Lifelong Learning Centre
UNIVERSITÀ DELLE LIBERETÀ DEL FVG

HealthBox

DESK RESEARCH REPORT

"State of the Art in Health education"

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Education and Culture DG
Lifelong Learning Programme

This project has been funded with support from the European Commission (Reference: 503146-LLP-1-2009-1-AT-GRUNDTVIG-GMP)
This publication reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein.

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We have added years to life, now we must add life to years
(World Health Organization)

INTRODUCTION

Even though Europe is considered to be an advanced society, every day we can see around us difficult situations related to some people living in poverty or as outsiders. These groups are likely to develop diseases, mostly connected to lifestyle, such depression, cardiovascular diseases, alcoholism (which reaches young people and women), discomfort, low quality of life and so on: the picture of the diseases in our society has therefore changed.

Here follows an overview of the research carried out by Italy, Austria, Denmark, Finland, United Kingdom, Romania and Germany about lifestyle health diseases. All the data are also reported in a detailed scheme in order to give a full view of the investigation.

SUMMARY

Lifestyle diseases are acknowledged in all Countries: Italy, Austria, Denmark, Finland, England, Romania and Germany.

Lifestyle diseases that are rated as the most frequent in each Country/territory, with reference to national researches and studies are: **cardiovascular diseases** (mentioned by all partners: Italy, Austria, Denmark, Finland, United Kingdom, Romania and Germany); **alcoholism** (Italy, United Kingdom, Germany, Austria and Romania); **depression** (Italy, Austria, United Kingdom, Germany and Romania) and **diabetes** (Austria, Finland, Denmark, Germany and United Kingdom).

Countries not mentioning alcoholism as a lifestyle disease reckon that alcohol is one of the causes of cardiac diseases. Despite of the fact that Denmark and Finland do not specifically mention depression as a lifestyle disease, they reckon psychiatric disorders (Denmark) and an increase of mental stress (Finland).

Unhealthy diets, smoking and a lack of exercise seem to play a key role in developing lifestyle diseases.

Romania's situation needs to be taken into consideration: since 1989, mortality due to the above mentioned causes appears to be related to an explosive rise in social stress, a condition which arises when individuals have difficulty in responding to new and unexpected situations.

The social groups that are mainly and directly affected by these diseases: population in general and more disadvantaged groups

As a matter of fact, people in general suffer from lifestyle diseases, but disadvantaged groups are more likely to be affected: women, elderly, unemployed, homeless, migrants. Education, financial situation, employment, age and access to information are crucial factors for the development of the diseases.

Slightly different is the Romanian case: the health crisis has hit mostly male adults (20-59 year old). This is due to a 'social adaptation crisis' related to 1989 event, which has been exacerbated by the collapse of the political, social and economic organizations which framed people's lives for 50 years or more.
Moreover, Romania has to deal with Roma population, a stigmatized and vulnerable minority ethnic group. Factors leading to inequalities between Roma and the rest of the Romanian population are: homelessness, overcrowded living conditions, lack of access to safe water and adequate sanitation, inadequate nutrition, poor communication between health professionals and Roma health system users, little information on health issues and a lack of identity cards and documentation which precludes the access to health insurance.

The main needs within the identified target groups in relation to lifestyles diseases

The main needs are:

- Raising awareness
- Providing Information
- Individual and Group support
- Motivation / Health Services
- A sensitive approach
- Participation
- Creating incentives for taking part in health promotion activities
- Considering environmental aspects

The health policies that have been initiated / implemented in each Country/territory
(please refer to page 62 for the sources of the following information)

All partners acknowledge different initiatives from government/local authorities such as:

- National and/or international programs promoting prevention and healthy behavior: proper eating, stop smoking, fighting alcoholism and encouraging sports – Italy, United Kingdom, Austria, Finland, Romania and Germany
- Local activities and projects – Austria, United Kingdom and Germany
- Policies against alcoholism – especially Italy United Kingdom and Romania
- Health check and social surveys – especially Denmark, Germany, Austria and Finland
- Studies – especially Denmark, Germany and Finland

- Studies in collaboration with other Countries – Finland and Italy
- Training seminars - Finland
- Health reform – especially Romania

- Health education – especially Romania and Austria

- Taxation and price increase – especially Romania, Italy
- Smoking and alcohol restrictions – especially Romania, Italy, United Kingdom and Austria
- Advertising and communication campaigns – especially Italy, Germany, Finland and Romania

- Free medication – Romania and Italy
- Incentives for family doctors to locate themselves in isolated rural areas - Romania
- Social supermarkets – Austria
- Tutoring - Austria

Overview of the settings and areas (schools, family, public or private Institutions) that have already started health knowledge actions in each Country and their level (basic and/or more specific)

Schools seem to be the area in which all partners have already started knowledge actions (Austria, Finland, United Kingdom, Italy, Romania, Germany and Denmark), nevertheless the general public has also been targeted: both communities and network play an important role.

It is remarkable that:
- in Finland's health system all people have free access to nurses, doctors, laboratories, X-ray examinations and so on.
- Denmark has free access to doctors, vaccination program, dentist to the age of 18, child nurse for the first years – and continuing for the family who seems to need support.

School meal services are provided in United Kingdom. In Finland every child gets a warm meal every day for free in the daycare and in the school, even in the upper secondary and vocational schools. In Denmark, by law all kinder gardens have to offer free meals to assure that all children at least will have one proper meal per day.

In United Kingdom, clinics offer health related services.

Private initiatives and institution also play a role in Finland as regards health issue.

In Germany, in order to initiate a structural change of the health system, projects and actions are being developed in a participatory way together with potential providers, such as: education institutes, (sports) associations, schools, insurances, charitable associations, self-help groups, etc.

Already existing health knowledge actions: modalities and priorities, efforts and motivations in order to develop healthy life styles in each Country

Health information campaigns (Italy, Austria), brochures, leaflets (Italy, Finland), personal contacts (Austria), regional projects (Italy, United Kingdom, Austria, Germany), conferences (United Kingdom, Germany), workshops to inform about current tendencies and to develop

strategies to improve the situation (Germany), health education (Romania, Austria, Finland), database (Germany).

The internet based multimedia learning materials available in each Country for the basic care education: target of disadvantaged groups reached; possibilities to rate the level of necessity of these ICT tools; motivation of each action

Most partners acknowledge that the material is available on the internet. For example, as for Germany, more than 1.800 projects and actions are available online. Not only that: many websites have been developed on purpose (Italy, United Kingdom, etc). The problem is that some disadvantaged people have scarcely access to internet facilities or they do not know how to use ICT tools. On the other hand, even if a number of disadvantaged people have access to computers, they would not necessarily search for health related topics.
The same applies to young people who have mostly access to computers but lack interest in the topic. They would not necessarily look for health issues by themselves but would need a special motivation to do so.

As regards Denmark, instead, even though net based learning material for basic care is available, it is not suitable for the disadvantaged groups: the existing material is mainly directed to people who are supposed to become professionals.

As for Romania, for the adult population there is no internet based learning material. The level of necessity is high referring to trainers. As already said, it is unlikely that the disadvantaged population will start to gather information from the net.

Concerning Finland, multimedia materials usually belong to the school or organizations that have made it. In addition to that, there are organizations that make material for free sharing. Like all partners, also Finland acknowledges that people who need the material are not the ones who find and use it.

Target groups to whom each Country/territory has addressed the main concerns and attention. Motivation of these policies

Generally speaking, much attention has been given on health prevention among:

- young people and children who usually are vulnerable, more sensitive and feel often alone, in order to develop responsible attitudes and behavior, to raise awareness among the involved communities (parents, teachers, school principles, key local and central stake-holders)
- individuals overweight, with hypertension / high cholesterol, diabetes, smokers.
- pregnant women (Finland)
- disadvantaged communities such as migrants, socio-economical disadvantaged people, women, elderly, unemployed, homeless

As regards special projects, Italy and Denmark have addressed a lot of concern to cardiovascular diseases prevention and care.

Extent to which the most widespread lifestyle diseases have been considered and studied, most of all the ones specifically linked to psychological, affective, and social areas

As far as social areas are concerned, studies carried out in Germany revealed that socially disadvantaged classes are most affected by poor health.
After the reunification in Germany, the regional differences are due to social reasons: health opportunities are lowest where living conditions are at their worst – as a result from unequal distribution of education, unemployment, income and private wealth in the federal states.

In Denmark there are many studies showing a negative circle: the more people are affected by these problems, the more isolated they will become. Not only that: people who suffer from psychological, affective, social or psychiatric problems are more at risk to develop lifestyle diseases than the rest of the population.

In Italy, diseases related to alcohol are being studied nationally, but only recently it has been paid attention to stress or depression associated with the issue. Italian alcohology was born in Friuli Venezia Giulia through the cooperation of public and private boards. Currently, the network of alcoholism FVG has its technical and scientific support in the Local Authority of Health and Social Protection and in the Coordination Group PPAC. Other facilities are: universities, social welfare boards, healthcare organizations (hospitals, districts, departments of employees) and the third sector (associations, groups, cooperatives). As for cardiovascular diseases, they are studied at municipal, regional and national level through projects that specifically investigate the close interaction between lifestyle and the incurring of the such diseases.
A sociological University Research on depression states that as regards women, the disease is connected with gender inequality and the contradictory conditions related to the ongoing changing in social, political and economic sphere: for example, in Italy 9 women out of 100 suffer from depression.

As regards United Kingdom, Doncaster has an 'Improving Access to Psychological Therapies' programme which is a Government led psychological programme aimed at supporting mental health needs within communities. It was piloted in the Doncaster borough first, with over 5000 individuals being seen in its initial year. This pilot was so successful that it has now been rolled out across the country.

In Romania instead, the diseases have been studied and linked to different lifestyle patterns but only one study, done in 1994 by UNICEF focuses on linking lifestyle diseases to psychosocial factors.

Many studies and researches regarding lifestyles have been carried out in Finland. It is remarkable that in order to guarantee the top level of expertise in modern genetic and biological analyses, the government has built an infrastructure that facilitates the collection of genoma-wide information on the genetic background of diseases as well as functional information on the molecules that are critical in the disease process. It is called "National Biobank of Finland".

Specific statistic studies existing in each Country regarding the effects achieved in consequence of prevention initiatives on health issues

In Italy, there is a statistical study of the Department of Health stating the level of alcoholism in Italy in recent years (2006-2008), following the Law 125/2001. The document, having recognized alcoholism as one of the three major factors of disturbance in Italy, provides the monitoring of the situation. Moreover, Eurisko Institute monitored the results in terms of knowledge of cardiovascular risk.

As for Denmark, they have a lot of statistic and it is possible to see positive changes before and after different prevention initiatives on health issues.

In United Kingdom, the Doncaster Annual Review identified target areas for prevention initiatives, for example: smoking targets for quitting were 1848, actual 2622; attendance at GUM clinics (sexual health) rose from 75.7% to 86.69%.

In Romania, in the last decades, the prevalence of chronic disease has increased a trend which is associated with the synergic action of biological, environmental and lifestyle determinants together with the influence of socioeconomic and health care conditions. Data of good quality are available only from the *Health status surveys* performed by the Computing Centre of Health Statistics and Medical Documentation of the Ministry of Public Health. The last survey was carried out in 1997 (Ministry of Public Health and Family, 1997).

In Germany, since 1989 health insurances are legally obliged to contribute actively to prevent work related health risks. In 2007, the law was amended and work place health promotion has become a standard benefit and is paid by the health insurance. Reports on the effects of work related health prevention programmes are available and show the positive effects of such programmes in terms of a reduced number of sick leaves. Apart

from work place health prevention many other initiatives and projects for groups at risk have been carried out and show positive benefits for the involved people.

As for Austria, single studies and statistics on correlation between a disadvantaged social status and health have been carried out but evaluation studies are not often published.

Finnish research showed that when people got better nutrition facts, the heart diseases have also diminished. Moreover, food habits in the Country have improved: people eat less fat and more vegetables and fruits.

The actual impact and consequences of the prevention policies among the adult population. The particular case of the most disadvantaged groups of adults

In most cases, there is a higher awareness for health prevention in the population: actions and projects have been initiated years ago. Nevertheless, concrete consequences among disadvantaged groups are not so noticeable: groups suffering from poor health are also those who have not yet adopted a healthier lifestyle.

It is also stated that in all the examined Countries, the majority of people do not exercise enough.

The groups of population that have received more benefits and the groups that have received less benefits. Motivations.

All partners acknowledged that people with the highest educational and salary level are the ones who benefits most from campaigns, information and public advice. On the opposite, people with little education, low salary or not connected with labour market are the ones who benefit less from those initiatives.

The allocated financial resources and the needs of population in each Country

In Italy health expenditure is increasing for factors such as population-aging but financial resources are limited. Same problem in Austria: fundraising is quite difficult, especially for small projects in deprived areas.

In Denmark, during the last ten years, a lot of money has been spent on prevention initiatives. This has created a positive change in the numbers of lifestyle diseases occurred during the last years.
In Denmark it is also believed that changing lifestyle is a very slow process for the individual, for the family and groups and that many initiatives do not need money – but only a change in understanding and attitude by relevant persons.

In Romania, not always the allocated financial resources met the needs. Moreover, not all diseases are covered.

As for Germany, most projects do not publish their budget, they give only information about the project objectives, target groups and actions.

Aspects of health education issues that have been left aside and that could be taken into consideration

In Italy, studies show that women are the ones who suffer the most from depression, an underestimated insidious disease known as “evil soul” that must be recognized and discussed. To deal with it, National Health System must invest on qualification of health personnel, especially the family doctor. Not only that: specific policies for elderly female population should be taken into consideration: ¾ of elderly people are female, a weak category for several reasons: less income, duty of children care, less healthcare resources spent for.

Denmark has slowly started to put health education and daily physical exercise into different care institutions. There are a lot of activities when it comes to the big groups in care area – the mentally handicapped, psychiatric patients, elderly and so on.

But government still needs to reach the big “normal group” of disadvantaged people: single young mothers, alcoholics, immigrants and unemployed people.

In England, the majority of health education is covered. The issues are about access and taking education and prevention to the communities.

As for Germany, a lot of good initiatives have been realised: the regional knot is a valuable source of information and a first contact will be established in the near future.

As far as Austria is concerned, the combination of health issues with adult education – as in Health Box – seems to be an innovative approach.

Practices that could be started in order to be more effective on the issue of health and wellbeing inside each Country and territory

With reference to Italy, an innovative way to prevent depression might be the developing of special programs and courses such as drama courses, creative writing courses, breathing courses and so on: people and especially women can express their deep and private feelings such as fear, anger; etc which if retained can lead to sadness, depression, alcoholism and even suicide.

As for Romania, a prevention focused policy ought to be implemented by the Health Authorities regardless the government orientation. Measures to address the poverty, unemployment and lack of opportunity that contribute to the diseases must go hand in hand with modern, effective and well informed methods of health education.

