategic documents will show how well the health promotion policy and actions are implemented, what the municipality considers to be the most important health challenges and how they can be addressed.

2.3. The Public Health Act

The Public Health Act is part of the Cooperation Reform² and was adopted in 2012 as the Ottawa Charter in practice (Fosse, 2013). According to Fosse (2013) the act represents a change in the understanding of health promotion which demands changes in working methods and organisation, especially

² The Cooperation Reform is a health reform with the goal of preventing more, treat earlier and interact better. The reform began officially on 1 January 2012 with two new laws, the Public Health Act and the Health Care Act, and a number of financial and technical means.

cross-sector collaboration (The Directorate of Health, 2011). Given the act, governments are required to have a pro-active approach to health promotion based on scientific evidence and data when ensuring the overall health and living conditions of the population (Lillefjell et al., 2013). The act builds on a broad perspective of SDH which also defines the key actors and tasks for tackling the gradient at different political levels (Fosse, Grimm and Helgesen, 2014).

Five principles govern the act: 1) Health in all policies, 2) Social inequities in health, 3) Sustainability, 4) The precautionary principle and 5) Collaboration. Fosse states that these principles, particularly health in all policies, launched by EU as a basic principle in the health promotion work, need cross-sectoral collaboration (Ministry of Health and Care Services 2011; Fosse 2013).

According to the Public Health Act, the responsibility for health promotion is placed at the Councillor's desk. Municipalities must use all sectors and all types of resources to meet their health challenges and to promote health promotion. They also have to anchor policies and strategies in their planning system. An overview of health challenges in each municipality will form the basis for strategies, goals and measures. In the act regulation, the Norwegian Ministry of Health and Care Services (2013) has given minimum standards for how an overview of the health situation might be executed, and will conduct inspections with both counties and municipalities from the autumn 2014 to check if health challenges and

planning have been executed according to the act and the health overview standards; knowledge adopted from the Norwegian Board of Health

Supervision, available at

<http://www.helsetilsynet.no/no/Tilsyn/Tilsynsomrader/Tilsyn-pa-folkehelseomradet/>

In a Norwegian context, the conditions affecting people's everyday lives are strongly influenced by the municipality through public policies and services. This study will add knowledge to how municipalities implement the concept of HiAP and the SDH approach, what policies and strategies are made in regards to the health gradient, how the work is organised and the level of collaboration. Little research has been done in these areas in Norway.

3. Research Questions

The main objective of this study is to investigate how HiAP, SDH and SIH are implemented in a municipality according to the Public Health Act and how inequities are handled in a structure of multilevel governance. How do different types of policies work together to reduce the health gap? Is there any collaboration between sectors and within each sector? These objectives will be examined by pursuing these research questions:

1. What policies are in place at the municipal level concerning health promotion and social inequities?
2. How are social determinants of health a subject to governance at the municipal level?
3. What interventions are taken to reduce inequities in health?
4. Is there any collaboration in development of policies and actions between and within sectors?

These research questions will be answered by combining an analysis of seven municipal plans revealing signs of the HiAP perspective and a SIH approach of health. Main findings will be provided through eight semi-structured face-to-face interviews with participants representing the political and administrative level in the municipality.

4. Research Methodology

Most qualitative research designs, shapes and reshapes its problems as the research material is "showing the way". This is one of the advantages of qualitative analyses (Holter and Kalleberg, 1990). Qualitative method means that one tries to understand, describe and analyse the participants' own perceptions of reality and motive for their actions, and they determine what is important, not the researcher (Repstad, 1998).

This study includes eight interviews with selected leaders in a medium-sized municipality located at the west coast of Norway. This particular municipality was chosen due to its partnership with the county and their full time public health coordinator. Also, their understanding of health promotion both politically and administratively, shown by earlier and present work, was a criterion. The interviewees are the Mayor, the Councillor, the public health coordinator and leaders from all sectors. They are therefore considered to have the overall knowledge of how the municipality is run.

4.1. Study Design and Research Methods

This qualitative case study uses a methodology combining a contents analysis of official policy documents and semi-structured in-depth face-to-face interviews with open-ended questions. This triangulation of methods enables the researcher to explore holistic information that is filtered through the views of the interviewees (Creswell, 2009; Yin, 2009) where the holistic

view is more than the sum of each part (Kvale, 1997). This makes it possible to present the personal opinions and experiences from the interviewees through conversations. This research is guided by the seven stages of an interview inquiry (Kvale and Brinkmann, 2009): thematisation, designing, interviewing, transcribing, analysing, verifying and reporting.

4.2. Sampling Procedure and Methods of Data Collection

The document analysis contains official overall plans provided by the interviewees and downloaded from the municipal web-page. Such documents are considered to be authoritative, credible, and representative for governmental policies and political perspectives on certain phenomena (Denscombe, 2007). The fulfilment of HiAP and SDH requires involvement from all sectors, not only the health-care sector (Commission on Social Determinants of Health, 2008; Dahlgren and Whitehead, 1991). The document analyse in this study is not a traditional text analyse. The aim is to look for signs of the political priorities connected to HiAP and SIH. The document review will provide knowledge of and reveal if the implementation of health promotion is in line with the Public Health Act, and if there is any coherence between the different plans.

The case study interviewee are eight key multidisciplinary informants employed by the municipality at the overall political and administrative level: the Mayor, the Councillor, leaders from the Health-, Social- and Care Sector, the Culture Sector, the Child and Adolescent Sector, the Technical Sector and the Planning sector, in addition to the public health coordinator. The coordinator has a cross-sectoral view and approach in the municipality,

and kindly acted as my doorkeeper who recruited and facilitated the interviews. The participants were approached by e-mail which provided an informative letter from the University of Bergen about the aim and nature of the study in addition to a consent form and the interview guide (Appendix 1, 2, 3 and 4).

All semi-structured face-to-face interviews took place in a municipal meeting-room at a time selected by the interviewees following a semi-structured interview guide (Appendix 1). The interviews were held in Norwegian, and lasted for approximately one hour as agreed upon with the interviewees, except for one interview which lasted for one and a half hour. All interviews were recorded after consent from the interviewee, then transcribed, analysed and translated into English. Prior to the interviews a test interview with a public health coordinator from another municipality in the same county was conducted to get experience and to reformulate some questions if needed.

When transcribing the first interviews, several opportunities to follow up interesting threads which had not been explored, became visible. In the next interviews it then became a more conscious mission to explore new and interesting strings. Also, the interview guide was extensively modified based on new information from the participants to improve its purpose.

4.3. Data Management

The analysis of both documents and interview transcripts was done manually by using office software. To ensure confidentiality of interview

participants, interview records will be destroyed latest one year after the analysis

4.4. Data Analysis and Interpretation

A combination of concept-driven coding using codes developed in advance from the content of the material, and a data-driven coding developing through readings of the material (Kvale and Brinkman, 2009) was performed. First, to get an overview, the transcript material was roughly sorted into the main categories from the interview guide. Kvale and Brinkman (2009) emphasized this as a sensible way to start the analysis when the material is large. Then the material was sorted into new themes again and again as the interpretation process developed revealing new meanings and patterns. In this process the researcher goes beyond what is directly said to reveal a deeper and more critical interpretation.

Governmental documents can be considered as authoritative, credible, and representative for governmental policies and political perspectives on certain phenomena (Denscombe, 2007). While analysing the documents, the issue was to reveal signs of HiAP and the SDH perspective in political strategies, and how, if at all, health promotion and SIH is highlighted. To be able to understand the depth of the health promotion commitment in the municipality of study it is important to reveal if SIH are approached through general and universal strategies or strategies aimed at disadvantaged groups.

4.5. Role of the Researcher

As outlined by several researchers, all qualitative analyses are influenced by the researcher to some extent. The role of the researcher as a person and the researcher's integrity are critical to the quality of the scientific knowledge and the soundness of ethical decisions in a qualitative inquiry (Kvale and Brinkman, 2009). This involves the moral integrity of the researcher, the sensitivity and commitment to moral issues and actions. In interviewing, the importance of the researcher's integrity is magnified because the interviewer becomes the main instrument for obtaining knowledge. Being familiar with value issues, ethical guidelines and ethical theories may help the researcher to make choices that weigh ethical vs. scientific concerns in a study (Kvale and Brinkman, 2009).

As a researcher I must be aware of how my work as a public health coordinator at county level influences my research throughout the whole process. My knowledge of the health promotion field and about some work in municipalities might influence the validity of my data. Throughout the process I have tried to be conscious about my own role as a researcher and my subjectivity, particularly in regards to the collecting and interpretation of data. This is also a matter of ethical concern. On the other hand, my knowledge of the field provides me with an understanding that might strengthen the validity because it is easier to conduct the interviews and to formulate more relevant questions.

4.6. Ethical Considerations

An interview investigation must consider ethical issues at all stages of the inquiry as they apply through the entire process and to all stages of an interview inquiry (Kvale and Brinkman, 2009). Thus, ethical consideration should be a factor through the entire process. This study follows the ethical guidelines in Norway (National Committee for Research Ethics in the Social Sciences and the Humanities Norway, 2006). Furthermore, the study needed approval from the Norwegian Social Science Data Services before the research started. In addition, the study required voluntary consent from all interview participants who also were informed about their right not to answer some questions or withdraw from the study at any time. A consent form containing information about all efforts of participant protection was sent in advance to ensure that it was read thoroughly and without external interference (Appendix III and IV). This information was repeated at the start of each interview.