As far as Germany is concerned, after comprehensive desk research activities, they can say that not only awareness is high for the importance of health prevention among disadvantaged groups but also that a lot of actions have been realised so far.
The Health Box approach is absolutely in line with German policy that has a clear mission to implement health prevention actions in existing services and offers.

Numerous good practice examples are available and published on a specific data base.

Austria's point of view is that it is important to start with activities at an early age. Moreover, working with families is important: parents should be involved.

Regarding Finland, a crucial subject to be taken into consideration is physical activity which is scarcely practised.

The potential of an informative health policy at a European level for a wider and global approach to health training

From what it can be learnt from social surveys and literature, not only do Italian citizens feel to belong to the EU, but they also prefer European initiatives to the national ones. Furthermore, European models are well seen among population. Because of this arousing

interest in European projects, preventive measures and information on lifestyle diseases proposed by the EU would be very effective.
However, each Italian region should have the opportunity to implement its policies. Since local forces have specific social and cultural features, regions can get closer to the needs of citizens and act accordingly. Concerning depression, a network of information at both European and national level would surely allow an expansion of prevention strategies: it has been given very little attention to depression because of prejudice and poor assessment. In addition to that, the scope issue tends to be unspoken.

Denmark and Romania also believe it could be good to make a policy at European level. For Denmark, the aim of this policy should be to assure that health will become both a theoretical and a practical subject in kinder garden as well as in primary school.

In Finland, it is thought that it would be important to work down to a more personal level.

New material that should be produced

Concerning Germany, materials should be created for a very practical approach. As for Romania, video and paper based materials are kindly recommended. Regarding Denmark, material should reach very different target groups when it comes to age, social position and cultural understanding. Moreover, Denmark hopes for the creation of material addressed to staff in kinder garden, primary and secondary/vocational school.

As for Italy, as experienced so far, along with traditional material such as brochures and TV commercials, self-assessment tests could be developed. Moreover, more general topics

such as eating habits might be considered to help people learn to take care of themselves with sincerity and serenity, but also to encourage self-awareness. Other material could be:

- researches in the different recipients of health promotion initiatives;
- effective communication campaigns that could put the messages within the threshold of attention of the recipients, i.e.: producing informative materials able to reach even the socio-culturally disadvantaged groups: television advertising campaigns, road signals,
- brochures spread to health practitioners, health boards, cultural centres, websites, information points and so on;
- consumer education campaigns: starting with existing education programs to schools, i.e. in order to control and decrease overweight and obesity in young generations through actions which do not only involve home and family, but also school and place of living, mass media and control bodies that need to spread the culture of healthy foods (fruits and vegetables) and fight misleading food advertising.

As regards depression, it is needed easily readable informative material, capable of providing a clear and exhaustive view of symptoms, effects and treatments of this mental distress.
An interesting idea which came out from the Finnish team is to produce materials in form of pictures in order to help migrants with the language.

The overview summarizes the research carried out by the partners (Italy, Germany, Finland, Austria, Romania, Denmark, United Kingdom), whose data are reported here below.

INTERNATIONAL DESK RESEARCH

1. Lifestyle diseases

1a. Lifestyle diseases rated as the most frequent in the following Countries/territories

(please refer to page 62 for the sources of the following information)

ITALY

Alcoholism, **heart disease** and **depression** are the most frequent lifestyle diseases rated in Italy.

Alcoholism.
Alcoholism is closely related to the wellbeing of individuals, families and society, since alcohol is a psychotropic drug that can induce violent behaviour (1 murder out of 4 and 1 suicide out of 6 are alcohol-related), abuses, abandonment, loss of social opportunities, inability to build emotional bonds or stable relationships and disability. Violence caused by alcohol is intentional both to themselves and to others: suicides, family violence, violent crimes, criminal behaviour and harm to people considered as victims (including theft and rape). Furthermore, alcohol is a major cause of accidents at work and on the road. Furthermore, alcoholism is associated with a substantial increase in overall mortality and with the direct and indirect risk of many diseases (liver cirrhosis, alcoholism, alcoholic psychosis, alcohol intoxication, gastritis, alcoholic cardiomyopathy and alcoholic polyneuropathy, hemorrhagic stroke, fetal-alcohol syndrome etc.).
Alcohol-related diseases affect the quality of life. The Regional Plan for the Rehabilitation of Friuli Venezia Giulia reports that alcohol-related problems are at the 5th place for Daly (years of life lost and disability).

Cardiovascular diseases.
In Italy, the highest mortality rate for diseases is related to the circulatory system ones (42% of all deaths). In adult population (35-74 years) 28% of the deaths are caused by cardiovascular diseases.
Depression.
Depression is a disease highly prevalent in the general population. According to WHO/OMS, the first emergency in Europe is mental illness together with psychic suffering. In Italy, 2009 statistical data published on the International Journal of Public Health shows that 1 person out of 10, aged between 18 and 69, has suffered from depression. 50% of these people have never asked for help. The small percentage of diagnosed cases has passed thorough general practitioners, who tend to play a strategic role in such cases.

AUSTRIA

The most frequent lifestyle diseases in Austria are

- Cardiac diseases caused through smoking and alcohol
- Diabetes
- Hypertension
- High blood cholesterol level
- Overweight/Adiposities
- Cancer,
- Respiratory diseases
- lack of physical activity,
- High risk for accidents,
- Chronic disease
- Mental disease (f.e. stress, depression)

DENMARK

Lifestyle Diseases defines in DK as a label for a number of diseases that occur as a result of a poor lifestyle with unhealthy diets and lack of exercise, such as hypertension, thrombosis in the brain and heart, chronic bronchitis, liver cirrhosis and cancer because of to fat diet, obesity, lack of exercise, alcohol and tobacco use. Hereditary factors have, however, also plays an important role for the incurrence of these diseases..

Studies suggest that 20% of the Danish population are suffering from lifestyle-related illnesses or are in a high-risk group.

Sundhed.dk is the official Danish Health Portal to the public Danish Healthcare Services ('health' means health in Danish). Sundhed.dk Bring The public Danish Healthcare Services together on the Internet. This makes it possible for patients, their families and healthcare professionals alike to access information and two communicate with each other. According to sundhed.dk suffer every 10 Dane of one of the eight major diseases. That's why health care particularly have much focus on enhancing quality of life of patients suffering from these diseases listed in non priority order:

- Type 2 diabetes
- Cardiovascular disorders
- Preventable cancers
- Brittle bones (osteoporosis)
- Musculoskeletal disorders
- Psychiatric Disorders
- Hypersensitivity Sick Judgments (asthma and allergic diseases)
- Smoker Lungs / chronic obstructive pulmonary disease (COPD)
- Of these 8 common diseases seen especially following 3 as lifestyle diseases:
- Diabetes 2:

Between 200,000 and 300,000 people in Denmark are estimated to suffer from diabetes type 2 - diabetes age. Only half have been diagnosed. Between 10,000 and 20,000 patients are diagnosed each year. The incidence of type 2 diabetes is rapidly increasing in population. This is partly because

more elderly and patients with type 2 diabetes are living longer.

Cardiovascular Diseases:

Almost 200.000 Danes are now living with a bad heart condition and there are approximately 13.000 annual deaths from these diseases.

Every year around 57,000 people is hospitalized with bad heart condition.

Chronic obstructive pulmonary disease - COPD:

In Denmark there are about 200,000 COPD patients. Every year dies 3500 Danes of COPD and another 2,200 die from illnesses in which COPD is a contributing factor.

FINLAND

In Finland we have a lot of lifestyle diseases. Cardiovascular disease, cancer, diabetes, and diseases of the organs of support and movement are important public health problems closely related to lifestyle. But we can also see that mental stress in work has increased.

UNITED KINGDOM

Locally

Within the Borough of Doncaster (300,000 population approx: 97.7% White, 2.3% other (0.6% mixed, 1.1% Asian or British Asian, 0.4% Black or British Black, 0.3% Chinese or other, 1.) the main lifestyle diseases are; obesity, diabetes, mental ill health, sexual health, drug and alcohol related illnesses, cancer and coronary heart disease.

ROMANIA

The most frequent lifestyle diseases in Romania are

- Cardiovascular diseases
- Obesity
- Malignant tumors
- Digestive diseases
- Tuberculosis
- Respiratory diseases

GERMANY

Life style diseases are covering functional and organic disorders and disease that are influenced by a lot of external and internal effects. The scale of these influences is extremely wide, ranging from the simplest living conditions of housing, clothing, food, sanitation, the working and living habits to the conditions of the coexistence of people and the possible negative sides of mechanisation as one-sided non-physiological stress, depression, alcoholism, lack of hardiness, noise impact, air pollution, tobacco abuse, abnormal activity of the modern working life, insecurity, existential fear. Life style diseases include digestive and metabolic disorders, deterioration of the dentition (tooth decay), numerous colds, neuroses and circulation problems.

These influence lead to diseases that are structured in groups.

The six most often found diseases are:

- Diseases of the spine and muscle-system
- Pneumological diseases
- Injuries (Accidents) and Toxication Psychological diseases
- Diseases of the digestive system
- Diseases of the cardiovascular system

1b. People concerned from lifestyle disease

ITALY

Alcoholism affects population in general, but especially 35-45 years old people, regardless of their degree of education. The peak of greater frequency of problematic use of alcohol is placed in correspondence with the peak prevalence in women's consumption. And this is probably the most

critical phase in a woman's life, a delicate moment in which females may outweigh concerns about loss of youth, reduction of fertility and procreative capacity. Women may also consider to have failed in carrying out youth projects. Furthermore, they might draw up budgets of experiences that have proved to be inadequate in terms of relationship: love or family life ended up ruining important relationships. Nowadays, for many women, mature age is characterized by a deep conflict between a cultural model of personal and professional achievement and a second model that pushes towards a role of 'traditional' wife and mother, especially in Italy, as such model is deeply rooted in the Mediterranean culture compared to other European countries. A very different case concerns the elderly one: with age even one glass of wine per day can be considered as risky behaviour. As a consequence elderly people should be advised that what it used to be a proper habit has become an harmful one.
As regards alcohol-related diseases, in 2001-04 the Departments of Addiction provided services for: 11.262 males (83% of the total sample) and 2.377 (17%) females. The number of users increases with the age of users.

REGION 2001-04	M	F
<19 years	116	2377
20-29	1584	172
30-39	2213	408
40-49	2772	662
50-59	2819	679
<60	1758	431
TOTAL	11262	2377

Cardio-cerebrovascular diseases usually affect people in their older age: men in their 40-50s and then the disease increases exponentially with age; women in their 50-60s-menopausal age-and then the disease grows quickly. The highest percentage of diseases is recorded in both men and women in the South of Italy.
The first determinant (risk factor) is therefore the age, but other determinants-such as smoking and obesity-are present in far larger groups of disadvantaged people who have less ability to pay attention to their lifestyle.

As for depression, according to statistical data and literature, women suffer the most from mental distress, especially in urban areas with population exceeding 200,000 units.
This is due to factors such as: the spread of social unrest together with poverty and degradation situations, a more stressful environment which does not help to establish relationships and perform effectively, but also traffic, pollution, and – as noted in a recent documented clinical study, the possibility to have access easily to alcohol and drugs.
Among women, the registered trend is the manifestation of more depressive symptoms in a metropolitan context, rather than in a rural area. The degree of increased risk of developing depression is related only to the female gender.

AUSTRIA

In general those diseases effect all groups, but socio-economically disadvantaged people tend to be more at risk for there diseases because of an often unhealthy lifestyle and bad access to health promotion activities. (study results state a correlation between social status an health status – the more you are socio-economically disadvantaged the more you are at health risk or have a bad health status)
For the target group of ***die Berater®*** in the Health Box project –> unemployed people: often more

isolated, lack of self-esteem and self confidence – not only physical diseases but also psychological disease like stress, depression. Apart from this it is also the financial situation – poverty leads to a decline of the health status. Especially long term unemployed persons suffer more from physical and mental diseases.

DENMARK

There is social inequality in the development of type 2 diabetes . People with low skills, the incidence of type 2 diabetes is approximately twice as large as among highly educated.

Heart disease is also socially unequal in population. There is a clear correlation between education and mortality related to heart disease. For example, some groups has a significantly higher mortality than average

For men, mortality from cardiovascular disease is markedly higher in professions, such as cleaning and waste collection, transportation and construction and manual labor in bygge-/anlægsbranchen and transport. For women, mortality from cardiovascular diseases in markedly higher in professions such as: cleaning, refuse collection, service and care.

COPD disease affects the socially disadvantaged hardest. For example, a high proportion of smokers among unskilled and unemployed compared with other groups. And there are three times as many hospitalizations among persons from the lowest socioeconomic group compared with those in the highest socioeconomic group.

FINLAND

Specific determinants perspective to health inequalities (SPEDE)

Low socio-economic position is associated with poor health. This research project, initiated in 2003, is based on the assumption that socio-economic position has a causal effect on health through specific behavioural and psychosocial determinants. The study will examine the associations of occupation, education and income with health behaviours (e.g. smoking, alcohol consumption, food habits) and the contribution of health behaviours and psychosocial factors to the socio-economic mortality differentials. Information and expertise provided by the project will be used in the TEROKA partnership project aiming to reduce health inequalities. The data sets used in the study include the Health Behaviour and Health among the Finnish Adult Population -surveys. The survey data have been linked with register based data on socio-economic factors and mortality.

Socio-economic determinants of physical activity among Finnish men and women since the 1970s (SOPHY)

Health behaviours play an important part behind socio-economic inequalities in mortality, but the role of physical activity in this is poorly understood. The project examines the variation of different forms of physical activity by education, occupational class and income among Finnish men and women since 1972. In addition the variation of physical activity by age, marital status, and place of residence, smoking, alcohol consumption and overweight is examined. The study will use the large cross-sectional population surveys collected by the KTL, the Finrisk, Health Behaviour and Health among the Finnish Adult Population and Health2000 –surveys.
http://www.ktl.fi/portal/english/research people programs/health promotion and chronic disease prevention/units/chronic disease prevention unit/main areas of activities/lifestyles and health inequalities/

Impact of work and socioeconomic circumstances on physical activity and fitness at different

stages of life (WOSPA)

Health behaviours play an important part behind socio-economic inequalities in mortality, but the role of physical activity in this is poorly understood. The project examines the variation of different modes of physical activity and physical fitness by childhood living conditions, working conditions and socioeconomic circumstances (education, occupational class and income) among Finns at different stages of life. The variation of physical activity and fitness by smoking, alcohol consumption and overweight is also examined. In addition, the study will examine whether the effect of working conditions to physical activity is similar between European countries. The study will use the large cross-sectional population surveys collected by the KTL, the FINRISK, Health Behaviour and Health 2000 –surveys. In addition, data from European health surveys will be used

UNITED KINGDOM

All affect the general population of Doncaster but the prevalence amongst areas of economic and social deprivation is increased. Doncaster has 11 communities which constitute the most deprived 20% of the borough with some 56,364 population within them (2001 Census) 2.

ROMANIA

They affect the population in general.
The risk factors vary, the gender and age gap being important in some cases.