Since no sensitive or personal issues, and no intervention or manipulation, are addressed in this study, important ethical issues are not at hand. Nevertheless, to secure the anonymity of the participants, and by this protect them from potential harm, is important. Details that can identify the interviewees, such as names or sex, are deleted in this study and will remain so in future articles or other publications developed from the study. Identification details of the municipality, like names of places and persons, are also deleted. If a study wishes to publish information that is recognizable to others, the participants should agree to this. The research quality of this

study rises to a higher level using titles along with some quotations. While this means that certain statements will be identified by the other participants, and maybe also by close colleagues, a complete anonymity cannot be secured as promised. Therefore all participants gave their permission to use title identification when needed. In order to guarantee a correct presentation and use of interview statements, the participants received the result chapter to verify the use of statements.

All interviews were tape recorded and kept entirely confidential, stored on a private computer secured with password. The interview records will be destroyed one year after the interview conduction, which gives enough time to residual checks of correct transcriptions and interpretations, and the publication of an article after the submission of the thesis.

4.7. Validity

Validation should not be limited to a separate stage of an interview's inquiry. According to Kvale and Brinkman (2009) validity permeates through all stages of the study from thematising and interviewing to the final reporting. As emphasized by several authors (Creswell, 2009; Green & Thorogood, 2009; Kvale and Brinkman, 2009) validity refers to the accuracy of findings and "truth" of interpretations.

This present case study uses interviews and documents analyses. This triangulation of methods may be perceived as strengthening to the validity of the study because it provides better understanding and significance of the data material. The validity of interviews is promoted by including the

highest political and administrative level in the municipality. The interpretations and response validation during the interview was done by reformulating statements to check the interviewee's agreement. This adds to the validity. The validity of documents was ensured by including policy documents downloaded from the municipality's website or handed over from participants. Governmental official documents are regarded as authentic and credible.

The validity of interviews is strongly connected to the creditability of researcher and participants' accounts. This credibility is ensured by interviewing head political and administrative leaders and managers from different sectors and disciplines who are experts in the field of study. Continuously checking of meaning during the interview and verifying of interpretations and response validation ensured appropriate interpretations. Additionally, through the triangulation of data the credibility of participants' statements could, to some extent, be checked through a comparison with findings from the document analysis. The validity of interview data was strengthened through the identification of discrepant findings, and the clarification of possible bias and the role of the researcher. Also, the interviewees were asked to verify the use of their quotations in the empirical part of this thesis before submission. According to Creswell (2003) this is a method utilised to increase the validity of this thesis.

4.8. Reliability

The reliability of this study is supported by the selection criteria for documents and participants. Key words, documents sources and criteria of interviewees were clearly documented. This also applies to any other kind of data, including field notes and interview transcriptions. An approach to secure the reliability of the study was the discussion of code with the supervisor and colleagues and that codes were used in a coherent way. In addition, interpretations were explained and supported by descriptions. The interviews were performed in Norwegian and translated into English. This was executed with special considerations to the context of the study to ensure the reliability of the data. The reliability of this study will be enhanced through a rigorous and transparent reflection of all decisions, proceedings and conclusions of the research process.

4.9. Transferability

This case study is an in-depth analysis of municipal anchoring and implementation of HiAP, SDH and SIH and the study findings are not necessarily valid for other municipalities in Norway. Yet, the study is transferable, as its findings contribute to a broader knowledge and an understanding building on earlier research in this field (Fosse, 2009; Fosse & Strand, Helgesen and Hofstad, 2012; Hofstad and Vestby, 2009; Kassah, Tingvoll and Kassah, 2014). This study might provide a richer and more contextualised understanding of the importance of the municipality's practice. It might also be adapted for further research as this study adds knowledge to a field with limited earlier research.

4.10. Methodological Limitations of the Study

Being a master thesis this study is subject to several methodological limitations. The number of interviewees and their professional background represents a limitation. The inclusion of interviewees from the practical level in sector services and more politicians might have promoted a richer set of data. This was not possible within the given frame of this study. However, eight participants, who are regarded as experts of how the municipality is managed, were expected to provide vital information about the research topic.

With regard to political documents, seven different plans were analysed. If more political plans or other policy documents had been included, the data source could have shown other patterns. However, the political documents included provided a credible data source for this study, representing the overall political level and policy at different sectors of importance for health promotion. They are considered being a mirror of political values in regards to HiAP and the intentions of tackling SIH.

This study will explore to what extent a Norwegian municipality addresses the challenges of HiAP and SIH. Findings in this study cannot be generalized to other municipalities but will contribute to the understanding to the field and will demonstrate its significance above and beyond the single study by locating findings to literature, theory and findings of other researchers. This will contribute to a broader understanding of how HiAP and SIH are addressed.

5. Case study

5.1. Municipal Characteristics

The municipality in this case study is regarded as medium sized with nearly 12 000 inhabitants. The municipality has fewer inhabitants > 80 years and more immigrants and foreign cultural inhabitants than average for its county. The job opportunities are essentially within secondary-, service and technical industries, but there is a lack of opportunities for highly educated people. This is considered to be a challenge for the health situation of the population. Until 2013 the municipality was on the Robek-list³, which means that the financial ability is strained. The municipality is governed politically by a conservative leadership and administrative through a two-level model⁴.

Health promotion has been a concern in the municipality for many years. A community based project started in the late 1980s targeting people in general focusing on resources, empowerment and participation. At the time their program represented a new way of thinking with a settings perspective and a focus on civil society. One might say that they to a certain extent had a HiAP approach already then. The program contained several smaller projects and activities which were integrated in the municipality and set out in cooperation with various stakeholders in the communities that were involved. At that time leaders from different sectors (health care-, school-

³ A Robek municipality must have the approval of the Government and the Ministry of modernization to make valid decisions about borrowing money or long-term leases.

⁴ A two-level model implies a flat management structure which is often connected to New Public Management by researchers.

and culture) participated in the work and brought forward ideas and methods even after the project had ended (Holck, 1995). In the early 90-ties the municipal became a member of “Sunne kommuner” which is the Norwegian network of the WHO concept of “Healthy-Cities”⁵. They are not a member today.

In 2004 the county council started a regional partnership for health promotion with many municipalities and some institutions at the regional level. Agreements between the county and each municipality were signed by the Councillors at both governmental levels after political agreement in the municipalities. By this, all municipalities agreed to hire a public health coordinator in at least a 50 percent position and to establish a cross sectorial group to anchor the health promotion perspective in all sectors. The municipality in this study was incorporated in the partnership some years later, and hired a coordinator in full time position organizing in the Councillor’s staff.

5.2. Document analysis

This study provides an analysis of the most important municipal plans in regard to their importance to health promotion issues. The aim is to reveal signs of the HiAP perspective and SIH approach in policy documents, which will be in accordance with the requirements of the Public Health Act and the Plan and Building Act to determine overall goals and strategies for

⁵ The WHO Healthy Cities project is a global movement. It engages local governments in health development through a process of political commitment, institutional change, capacity-building, partnership-based planning and innovative projects.

health promotion to meet the challenges the municipality faces (Norwegian Government, 2011 and 2009).

The Municipal Society Plan 2013-2016

This is a strategic plan which has chapters for: 1) Growing up, 2) Housing, 3) Economic development and competence, 4) Traffic and infrastructure, 5) Culture and sports, 6) Health care, 7) Social inequity in health, and 8) The municipality as an organisation and participation out-side the municipality. HiAP, SIH and therefore also SDH, are highly emphasized in this plan. There are clear evidence of health promotion within each chapter. The fact that the SIH perspective has its own chapter indicates its importance, which also seems to be evident in the other chapters. This might be a token of SIH being a consistent perspective.

Some measures of special interest are that the municipality wants to strengthen collaboration with private actors to get young people in the establishment phase and other economically weak groups into the housing market, the strong focus on promoting environmentally friendly and healthy measures for traffic, to establish a coherent walk and cycle network and a safe route to school for everyone, and that everyone in kindergartens, schools and care institutions is offered cultural experiences.

Some interesting measures in the social inequity-chapter: 1) It is legitimate to treat children differently for them to be successful in school with the goal of equalisation of social inequity, 2) Require that public and private sector offer jobs that are meaningful for those who have not mastered the ordinary

labour market, 3) Available leisure activities that ensure cohesion of social inequity and good inclusion.

The Health-, Social- and Care Plan 2013-2016

This plan contains an entire chapter on health promotion and emphasizes these perspectives for all groups in the municipality through: 1) Prevention before reparation, 2) Early intervention towards kids who live under problematic family conditions and 3) Facilitate for help and self-guidance at the highest level. The main priorities related to SDH are building houses for elderly and other disabled groups, to strengthen health promotion and health services for people living in their own homes in participation with the culture sector and to intervene against school and work drop-out and to follow up on other priorities related to kids and youth, this is anchored in the Child and Adolescent Plan 2011-2020.

There is a specific focus on children, youth, elderly and immigrants. The main challenges are related to young people dropping out of school and work, physical inactivity and better nutrition. Action steps must be taken towards all inhabitants and the prioritised groups. To be able to manage this, there is a need for increased collaboration and coordination between the health sector and other sectors, especially the kindergarten, school and culture sector, in addition to different working places, establishments and voluntary organisations.

***The Sport, Outdoors Activity, Physical Activity and Public Health Plan
2011-2015***

This plan's main focus is to prioritise in- and out-door sport arenas in the municipality. The plan is a necessary tool for getting funding from the state. Nevertheless, the municipality has a broad perspective on physical activity. Health promotion seems to be emphasized throughout the whole plan, also in regards to sports arenas. The universal design principle⁶ which makes it possible for everyone to participate is specially emphasized. The Public Health Act is mentioned as one of several guidelines for the plan, and there is a clearly stated connection to other plans in the municipality.

The Child and Adolescent Plan 2011-2020

This plan contains all municipal settings of importance for the up-bringing of children and youth: kindergarten, school, culture and leisure, including library, Municipal Cultural School and youth club. The health preventive and promotional work which is integrated in kindergartens and schools in a systematic way is highlighted. Their aim is to help children and youth to become independent individuals with good social competence to tackle both successes and disappointments. To achieve this, a close collaboration with the public health services and culture sector is necessary. A team called "Child and Youth Services" is established to manage this and to provide help for children when necessary at an early stage. Integration and multicultural work is highlighted in its own chapter, emphasizing language assistance and integration of small children and their families. Culture

⁶ Universal design is a concept of designing all products and the built environment to be aesthetic and usable to the greatest extent possible for everyone, regardless of their age, ability, or status in life.

activities in kindergartens, schools, youth clubs and other leisure arenas are considered important.

The Centre Plan 2012-2016 (2028)

As a knowledge base for the plan, the municipality assigned the Norwegian Institute for Urban and Regional Research (NIBR) to conduct a socio-cultural analysis of urban development and profiling. Involvement from the population and academic-, cultural- and business interests and other stakeholders, was considerable during the process. This plan contains several chapters of specific interest for health promotion: aesthetics and quality, green structure, car-free ring around the primary school, continuous bicycle network and universal design. Within these chapters there is great focus on physical activity, social networks, pedestrian and bike friendly areas. Special emphasis is placed on the concept of universal design as a general perspective of the plan.

The analyse of plan documents provides proof of health promotion strategies in all the respective plans and a systematic HiAP, SDH and SIH approach which seem to be a product of deliberate policy. Being implemented in the plan system, health promotion is viewed in a long-term perspective which means a responsibility for all sectors. Strategies are to a great extent targeting living conditions and better services for all, in addition to efforts aimed at disadvantaged groups.

5.3. Interview Analysis

This section presents the results from the interviews in regards to these areas:

- The understanding of health promotion and health in all policies
- The implementation of health promotion in plans and strategy
- Strategies to reduce social inequality in health
- Interventions – activities being implemented
- The public health coordinator
- Cross-sectoral collaboration

5.3.1. The Understanding of Health Promotion and HiAP

To understand health promotion in a broad perspective is of vital importance when municipalities decide their policies, choose their strategies and where, and how to intervene. Therefore the interviewees were asked to describe their understanding of the health promotion concept. Most interviewees had a broad perspective on health and recognised this as a cross-sectoral responsibility in line with the HiAP approach. Some reflected on health as the conditions that made it possible for individuals to be a part of the society, to fulfil their potential, to take on a healthy lifestyle and to live in healthy surroundings.

“In an overall perspective I think health promotion means to protect and prevent and think about citizens’ welfare so that they might maintain an optimal health as far as possible.” (P4)

“Health, I think, is to create a residential area or a good place for people to live, simply. If one does not think of health, one thinks that people should live a good life, and that's health.” (P7)

“I think it is the possibility of living a healthy life and a good life. For me it's everything from bike paths to having a good meal in kindergarten. So I'm probably very much on health in all policy areas in my understanding of the concept of health promotion.” (P5)

On the other hand, a few interviewees had a more reductionist view emphasizing physical activities as the most important area of health promotion, and stated that the municipality should provide universal areas and hiking trails which enable everyone to participate and take on an active lifestyle.

“The first I'm thinking about is to have people in activity during active leisure. [...] We facilitate excellent opportunities to go hiking in the woods and stuff like that. It's the most important thing that contributes to good health because then people simply get in better shape.” (P2)

This quote points to the importance of facilitating for better health and that this is a responsibility for the municipality. I was surprised by how strong the interviewees emphasized the impact of physical structures, easily accessible and well planned surroundings would have on health for everyone.

” Yes, universal design is essential for everyone to participate. Otherwise, I think of other groups – to place benches around the grounds, and now we are talking about the same in town also, because if someone cannot go further than 200 meters, they must be able to sit down. So, this is something we have in mind and do some work on. We also have an awareness of the steepness when we build new roads for walking or such, the steepness when entering a building and that one does not encounter barriers and such, that the entrance is properly marked for visually impaired with colours and stuff.” (P3)

The most important sector in the health promotion work was emphasized by the majority of the interviewees to be the child and adolescent sector which provides arenas where everyone can be reached.

“I think that the child and adolescent sector is important because in school, and mostly in kindergarten, but especially in school, you meet all the kids ... it's really a neutral arena to be in.” (P1)

“Then I will of course say the child and adolescent sector because in kindergarten and school absolutely everyone is reachable. It's that simple! And the basics are that if we have a good school to offer everyone, we can prevent a lot of disease, suffering and inequality.” (P5)

On the other hand, some interviewees expressed that all sectors were important because they play different roles in the health of the inhabitants.

“Since all plans concern this, then all sectors are most certainly responsible for implementation and [...] But, otherwise it is clear that the cultural sector plays an important role here, as does the child and adolescent sector - schools and kindergartens and everything – there are very few sectors that does not work with public health, really.” (P2)

“No I do not know - maybe it's a little difficult to say that some are more important than others. We play different roles and have different instruments and different methods. If we who work in the public sector manages to collaborate well, have good meeting places, we ...” (P8)

This last quote also points at the importance of having arenas for inter-sectoral and interdisciplinary interactions and cooperation, which is outlined in pkt.6.8.

5.3.2. The Understanding of SIH

To reveal the understanding of social inequity in health, the interviewees were asked to describe what the term meant to them. Everyone revealed a broad understanding about SIH as being a matter of health promotion for all and early intervention in kindergarten and schools. The interviewees rated academic achievement and education as the most important tools for leveling out inequities in health. This may be seen as proof of a broad

determinant view and early intervention in a life span perspective. These quotations from the leader of the health care sector and the Councillor may represent the interview findings in this aspect:

“I think the most important in reducing social inequalities, is simply education. I do not doubt it, and research shows this too. If people get a platform and get an education, that's what it takes to reduce inequity. [...] To start early so children get an equal footing when they begin school so no one has a handicap which follows them throughout the school course and causes that they are not getting the education they really have the potential to master.” (P7)

“If I'm going to add a perspective about health promotion over a very long period, I will say that the work must start early in the life course, and that you work targeted and preventative in kindergarten, this might in the long term be the strategic perspective with the greatest effect.” (P4)

Even if the gradient perspective was not pronounced, some interviewees highlighted the gradient and health gaps without using the terminology. The quotation from the Councillor may serve as the meaning of several statements:

“I see social inequalities in health in a demographic perspective as differences between age groups, we see differences between social strata, we see differences between what we commonly regard as native and new citizens. This we see across cultures and ancestry.” (P4)

5.3.3. The Implementation of the Public Health Act

At the time of interviewing, the Public Health Act with its strong claim about anchoring public health in all plans, was adopted a year before. All interviewees had some knowledge about the act. Even though the municipality has prioritised health promotion for many years and they have their own motivation for doing so, the act was considered to be a helpful

tool in their systematic, inter-sectoral health promotion work. The Mayor and the Councillor state that:

“In other words, the Public Health Act has led to a change [...] it simply adds to the guidelines for the municipal work”. (P2)

“The Public Health Act has contributed to health promotion, and preventive work has gained greater legitimacy in the organisation. And this focus that also involves inter-sectorial working methods is also a product of the Public Health Act, and insofar the Health and Care Act, and it helps to provide legitimacy. But I feel that [...] the municipality has had great self-motivation to work with this topic.” (P4)

In line with the document analysis two interviewees highlighted that the implementation of health promotion in the plan system started several years ago – long before the act was adopted, but the law made this effort stronger.

“The Public Health Act has maybe not lead to a great change, but it has certainly contributed to a greater emphasis on the health promotion thinking”. (P5)

“I participated in the work of the health plan [...] and then the new laws came. And I think that that plan was built on the new Health and Care Act, the Cooperation Reform and the Public Health Act. So the way I see it, it is a strong focus on disease prevention and health promotion. We have at least tried to pay attention to it and implement it everywhere. Because this is the way we have to work.” (P7)

On the other hand one interviewee saw the Plan and Building Act as their formal tool in planning processes and stated that there was no focus on the formal aspects of the Public Health Act, even though the informal inputs were taken. An important requirement in the Public Health Act is that municipalities must have an overview of the health situation and determine their area of priority from this knowledge. Four interviewees knew for a fact that a health overview was a part of the factual knowledge of the planning

process, and that all sectors and some stakeholders had participated in bringing knowledge about the municipal health challenges forward.

“Yes, I would say that our plans are based on a factual basis. Then, it is always possible to say that the facts could have been both deeper and broader, but we build on the data material that we collect where the challenge areas emerges from the indicators they measure.” (P3)

“We hope we will be able to respond factually and prioritise based on what we see is important built on knowledge about research, but also about the status of our own municipality.” (P5)

One participant had no concrete knowledge about whether the health challenges had been a concern during the planning period or not, another participant believed that this was secured by the public health coordinator and through the broad participation in the planning process.