GERMANY

Lifestyle diseases affect the population in general. Within the Health Box project the German team intends to work with unemployed people that according to several studies and statistics are more likely to suffer from psychological diseases than employed people, whereas for all other lifestyle diseases there is only a slight difference between unemployed and employed people.

1c. Socio-economically disadvantaged people: main needs in relation to lifestyles diseases

ITALY

Most of all, **alcoholism is related to depression**, a feeling of inadequacy and tensions that evolve in misunderstanding, in loneliness and consequently lead to the adoption of behaviours such as alcoholism as a response of the inability to cope with socio-relational difficulties. Recently, evidence has shown that alcoholism is also a possible consequence of a trend. Indeed, in Italy there is a tendency to give up the typical glass of wine during the meal, according to the 'Mediterranean diet' model, and to consume alcohol between meals, especially with appetizers. On an empty stomach, drinking effects are enhanced. Such lifestyle, which is potentially disruptive and harmful, affects mainly young people (13-17 years) and women (even older). One possible cause is the need of approval. This custom of drinking between meals, closely related to the habit of smoking, is more prevalent in the north-east, but the trend is also spreading into other regions in northern and central part of Italy. Moreover, for young people, the destructive trend of 'drinking to get drunk' seams to act today as a "drug access" or "bridge", a way of approaching other dangerous illegal drugs. Lifestyles alone do not explain the problem of excessive consumption of alcohol: one has to consider also the genetic, environmental and health services available and the economic and social categories.
As regards alcohol-related diseases, the focus should be on the family, who is a victim of the disease as well as the patient, but it is also the key resource that must be activated in a therapeutic environment. The family should play a protective role. Relatives need to acquire the information and the necessary training to enable people involved to develop their critical ability to deal adequately with the difficulties of the daily living that such cases necessarily imply.
Considering instead **cardiovascular diseases**, the main needs are: 1. Health education; 2. Environmental Policies; 3. Investment in health research and health service.
People suffering from **depression** need to: establish friendly relationships in order to overcome loneliness; get some help from neighborhood, also in cases of violence or serious economic difficulties; acknowledge a state of distress and take action on time.

AUSTRIA

Awareness rising in combination with **information** is very important. To change a person's lifestyle is - especially in groups of social disadvantaged people a very precarious aspect, because you influence people´ s culture of living. So **sensitivity** is important.

- Participation
- Creating incentives for taking part in health promotion activities
- Working with groups and networks
- Setting realistic goals
- Consider not only personal aspects of health but also environmental
- Consider possible problems in life situation
- Orientate on daily life of the target group

DENMARK

According to KRAM study, which is one of the largest global surveys of the Danish health, there is a particular need for focus on the 4 KRAM factors: diet, smoking, alcohol and exercise in prevention and health promotion efforts.
Municipalities were given from 1 January 2007 the main responsibility for health promotion and prevention efforts, and KRAM study has been undertaken to promote this work. With the KRAM study

the focus was increased on public health in Denmark, the Danish health were identified, prevention efforts in the municipalities strengthened and municipalities were able to compare their own performance with others.
The lifestyle factors that are most relevant to the case of serious illness and premature death seen in Denmark is, smoking, physical inactivity, poor diet and high consumption of alcohol. While the number of smokers has been decreasing, the number of people with obesity and physical inactivity, however is increasing. There has been done much research into the health impact of these risk factors, but lack of knowledge and evidence about what interventions and prevention activities to make a difference. With KRAM study strengthened the scientific basis for future work on health promotion and prevention.
So the main needs relating to our target groups is to come to an understanding of, how we get in regular contact with these groups, how we communicate them, what kind of activities do we need to offer to motivate these groups to make a start in changing their way of lifestyle.

FINLAND

From my point of view the main needs would be clear and simple information about what kind of lifestyles lead to what kind of diseases. It would be good to get it in a way that they have to take opinion on their own habits in their own lives. It would also be good to find solutions that can be used in the education, this means that they really can see that we promote healthy lifestyle, not just speak about it. Usually we tell them about important things, but we don't manage to implement this in practice. When we think about health it would be the best if we could implement the healthy "lifestyle" during the lessons also, not just to sit and listen.
To avoid these diseases as much as possible, there would be a need to do more exercising, to know about nutrition, use less alcohol and tobacco, and also to work for the psychological wellbeing. The areas of policy concern policies on drinking, smoking, and physical activity and nutrition, as research identifies these to be the most important areas affecting socio-economic and gender differences in mortality. Excessive drinking and smoking lie behind up to half of the cases that cause a difference in life expectancy between blue-collar and upper white-collar workers. If we are to reduce socio-economic inequalities in obesity levels, we must also influence nutrition and physical activity. Physical activity is also important for reducing inequalities in general fitness and mental health.(*National Action Plan to Reduce Health Inequalities 2008–2011.)*

UNITED KINGDOM

The main needs within the target groups are; mental health issues, alcohol/substance misuse, sexual health and diet/nutrition.

ROMANIA

Raising awareness
More focussed information
Individual support

GERMANY

Guidance to more health awareness
Clarification of what they can do (taking into consideration their financial and educational background)
Motivation and stimulation to actually get more active and take care of themselves

2. Initiatives concerning health that have already been activated within Italy, Austria, Denmark, Finland, United Kingdom, Rumania and Germany

2a. Initiated and implemented health policies

ITALY

Nationwide, the governmental Program "Gaining Health" promotes the adoption of healthy behavior in order to lessen chronic diseases and increase citizens' life expectancy. Specifically, the program consists of four focal points: healthy eating, stop smoking, fighting alcoholism and encouraging sports.

In Italy, implemented policies against **alcoholism** have the following aims: giving much more general information, improving health services, training teachers for targeted education campaigns, decreasing the consumption of alcohol, raising awareness between suppliers of alcoholic beverages.
Friuli Venezia Giulia has been asked to coordinate the Working Group of the Italian Regions on alcohol. The treatments delivered from 2001 to 2004 in FVG to persons who have turned to the Departments of Addictions are: counseling (26.4%), outpatient treatments (25.3%), group treatments (14.4%), placement in mutual aid groups (13.9%), hospitalizations (9.5%)

For cardiovascular risk:
1a. Papers of the absolute global cardiovascular risk (R MCV) calculated for categories of risk factors (age, sex, diabetes, smoking, systolic blood pressure and total cholesterol) are used to estimate the probability of experiencing a first major cardiovascular event in the following 10 years;
1b. Individual score: it provides an accurate assessment because it considers continuous values for some risk factors and in the estimation it also includes the consideration of anti-hypertensive therapy (which is moreover a longstanding indicator of arterial hypertension). It is calculated by using the risk map and the "Cuore.exe program".
2. Decipher project (Development of a method based on evidence for the investment on public health strategies either locally or in Europe).
Main purpose: to develop and disseminate a new methodological model, based on evidence, which may becomes a training / operating tool for effective use of European municipalities. Such tool should be able to support administrators and local politicians in the process of setting / planning, investment and evaluation of programs, policies and strategies regarding the health issue.
This tool-built according to the principles of cost/profit analysis- was applied experimentally to the primary prevention of cardiovascular disease (coronary Heart Disease-CHD).

AUSTRIA

In Austria, the federal ministry of health holds a sub-organisation - the "Fonds Gesundes Österreich", which is responsible for initiating and also funding projects on health issues.
Within this framework, here are a lot of single project, relating to health promotion activities for social disadvantaged people. Many of these activities are on a regional level, like projects in schools, communities.

Some examples:

Health promotion for homeless women (Vienna): scouting health care work, participative offers for counselling & information on health issues in combination with social work.

Health promotion in Social –Supermarkets (Lower Austria)

SOMA – is a special supermarket for low income people. The setting supermarket is used to reach the target group, activities are directly set in the supermarket f.e. sports, information on health issues in general, information on healthy nutrition….

"together healthy" (Salzburg): health promotion project especially for migrants/migrant women
Tutors with similar cultural background visit target group in combination with social work

(f)itworks (Vienna) : programme for long-term unemployed in cooperation with health-organisations. The aim is, to support long term unemployed people in health issues and to offer activities in accordance to gender and diversity.

"inspite of it all…healthy ": (Vorarlberg) Debt advice service , using the personal contact to clients in difficult financial situations to support and inform then on health issues.

DENMARK

KRAM study was undertaken in 13 municipalities during 2007 and 2008.
In each municipality, all adult citizens were invited to participate in an Internet-based questionnaire on health habits, health, use of municipal health promotion facilities and their wishes to municipal health promotion facilities. In Sønderborg Municipality was however used a paper-based questionnaire, which was sent to 20,000 randomly selected citizens. In small and medium municipalities all citizens were also invited to review a health check by KRAM bus. In larger municipalities were approximately 20,000 randomly selected citizens invited to participate in this study including: measuring blood pressure, heart rate, cm of waist and Hip, fat percentage, height and weight, measuring lung function, bone mineral content, muscle strength, balance and fitness level and blood sampling. Moreover, the examination register-based information on the health of 650,000 people
KRAM study is both innovative and unconventional, with a portion of the data collection is done by a bus tour around the country. The 13 municipalities were visited by a Kramer-bus, which stood in the municipality during the month; the study lasted, while investigations took place in premises adjacent to KRAM bus. In the month KRAM bus held in the municipality, and conducted investigations launched the municipality, in cooperation with other public and private actors, a number of special activities and interventions aimed at Kramer factors. Results of the survey, record review and surveys conducted by KRAM bus involved in a KRAM-profile, the municipality can use as a basis for planning of future health as well as health promotion and prevention initiatives. Results will also be included in a comprehensive database that will provide an extremely valuable basis for future research.

FINLAND

http://www.ktl.fi/portal/english/research people programs/health promotion and chronic disease prevention/units/chronic disease prevention unit/main areas of activities/lifestyles and health inequalities/

Lifestyles and health inequalities

Finbalt Health Monitor

Finbalt Health Monitor is a system for monitoring health related behaviour, practices and lifestyles in Finland and in the Baltic countries. The collaborative work to develop health behaviour monitoring and research has been carried out since 1994. The data gathering comprises postal surveys conducted every second year among adult populations of the participating countries. The data are used to carry out comparative studies related to major public health problems with the emphasis on the changes in smoking, alcohol consumption, food habits and physical activity in different countries and population groups. The results can be used in planning national health policies and health promotion activities. The Finbalt Health Monitor project has served as an example for corresponding monitoring surveys also elsewhere in Europe (see CINDI Health Monitor).

Monitoring food services

The project launched in 2002 aims to describe the use and quality of food services provided by institutional kitchens to different age groups, and to develop means to monitor these services. The project focuses on the nutritional quality of meals and on the use of food services in different socio-demographic groups. The project uses national monitoring data collected by the KTL and other Finnish research institutes. Studies included in the project will examine e.g. trends and socio-economic differences in meal patterns during working hours, associations of meal patterns with quality of diet, well-being and functional capacity. The most important collaborators are Finnish Heart Association, Finnish Institute of Occupational Health and STAKES.

International health promotion activities

CINDI Finland

Finland is a member state in the WHO EURO CINDI programme. CINDI Programme (Countrywide Integrated Non communicable Disease Intervention) was developed in 1984. The aim of the CINDI programme is to develop and evaluate intervention strategies and methods for chronic disease prevention. In Finland, CINDI programme is coordinated in the National Public Health Institute in the Department of Health Promotion and Chronic Disease Prevention, which is also a WHO Collaborating Centre for Non communicable Disease Prevention, Health Promotion and Monitoring. The Finnish CINDI Director is Professor Erkki Vartiainen. Practical coordination of the programme is carried out in his department in the Chronic Disease Prevention Unit. Unit coordinates several CINDI activities such as the development of health monitoring system in CINDI countries (CINDI Health Monitor) and the International training seminar on integrated non communicable disease strategies and prevention (Non communicable Disease Seminar, see below). Contact person: Tiina Laatikainen

Non communicable Disease Seminar

NCD Seminar is an international training seminar on integrated non communicable disease strategies and prevention. The seminar is organized yearly in collaboration with the WHO Regional Office for Europe and the North Karelia Center for Public Health. North Karelia project is a well known example of community-based chronic disease prevention programme. The seminar reviews the experiences of the North Karelia project in planning, implementation and evaluation of prevention interventions. Programme includes a three day interactive training in national Public Health Institute in Helsinki and a two day site visit in North Karelia. The seminar is aimed at health authorities and health professional working with national NCD strategies and prevention programmes. Training is given in English by international experts.

Karelian allergy and asthma survey
Since 1997 a collaborative study between the Helsinki University Skin and Allergy Hospital and the National Public Health Institute has been carried out to examine the prevalence and aetiology of allergy and asthma in economically and environmentally very diverse circumstances in Finnish and Russian Karelia. The first survey was carried out in 1997-1998 among adult population. It was observed that allergy and asthma is much more prevalent in Finnish Karelia compared to Russian Karelia. Study was continued in 2003 by surveying 7-15 year old children and their mothers in the same areas. the aim of the study is to assess allergy and asthma related risk factors, behaviours, environmental factors and genotype. Asthma and allergy prevalence is further assessed in 2007 in a sub study of the National FINRISK Study.

Pitkäranta Risk Factor Study

Since 1990 National Public Health Institute has had health collaboration with the Republic of Karelia in Russia. One of the main areas of collaboration has been the development of the health monitoring system. First risk factor survey among adult population was carried out in the district of Pitkäranta in 1992. Monitoring activities were continued in 1997, 2002 and 2007. The aim of the health monitoring is to follow the prevalence main risk factors and behaviours related to chronic diseases such as heart disease, diabetes, cancer and asthma and allergy.

Health Behavior in Pitkäranta
Health behaviour surveys among adult population in Pitkäranta are part of the larger health monitoring system development approach in the area. Surveys are carried out in collaboration with the Ministry of Health in the Republic of Karelia and the Central Hospital of Pitkäranta. So far surveys have been conducted in 1994, 1996, 1998, 2000 and 2004. The aim of the health behaviour monitoring is to follow the trends in health related lifestyles, use of health services and self-reported health and illnesses. The target population in the surveys has been adults between 25 to 64 years of age.

Study on school children health from Pitkäranta, Republic of Karelia, Russia
In 1995 and 2004, the KTL, University of Kuopio, Ministry of health and social development of the Republic of Karelia and Central hospital of the Republic of Karelia, have implemented a health survey among all 9th grade school children in Pitkäranta, in the Republic of Karelia, Russia. Survey included self-administered questionnaire and physical measurements of height, weight, blood pressure, total cholesterol and high density lipoprotein (HDL). The purpose of the survey was to study prevalence and changes in health behaviour and chronic disease risk factors among adolescents from the Pitkäranta region.

Together against substance misuse – School and community based intervention in Pitkäranta, Republic of Karelia
“Together against substance misuse” is a school and community based intervention in the district of Pitkäranta, Republic of Karelia, Russia. The project is aiming at raising awareness and communal responsibility of issues related to substance use of young and preventing the use of alcohol and tobacco among young people, encouraging substance free lifestyle. The project comprises of activities that are targeted directly at young people, for example teaching social skills and organising activities aiming at making an impact on the school environment and the whole community. The project is carried out over a period of three years (2006-2008). In the beginning phase there are four schools taking part within the district of Pitkäranta. The implementing body of the project is KTL, collaborating bodies are University of Helsinki, University of Kuopio, Central hospital of Pitkäranta, Pitkäranta project and Public Health centre of North Karelia.