“There have been broad-based professional groups who have been behind these master plans - especially the Child and adolescent plan and the Health care plan, and I will of course say that it is a knowledge-based approach to how we really recommend the text material and the way to prioritise.” (P2)

5.3.4. Public Health in Plans and Strategies

All interviewees emphasized the importance of health promotion as a part of the plan system and as a focus topic and tasks for all sectors. In regards to anchoring health promotion in plans, all interviewees highlighted the importance of increasing the understanding and priority of the health promotion field in the municipal in general. In addition, the participants believed that this was in place both in the overall plan and in all sector plans. In this aspect all interviewees confirmed the findings in the prior document analyses that health promotion is an integrated part of the plan system.

“I can’t, of course, say that I know these plans in detail, but I took part in making the Child and adolescent plan, and there is a lot of health in some of the chapters there. And the Health-, social and care plan says a lot about it, and clearly, in the Centrum plan there are a lot of elements which might be about health promotion. Now we are working on the community section of the municipal plan, and we cover this topic there of course. So I feel in fact that at an overall level we have sort of a ... well, a good attitude regarding that health promotion is important work.” (P2)

When a topic is anchored in the community section of the overall plan it should also become an obligation for other plans the municipality decides to have. The document analysis seems to indicate that this is the situation, which is confirmed by the participants.

“It's all about this new community section of the municipal plan. And there, as long as you start with a theme, we are in a way obliged to take it further into other overall plans for the municipal sectors. And, there we are [...] we have anchored health promotion in the social community section and in that way it shall also be a topic in the other policy areas.” (P4)

“Yes, well, all of these have been cross-sectoral projects, because it is extremely important that things are connected. We cannot have a Child and adolescent plan that has a firewall between itself and the Health-, social- and care plan.” (P2)

However, even though coherent planning is a clear goal for the municipality, it might be difficult to achieve this at a full range because the different sectors write their own plans.

“It's a bit like the child and adolescent sector writes their part, the health-, social- and care sector writes theirs, and then something will be in the Health plan but not the Child and adolescent plan.” (P1)

5.3.5. Addressing SIH

In line with findings in the document analysis, it seems important for the participants to reach everyone across social borders. To facilitate for an

active lifestyle for the whole population is considered important by all interviewees highlighting the importance of physical activity and a comprehensive program facilitating hiking trails close to living areas. The aim by doing this is not to facilitate for the most active groups, but for everyone.

“When we plan for hiking trails [...] and stuff like that, it is a part of the public health umbrella, in a way. It's not because people that run up there in 14 minutes shall have better trails to run, it is because the trail should be more available so more people can participate, in a way.”
(P2)

In school and kindergarten about 160 teachers and some other employees have started a postgraduate study lasting for one and a half year. The aim of this program is to enable them to take a clear leadership in the classroom. The leader of the child and adolescent sector considered this to be a health promotion initiative that specifically captures the most unstructured students.

“It will be approximately 160 people, mostly teachers and some assistants. [...] Everyone shall participate in a post-educational program. [...] Teachers' way to interact with the students, reactions to how they talk with students, how they inform about transitions from one activity to the next activity, how clearly the teachers show what students will learn in the lesson - a little more emphasis on what they are actually going to learn. And it is the most unstructured students that do not have quite so many resources who fall through if structures in school are not good enough.” (P5)

The municipality considers cultural experiences to be resilience factors and provides professional artists and musicians to visit kindergartens, schools and retirement homes rapidly over several years. The municipality

participates in two programs, “The Cultural Walking Stick”⁷ and “The Cultural School Bag”⁸ which is partly financed by the state but mostly financed over the municipal budget. A third program, “The Cultural Kindergarten Bag”⁹, is initiated and financed by the municipality without any participation from the state. This is done because they want to reach all children because they benefit from this by socializing more and learning better.

“It is quite deliberate that we want to achieve systematic cultural activities in kindergarten in the same way as in primary school. We do this because it's the only way we can reach everyone. [...] Result shows that those who receive culture in this way learn better. We use this in kindergarten and with the elderly. So, I will say that we have a systematic approach where we reach out to virtually everyone, at least in kindergarten and elementary school.” (P8)

Another interesting approach is that the municipality force private entrepreneurs to plan for well facilitated outdoor areas by using what they call “sequence requirements”. This means that entrepreneurs do not get permission to build new housing complexes before they have built and facilitated green areas in the surrounding living areas. This is a clear strategy in order to provide good living conditions where people live. Head of Planning explains:

“The last 5 years we have changed some strategy for how we will carry out the sequence requirements. So, instead of creating a green corridor through a residential area as it was done before, and doing nothing to demand that it should be green [...] So what we have done in recent years is that we impose order requirements to the developer about the trails and green structures to be built up and be in place before they are

⁷ “The Cultural Walking Stick” is a national programme which provides professional culture activities to elderly on a regular basis.

⁸ “The Cultural School Bag” is a national programme which provides professional culture activities to school children on a regular basis throughout the school year.

⁹ “The Cultural Kindergarten Bag” is a municipal programme initiated after the model same as “The Cultural School Bag”

allowed to use the area. In this way we ensure the implementation in a completely different way.” (P6)

Several initiatives aimed at vulnerable children, youth and families with little resources are organised in a way that they might reach everyone. For instant, some interviewees emphasized an equipment central where all kids and youth might lend the equipment needed to participate in sports and other leisure activities on equal terms without being stigmatised.

“We have an equipment central and it has been a huge success! It was almost emptied for equipment last winter, so people are very enthusiastic about it. And what's nice is that all kinds of people are using it. It is not negative for people to go to the equipment central and rent equipment.” (P1)

Several cultural arrangements have low prices for elderly, kids and families to reduce access limitations and make it possible for everyone to participate.

Head of culture states:

“We work works towards a goal of social cohesion because it affects how we would price the event. [...] We have pensioner rates at the cinema [...] and special children's- and youth rates. We are relatively free in how we decide prices, but we have such a conscientious attitude to this because everyone should be able to participate.” (P8)

According to plans, providing housing for all who need it are considered a major task for the municipality which also is emphasized by several participants. “Social welfare housing program” (Boligsosialt velferdsprogram) shall provide housing for young people and groups that struggle to buy their own homes. The politicians have prioritised 60 million Norwegian kroner to this purpose, and all sectors will participate. This really proves the importance of the field of concern. The Councillor states:

“We will work across all sectors to solve a problem that is relatively large in the community concerning housing capacity for young people, disadvantaged people and groups who might otherwise struggle to get into the housing market. I regard this as prevention as well, right? And the politicians have followed a suggestion from me to provide 60 million (NOK) in the financial period.” (P4)

Connected to the social welfare housing program, another program initiated by the health care sector called “From rent to own” (Fra eige til leige) is implemented, offering homes to specially prioritised disadvantages groups. One participant highlights the health promotion effect good residential surroundings might have if vulnerable groups are not gathered in homes in the same place:

“Housing policy is indeed very important here. We are very conscious that we should not create ghettos, but that all groups should be able to be integrated in good residential area. The municipality buys apartments in new blocks or residential areas and stuff. Social housing will provide flats and houses where people can live for a while, and then we will help them to buy their own home. [...] Because we see that owning your own home is very important when it comes to sense of mastery and taking care of something that one owns. We shall see this in the context to the social welfare housing program.” (P7)

Another prioritised area is to prevent young people from dropping out of school and work, something which was highlighted in plans and by most interviewees as a big challenge. In this aspect several participants stated that early intervention, before the problem had developed was important in addition to helping those who already have a problem. This is seen as a cross-sectoral and interdisciplinary task which starts already in kindergarten.

“We try to reach young people sitting at home in front of their PC and who fall out when they begin at upper secondary school. [...] We’ll have a parent group and a youth group where we’ll sensitise them on their

own problems. [...] When they become aware that "I have an Asberger diagnosis, true, and it means that I am so and so" - they may understand themselves better and become able to master the end. [...] The kindergarten says that "we see them even at our level", so it is important to get in early. So here we work very interdisciplinary, there are schools, kindergartens, health care - all these areas participate." (7)

In addition to the early intervention in preventing young people from dropping out of school, a systematic approach to help those who have left school away from social support and in to the labour market started a few years ago. It is called "Turn around in the door" (Snu i døra) and here the municipality participates with some businesses which have developed great competence in handling young people at risk. This is regarded as an important health promotion approach by the Mayor:

"The young people approaching 20 years who have dropped out of upper secondary school and that we have an awareness to prevent from getting into the men's social benefits motions. They are told that they will get money, but are asked to sign up for work at [...] It's called "Turn around in the door" - we have great businesses in town that are very competent in terms of getting people back on track. But it is extremely important to get involved as early as possible. This is the clear part of the health promotion perspective. "(P2)

5.3.6. Promotional and Inhibitory Factors

Even though health promotion is integrated in the plan system and adopted by politicians, some of the interviewees states that in the end this will not ensure that interventions happen, even if health initiatives also are part of political documents and action plans. There are many barriers to overcome. Lack of funding and staff resources were emphasized by some. In this

aspect links between plans and the municipal budget is important and is often missing.

“The link to the budget is probably not so good - there is an inadequate link between what is decided and what is being implemented. So, now we have tried to link the new budget and our action program closer together.” (P1)

Some pointed at the lack of participation from people in the municipal organisation. Some also recognised that there might be some disagreements regarding the plans and the prioritised activities.

“It is essential to anchor these things from day one and the anchoring part can almost never be good enough. Because you will always meet someone who has not taken any part in the discussion, who has strong opinions that may disagree with the way... maybe not the goals, but the way it is done.” (P1)

In addition, some interviewees outlined that the cross -sectoral nature of health promotion might lead to problems or unclear responsibilities in the government of the municipality. Who is responsible for bringing things up, involving and coordinating other sectors and following the execution of a task from start to finish? For some services this is not clear, and they face different organisational challenges.