Healthy ageing

CAIDE (Cardiovascular risk factors, Aging and Dementia)

CAIDE aims to study the association between cardiovascular risk factors at midlife, and dementia and Alzheimer disease at late life. The study population is derived from the participants in the FINRISK surveys from 1972 to1987. In 1998 altogether 1,449 persons took part to a comprehensive re-examination. The results show e.g. that high blood pressure, high total cholesterol, overweigh, and physical inactivity at midlife predict independently Alzheimer disease in 21 year follow-up. The second follow-up takes place in 2006-2007. The research is scientific collaboration between KTL and University of Kuopio from Finland and Karolinska Institutet from Sweden.

Ageing Women in Eastern Finland (ITSYT)-study

The ITSYT study aims to examine associations between functional capacity, diseases and their determinants, and progression of atherosclerosis in elderly women. The follow-up of a cohort of 50-59 year old women examined in 1982 in the FINMONICA study has been organized in 1991, 1992 and in 2003. Results from 12 years of follow-up show, that metabolic syndrome increased from 13% to 46% among old women and the progression of atherosclerosis (carotid intima-media thickness) became twofold among those with metabolic syndrome. The study is a scientific collaboration with Kuopio Research Institute of Exercise Medicine and University of Kuopio

The Veteran Project

In 1992, a survey on Finnish war veterans was carried out. The Ministry of Social Affairs and Health delegated the National Public Health Institute to organize the survey. The aim was to collect information on war veteran's living conditions, health, use of health and rehabilitation services and their additional service needs. Survey was linked to a development project where the aim was to find those veterans whose rehabilitation, social and health services were inadequate and to inform the local authorities in municipalities about their needs. The Veteran project was continued in 2004 when a follow-up survey was conducted to a randomly selected sub-sample of veterans. The aim of the follow-up survey was to analyse the current health situation, functional capacity, living conditions and again the use and need of rehabilitation, health and social services.

Health monitoring and regional health promotion

The Regional Health Promotion Cooperation Project

The project aims to strengthen health promotion activities in provinces and other regions. This work calls for various actors to work together. In addition to health care, other sectors of government, such as social affairs, education, community planning and transport, also have significant effects on health. Thus, health promotion requires solid cooperation among actors from all policy sectors, entrepreneurs and NGO's. National Public Health Institute, KTL, supports this task by disseminating and interpreting reliable regional information on population health and health inequalities. KTL provides this expertise in regional education seminars that cover three main themes: population health, lifestyle factors and health inequalities. Productive networking and the development of permanent regional operation models are required for making good use of health information and achieving high commitment among actors in health promotion. The project works actively to develop and strengthen these operation models and to expand health promotion networks. The project cooperates with other health promotion projects of KTL relying also on other health-related projects under the policy sector of Ministry of Social Affairs and Health. The

project disseminates information about these projects to the regional actors.

The Development of Child Health Monitoring (LATE)

The KTL is accomplishing the Development of Child Health Monitoring –project, which is a part of a larger project conducted by the Ministry of Social Affairs and Health to develop registering and monitoring of children's health. The aim of this project is to design a comprehensive child health monitoring system in Finland including data collection from child health clinics and school health care and separate health surveys conducted among children. Indicators, which are important in regards to children's health and public health, will be defined and a proposal for a process to collect information on children's health both through existing structures and through special approaches will be made. The purpose of the project is to develop recommendations and practical tools for data collection in child health clinics and school health care. The information, which is not available and feasible to collect in primary health care, will be collected in separate child health survey.

UNITED KINGDOM

- The 'Choosing Health' Government White paper (2004) (3) addresses the health key priorities at a National level. 2. The 'Our Healthier Nation' (1999) (4) a Department Of Health document sets targets to reduce deaths from circulatory disease which Doncaster has locally set its own targets against.
- Doncaster has a five year (2008-2013) strategic plan 'Better for You' (5) for NHS budgets in relation to Health 16 priorities which is underpinned by the Joint Strategic Needs Assessment (2008).
- Doncaster has implemented the cross Government strategy 'Healthy weight, Healthy Lives' (2008) on five weight related themes in the form of a large scale community based programmes (6).
- Change 4 Life (National Health promotion policy 2009) (7) looks at eight key messages for healthy living.
- These national initiatives have informed an Enhanced Public Health programme to commission nine Public Health related projects (2009) (8).
- 6. 'Healthy Ambitions' launched in 2008 by NHS Yorkshire and Humberside sets out (via a NHS report) recommendations across eight clinical pathways on health (9).

More specifically:

Existing Health Policies

- Local health Authority Projects;
  An Enhanced Public Health agenda which employs specific workers to work within the community on projects this is a health led provision
  These public health programmes could include;
  - Quit n Fit programme- smoking cessation sessions followed by taster exercise sessions
  - Oral health early intervention programme
  - Mobile gym pilot
  - Community based theatre in education drug and alcohol awareness
  - Low level mental health awareness raising, support and self management
  - Brief intervention training on mental health issues for frontline staff
  - Reducing social isolation in older people
  - Community development and health programme pilot.
  - Numerous projects looking to increase physical activity in young people, people over the age of 50 and the general population
  - Walking for health
  - Encouraging sensible alcohol consumption

Community allotment projects

This just a small snap shot of the many health promotion initiatives offered.

There are projects run by the local borough council aimed at health promotion.

- Health Checks and Social Surveys
  Free breast screening for women over 50
  Free NHS dental care for unemployed/women on maternity leave
  'Change for Life' programme which offers free 10 week healthier lifestyle programmes
  CaSh (contraception and sexual health clinics) offers free sexual health checks
  Smoking cessation clinics (free) based within communities and GP practices
  Well men/women/teenager clinics offered at most GP surgeries (will check blood pressure, weight, general health etc)
  Asthma/diabetes clinics and check ups held at all GP clinics
  Cervical smear testing for all women every five years
  Health checks/promotion for cancer
  Alcohol social marketing and awareness campaigns
- Studies
  Studies in Doncaster have included;
    The community mental health status
    The communities' engagement in sports and recreation
    NHS smoking services (2009/10) smoking prevalence
    Sports England Activity survey (2006)
- Studies in Collaboration with other countries
  EU health related projects through Further Education provider
- Training Seminars
  Training offered to professionals in health promotion in; sexual health, smoking cessation, substance misuse, alcohol misuse, healthy eating.
  It also offers significant training for services users such as; self management courses for recovery drugs and alcohol users.
- Policies against alcoholism
  Doncaster is currently revising the alcohol strategy
- Health reform
  Doncaster is linked to the National directives on health but also has its own agenda within Yorkshire.
- Health Education
  Health education is promoted across all learning environments to the under 19's through the Governments ECM (Every Child Matter) agenda which targets five outcomes; staying safe, being healthy, enjoying and achieving, economic wellbeing and
  Healthy Schools agenda which also encompasses ECM outcomes
  National Healthy Colleges which endeavours to promotes positive health and wellbeing across the Further Education sector
- Taxation and price index
  Alcohol and cigarettes each year have a VAT (taxation) added through the Government budgets.
- Smoking and Alcohol Restriction
  To buy cigarettes in the UK you need to be 16 years old. To sell or to buy for anyone under that age carries a large fine. Proof of age is always required
  To purchase/consume alcohol in the UK you need to be 18years old. Proof of age is always required. In supermarkets alcohol will be not normally be sold to anyone less than 25 years of age. Fines are given for selling alcohol
  ID cards are required by young people to buy alcohol in pubs and other premises selling alcohol.

Most young people carry ID cards
In most city/town centers there are zoned areas for consuming alcohol and these are usually around the public house entrances. Alcohol is not permitted to be drunk walking through the streets in many towns and cities.
Smoking in all building is illegal in the UK and heavy fines are given for non compliance

- Advertising and community campaigns
  The television runs campaigns related to health promotion in relation to;
  Eating
  Drinking sensibly and driving whilst over the legal limit
  There are health promotion campaigns on hoardings on main roads, buses, leaflets in key public places, sports facilities, GP practices
  The UK does not promote smoking on TV or in public areas
  There is a National Calendar of health events throughout the year which is promoted through the media (TV, radio, press), in education and health.

ROMANIA

Law 95 / 2006: Healthcare reform – easier access to healthcare system

- Law 349 / 2002 – The effect of tobacco products consumption - prevention and control
- The policy of taxation the alcohol products and sale of them over the legal age
- permanent price increases (scaled to inflation), notably through higher taxes on cigarettes and other tobacco products;
- comprehensive bans on advertising and promotion of tobacco products, logos and brand names;
- smoking restrictions in indoor workplaces;
- Programs of primary prevention for the risk factors of nutrition and physical activity
- Programs for the prevention of unbalanced nutrition
- National Health Education Program in Romanian Schools[i]
- Other initiatives[ii]

GERMANY

The Federal Ministry of Health attaches great importance to preventive measures in Germany. The various initiatives and national action plans are, in part, conducted in collaboration with other ministries Important prevention initiatives are:

- Physical Activity and Health: '3,000 Extra Steps'

The initiative aims at encouraging citizens to incorporate more physical activity into their daily lives.

'Walk together on Wednesday – 3,000 extra steps together' is the name of the campaign action the goal of which is to mobilise people all over the country to take a 3,000 step walk on Wednesdays.

- National Action Plan – IN FORM

Against the background that representative studies show that unbalanced nutrition and insufficient physical activity are significant problems in Germany, with the 'National Action Plan to Prevent a Lack of Physical Activity and Malnutrition', the Federal Government is seeking to make it possible for children to grow up healthier, for adults to live more healthy life-styles and for everyone to have access to a higher quality of life and greater productivity. For the purpose of implementing the action plan, 15 million euros each have been allocated in the budgets of the Federal Ministry of Food,

Agriculture and Consumer Protection and the Federal Ministry of Health, for an initial period of three years.

- Life has Weight

Eating disorders and the serious diseases associated with it such as anorexia, bulimia (binge-purge disorder) and obesity are increasing dramatically in German society. Most affected are young people, especially girls and women. According to the German Health Survey for Children and Adolescents (KiGGS) conducted by the Robert Koch Institute, one out of five children between the ages of 11 and 17 shows symptoms of an eating disorder. This is where the initiative 'Life has Weight – Together Against Slimming Mania' takes its cue. The goal is to transport a positive body image to young people and strengthen their self-esteem. Alongside awareness-building among the public and various prevention measures, 'Life has Weight' relies primarily on voluntary commitment. An important counterpart in this endeavour is the fashion and modelling industry.

- Women and Health

The current health care provision fails to sufficiently address the differences in the health requirements of women and men, even though the awareness of this problem is growing in many areas of health. In order to tailor prevention and health care provision to the needs of patients, to avoid over-, under- and misuse of health care services and to effectively contribute to improving the health status of the population, it is imperative that increasing account be taken of gender-specific requirements.

- Child Health

Despite the generally good health status enjoyed by children and young people in Germany, their chances of living a life free from disease and health disorders are not equally distributed. Especially children from socially disadvantaged families face a higher health risk as a result of their family's lifestyle and life circumstances.

This is why the Federal Government adopted the 'Strategy of the Federal Government for the Promotion of Child Health' in May 2008. The starting point of the measures is the findings of the German Health Survey for Children and Adolescents. This was the first survey to compile comprehensive and representative data on the health, health-related behaviour and health care

provision of children and young people in Germany.

- AIDS/HIV

In 2008, an estimated 3,000 persons became infected once again in Germany. For 2009, the Federal Government has once more increased the funds allocated for AIDS prevention by an additional million, to 13.2 million euros.

In Germany there is awareness of the fact that social disadvantaged groups are more likely to suffer from health problems. This is evidenced by the fact that each of the 16 federal states in Germany

have implemented a so called regional knot point (Regionaler Knoten). The regional knots cooperate in order to improve health prevention among socially disadvantaged groups by:

- sensitising for discrimination in terms of healthcare
- promoting networking among relevant stakeholders in the field
- demonstrating potentials in health prevention
- identifying examples of good practice

-
- promoting an exchange of knowledge in health prevention

The main focus is on:

- health care and unemployment
- health in disadvantaged quarters

Another focal point of the work of the regional knot points are health prevention measures for children. A specific strategy was developed and published in May 2009.
Among other actions, there is a huge initiative from the Ministry of Health to give people guidelines on how to initiate micro projects in the quarter they live (see link above).
Some Universities have a department for healthcare prevention and work security

On the local level:
The administrative district of Göttingen and the city government implemented health care prevention with a focus on

- health prevention in schools
- children and youngsters
- Homeless people
- Migrants
- Women

This is just a first short overview of existing initiatives, but there are a lot more.

2b. Health knowledge actions

ITALY

In Italy, schools are the first promoters of health by means of projects created for raising awareness regarding **alcoholism**. Furthermore, cooperation with voluntary and non-profit associations is also been sought.
On one hand, as regards alcohol abuse prevention, actions supported by Friuli Venezia Giulia involved schools, voluntary associations and driving schools in a "Basic Training". On the other hand, social welfare and social and health public services departments have developed a "More specific training"
CCM (National Center for Disease Control and Prevention): national training program aiming at increasing the awareness of the value of **cardiovascular prevention** among general practitioners.
- Project Decipher: addressed to the municipalities (with their cross-sectoral partners: health care companies, schools, voluntary associations, private parties ...), considering that they play a strategic role in improving the health of the community (and hence need to operate in an integrated way).
- As regards school, pupils of primary schools and students of secondary schools and college have been targeted for nearly a decade through Health Projects, carried out by internal teachers (often P.E.) with the assistance of outside experts, such as club instructors, P.E. experts (trained by CONI) in order to create the conditions for a healthy and proper lifestyle.

The prevention of **depression** and suicide - and sometimes suicide is a consequence of mental illness, requires a multi sectoral approach. Programs should focus on promoting healthy lifestyles and reducing risk factors, such as easy access to medications, drugs or alcohol. Furthermore, it is necessary to give support either to people who have tried to commit suicide or to their relatives.
It is important to stress on the fact that depression is a treatable disease and that suicide is an act that can be prevented. Consequently, it is essential to develop structured services for women, families and for those social partners who are closer to their daily lives

AUSTRIA

Most common settings are
- schools
- Communities/Community networks

Especially when working with hard -to-reach- target groups – create settings where you can catch them in daily life situations
Since social disadvantaged groups often tend to be isolated, working with peer groups and networks is important
Special settings (as mentioned before): health promotion in combination with social work, in the framework of integration projects (f.e. for immigrants)
Level should be low-threshold – not to expect too much of these target groups

DENMARK

Denmark has free access to

- doctors.
- Vaccination program
- Child nurse for the first years – and continuing for the family who seems to need support.
- Dentist to the age of 18

Many companies in Denmark offer facilities of physical training for the employees. Stop smoking courses – food making arrangements – participate in company tournaments. Personal counselling to lose weight or to handle stress.
By law all kinder gardens have to offer free meals to assure that all children at least will have one proper meal pr day.
We are in the beginning of a change in kinder gardens, more and more kinder gardens have focus on given children good habits' about physical training.
We have national days of exercise in primary school and a lot of different sport tournaments.
We have competitions between different small villages – which can lose most weight pr inhabitants during a period of ex. 3 month.
Many municipalities have established Teams for Prevention – to reach the groups of people, who not normally by them self takes part in any "normal" general health activities.
Examples: walking bingo, social food clubs for young mothers to introduce how you can create healthy food for themselves and their children.
National football tournament for homeless people – has been a great success. Lifestyle mentor seems also to have good perspectives to reach this group.
So for us the question and challenges is – to be more and more creative to understand and adventure the activities that can motivate and inspire more and more specific sub-groups.