“One thing is that the plan sector has an administrative responsibility [...] It is more unclear who is responsible for the detailed planning and implementation of that kind of project. The operation part is partially clear, it lies in technical operations. However, we have a discussion about how to implement it because it is a discipline that can be placed in culture; it could be placed in technical ... So we struggle a bit now about how to organise it properly.” (P6)

All interviewees considered participation to be important for legitimacy and understanding of health promotion initiatives and to secure the

implementation of services. One interviewee stated that it is very hard to achieve participation at a full range even if this is a prioritised goal in the plan process.

“What I see in all planning work ... how wide we may try to reach, and how interdisciplinary we are trying to work, we never manage to reach everyone, there is always someone who has not been invited who shall follow up retrospectively what others have determined. For, planning implementation is almost a job that is impossible to do well enough.”
(P1)

The Importance of Leaders’ Involvement

A clear and positive approach towards health stated from the top level in the municipality provides the best possibilities for all sectors to prioritise health promotion. Some interviewees emphasized that the Councillor, in his monthly meetings with leaders from all sectors and service areas, highlights health promotion as topics for all to discuss.

“We have something we call municipal day - the Councillor has, and there the topic for discussion very often is health promotion [...] It has been repeated many times, even this legislation.” (P3)

A known challenge in the health promotion work is the lack of involvement and support from leaders. During the interviews, token of top leaders' support was highlighted. The public health coordinator emphasized an active participation of several top executives who have provided the foundation for policy and strategies in the implementation of health promotion.

“The municipal manager at that time made an important move and asked if I would be secretary of health plan [...] because as he said “What we need to do now is to arm ourselves to think more preventable”. So, I had the overall responsibility for bringing the health promotion thinking in

where [...] also they (the municipality) have had a municipal doctor that has worked with health promotion over the years, so there has been an understanding about prevention and health promotion providing the foundation for working with these things.” (P1)

“We have a plan-chief who is very concerned about this here and is very into health promotion in his way of thinking. So, he is concerned that we shall implement health promotion and that we have broad processes in doing so.” (P1)

How leaders’ engagement has affected the political commitment and system is emphasized by the Mayor:

“I think we have a good attitude towards health promotion in the political system, actually, which might have arisen through talented people in the administration who help us to be conscious about these things.” (P2)

In addition to leader involvement, we know that how the municipality organises the public health coordinator position, is of vital importance for legitimacy and implementation force. This seems to be confirmed by this statement from the Councillor:

“We have placed health promotion in the Councillors’ staff to provide an organisational position that demonstrates the affiliation and the level of importance, so it is not a resource that we have hidden in the health and social services far out in an office, but we want to have a central placement of the position.” (P4)

5.3.7. Cross-sectoral Collaboration

Statements from interviewees confirmed that there is significant collaboration between sectors and service areas within the same sector.

These groups seem to have an overall approach. These statements from the leaders of technical and cultural sector cover the meaning of several interviewees:

“There are different networks in the community, and I participate in a network with 4-5 other sectors, but it's mostly within the plan and society, technical, fire and sweeping and culture. [...] That's the case in other sectors as well. People from 4-5 service areas sit in each group and meet once, twice a month. There is always a different theme to discuss, and often the subject comes from the Councillor – health promotion or something else - then we discuss it, and so the leader of this group reports back to the Councillor, and it has been in this way for many years.” (P3)

“We have established a solid body with all institutional leaders within elderly care in relation to the Cultural Walking stick where we have created structures for how to communicate. And we have done the same thing with schools because we coordinate the Cultural School bag. And we also have the same body with kindergartens because the City Council has allocated funding for the cultural program in kindergartens.” (P8)

In addition to groups with participation from two or more sectors there are groups or networks within each sector with interdisciplinary focus on duties and activities. Their role is to discuss challenges at system- and individual level in order to secure a healthy service chain, for instance to ensure the transition between kindergarten, school and work. Some interviewees emphasise this kind of groups to be important in the overall work within each sector.

“First we have these networks [...] between school and kindergarten. This is within the same sector, but if they had not worked well together we had missed the important transfer of expertise and capacity from kindergarten to school.” (P4)

The lack of a cross-sectoral group at an overall level leads to problem reaching sectors and arenas that must be a part of the practical work. Some interviewees emphasised the need for such a group to discuss and implement health promotion and meet with top leaders from all sectors at

the same time. Important time resources are used in conducting separate meetings with each sector.

“We do not have permanent inter-sectorial groups at an overall level, and that's something that I have missed because [...] (the municipal) has a two-level model with sectorial network meeting. And that's my challenge, because I would like to say the same thing to multiple networks simultaneously, right? And then these network meetings are focused on operational tasks in school, kindergarten, and then I'm invited when they think it is important that I'm present. But I have no forums where I, in a way, can work with public health at an overall level.” (P1)

5.3.8. The Public Health Coordinator

Without being asked, most of the interviewees highlighted the importance of the public health coordinator and the role this position represents in the municipality. The coordinator has a full time position and he provides greater expertise and focus on the field of study, and also greater collaboration at an overall level which might lead to better organisation and better services in all sectors.

“You get, in a way, a more conscious approach to health promotion. And of course the public health coordinator gets to travel a bit around the country and get some impulses on how one can organise things and we get the opportunity to improve the general activities.” (P2)

Furthermore, both the Mayor and the Councillor emphasized that the coordinator communicates health promotions throughout the organisation and assigns responsibility to different sectors in addition to coordinate municipal efforts:

“We have a public health coordinator, and that's great because then we have a person with an overall perspective on things who makes sure that the various other services are on their toes regarding health promotion measures which are implemented in plans. If we are all located in

separate sectors and only work with health promotion by ourselves, then it might be easier to forget it. [...] Having a public health coordinator helps us to be more aware. Without this position each of us would sit alone and think about public health every now and then, right?” (P2)

“Yes, well, it means a lot to have a public health coordinator! As much as you have a finance manager who coordinates financial services organisation, we have a public health coordinator who puts together a whole organisation's work and can both make a plan and also coordinate the service in it. And, in that respect it is a valuable position.” (P4)

On the other hand, as expressed by the public health coordinator, the role and responsibility of the coordinator is unclear. Even though the position is part of the staff and is located close to the Councillor, when it comes to implementation in some settings, the level of influence is experienced as relatively insignificant. The coordinator does not participate at the level where overall decisions are made.

“And I may not have the room for action and the impact force. [...] I could imagine an even clearer mandate from the Councillor that this (activities anchored in the plan system) will actually be implemented. I have little sparring and dialogue partners related to the implementation of the things suggested.” (P1)

6. Discussion

This discussion attempts to summarise, and critically discuss the findings of the interviews analysis. The first part discusses how the HiAP and SDH perspectives are implemented in policies and strategies in the municipality in light of the Public Health Act. The second part discusses how SIH is a subject to governance at the municipal level and what interventions are taken to reduce inequities in health. The level of cross-sectoral collaboration is a part of this discussion. The third part discusses factors that strengthen and weaken the HiAP and cross-sectoral work. Finally, the fourth part concludes and points forward with some recommendations of how municipalities might address their health promotion work and the need of further research in the field.

6.1. The Implementation of HiAP and SDH in Policies

Through documents and interviews accounts of the present study, there seems to be clear evidence that health promotion is seen in terms of promoting health and wellbeing and not the absence of disease (WHO, 1948). The majority of the participants highlight quality of life, to be able to work and participate in society and to lead a healthy life as their main perceptions. It is particularly interesting that no one emphasis lifestyle for regarded health as an individual responsibility. This might prove an orientation towards a SDH perspective which represents a system approach more than an individual approach. This contradicts the findings of Hofstad and Vestby (2009) and Helgesen and Hofstad (2012) who found that

although municipalities had started an orientation towards a determinant perspective, lifestyle and individual responsibility was the major approach.

Also, there seems to be a clear understanding that facilitating for better health is important, and is considered to be a responsibility for all sectors. In this aspect the interview findings seem to be in line with the plan documents where universal strategies and physical arrangements were highly prioritised. This provides proof of an effort within several services to develop a good environment that might promote health for all.

Regardless of what topic the interviews highlight as being most important for health, all points at up-streams structural measures and early intervention as the main approach, in addition to proper health care and initiatives from other sectors aimed at disadvantaged groups. This provides evidence of a SDH approach at the system level, and not just a personal responsibility of individuals (Whitehead, 1998). The use of complementary approaches aimed at the worst off and the whole population at the same time seems to correspond with the universal and target interventions approach, or Marmots' proportionate universalism (Marmot, 2010) which is considered important in addressing the gradient.

In addition, the importance of all sectors' participation was also strongly emphasized due to the impact that different sectors have on the health of the inhabitants. This seems to be a clear understanding of HiAP and SDH as outlined in the Dahlgren and Whitehead model (1991) and appears to be in line with the new health policy framework for Europe: Health 2020 (WHO, 2013).

In contradiction to findings in other studies (Hofstad and Vestby, 2009; Helgesen and Hofstad, 2012; Ouff et al., 2012; Kassah, Tingvoll and Kassah, 2014; Lillefjell et al., 2013) which conclude that the health sector is the most active sector, this present study reveals that the participants do not consider the health sector to be the most important sector in the health promotion work. It also deviates from these studies with regard to the broad and partly extensive participation from all sectors. This corresponds with the basic idea of HiAP and the importance of SDH and the policy behind the Public Health Act.