FINLAND

In compulsory school, the health education has become a special goal in the curriculum. This has happened in the beginning of 2000^{s} . It starts from when the children are 11 years old and continues in the upper secondary school also. Already before there has been physical education as a separate goal, but now also the knowledge about health has become a part of the curriculum.
Every child gets a warm meal every day for free in the day care and in the school, even in the upper secondary and vocational schools.
In our health system all people have free access to nurses, doctors, laboratories, X-ray examination etc. In our occupational health system we have in special annual health controls. We have also all kinds of research programs for different target groups for example on diabetes and cancer.
Related private institutions in the Swedish speaking area are Folkhälsan and Martha Association. Folkhälsan works in all Swedish speaking municipalities with different ways of implementing physical and mental health. Martha is specialized on women's and young girls' health, among other issues. Right now they have a campaign about sustainable lifestyle, where also health is one of the issues.
There are also private persons that do things for the health in Finland. Right now there is an event going on where a rich man decided to give money for teacher training in Nepal, but he decided to make this campaign to have an effect on the health in Finland also. He cooperates with the National Institute of Health and Welfare (THL-Institutet för hälsa och välfärd) and he will donate 15€ for every kg a person in Finland will lose weight. In February the persons that participate in this campaign have to check their weight and for every kg they have lost, he will provide 15€ to the teacher training, up to 10 million €.THL has recommended that about 200 000 inhabitants in Finland should lower their weight by 3 kg on the average. If this happens, he would support the teacher training, and also that we will get a healthier population in Finland. This could help the increasing type 2 diabetes for adult people (VBL 16.12010).

UNITED KINGDOM

- Nationally all Schools have a health initiative (The Healthy Schools Programme (10)). In Doncaster all schools (125 schools across 3-19 age range) now comply with the National School Meals Nutritional Standards.
- The schools meals services (providing 20,000 meals a day), Active Recreation Services and specialist weight management services address healthy eating and obesity (with specific targets) within the community as well as in schools.
- Doncaster College (11) complies with a National Healthy College programme (with specific targets in relation to health and well-being of both staff 1023 approx and students 14,000 approx)
- GP clinics offer health related services linked to the six health key priorities linked to the 'Choosing Health' priorities.
- Commissioned Health and Well Being related projects (by Doncaster NHS) operate within both community, NHS, Council and private settings.
- There is an Enhance Public Health Agenda (12) which is operational within the Borough in community settings and with educational providers and voluntary sector groups.
- Skills for Health (2008) is a National programme combining essential literacy and life skills with health improvement education (reaching 650 individuals in pilot year)
- Reduce the Risk is a targeted intervention aimed at young people to reduce risk taking behaviours and health inequalities. Parallel programme

ROMANIA

Schools have been mainly addressed, yet lately the general public is envisaged.
See Annex 1

GERMANY

There are several initiatives that deal with the topic.
As far is health prevention for children is concerned the Federal Ministry of Health has also launched a yearly award for best practice projects in the field of health prevention. Every year projects targeted especially at children can be submitted and are subsequently assessed by a jury of experts. The winners of the award receive 50.000€. In this context, the Ministry organises regular conferences for potential applicants and other interested people.
Moreover, 6 out of 16 federal states adhered to the EU-campaign school fruit providing fruit and vegetable to school children for free.
There is a national initiative called „MiMi – Mit Migranten für Migranten – interkulturelle Gesundheit in

Deutschland" (Healthcare prevention from Migrants for Migrants) It is an initiative from the ethno-medical association.
Additionally there are a lot of actions from private institutions, clubs and schools. Micro projects from neighbourhoods and many things more. There are so many that we can just show a few of them.
You can find a small list of regional best practice when you follow the link mentioned above.

2c. Modalities with high priority regarding healthy life style development

ITALY

As regard the program “Gaining Health”, with reference to healthy lifestyles and alcohol abuse fight, from 2004 to 2007 the Italian government (Department of Health) promoted and financially supported health information campaigns nationwide. The topic was alcohol abuse and its effects.
In order to capture youngsters’ attention, the Department of Health availed itself of the collaboration of some famous Italian football players. The head of the campaign said: “Do not play with your life. If you drink, do not drive” as it has been stated that in Italy young mortality is mostly connected with motor vehicle crashes due to drunk driving.
Another medium for the same concept was the radio: on that purpose, major stations were chosen nationwide. In addition to that, in 2007 Italian government organized the “Alcohol prevention day”. The message passed was that alcohol abuse is one of the major risk factors of illness and death.
Furthermore, the Department of Health realized a leaflet called: “Do you know what you drink?” where there was a listing of limits for alcohol consumption recommended by Oms and the American National Institute of Health.
Targeting families, young people and women, the Department of Health created also:

1) A Calendar with advices in order to help parents prevent their kids from drinking alcohol
2) A pamphlet for young people aged between 11 and 18, with facts and FAQ
3) A brochure for women entitled: “Woman and Alcohol. Alcohol. You sure?” in which the characteristics of female vulnerability were explained, as well as the risks concerning pregnant women who drink.
4) A brochure dedicated to young girls, entitled: “Alcohol. You sure? Girls and alcohol” in which also advices on diet and pregnancy could be found.
5) In 2009 the Department of Health chose young people as the unique target of the information campaign: “Guys, let’s see clearly” which was created in order to prevent drunk driving.

The so-called “Red Nose Operation” is another project concerning battle over drunk driving, promoted by the Ministry of Youth and the Istituto Superiore della Sanità (ealth Main Institute), the leading technical and scientific public body of the Italian National Health Service, in order to prevent young people form drinking and driving. The project involved night discos and bars in 11 cities all over Italy: not only were youngsters informed about the risks concerning drinking alcohol, but also, inside the discos, they could get a relaxation therapy or even be taken safely home.
In 2009, in the Province of Udine it was realized an advertising campaign called "Mole il bevi” – which means ”Stop drinking” in local dialect - in order make people aware of alcohol issue, the leading cause of death among young Europeans between 18 and 25 years . The Friulian language was chosen in order to create a greater emotional impact and to get local people involved.
In order to lead a better lifestyle and especially to fight alcoholism, prohibitions have come into force (they refer to alcohol limits for driving, time limits for public spaces, as so on). With reference to more serious cases of alcoholism, the distribution of medicines by health care companies has been assured.

As regards **heart diseases**, the Italian Department of Health, Work and Social Policies, in co-operation with doctors belonging to the Italian Federation of Cardiology, promoted an information campaign with a free telephone number which could be called in order to receive information about prevention of

cardiovascular diseases with reference to the adoption of healthy lifestyles. The head of the campaign was: “The number of your heart”.
Moreover, regarding cardio-vascolar diseases, for a healthy lifestyle different actions have been taken:
1. consumer information (labeling foods, commercial communications, consumer education ...)
2. exercise
3. monitoring activities

Referring to **depression**, the National Center for Mental Health has reported that screening is an essential test in growing age and that it has to be performed according to specific protocols in order to highlight behaviors that may subsequently evolve into mental illness. In order to achieve this result, it is necessary to create networks of relief around families, who are able to help or detect early signs of discomfort.

AUSTRIA

Campaigns on:
Smoking
Alcohol
Cardiac diseases
Physical activity
Personal contact during these information -campaigns is important, especially if you work with social disadvantaged groups. You have to activate them, give them incentives to participate in activities. Working in networks is also important. Most of this work is done within smaller regional projects.

DENMARK

I am not quite sure what you ask about?
But KRAM and the efforts based on the KRAM research has been giving the highest priority in Danish preventive work.

FINLAND

Brochures, books, material for lessons for teachers, nurses and doctors and materials on the net.

UNITED KINGDOM

The Choosing Health White paper (2004) identified six key areas; smoking, obesity, increased physical activity, alcohol awareness, improving sexual health and improving metal health. Doncaster held a number of community conferences with frontline worker from all agencies to look at health and social issues to engage the community. Following this an Enhanced Public Health programme commissioned in excess of 16 community projects to support, educate and motivate the Doncaster communities in health awareness

ROMANIA

Campaigns are mainly used in Romania but also health education in compulsory school.
See Annex 1

GERMANY

A major focus is put on sports and nutrition. From the initiative and projects that are quoted in the previous sections can be concluded that there is a clear tendency to introduce preventive actions in children's education both in the early childhood in the kindergarten or in schools. Since an increasing number of children already suffer from overweight due to bad nutrition and lack of movement, a main strategy is on the one hand to introduce healthy food and sportive activities in the respective institutions and on the other hand to raise their awareness for healthy food and to provide them in a playful way with information on healthy food.
The government has also recognised that disadvantaged target groups do not use health services to the same extent than other groups do. This is partly due to the fact that some groups such as migrants are not aware of the different services that are available for them and thus do not make use of them.
Regarding the important role of social class in determining health related behaviour, morbidity and mortality, the government has implemented the above mentioned regional knot that are putting a main focus on improving health prevention among disadvantaged groups. The cooperation "Health prevention among socially disadvantaged target groups" was initiated in 2003 by the Bundeszentrale für gesundheitliche Aufklärung (BZgA), Federal Centre for Health Education, and is being supported by health insurances, German Medical Association, other ministries, charities, and other stakeholders and experts from the field. In 2007, the regional knots were implemented in all 16 federal states in order to promote and improve the cooperation among the regions. These knots have tied up to regional structures and are setting up new working groups at local and regional level in order to promote a continuous exchange among stakeholders and to identify, promote and disseminate good practice by applying good practice criteria which have been defined by the BZgA.
As mentioned above the aim is to improve health prevention among socially disadvantaged groups with a special focus on

- health care and unemployment
- health in disadvantaged quarters

This is meant to be achieved by giving higher priority to health related aspects in offers and services provided for the target groups as well as by initiating a structural change of the health system. Projects and actions are being developed in a participatory way together with potential providers (education institutes, (sports) associations, schools, insurances, charitable associations, self-help groups, etc).
The regional knots regularly organise conferences and workshops for interested project coordinators, stakeholders from the field and service providers to inform about current tendencies and to develop strategies to improve the situation.
The regional knots have a database to publish good practice actions and projects. More than 1.800 projects and actions are available online.

2d. Availability of internet based multimedia learning materials for the basic care educations regarding disadvantaged groups

ITALY

As regard the **alcohol** issue, informative material exists primarily for the "insiders", but there is much more material on the Internet. The problem is that some disadvantaged people have scarcely access to internet facilities or they do not know how to use ICT tools.
As regards alcoholism, there are also websites - i.e. the Department of Health's one or the new www.beviresponsabile.it (which means "drink responsibly") and some advertising campaigns on the negative effects of the abuse of alcohol, with particular reference to traffic accidents. It is believed that television is more effective than other media, despite of the fact that it provides information passively, since it reaches a wider audience. Even though these media are easily reachable by youth and adults, one of the risk categories is left completely aside: elderly people. They do not use computers and the Internet, and do not get the message of TV spots targeted for drivers and clubbers.

Healthwise, materials for monitoring the absolute global **cardiovascular risk** are accessible via web
- In educational context: International / national / regional projects (in collaboration with organizations, associations and sports federations) are targeted to students from primary to secondary school and college.
In the information society the media are crucial in developing the concepts of health, illness, care, wellness... In particular, television dedicates much space to issues regarding the "body", with the result of transmitting –implicitly or explicitly - the popular concept of everyone's relationship with the quality of life.

AUSTRIA

There are some websites on health issues with interactive games, psycho tests, information and also incentives like contests or lotteries.
f.e. the website:
www.bummbumm.at – including information on prevention of cardiac diseases
We did not find any information on multimedia learning for this target group. The information out of various project reports is, that **participation** and **personal involvement** is very important in reaching the group of social disadvantaged people

DENMARK

Yes – Net based Learning Materials for basic care is available. But the material is not suitable for the disadvantaged groups.
The existing material is directed people who are supposed to become professionals – so it is quit theoretical and connected to the books used in these educations. We believe that the material should be much more directed to the situations, where we meet the disadvantaged groups and be much more directed to them as persons, and the levels of skills when it comes to personal skills and IT skills.

FINLAND

Usually multimedia material belongs to the schools or organizations that have made it. There are organizations that make material for free sharing, for example Finnish Institute of Occupational Health, UKK- institute and Age institute. These organizations have useful material on the net. While most of it is in Finnish, one can also find material in Swedish and English (for example, Physical activity pie diagram). You can also find tests on the web where you can find out if you are at a risk to get Diabetes type 2. This is from the Finnish diabetes association. These can be useful also when one works with health issues with adult students. The problem can be that the people that need it are not the ones who find and use them.

UNITED KINGDOM

1. Skills for Health is a National health literacy programme which is run within the communities. This has a web page and learning materials. The website is www.continyou.org.uk (skills for Health). This is available in community centres and libraries as well as on personal computers.
2. Doncaster also has a sexual health website www.morethananumber.co.uk and a drug service (support, advice and education) website; www.drughub.co.uk
3. There is also a National website www.nhs.uk/change4life which supports health changes to improve health lifestyles.

ROMANIA

There are computer based programmes, not internet based and they mainly address children.
For the adult population there is no internet based learning material.
The level of necessity is high if we refer to trainers.
It is unlikely that the disadvantaged population will themselves start to gather information from the internet.

GERMANY

Available are in the Internet:

- films accompanying awareness raising campaigns such as the above mentioned “3000 steps”, or films promoting sports and movement
- guidelines for health prevention with tips
- posters
- info materials
- newsletters
- etc.

These materials are available on the website of the Ministry of Health and on project website or the like. The problem is that even if an increasing number of disadvantaged people have access to computers, they would not necessarily search for health related topics.
The same applies to young people who have mostly access to computers but lack interest in the topic. They would not necessarily look for health issues by themselves but would need a special motivation to do so. In this case a PC might present an added value in the training process, since this is the tool they very frequently communicate with among their peers. A first step would be an awareness raising activity and as a second step ICT sources could be helpful to actually make them look at the topic from another angle.

2e. Main concerns of socio-economical disadvantaged persons regarding lifestyle diseases

ITALY

With reference to the problem of **alcoholism**, the categories which have been most targeted with initiatives to raise awareness and care are the young, who usually are more sensitive and feel often alone, and users of voluntary and non-profit associations dealing with alcoholism.
The alcohol-related problems are the leading cause of death among young people in Europe. The culture of harm prevention regarding alcohol is not widespread, especially in the elderly population. Old people's excess consumption is growing in proportion to the feeling of getting a good state of health. It has also been stated that behaviours of binge drinking (especially among women) are increasing.

Health field: the interventions were directed primarily to individuals at high **cardiovascular** risk * in order to promote change in lifestyle (closely linked to the onset of disease).
* (Individuals with hypertension / high cholesterol, overweight, diabetes, smoking)

Within the school: see "Projects to Health"-mentioned above-: thorugh them the foundations for a healthy lifestyle should be created by the means of a gradual commitment of young people to sports.

AUSTRIA

- young people
- children
- women/single parents
- socio-economical disadvantaged persons
- migrants

DENMARK

During the last ten years DK has addressed the main concern to following issues:

- People with weight problems
- To high use of alcohol
- Smokers
- Physical inactive

Because due to Danish research is this 4 areas the basic problems who cause most diseases/inclusive lifestyle diseases.

FINLAND

The attention has mostly been on preventive measures. From our point of view it is always better and easier to do something in advance than when it is too late. We have advisories for pregnant women and children. In schools we have school health services. When we are working we have occupational health services that both give advise and help when some problem has arisen. But also we have advisories for youngsters that have different problems with mental health, drugs or other problems. We

have also more general help towards people with alcohol and drug problems. One reason to put much emphasis on health advisory systems is that the old people are increasing in count all the time, and our society cannot survive if the old people are not in a good condition. We can see this in the research from University of Tampere where they have checked the difference between 1990 and 2000. 54% or boys are drinking more than 2 times a week, 30% of the girls, smoking has risen from 25% to 30% among the young. 40% exercise too little and the percentage of overweight has risen from 35% to 40%. The adult men consume too much alcohol; the amount of men in risk group has risen from 28% to 37% and of women from 8% to 20%,. Among the adults, 37% are exercising to little. But the old people's heath has been becoming better. This research says that we need to work for youngsters' health situation too.

UNITED KINGDOM

The target groups addressed were the 20% most disadvantaged communities within the Doncaster Borough. These were based on profiles indicated through the Joint Strategic Needs Assessment (2008) (13) based on data relating to health, crime, social care, demography and service accessibility.

ROMANIA

To children, adolescents and youth (aged 7 to 18/20), in order to develop responsible attitudes and behavior, to raise awareness among the involved communities (parents, teachers, school principles, key local and central stake-holders)

GERMANY

In general much attention is given on health prevention among children. The Federal Ministry of Health defined a clear overall goal "growing up in health" that is put in practice with targeted actions and structural as well as financial resources. Moreover, there is strong focus on socially disadvantaged people as was evidenced above:

vantaged children and youngsters

- Migrants
- Women
- Homeless People

2f. The most widespread lifestyle diseases linked to psychological/affective/social areas

ITALY

Nationally, diseases related to **alcohol** are being studied, but only recently it has been paid attention to stress or depression associated with the issue. Indeed, up to now, studies on alcohol focused on the ways of consumption rather than on individuals and on the cause itself.
Italian alcohology was born in FVG through the cooperation of public and private boards. Currently, the network of alcoholism FVG has its technical and scientific support in the Local Authority of Health and Social Protection and in the Coordination Group PPAC. Other facilities are: universities, social welfare boards, healthcare organizations (hospitals, districts, departments of employees) and the third sector (associations, groups, cooperatives)
For **cardiovascular disease**:
Italian-Atlas of cardiovascular disease
Risk assessment:
-Progetto Cuore /Heart Project)- Italy: "Preventive Potential of body mass reduction to lower cardiovascular risk;
Overall, cardiovascular diseases are studied at municipal, regional and national level through specific projects that specifically investigate the close interaction between lifestyle and the incurring of the such diseases.
A sociological University Research on **depression** states that as regards women, the disease is connected with gender inequality and the contradictory conditions related to the ongoing changing in social, political and economic sphere: for example, in Italy 9 women out of 100 suffer from depression.

AUSTRIA

It is very difficult to find specific studies in Austria – the studies we have found, they show, that lifestyle disease social problems, problems within the family, at the job, mostly go hand in hand. What studies on socio-economical determinates on health show, is that the more support people (social disadvantaged) find in their families, the more they have the chance to stay healthy.
But we could not find any specific studies showing how lifestyle disease are linked to family or social problems. Of course diseases affect the job situation but we could not find out quantitative data on that

DENMARK

In Denmark we have a lot of studies which shows these negative circles –
The more you are affected by these problems – the more isolated you slowly will be, over represented in a various of social psychological and psychiatric diseases/conditions – and so on.
And opposite we also know that people who in a start are suffering of social psychological, affective, social or psychiatric problems, are more in risk also to develop lifestyle diseases – than the average in the rest of the population.

FINLAND

No comments on this specific question

UNITED KINGDOM

Doncaster NHS commissioned a Mental Health Needs Assessment (2008) (14) to identify the impact, provision use and the promotion of mental health services within its borough. This identified priority areas and recommendations for mental health services, mental health promotion and education. Doncaster has an 'Improving Access to Psychological Therapies' programme which is a Government led psychological programme aimed at supporting mental health needs within communities. It was piloted in the Doncaster borough first, with over 5000 individuals being seen in its initial year. This pilot was so successful that it has now been rolled out across the country.

ROMANIA

The diseases have been studied and linked to different lifestyle patterns but only one study, done in 1994 by UNICEF[iii] focuses on linking lifestyle diseases to psychosocial factors.

GERMANY

As far as social areas are concerned studies revealed that social class plays a major role in determining health related behaviour, morbidity and mortality. This means that socially disadvantaged classes are most affected by poor health.
After the reunification in Germany in many health fields there were big differences between East and West Germany. This has been equalled ever since. The regional differences nowadays are mostly due to social reasons: health opportunities are lowest where living conditions are at their worst – as a result from unequal distribution of education, unemployment, income, and private wealth in the federal states. E.g.: Life expectancy of men from lower social classes is 11 years lower than of men from higher social classes. The difference for women is eight years. Considering the years of life in good health this differences are even higher.

3. Effects, impacts, consequences, benefits of health initiatives

3a. Statistic studies regarding the effects achieved in consequence of study and prevention initiatives on health issues

ITALY

There is a statistical study of the Department of Health stating the level of **alcoholism** in Italy in recent years (2006-2008), following the Law 125/2001. The document, having recognized alcoholism as one of the three major factors of disturbance in Italy, provides the monitoring of the situation. Each region was asked to respond to these initiatives: 1) promoting access to health treatment and care improving quality; 2) supporting information, prevention and education regarding the harm caused by alcohol; 3) ensuring training and refresher courses for the personnel; 4) encourage research and master degrees; 5) supporting self-help groups and non profit organizations; 6) monitoring the reception facilities in the territory; 7) promoting collaboration agreements with public or private institutions and associations; 8) collaboration activities with important institutions in order to respect the provisions on advertising-sales of spirits in the highways-alcohol level while driving; 9) encouraging activities or projects for safety at work; 10) ensuring delivery of anticraving anti-abuse or alcoholism drug therapy by NHS.
As stated in various statistical studies, it is a priority to dedicate sources to prevention initiatives targeting women – particularly those belonging to the most disadvantaged social classes. As a matter of fact, women tend to imitate negative behaviors (tobacco and alcohol consumption). It is important therefore to stop the epidemic effect of such behavior.

- Eurisko Institute monitored the results in terms of knowledge of **cardiovascular** risk (the so called "great killer of the industrialized societies"), as a result of prevention initiatives:
- 94% of the interviewed knew the phenomenon
- 27% of the interviewed spontaneously cited diseases belonging to this area.

AUSTRIA

Single studies, statistics on correlation – in order to start successful prevention/promotion activities
But no studies on the effect. Evaluation studies are often not published.

DENMARK

Yes, we have a lot of statistic. And yes it is possible to see positive changes before and after different prevention initiatives on health issues.

FINLAND

The Pohjois-Karjala research project showed us that when people got better nutrition facts, the heart diseases have also diminished. We can also see that the food habits in Finland have improved (Health in Finland). We are eating less fat and more vegetables and fruits.

UNITED KINGDOM

Mental Health Needs Assessment (2009) This clearly identified need and developed priorities and recommendations.
The Doncaster Annual Review (15) ; this identified target areas for prevention initiatives for example; smoking targets for quitting were 1848 actual 2622, attendance at GUM clinics (sexual health) a rise from 75.7% to 86.69%.
Healthy Ambitions is a delivery framework for Yorkshire and Humberside (2008) based on a National review about shaping NHS provision over the next ten years. It brings together eight groups of specialist health professionals to look at birth to end of life with consideration given to health related issues and their solutions.

ROMANIA

Yes, mainly statistics related to the campaigns run.
See Annex 2
Annex 2- Supplementary readings
In Romania, the patterns of morbidity and mortality have changed in the last decades. The prevalence of chronic disease has increased, a trend which is associated with the synergic action of biological, environmental and lifestyle determinants together with the influence of socioeconomic and health care conditions.
The main causes of death in 2006 in Romania were cardiovascular diseases (62.1%), followed by malignant tumors (17.6%), digestive diseases (5.5%), accidents, injuries and poisoning (4.9%) and respiratory diseases (4.9%). Deaths from external causes and from infectious and parasitic diseases are more common in Romania (4–5%) than in other EU Member States.
Routine data related to the morbidity of non communicable diseases and their determinant factors underestimate the real amplitude of the phenomenon. Data of good quality are available only from the *Health status surveys* performed by the Computing Centre of Health Statistics and Medical Documentation of the Ministry of Public Health. The last survey was carried out in 1997 (Ministry of Public Health and Family, 1997).
Evidence suggests the lifestyle factors with the greatest impact on health status are, as in other countries, smoking, alcohol consumption, illicit drug consumption, an unbalanced diet and low physical activity. Risk factors such as smoking, physical inactivity, obesity, hypertension and poor diets are clustered in the poor groups.
Taking these in turn, **smoking** rates have increased in Romania since 1990 among both women and men, but especially among young people. The *Health status survey* carried out in 1997 showed that 46% of men and 13% of women over 18 years of age are regular smokers (Ministry of Public Health and Family, 1997), which is higher than the EU average but comparable with the countries of central and eastern Europe. According to WHO *Health for All* data for 2003, 21% of the Romanian population over 15 smoked daily. Romania participated in the international negotiations regarding the Framework Convention on Tobacco Control. The Minister of Public Health also signed the Warsaw Declaration in support of the Framework Convention. Since 2002, smoking in public institutions is regulated by law. (349 / 2002).
The main aim of anti-tobacco media campaigns is to provide evidence-based information about the harm caused by both active and passive smoking to current and potential smokers, as well as to the general public who are often involuntarily exposed to passive smoking. Prevention and encouragement to quit smoking are among the main strategies in the fight against smoking. National programmes help to educate the public about the harmful effects of smoking and can motivate tobacco users to try to quit. One of the main aims of preventive actions is to stop children and adolescents taking up smoking. Preventive measures include education, the banning of tobacco advertising, health warnings on tobacco products, the enforcement of laws prohibiting tobacco sales to minors.
Regarding **alcohol consumption**, the national health survey carried out in 1997 revealed that 56.2% of persons over 15 years of age consumed alcohol, of which 3.7% reported dependency (Ministry of

Public Health and Family, 1997). That same year, alcohol consumption was most prevalent in those aged 25–44 years (66.3% of this age group consumed alcohol).

Illicit drug consumption emerged as a problem in Romania after 1990. Surveys of intravenous drug use produce widely differing prevalence estimates. The Institute of Health Services Management estimated 1000 intravenous drug users in Romania in 1998, whereas a preliminary study by UNICEF estimated approximately 30 000 intravenous drug users in 2002 in Bucharest alone (Galan et al., 2003). More work in this area is needed to reach firm conclusions.

The average **diet** is relatively unhealthy, characterized by high consumption of animal fats (there was a slight improvement between 1996 and 2001, which was followed by a more recent resurgence) (Table 1.10). In addition, Romanians tend to eat high-caloric food with a high sugar and salt content. It is likely that diet in large part explains the high rates of cardiovascular diseases. Being overweight is associated with a higher risk of disease, particularly if body fat is concentrated around the abdomen. The estimates of attributable mortality and burden due to being overweight and obese have been made using a measure of high body mass index (BMI) calculated as weight (kg) divided by height squared (m^2). BMI was chosen as a simple measurement of body weight in relation to height because it is in principle easier to measure at the population level than body fat. Analysis of the relationship between BMI and mortality and morbidity suggests that the theoretical optimum mean population BMI is around 21 kg/ m^2. The disease outcomes for overweight and obesity include: Diabetes type 2, Ischemic heart disease, Stroke, Hypertensive disease, Osteoarthritis, Cancers (colon, kidney, endometrial, and postmenopausal breast cancer).

Socioeconomic factors also have a marked impact on the health status of the Romanian population, in particular the high levels of poverty, unemployment, social exclusion and the structure of household expenses. Poverty was estimated at 27% in 2002, and extreme poverty at 11%, according to the World Bank Report from September 2003 (World Bank, 2003). The most affected area is the North-East region of Romania, where the poverty rate is estimated to be higher than 40%.

The diets of low-income groups are likely to be inadequate. Low-income groups and specific groups such as children, adolescents, pregnant and lactating women, and older people often face problems gaining access to a healthy variety of safe foods. They often eat less well, the proportion of their income spent on food is higher, they have poor access to food and little choice in quality and range, and they often suffer more ill-health. Equitable public policies can decrease infant mortality and improve health. The percentage of disposable income spent on food gives an indication of how severe the lack of food is likely to be. In Romania the average amount spent on food is around 60 % of disposable income, respectively, compared with 22% in the European Union (EU). Increased health inequalities are a result of poverty and social inequalities.

In fact, it is difficult to prevent and treat overweight and obesity. Most population-based prevention programs that have been scientifically assessed have not demonstrated any favorable effects on the prevalence of obesity. However, there are examples of successful programs for both adults and children.

Also, the environmental interventions need to be developed. Although many environmental factors have been cited as contributing to obesity, there have been few controlled studies showing that changes in these factors will prevent weight gain. Environmental interventions attempt to modify the external surroundings with a goal of affecting behavioral changes, such as improvement in diet, increased physical activity, and or decreased sedentary behaviors. The aim of such interventions is to prevent weight gain, without exclusive reliance on an individual's knowledge or motivation.

The environment also has a major influence on health status. According to data reported by the Ministry of Environment and Waters Management (2002), Romania has experienced a slight improvement in air quality. This improvement can be attributed to some extent to the reduction in industrial activities coupled with re-engineering programmes, in addition to increased activity of the Environmental Protection Inspectorates.