The Public Health Act

The participants regard the Public Health Act as a helpful tool for systematic, inter-sectoral health promotion work in the municipality. Some interviewees emphasized that health promotion was a prioritised area in the municipality long before the adoption of the act in 2012, but that the act had made their health promotion disease prevention work stronger. This finding tends to harmonise with the objectives of the act and implies a perspective of SDH impact (Grimm et al., 2013). This is also in line with the document evidences confirming a coordinated anchoring in the municipal plan system, which seems to be more evident than in most municipalities according to the study of Helgesen and Hofstad (2012).

Implementation in Plan

Health promotion must be a long-term, cross-sectoral responsibility for municipalities instead of a set of voluntary ad hoc initiatives and short term

projects (Norwegian Ministry of health and Care Services, 2002). To reach this goal, the political anchoring through the plan system is of vital importance because municipalities govern through prioritised policy and strategies decided upon in their plan system (Directorate of Health, 2002; Helgesen and Hofstad, 2012; Amdam, 2011; Grimm et al, 2014). The adoption of the Public Health Act and its synchronisation with the Plan and Building Act provides a legal basis for embedding health promoting policies in the municipal plan systems anchoring HiAP and the social determinants perspective. Supporting this view, all interviewees emphasized the importance of health promotion as a part of all plans. Anchoring health in the Municipal Society plan, as the document analysis and participants statement confirms, might provide the necessary legitimacy to an increased understanding and priority of the health promotion field.

Some participants emphasized that when a topic is anchored in the Municipal Society plan there is an obligation to include it in other policy plans which the municipality produces. This intention is consistent with Norwegian policy documents and the legal requirements in the Public Health Act and the Plan and Building Act. In this study, execution of this obligation seems to be confirmed by participants statement and the document review revealing implementation of health promotion in other municipal plans: The Health-, Social- and Care Plan 2013-2016; The Sport, Outdoors Activity, Physical Activity and Public Health Plan 2011-2015; The Child and Adolescent Plan 2011-2020; The Centre Plan 2012-2016 (2028).

In line with the obligation in the Plan and Building Act, and also in the Public Health Act, the municipality seems to have a practice of broad participation in planning processes. All interviewees highlighted this fact, and considered participation to be important for the legitimacy of health promotion which might secure the implementation of efforts. This harmonises with the participatory planning model emphasized by Amdam (2011) and is essentially relevant because mobilising, organisation and anchoring is important for health promotion (Ouff et al., 2010; Amdam, 2011)

6.2. Social Inequity in Health as a Subject to Governance

The interviewees revealed clear signs of an understanding about SIH as a matter of health promotion for all, early intervention when needed and a multi-sectoral responsibility. The majority of the participants consider the most important settings for health to be kindergartens and schools regardless of their own positions and workspace. Their most pronounced argument was the importance of reaching out to the youngest early, and that kindergartens and schools represent arenas where every child is reachable regardless of their social heritage. The participants also highlighted the potential for identifying children and young people with problems early. This provides proof of an understanding of early intervention and a life course perspective which is considered essentially important by several researchers (Stegman and Costongs, 2011; Marmot et al, 2010; Dahl et al., 2014). Preventing drop-out from school and work is considered to be the most important effort in preventing social inequities. This harmonises with Dahl et al. (2014) as he points out that policy and social institutions can determine how

individuals are channelled into the layering structure by reducing drop out in upper secondary school and preventing exclusion from the labour market.

The gradient perspective was pronounced only by the public health coordinator. Even so, the problem connected to the gradient and the health gaps was highlighted indirectly in terms of providing better conditions through a considerable amount of strategies and activities for the whole population. This was emphasized by all interviewees, and seems to implicate a gradient understanding. At the same time children, youth and elderly, in addition to several disadvantaged groups like immigrant women, poor families, alcohol- and drug abusers and young people dropping out of school and work were brought forward as prioritised groups. This indicates a broad and lifelong perspective which is reflected through the interventions that are taken, and seems to be a mixture of universal activities aimed at the whole population and activities aimed at disadvantaged groups. This underlines again Marmot's concept of proportionate universalism (Marmot, 2010).

Addressing SIH – Universal and Group Strategies

There is clear evidence from documents and interview analysis that universal and population-based measures are considered important by all sectors. This seems to operationalise the perspective of HiAP and to have a potential of preventing and levelling out the social gradient. As emphasized by the head of the department of planning the municipality forces private entrepreneurs to plan for well outdoor facilitated areas before they are given permission to build new housing areas. This is done through a preventive

perspective as a clear strategy for providing safe and good living conditions where people live their lives and the children play. This is in line with valid policy which is important for SIH (WHO, 2013; Ministry of Health and Care Services in Norway, 2006).

In line with the document findings, physical activity and an active lifestyle are considered important, and a comprehensive program to build hiking trails close to living areas has been started. Based on the finding of this present study, facilitating for physical activity seems to be the first priority when it comes to population based initiatives. This seems to confirm the research of Hegland and Hofstad (2012) as they found that the majority of municipalities prioritised physical activities as the most important tool in the health promotion work. Their study also emphasizes the importance of the Norwegian concept “Frisklivssentral” (Healthy Living Centre)¹⁰ as a responsibility for the health sector to provide for physical activity for patients. In this aspect this study differs from the prior study of Hegland and Hofstad (2012) as such centre was not positively emphasized by any participants.

According to the findings in this study the municipality regards cultural experiences to be resilience and empowering factors important to the health promotion work. This seems to be in line with the already mentioned study of Hegland and Hofstad (2012) and also the study of Abelsen et al (2012) as they found that cultural activities are considered important by some

¹⁰ “Healthy Living Centre” is a health service promoted by the National Directorate of Public Health to facilitate for physical activity adapted to different patient groups as a preventive initiative initiated in municipalities.

municipalities. This study reveals that cultural arrangements in general operate with low prices for elderly, kids and families, reducing access limitations for participation and making it possible for everyone to participate. The Culture sector also provides for professional artists and musicians to visit kindergartens, schools and retirement homes rapidly over several years through the programs “The Cultural Walking stick”, “The Cultural schoolbag” and “The Cultural Kindergarten bag”. The latest program is initiated and financed by the municipality without any participation from the state. This is done because culture is considered to be important for learning and participation and might affect health positively. This seems to be supported by earlier and recent research revealing connections between health and participation in cultural life (Knudtsen et al., 2005; Cuypers et.al., 2011). The research involved activity particularly aimed at children and young people in general, but especially targeting vulnerable groups among them.

According to this present study children and youth are prioritised groups in the municipal health promotion work; this is confirmed by plan implementations and statements from all participants. The Child and adolescent sector collaborates with the Culture sector as outlined in the previous section and with the Health sector for instance to prevent drop out from school. One measure in this connection is to enable teachers to take a clear classroom leadership. About 160 teachers, and some other employees, have started a postgraduate study lasting for one and a half year. Even though the course is provided by the University College in the county and is free of charge, the cost of having this significant number of employees

attending courses at the same time must be considerable. The Child and adolescent sector considers this to be an important health promotion initiative that specifically captures the most unstructured students and in that sense might reduce the drop out problem. This effort is strongly supported by several researchers as important for levelling SIH (Marmot, 2010; Dahlgren and Kelly, 2004, Dahl et al., 2014) and policy framework and documents (WHO, 2013; Ministry of Health and Care Services in Norway, 2006). Supportive and preventive initiatives in kindergartens and schools in general are regarded as the most important determinant of health which has a great impact on SIH.

As outlined by Dahlgren and Whitehead (1991) in their socio-ecological model, another important determinant for health is housing conditions. Anchored in the Centrum plan and highlighted by the Councillor and the health manager a new social welfare program for housing is started to provide homes for young people, disadvantaged people and groups that might otherwise struggle to get into the housing market. This seems to harmonise with national governmental policy. In the yearly report about the work to level inequities in health, the Norwegian Directorate for Health (2010) outlines that access to good and stable housing is an essential resource for opportunities to display and participation for all, and that lack of housing also might contribute to an exacerbation of health condition of people already in need of monitoring and supervision. Even if the municipality recently has been on the Robek list, the politicians have founded 60 million Norwegian kroner over the economy period in order to reach this goal. The municipality considers housing policy important and

participates with private entrepreneurs to make houses that are adapted to adolescents' economy. In addition, the head of the department of Health care emphasizes this to be done in a way that facilitates for all groups to be integrated in good residential areas and to avoid ghettos and stigmatisation of some people and groups. This provides proof of housing being a particularly major focus considered to have an important health impact for young people entering the housing market, often having kids of their own. The relationship between housing and health is obvious. This harmonizes with national policy and seems to be a strong SIH approach (Dahlgren and Whitehead, 1991; Marmot, 2010; Dahl et al., 2014; the Norwegian Directorate for Health, 2010).

A systematic effort to prevent young people from dropping out of the labour market is called “Turn around in the door” (Snu i døra). Some participants state that the municipality is actively trying to avoid that young people get into the social benefit track, so instead of getting financial support they get a job offer. To manage this, the municipality cooperates with the labour market and some specially adapted workplaces to mute the adverse consequences of SIH by preventing exclusion from the labour market and contribute to an inclusive working situation (Dahl et al., 2014). The Mayor highlights this effort in particular as a preventive measure which hopefully will get young people back on track again and in to a healthier life as being out of work will be a challenge to their health. This view is supported by national government stating that unemployment is a major cause of persistent low income; and has great significance for the individual's health (the Norwegian Directorate for Health, 2010) and by earlier research

concluding that people who receive social financial support in Norway are approximately three times more likely to die from behavioural causes than people in general (Naper 2009). Having a job is regarded as one of the strongest determinants for health (Dahlgren and Whitehead, 1991; Marmot, 2010; Dahl et al., 2014; Norwegian Ministry of Health and Care Services in Norway, 2006)

Several initiatives aimed at vulnerable children, youth and families with little resources are organised in a way that they might reach everyone and avoid stigmatisation. For instance, some participants emphasized an equipment base where all kids and youth might lend the equipment needed to be able to participate in sports and other leisure activities on equal terms. Low prices at culture activities and the way the housing programme is conducted, seems to be performed in a way that prevents stigmatization. This might point in the direction of a perception that the municipality wishes to prevent in a way that strengthens people and gives them opportunities to live healthy lives (WHO, 1985, 1986, 2012, 2013a)

Considerations of fairness and equitable distribution of health and social determinants of health are central to the SDH perspective and in the Norwegian political strategy to reduce SIH (Norwegian Ministry of Health and Care Services in Norway, 2006). Based on these examples of strategies designed for the inhabitants in general, which also reach vulnerable individuals because the important initiatives are implemented in arenas where everyone is present, provides prove that they are in line with Dahlgren and Whitehead's (2006) statement that health policies designed

for an entire population also must address the most vulnerable sections of society.

Cross-sectoral Collaboration

Partnership, cooperation and participation are important tools in the health promotion work, and municipal policies and structures that promote these are essential. Several authors have argued that such a cross-sectoral collaboration is complicated to achieve, partly because municipalities are organised in sectors around subject areas (Fosse 2013, Axelsson and Bihari Axelsson 2007, Amdam 2011). The findings in this study seem to reveal a range of collaborations between two or three sectors, and interdisciplinary collaboration within each sector. Some groups tend to discuss challenges at system- and individual level in order to secure a healthy service chain, for instance to ensure the transition between kindergarten, school and work. Other groups are mostly targeting the individual level, and are put together based on the problems that may occur.

Some interviewees emphasized the lack of a top-level group where all the sectors' leaders participate in discussing health promotion at an overall level. This seems to be in line with the study of Kassah, Tingvoll and Kassah (2014) which found that a top-level group is needed to implement health promotion strategies in all sectors.

6.3. Factors that Strengthens and Hinder the HiAP work

Strengthening factors

In addition to the importance of implementing plans, the findings of this study reveal some organisational factors of importance for how the municipality handles HiAP, SDH, and SIH. First, some interviewees pointed at the important role the Councillor had in bringing health promotion up as a prioritised topic in the municipality. In the Councillor's monthly meetings with leaders from all sectors, health promotion has often been a topic for discussion. This seems to provide a broader knowledge and understanding about the Public Health Act and health challenges in the municipality. This might be one important reason why there are clear signs of HiAP in the documents and interview material in addition to visible signs of collaboration within and between sectors. This seems to correspond with the main findings of Kassah, Tingvoll and Kassah (2014) that too little attention on HiAP from the Councillor reduces the possibilities to establish overall cross-sectoral public health initiatives. The HiAP perspective demands that the upper administrative level is involved and works towards an integration of SDH perspective in all sectors (Dahl et al., 2014). WHO (2012) outline that a strong political or bureaucratic leadership is required as a driving force to implement the HiAP principle.

The Role and Organisational Placement of the Public Health Coordinator

Without exception all interviewees emphasized the role of the public health coordinator, which proves that this position is well known in the organisation. The most expressed responsibility for the position is to have a high level of competence within health promotion framework and policies,

to be an active advocate for health and make all sectors pull in the same direction. This might point in the direction that professionalization in health promotion is needed and appreciated, which is considered vital by Mittelmark (2007) as he emphasized that lack of professionalization is a key barrier in health promotion. Furthermore, some interviewees emphasized that an important task for the coordinator is to communicate health promotion throughout the organisation and assign responsibility to different sectors and coordinate municipal efforts. This corresponds with the Directorate of Health (2011) Fosse (2013) emphasizing the cross-sectoral approach this position must have.

This particular municipality has a public health coordinator in full time employment organised in the staff. According to Helgesen and Hofstad (2012) this is not the usual level of employment as only 20 percent of the municipalities in Norway have a full time resource as a coordinator. As a deliberate strategy, strongly emphasized in statements from the Councillor, the position is located in the municipal building together with the Mayor, the Councillor and the majority of sector leaders. This is done to highlight the HiAP approach and the perspective of SDH which is difficult to do if the coordinator is hidden in some service down in the organisation. This corresponds with the organisation highlighted by some researchers as the best place to be organised to implement health promotion measures in the whole municipal organisation. The most common placement for this position is the Health sector (Helgesen and Hofstad, 2012; Fosse, 2013) which limits the possibilities to affect all sectors.

From two studies, Fosse (2013) concluded that the function of coordinating plays a significant role and that the health coordinator should be placed in a sector outside the health sector. By placing the coordinator close to the Councillor and the Mayor, the cross-sectoral nature and responsibility of HiAP is communicated clearly. Both Helgesen and Hofstad (2012) and Kassah, Tingvoll and Kassah (2014) agree to this as their findings show that having a top level position is the best way to implement health promotion throughout the municipality.

Barriers

On the other hand, as expressed by the coordinator, the role and responsibility of the coordinator are experienced to be unclear. Even though the position is a part of the staff and is located close to the Councillor, the level of influence is experienced as relatively insignificant. In addition the public health coordinator does not participate at a level where overall decisions are made. A reason for this might be the lack of a cross-sectoral group at upper level where all leaders are present at the same time to follow up policies and strategies given in municipal plans. This seems to add to the research from others that a description of responsibilities and tasks for the coordinator is needed, especially because health promotion influences all policies and services (Kassah, Tingvoll and Kassah, 2014).

The findings in this study also points at barriers which are considered to be a problem in the HiAP work. Even though the findings revealed a clear connection between policy, strategies and interventions, several participants pointed at barriers to performing health promotion initiatives. Lack of

funding and staff resources were emphasized by some, mostly because economic priority is necessary and that a link between plan and budget is missing. This missing link seems to be a challenge in the HiAP work. According to the research done by Amdam (2011) and the often mentioned study of Helgesen and Hofstad (2012) links between a plan, initiatives and the municipal budget are important, but often missing. One participant stated that the connection between plan and budget was stronger now than in earlier years, but the lack of money is still a problem when health promotion activities are set up against treatment and “more important” tasks that need to be solved. This seems to harmonise with findings of Abelsen et al. (2012) that poor funding of preventive measures from the national government in the cooperation reform is a barrier to the health promotion work.

Due to the HiAP approach and nature of the health promotion field, initiatives often involve more than one sector when put into practice. This means that several leaders, budgets and disciplines have to collaborate in dividing responsibility and effort. This represents challenges highlighted by several researchers (Fosse, 2013; Abelsen et al., 2012) and outlined in the earlier section regarding collaboration. In this study some token of these challenges are brought forward in connection with the implementation of certain inter-sectoral initiatives which involve several sectors in how to divide leadership and resources among them. This seems to be in line with the findings of Abelsen et al. (2012) emphasizing that difficulties in organising cross-sectoral initiatives might occur because municipalities do

not change their organisation before the implementation of health promotion efforts. It may also add to the findings of Kassah, Tingvoll and Kassah (2014) that a cross-sectoral leader forum is needed in to implement HiAP, but not in their discussion that such a group might replace the public health coordinator. In this present study the challenges of reaching out to all sectors simultaneously was highlighted by some participants. Their answer to this problem is to establish a cross-sectoral group at top level where decisions can be made and strategies decided upon, not as a substitute to the coordinator, but in addition to the coordinator and as important for the HiAP work in general. Without such a group it seems like the health promotion work suffers from the lack of capacity to implement strategies in all sectors when needed.

The public health coordinator also misses a clearer mandate from the Councillor and also seems to miss a clear description of the working area of the coordinator position.

7. Conclusion

The adoption of the Public Health Act is expected to foster a change in how the Norwegian counties and municipalities prioritise and implement the concept HiAP which implies a SDH perspective, and how SIH is addressed. Limited research has been conducted to reveal how municipalities handle health promotion both prior to and after the adoption of the act. This present study provides insight to this area adding some knowledge to the SODEMIFA project and the field of practice, and seeks to narrow the research gap in this important field.

This study reveals that the municipality has implemented HiAP and a holistic approach to health promotion to a larger extent than many other municipalities. This is proved by findings showing a coherent planning and implementation of health promotion policy and initiatives in all sectors. In the community section of the municipal plan, inequity in health has its own chapter with signs of health levelling initiatives in most of the other chapters. Even though the term “health promotion” was not specifically mentioned in some plans, an intentional understanding of the health impact of prioritised initiatives was visible. These initiatives are emphasized by the participants as being health promotion measures.

The plan anchoring provides an important fundament for execution of health promotion measures. The plan analyses and most participants highlight several long term programs being implemented through a cross-sectoral responsibility and collaboration. These programs are developed as part of

existing services as answers to identified health challenges in the municipality. Their long-term work is led by permanent employees within existing services instead of short-term projects led by temporary staff outside the formal organisation. This is particularly interesting because this proves a strong integration both politically and administratively and might prove that a healthy population is seen as a resource. An indication of this view is the strong universal strategy approach in most programs as they are aimed at the population in general or different age groups. The most prioritised groups are children and youth, which are reached through cultural activities, class management, preventive drop-out programs in kindergarten and school and integration into the labour market. These arenas are highly emphasized by almost all participants as the most important arenas for preventive initiatives because everyone can be reached at an early stage in life regardless of social heritage. This proves that health promotion is seen through a life-span and early intervention perspective which is essential to level the SIH.