The most important environment problems in terms of surface waters are organic nutrients (nitrogen and phosphates), flow modification of transport conditions of sediments, contamination with dangerous and oxygen-consuming substances, and lack of water-purifying units. Inappropriate safety measures for storing and disposal of solid and dangerous waste and the management of industrial wastewater may

also contribute to the degradation of subterraneous waters.
Overall housing conditions seemed to show a slight improvement between 1992 and 2002, at least regarding access to water and the sewage system. The decrease in heating facilities could be related to the significant price increase of fuel and also to poverty.

GERMANY

Data are available from more than 100 different sources, among which there are many statistics from the Statistical Offices of the Länder and the federation. There are also data from numerous other institutions from the health sector. These data deal for example with: health monitoring, framework conditions, health status, behavioural and risk aspects of health, diseases and health problems, expenditures, costs and financing.

3b. Impact and consequences on socio-economic disadvantaged groups

ITALY

Even though there has been a general decrease in the consumption of **alcohol** up to ten years ago, when Italy was the 1st Country out of 51 relating to the European Region of WHO meeting the target of a 25% decrease in individual consumption of alcohol (1981-2000), in recent years some exceptions have been recorded because of some social 'weak' groups as young people, women and elderly. Thus, along with a decrease in the consumption of alcohol, an increase of consumption of alcohol (especially in young women, as seen) should be registered. Consequently, the number of people at risk of alcoholism grows. Anyhow, the most recent statistical studies do not take into consideration the economic and financial situation of people at risk of alcoholism; they simply register the consumption of alcohol within a wide range of age (14-69 years). That is why it is impossible to make assessment on the actual distribution of consumption of alcoholic beverages: population is only differentiated by the means of age or sex. However, the consumption per person is useful for comparing international data and monitoring trends in alcohol consumption over time; it is also an indirect indicator of the level of alcohol-related diseases in the population.
As for **cardiovascular** diseases, the amount, variety and different accessibility of sources on such issue inevitably create an inequality between citizens according to their level of education or, more specifically, to their health literacy.
Three levels of health literacy should be considered:
1. clear and coherent information
2. information and awareness campaign about specific issues regarding the use of services, tests, medicines..
3. responsible and participated involvement in the definition of strategies regarding the health issue.

AUSTRIA

There are some recommendations given for health promotion projects for social disadvantaged persons:

- Avoid stigmatisation and be sensitive in your wording/language and topics
- Avoid victim-blaming: let people participate in the process of defining the problems, in planning, decision making and empowerment
- Be aware of continuity and sustainability
- Don’t set too unrealistic goals, all determinates of Health have to be considered – not only

personal aspects

- Difficult life situation have to be considered
- Orientation on daily life

DENMARK

The statistic shows that the biggest impact among adults has been among the best educated, well paid adults and that the disadvantaged groups all most are not affected until now.
The numbers of smokers are reduced very much, among group no 1, they buy and maker proper food and they are the most physically exercising group. Among the disadvantaged group we don`t see the same positive development. The still smoke, the are the group who buy most pre prepared food and they almost do not participate in physically exercise.
All together it means that there are a different of 10 years in expectation of lifetime between group 1 and group 2
When it comes to alcohol – Dk produce just as many alcoholics among disadvantaged as group 1.

FINLAND

In Finland the education level of the population is increasing all the time. The people that only have the minimum of education are generally retired today. We can also see that people are eating more healthy food nowadays, but also that they do not exercise enough.

UNITED KINGDOM

In the Department of Health's indicator 'all age all cause mortality' (2008) (16) in England the health of the population as well as the local population has improved. However, there is still a small remaining gap between the more deprived communities with still higher death rates and poorer health (obesity Doncaster Central23.8% Nat average 18.2%, Binge drinking Doncaster Central 20.8% Nat average 18.2%, Smoking Doncaster Central 31.2% Nat average 25.8% - Office for National Statistics and Health Info Centre) (17)

ROMANIA

See Annex 1

GERMANY

Actions and projects have been initiated some years ago; concrete consequences among disadvantaged groups are merely noticeable. In general, there is a higher awareness for health prevention in the population but those people from disadvantaged target groups that are suffering from poor health due to bad nutrition and lack of movement are also those who have not yet adapted a healthier lifestyle.
Specific health projects for unemployed people in order to improve their job opportunities are fairly new, thus not showing any consequences yet.

3c. Groups with more benefits and reasons therefore

ITALY
Statistics regarding the consumption of **alcohol**, even when it is not really an addiction, are limited to numerical data, regardless of population categories and socio-economic factors.

AUSTRIA
Hard to say – even if Austria has a good health care and social system, it is a fact that health is still dependent on social status/income. F.e. it is easier to start additional health promotion offers in more prosperous areas.

DENMARK
People with the highest educational level, highest levels of salary are the ones who benefits most from campaigns, information and public advice.
The one who benefit less from these initiatives is low or none education, low salary and particularly people who are not connected to labour marked

FINLAND
The possibility to get and use knowledge is the same for all. There are benefits for all kind of groups, but they don't reach all because many who need it don't search for it. The economic situation has also a part in the problem. The old and poor people have also access to less (or worse) health service.

UNITED KINGDOM
Doncaster profiles a range of indicators to use in order to improve health and reduce health and social inequalities based on the 20% areas of social and economic deprivation.

ROMANIA
Mainly smokers and drug users.
See Annex 1

GERMANY
Actions and projects have been initiated some years ago; concrete consequences among disadvantaged groups are merely noticeable. In general, there is a higher awareness for health prevention in the population but those people from disadvantaged target groups that are suffering from poor health due to bad nutrition and lack of movement are also those who have not yet adapted a healthier lifestyle.
Specific health projects for unemployed people in order to improve their job opportunities are fairly new, thus not showing any consequences yet.

3d. Financial recourses

ITALY

It seems so far that the available funds for the public awareness campaign on the risks associated with excessive consumption of **alcohol** have permitted the implementation of initiatives supervised at a national level by the Government and at a local level by the Regions. Each Region has implemented differentiated programs, according to the needs of the territory and its existing structures, and has activated new collaborations and social support structures.
Health expenditure is increasing for factors such as population-aging but financial resources are limited. Therefore it is necessary to apply principles of health economics regarding choices in the medical and in the research field.

AUSTRIA

Money is always scarce!

Especially small projects in deprived areas have problems with funding. Often projects are too small to get official funding, finding of sponsors is very difficult but especially in working with social disadvantaged groups external funding is needed, because –f.e. parents can not effort to support school projects…or are often not interested in.

DENMARK

In Denmark we have used a lot of finance directly and indirectly during the last ten years. If it is enough is always an open question. The level of money used for prevention initiatives, has created a positive change in the numbers of lifestyle diseases occurred during the last years.
In Denmark we believe that changing lifestyle is a very slow process for the individual, for the family and groups. A process you might not be able to force – but will slowly appear if society keep the pressure. A lot of initiatives don't need money – but only a change in understanding and attitude by relevant persons. It does not cost anything – to change daily routine in institution from not running at all to make the children run 2 or 3 km 2 or 3 times per week, and so on.

FINLAND

They meet the need of knowledge and there are good plans for how to solve the problems, but when we come to a personal level, then we can see that the people that need the knowledge do not always find it (or search for it) - and to change a person's lifestyle a lot more than knowledge is required.

UNITED KINGDOM

Doncaster via its 'Better for You' strategic plan aims to spend (on health and Well being needs), approx £1500 a year (till 213) on each of its residents. The allocation of Public Health resources is via the health care commissioning. Doncaster is working towards 'World Class Commissioning Assessors'. This meets the Governments target objectives from the HealthCare Commission.

ROMANIA

Not always and since not all diseases are covered, not all the needs are met.

GERMANY

Most projects do not publish their budget give only information on the project objectives, target groups and actions.

4. Comments and proposal for new best practices in health education

4a. Further health education issues

ITALY

Surely the limit of the research regarding **alcoholism** and the spread of alcohol consumption in the national territory lies in not paying much attention to the psychological aspects of the matter, in not comparing the problems between the different age groups or the motivations. In Italy, institutions tend to consider people as patients. For these reasons, the reduction of alcohol consumption should be much better incorporated into national and regional health planning as a priority objective of health, to be achieved by means of multidisciplinary approach rather than a purely medical one, according to the European principle of "health in other policies".
On the bases of data obtained in the course of Alcohol Prevention Day 2009 and the pilot project related, the concern is that there will be an increase of young people abusing of alcohol. If some years ago the intoxication was most related to adults, now it has become frequent among minors and young people. It has become a voluntary behavior. People attend bar, not so much for socialization as before, but to consume alcohol. Is not sufficient to activate actions in the sanitary field. It is important to act in the cultural sphere. Families must watch their children and educate them to the value of moderation and the concept of limit.

Nobody is immune of depression, also known as “evil soul”, even though studies made by O.N.Da show that women are the ones who suffer the most. Depression is an insidious disease that hides behind others and therefore must be recognized and discussed. Institutions are too often focused on physical health: depression is on the other hand underestimated. To deal with such illness, National Health System must invest on the qualifications of health personnel, especially the family doctor.
Specific policies for elderly female population should be taken into consideration:
- ¾ of elderly people are female, a weak category for several reasons: less income, duty of children care, less healthcare resources spent for.

AUSTRIA

The combination of health issues with adult education – as in Health Box – seems to be an innovative approach

DENMARK

In Denmark we have slowly started during the last years – to put health education, daily physical exercise and so on into our different care institutions. We have a lot of activities when it comes to the big groups in care area – the mentally handicapped, psychiatric patients, elderly and so on.
But we still need to adventure the key to reach the big “normal group” of disadvantaged people who are no daily contact with institutions. Single young mothers, alcoholics, immigrants, unemployed people.

FINLAND

We have a lot of knowledge but we don't reach the people that need it most.

UNITED KINGDOM

The majority of health education is covered. The issues are about access and taking education and prevention to the communities.

ROMANIA

Annex 2- Supplementary readings

In Romania, the patterns of morbidity and mortality have changed in the last decades. The prevalence of chronic disease has increased, a trend which is associated with the synergic action of biological, environmental and lifestyle determinants together with the influence of socioeconomic and health care conditions.

The main causes of death in 2006 in Romania were cardiovascular diseases (62.1%), followed by malignant tumors (17.6%), digestive diseases (5.5%), accidents, injuries and poisoning (4.9%) and respiratory diseases (4.9%). Deaths from external causes and from infectious and parasitic diseases are more common in Romania (4–5%) than in other EU Member States.

Routine data related to the morbidity of non communicable diseases and their determinant factors underestimate the real amplitude of the phenomenon. Data of good quality are available only from the *Health status surveys* performed by the Computing Centre of Health Statistics and Medical Documentation of the Ministry of Public Health. The last survey was carried out in 1997 (Ministry of Public Health and Family, 1997).

Evidence suggests the lifestyle factors with the greatest impact on health status are, as in other countries, smoking, alcohol consumption, illicit drug consumption, an unbalanced diet and low physical activity. Risk factors such as smoking, physical inactivity, obesity, hypertension and poor diets are clustered in the poor groups.

Taking these in turn, **smoking** rates have increased in Romania since 1990 among both women and men, but especially among young people. The *Health status survey* carried out in 1997 showed that 46% of men and 13% of women over 18 years of age are regular smokers (Ministry of Public Health and Family, 1997), which is higher than the EU average but comparable with the countries of central and eastern Europe. According to WHO *Health for All* data for 2003, 21% of the Romanian population over 15 smoked daily. Romania participated in the international negotiations regarding the Framework Convention on Tobacco Control. The Minister of Public Health also signed the Warsaw Declaration in support of the Framework Convention. Since 2002, smoking in public institutions is regulated by law. (349 / 2002).

The main aim of anti-tobacco media campaigns is to provide evidence-based information about the harm caused by both active and passive smoking to current and potential smokers, as well as to the general public who are often involuntarily exposed to passive smoking. Prevention and encouragement to quit smoking are among the main strategies in the fight against smoking. National programmes help to educate the public about the harmful effects of smoking and can motivate tobacco users to try to quit. One of the main aims of preventive actions is to stop children and adolescents taking up smoking. Preventive measures include education, the banning of tobacco advertising, health warnings on tobacco products, the enforcement of laws prohibiting tobacco sales to minors.

Regarding **alcohol consumption**, the national health survey carried out in 1997 revealed that 56.2% of persons over 15 years of age consumed alcohol, of which 3.7% reported dependency (Ministry of Public Health and Family, 1997). That same year, alcohol consumption was most prevalent in those aged 25–44 years (66.3% of this age group consumed alcohol).

Illicit drug consumption emerged as a problem in Romania after 1990. Surveys of intravenous drug use produce widely differing prevalence estimates. The Institute of Health

Services Management estimated 1000 intravenous drug users in Romania in 1998, whereas a preliminary study by UNICEF estimated approximately 30 000 intravenous drug users in 2002 in Bucharest alone (Galan et al., 2003). More work in this area is needed to reach firm conclusions.
The average **diet** is relatively unhealthy, characterized by high consumption of animal fats (there was a slight improvement between 1996 and 2001, which was followed by a more recent resurgence) (Table 1.10). In addition, Romanians tend to eat high-caloric food with a high sugar and salt content. It is likely that diet in large part explains the high rates of cardiovascular diseases.
Being overweight is associated with a higher risk of disease, particularly if body fat is concentrated around the abdomen. The estimates of attributable mortality and burden due to being overweight and obese have been made using a measure of high body mass index (BMI) calculated as weight (kg) divided by height squared (m^2). BMI was chosen as a simple measurement of body weight in relation to height because it is in principle easier to measure at the population level than body fat. Analysis of the relationship between BMI and mortality and morbidity suggests that the theoretical optimum mean population BMI is around 21 kg/ m^2. The disease outcomes for overweight and obesity include: Diabetes type 2, Ischemic heart disease, Stroke, Hypertensive disease, Osteoarthritis, Cancers (colon, kidney, endometrial, and postmenopausal breast cancer).
Socioeconomic factors also have a marked impact on the health status of the Romanian population, in particular the high levels of poverty, unemployment, social exclusion and the structure of household expenses. Poverty was estimated at 27% in 2002, and extreme poverty at 11%, according to the World Bank Report from September 2003 (World Bank, 2003). The most affected area is the North-East region of Romania, where the poverty rate is estimated to be higher than 40%.
The diets of low-income groups are likely to be inadequate. Low-income groups and specific groups such as children, adolescents, pregnant and lactating women, and older people often face problems gaining access to a healthy variety of safe foods. They often eat less well, the proportion of their income spent on food is higher, they have poor access to food and little choice in quality and range, and they often suffer more ill-health. Equitable public policies can decrease infant mortality and improve health.
The percentage of disposable income spent on food gives an indication of how severe the lack of food is likely to be. In Romania the average amount spent on food is around 60 % of disposable income, respectively, compared with 22% in the European Union (EU). Increased health inequalities are a result of poverty and social inequalities.
In fact, it is difficult to prevent and treat overweight and obesity. Most population-based prevention programs that have been scientifically assessed have not demonstrated any favorable effects on the prevalence of obesity. However, there are examples of successful programs for both adults and children.
Also, the environmental interventions need to be developed. Although many environmental factors have been cited as contributing to obesity, there have been few controlled studies showing that changes in these factors will prevent weight gain. Environmental interventions attempt to modify the external surroundings with a goal of affecting behavioral changes, such as improvement in diet, increased physical activity, and or decreased sedentary behaviors. The aim of such interventions is to prevent weight gain, without exclusive reliance on an individual's knowledge or motivation.
The environment also has a major influence on health status. According to data reported by the Ministry of Environment and Waters Management (2002), Romania has experienced a slight improvement in air quality. This improvement can be attributed to some extent to the reduction in industrial activities coupled with re-engineering programmes, in addition to increased activity of the Environmental Protection Inspectorates.
The most important environment problems in terms of surface waters are organic nutrients (nitrogen and phosphates), flow modification of transport conditions of sediments, contamination with dangerous and oxygen-consuming substances, and lack of water-purifying units. Inappropriate safety measures for storing and disposal of solid and dangerous waste and the management of industrial wastewater may also contribute to the degradation of subterraneous waters.
Overall housing conditions seemed to show a slight improvement between 1992 and 2002, at least

regarding access to water and the sewage system . The decrease in heating facilities could be related to the significant price increase of fuel and also to poverty.