In contrast to other studies the health care sector is not seen as more important than other sectors, in fact the health sector was not highlighted as most important by anyone, not even the head of the health sector or the public health coordinator. This might be seen as proof of acceptance of the HiAP perspective. This acceptance might be gained through the influence from the Councillor who often raises health promotion issues and the Public Health Act in his meetings with his leaders. The study results prove that the Councillor's role has been important for how health promotion is anchored in the organisation. First of all, the public health coordinator has a full time

position which is located in the staff next to the Mayor, the Councillor and some sector leaders. The Councillor states very clearly that this is a conscious and necessary placement to give the public health coordinator the legitimacy needed to take a cross-sectoral responsibility at an overall level. The role of the coordinator is also highlighted by all participants as important for pushing health promotion forward and being up-dated on health policy and knowledge, and bringing this competence out in the municipal organisation. This was particularly emphasized strongly by the Mayor and the Councillor. However, a clear mandate and descriptions of the working area for this position seems to be missing.

In contrast to findings from previous research, this present study also provides proof of a considerable amount of collaboration through networks and groups between and within sectors and service areas. The collaboration handles both structural issues and issues aimed at individuals, especially groups within the Child and adolescent sector and the Health sector. Being expressed as the most important sector, the Child and adolescent sector seems to collaborate with all other sectors to some extent. In spite of the established cross-sectoral collaboration that seems to be well anchored, the lack of a cross-sectoral top-leader group is strongly emphasized by some.

This study concludes that health promotion seems to be anchored in the municipality politically and administratively, working with universal initiatives aimed at the whole population and towards prioritised groups in line with the concept of proportionate universalism which targets the health gap and the gradient. The municipality appears to make progress in

implementing the Public Health Act and has proven to work according to the perspectives of HiAP and SDH being concerned about levelling SIH.

This municipality started their health promotion work in the 80s building a knowledge platform through a combination of practical work and policy making which seems to have provided a basis for broad and coherent work at system level. The municipality was a part of the Healthy-City network in earlier years and is now a part of a partnership with the county. This might support health promotion to develop year by year stimulated by external collaborations.

This study does not consider the impact that national policy and county policy and support might have in the development of health promotion. It can be assumed that the contribution of the Directorate of Health and the active collaboration between counties and municipalities might affect the reduction of SIH and promote the political awareness of the topic. There is need of further research in this matter.

Another recommendation concerns research on the impact organisational issues might have on the anchoring of health promotion, and the size of the position and the guidelines for the public health coordinators are also important. It can be assumed that conditions that facilitate for better working conditions for the public health coordinator are important for the anchoring of health promotion strategies. Further research on this topic might help to anchor and prioritise long-term health promotion initiatives in the future.

Finally, there is also a need for further research to shed light on the positive and negative factors that inhibit and promote HiAP and SIH in Norwegian municipalities. It might be assumed that there are some positive forces that one must be aware of and further develop and some negative forces that must be avoided. Research that brings clarity to such conditions will be of invaluable help to further develop the health promotion work.

Health inequities are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all. People live their lives within the borders of the municipalities; therefore municipalities have a particular responsibility to promote healthy conditions for all its inhabitants. Health promotion initiatives must be a natural part of all policies and governmental services which enable people to take individual responsibility and live healthy lives.

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Intervjuguide

Hva betyr disse begrepene for deg:

- Folkehelse?
- Helse i alle politikkområder?
- Sosiale forskjeller i helse?

What policies are in place at the municipal level concerning health promotion and social inequities in health?

- Hvordan er folkehelse forankret i kommunens planstrategi?
 - o I hvilke planer?
 - o På hvilken måte bygger planarbeidet på faktakunnskap om helsesituasjonen i kommunen?
 - Har kommunen utarbeidet helseoversikt, i tilfelle hvordan?
 - Hvilke datakilder er benyttet?
 - o Hvordan deltar kommunelege/folkehelsekoordinator eller andre med ansvar for helse i planarbeidet?
 - o Hvilke andre aktører (kommunale, frivillige organisasjoner, fagmiljø, private) deltar i planarbeidet?
 - o Hvordan er hensynet til sosiale ulikheter og utsatte grupper ivaretatt/omtalt i planarbeidet slik du ser det?

In which ways are the social determinants of health addressed from a municipality level?

- Hvilke sektorer mener du er viktigst folkehelsearbeidet?
 - o Hvorfor?

- Er det etablert tverrsektorielle grupper som samarbeider om folkehelse?
 - o Hvis ja, hvilke grupper er det og på hvilket beslutningsnivå?
- Hvilke ressurser (finansielle og stillinger) er rettet inn mot helsefremmende arbeid?

What interventions are taken to reduce social inequities in health?

- I hvilken grad er reduksjon av sosiale ulikheter i helse et utgangspunkt for kommunens tjenester?
- Hvilke grupper er prioritert?
- Hva er de viktigste tiltakene kommunen iverksetter?
- Hvordan er gruppene/brukerne tatt med i utformingen av tiltakene?

Is there any collaboration in development of policies and actions between sectors with responsibility for families and children?

- De fleste sektorer's ansvarsområder berører familier med barn
 - o Hvordan samarbeider disse om
 - Å belyse/få frem helseutfordringer for barn/unge?
 - Å utforme politikk og strategier?
 - Å gjennomføre tiltak?
- Er det noe du vil tilføye?



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TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 08.05.2013. Meldingen gjelder prosjektet:

34496

Implementation of the Public Health Act in a municipality in Norway with regard to health inequity

Behandlingsansvarlig
Daglig ansvarlig
Student

Universitetet i Bergen, ved institusjonens øverste leder
Elisabeth Fosse
Emma Helene Bjørnsen

Etter gjennomgang av opplysninger gitt i meldeskjemaet og øvrig dokumentasjon, finner vi at prosjektet ikke medfører meldeplikt eller konsesjonsplikt etter personopplysningslovens §§ 31 og 33.

Dersom prosjektopplegget endres i forhold til de opplysninger som ligger til grunn for vår vurdering, skal prosjektet meldes på nytt. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>.

Vedlagt følger vår begrunnelse for hvorfor prosjektet ikke er meldepliktig.

Vennlig hilsen

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UNIVERSITETET I BERGEN

Det psykologiske fakultet

HEMIL-senteret

Informasjon til deltakarane til studien: “Implementation of the Public Health Act in a municipality in Norway with regard to health inequity”

Studien er ei masteroppgåve som ser på korleis norske kommunar har implementert folkehelselova av 2012. Den ser også på dei politiske og administrative strategiar i arbeidet for å redusere sosiale skilnader i helse blant familiar og barn. Studien omfattar både analyse av politiske dokument og intervju med leiarar for ulike etatar. Studien er også eit bidrag til forskingsprosjektet “Addressing the social determinants of health: Multilevel governance of policies aimed at families with children» (SODEMIFA) som HEMIL-senteret ved Universitetet i Bergen har det faglige og administrative ansvaret for.

Vi trur erfaringa di kan gje oss viktig informasjon, og set pris på at du er villig til å delta i eit intervju om desse hovudtema: Korleis er folkehelse forankra i kommunen sitt planarbeid? Kan folkehelse vere eit tverrsektorielt ansvarsområde? Korleis kan kommunar bidra til å jamne ut sosiale skilnader? Korleis kan dei kommunale tenestene vere ein reiskap for å jamne ut sosiale skilnader? Vi reknar med at respondentane har ulike innfallsvinklar til dette, og det er viktig at de delar dykkar kunnskap med oss.

Datamaterialet skal handsamast anonymt. Namn og kjønn vert sletta i den skriftelege rapporten. Det som vert sagt eller gjort under intervjuet vil ikkje verte kommunisert til andre personer eller organisasjonar. Ingen enkeltpersonar vil kunne kjennast att i publikasjonar. Prosjektet er meldt til Personvernombodet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Vi nyttar bandopptakar under intervjuet. Råmaterialet vert sikra med sikkert passord på personleg datamaskin og vert øydelagt seinast eitt år etter intervjuet. For å garantere at vi har forstått dykkar opplysningar rett, og publiserer dei slik de har meint det, får de høve til å sjekke resultatkapitlet før rapporten vert publisert.

Deltaking i prosjektet er frivillig. Du kan også avslutte di deltaking når som helst under intervjuet. I så fall vil alle opplysningar bli sletta med det same.

Dersom du har spørsmål til studien, kan du kontakte oss på e-post eller telefon.

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SKRIFTLIG SAMTYKKE

Målet og metodene som brukes i studien ble forklart på en forståelig måte. Det ble opplyst at dersom jeg deltar i intervjuet, vil mitt navn og kjønn bli slettet i den skriftlige rapporten. Ingenting som blir sagt under intervjuet vil kommuniseres til andre personer eller organisasjoner uten fullstendig anonymisering. Innspillingene skal ødelegges senest ett år etter intervjuet.

Jeg har rett til å nekte å svare eller avslutte min deltakelse når som helst mens intervjuet pågår. I så fall vil alle opplysninger slettes med det samme

Navn:.....

Signatur:.....

Dato:.....