GERMANY

There are a lot of good initiatives that have been realised that we could learn from. Especially the regional knot is a valuable source of information and a first contact will be established in the near future.

4b. Potential practices for health and wellbeing

ITALY

In order to maximize the action against the abuse of **alcohol**, considering some typical Italian laziness, it should be advisable to encourage free check-ups as well as the spread of awareness raising campaigns in the workplace: reaching out directly the individuals, even by means of high impact such as visits and face-to-face relations, optimize the efforts of information and increases the positive effects of the campaign.
The national program "Gaining Health" shows how the risk factors related to alcoholism are predictable. Initiatives for young people must be activated in order to provide correct information and to resist social pressures i.e. drink alcohol. An alliance between school and health must be promoted. Parents, teachers, medical staff member must participate in training courses. Other measures to be promoted are: lessening of alcohol in alcoholic beverages, reducing the availability of alcohol at work and on the roads and increasing the number of checks on the BAC.

A project of "Positive Health", specifically aimed at "Nutrition and Physical Activity" may be developed. It should focus on priority actions in order to network and spread:
1. best practices to fight overweight and obesity;

2. best practice to encourage physical activity;

3. knowledge about nutritional and physical aspects among teachers, health professionals and staff of the hotel / catering industry.

In order to be more effective on the **depression** issue, forms of care within public hospitals should be created. In addition to that, it would be advisable creating advice and listening centers managed by associations made of relatives of mentally ill people. Furthermore, it should be positive to sensitize the community through volunteer and institutional forms.

An innovative way to prevent depression might be the developing of special programs and courses such as drama courses, creative writing courses, breathing courses and so on: people and especially women can express their deep and private feelings such as fear, anger, guilt, etc which if retained can lead to sadness, depression, alcoholism and even suicide.

AUSTRIA

Important is to start with activities at an early age – f.e. in kindergarten/schools because a lot of unhealthy lifestyle-habits are based in early childhood. Working with families is important, parents should be involved – activation and participation have to be reinforced.

DENMARK

All most all municipalities have during the last years established a team of prevention. To figure out how to reach these groups, what kind of activities should be offered for these groups, what kind of activities can motivate them? How should it be arranged, so these groups find it interesting, to take a little more responsibility for their own health. What kind of personal support do they need to start a change in their lifestyle?

FINLAND

The researches show us that Finnish people don't do physical activities often enough and this is one of the things we haven't been able to develop. We have learnt to eat healthier food (and we can still be much better), but we still don't move enough. We drink too much alcohol and use tobacco too much.

UNITED KINGDOM

No comments on this question

ROMANIA

A prevention –focused policy to be implemented by the Health Authorities regardless the government orientation.[iv]
Measures to address the poverty, unemployment and lack of opportunity that contribute to the diseases must go hand in hand with modern, effective and well informed methods of health education.

GERMANY

After comprehensive desk research activities, we can say that not only awareness is high for the importance of health prevention among disadvantaged groups but also a lot of actions have been realised so far. The Health Box approach to integrate health preventive modules in existing courses is absolutely in line with federal policy and is a topic which is on the agenda of the above mentioned regional knots that have a clear mission to implement health prevention actions in existing services and offers.
Numerous good practice examples are available and published on a specific data base. To be listed in the database a project needs to meet defined good practice criteria that are also accessible.

4c. Possible impact of informative health policy at European level

ITALY

From what we can learn from social surveys and literature, not only do Italian citizens feel to belong to the EU, but they also prefer European initiatives to the national ones. Furthermore, European models are well seen among population. Because of this arousing interest for European projects, preventive measures and information on the proper behavior regarding, for example, the consumption of **alcohol** proposed by the EU would be very effective.

If each State and all regions agree on the general aspects, a better health education could be promoted. However, each region should have the opportunity of implementing its policies. Since local forces have specific social and cultural features, regions can get closer to the needs of citizens and act accordingly.

Concerning **depression**, a network of information at both European and national level would surely allow an expansion of prevention strategies: it has been given very little attention to depression because of prejudice and poor assessment. In addition to that, the scope issue tends to be unspoken.

AUSTRIA

Hard to say - acting more global you can reach more people – but if you really AFFECT their habits?

DENMARK

Yes – we believe it could be good to make a policy at European level. The aim of this policy should be to assure that health will become a subject in kinder garden as well in primary school.
Theoretical and practical. An early knowledge and understanding of personal health issues and personal responsibility of one's own health shows to be very crucial for how the individual will coop for the rest of her or his life.
We know in Denmark; who for many years have had the highest rate of children in Kinder garden 95% - that the physical architecture of the kinder gardens has a major impact on the developing of good or bad habits' when it comes to be a physical/healthy person and the same in primary and secondary school.
Rules about an architecture that stimulate a healthy way of living would be very helpful as well as rules/guidelines for a daily minimum of physical exercise for children from 2/3 years up to 18 years would be very supporting. The habits' you bring in to your adult life is crucial for the rest of your life.

FINLAND

We have been working with our health many years with different approaches, we have also made different studies with other countries, but of course, together we can do things better. It would be important to get the work down to a more personal level and to find good training solutions. For example, why do we put students in discussion groups to sit down and discuss? If we think about the healthy way to do it, let them walk in pairs and discuss, meet other pairs in half of the way and exchange the results, then walk on and discuss. This would involve the health concern to education in a natural way.

UNITED KINGDOM
No comments on this question

ROMANIA
Yes, it would support national initiatives.

GERMANY
The EU promotes health prevention and has set up various policies so far, e.g. school fruit schemes and the like.

4d. Ideas of materials for Health Box

ITALY
As experienced so far, along with traditional material such as brochures and TV commercials, self-assessment tests regarding the habit of drinking alcohol could be developed. Moreover, more general topics such as eating habits might be considered to help people learn to take care of themselves with sincerity and serenity, but also to encourage self-awareness.
- Researches in the different recipients of health promotion initiatives;
- Effective communication campaigns that could put the messages within the threshold of attention of the recipients (producing informative materials able to reach even the socio-culturally disadvantaged groups: television advertising campaigns, road signals, brochures spread to health practitioners, health boards, cultural centres, websites, information points and so on;
- Consumer education campaigns: starting with existing education programs to schools (i.e. in order to control and decrease overweight and obesity in young generations through actions which do not only involve home and family, but also school and place of living, mass media and control bodies that need to spread the culture of healthy foods (fruits and vegetables) and fight misleading food advertising.

As regards **depression**, it is needed easily readable informative materials, capable of providing a clear and exhaustive view of symptoms, effects and treatments of this mental distress.

AUSTRIA
No comments on this question

DENMARK
Material, that reached very different target groups when it comes to age, social position and cultural pre understanding.
Better material of ideas for staff in kinder garden, primary and secondary/vocational school.

FINLAND

When one of our target groups is migrants, and in our case they can't speak the language yet, then it would be good to have materials in form of pictures. To make material with pictures and organise some sort of condition-improving social activity would be the best for our target group in our country.

UNITED KINGDOM

No comments on this question

ROMANIA

Mostly video materials but also paper based

GERMANY

Materials need to be all but schoolmasterly. Our target groups are likely not to be happy with lectures on the topic but would rather need very practical approaches.

5. Other comments

ITALY

Depression may be a necessary factor for most suicides. It has been found that only a minority of affected individuals receive adequate treatment.

FINLAND

More about the research in Finland.
Helsingfors Univeristet
The Finnish Twin Cohort Studies, profs. Jaakko Kaprio and Markku Koskenvuo investigate genetic and environmental determinants of common, complex diseases, and their behavioural risk factors in Finland. Since 1974, some 16,000 like-sexed twin pairs born before 1958 have been followed-up. A major current sub study initiated in 2000 is the family study of nicotine dependence as part of an international consortium.
Two longitudinal studies of adolescent twins and their families initiated in 1991 and 1994, FinnTwin16 and FinnTwin12, each with about 2,700 participating families, form a complementary ongoing study base (Kaprio). The primary focus is on behavioural risk factors. Sub studies of twin pairs discordant for alcohol dependence, eating disorders, obesity and physical fitness are ongoing. The twin cohorts participate in the GenomEUtwin-project of European twin cohorts (www.genomeutwin.org) and the group has extensive links with US researchers as well.
Prof. Koskenvuo (professor of epidemiology as of 2005) leads two further studies 1) Allergy-1995 with 11,000 university students, 3) Health Effects of Social Support on 25,000 working aged Finns.
The Helsinki Health Study, prof. Eero Lahelma focuses on health, functioning and mortality among ageing employees of the City of Helsinki (www.kttl.helsinki.fi/HHS). Determinants of socioeconomic differences in health from biological risks through behaviours to working conditions are investigated in collaboration with the London based Whitehall II Study and Japanese partners. Multiple data have been collected: 1) baseline surveys (n= 8,970), 2) medical check-ups from 2000-2002, and 3) personnel register data from 1990-2003. Starting in 2000, the study has already yielded novel evidence on population health in Helsinki, London and west Japan. Further international comparative research include 1) a Nordic Network on Health Variations, and 2) an EU funded European network EU Working Group on Socioeconomic Inequalities in Health.
The research activities of doc. Sirpa Sarlio-Lähteenkorva focus on weight-related issues, health behaviours and socioeconomic factors, investigating problems and determinants of unhealthy behaviours and obesity as well as predictors of lifestyle changes. Data sources include many Finnish large and comprehensive surveys and data sets, such as the Helsinki Health Study and the Twin Cohort Studies (see above), as well as qualitative data.
The study of mortality, morbidity and health habits of former elite athletes (n=4500 including referents) is led by prof. Seppo Sarna. The main target of the project is to clarify the long term effects of physical exercise on health and well-being. Research has been published on physical activity and sports history in relation to multiple outcomes and diseases.
Prof. Jaakko Tuomilehto, Academy prof. 2000-5 is active in many national and international studies on diabetes, cardiovascular diseases and autoimmune disorders, with particular interest in genetic epidemiology and prevention. These studies are done in close collaboration with the National Institute for Health and Welfare and they include genome-wide scans of type 1 and type 2 diabetes and diabetic nephropathy. He initiated the Finnish Diabetes Prevention Study, the first randomised controlled trial in prevention of type 2 diabetes. As part of these diabetes projects, the department is involved with the European/Asian collaborative DECODE/DECODA studies comprising population-based surveys of diabetes and glucose intolerance dos. Qing Qiao.

Prof. Harri Sintonen leads research in health economics and he is also research professor of health economics in the Finnish Office for Health Care Technology Assessment, FinOHTA at STAKES, National Research and Development Centre for Welfare and Health. Sintonen has developed the 15D, one of the most widely used utility instruments for measuring health-related quality of life. Under his supervision there is a wide range of ongoing studies in health economics, both related to the 15D instrument as well as applied research in many different health care area such as economic evaluation of screening programmes (antenatal, rare metabolic diseases in newborn infants, glaucoma), prevention programmes (the Finnish diabetes prevention programme, new Finnish vaccination programmes), and a number of treatments provided by secondary and tertiary health care routinely.
Prof. Mats Brommels, Health Policy and Management, the Medical Management Centre at the Karolinska Institute continues as the Director of the Centre with joint appointments at the University of Helsinki and the Karolinska Institute. The collaboration is expected to benefit the Helsinki unit. The major project in Helsinki is directed by dos. Ritva Laamanen: “Does performance depend on form of provision in primary health care? A multidimensional comparison of voluntary and municipal organizations.” It is included in the Research Program on Health Services Research TERTTU funded by the Academy of Finland in 2004-7. The study makes systematic comparisons between the town of Karjaa, which outsourced all its primary services to a non-profit voluntary organization, and three “reference” municipalities.
Medical humanities and philosophy of medicine is a niche area of study by doc. Pekka Louhiala, that has produced internationally recognized books (reviewed in JAMA 2005;Jan 5, pp103-4) on medical ethics. Doc. Heikki Vuorinen**,** a leading authority on history of medicine in Finland, has published recently a book on history of diseases in Finnish, and is involved in comparative studies on: 1) ideas of disease causation, especially the role of water, 2) emergence of new diseases, and 3) boundaries of human intervention. Doc. Harri Hemilä has collaborated closely with KTL in analyses of infectious disease risk in relation to vitamin intake and supplementation in the ATBC study base, and written meta-analyses of studies examining the effect of vitamin C on the common cold and pneumonia.

University of Jyväskylä

Evaluation of the effectiveness of lifestyle interventions in the Central Finland Health Care District (EVIDE): the Early Recognition of Lifestyle Diseases (EVI) and the National Type 2 Diabetes Prevention Programme (FIN-D2D)

EVIDE is a collaborative study of the Research Centre for Health Promotion (University of Jyväskylä), Central Finland Health Care District, and the University of Kuopio. The purpose of the study is to evaluate the effectiveness of brief intervention (EVI) and more intensive intervention (FIN-D2D) in relation to health-related behaviour, namely nutrition, physical activity, alcohol use and smoking.

The research material consists of three data samples collected in the Central Finland Health Care District during 2004-2008.

- EVI study conducted in nine municipalities (Hankasalmi, Konnevesi, Laukaa, Petäjävesi, Pihtipudas, Toivakka, Uurainen, Viitasaari, and the rural district of Jyväskylä)
- National Type 2 Diabetes Prevention Programme (FIN-D2D) (the Central Finland part)
- The comparison study of the FIN-D2D study (the Central Finland part)

These materials are congruent in terms of the baseline data (age and gender) of the study populations. Moreover the quantitative questionnaires of the studies are identical to some extent. In addition to quantitative research data, also data regarding clinical measures is used to complete the information.

The EVIDE study yielded information on the efficacy of lifestyle based interventions, and the results can be utilized widely in the prevention of lifestyle diseases e.g. in the planning and promotion of an effective strategy to prevent lifestyle based diseases in the Central Finland Health Care District.

http://www.nationalbiobanks.fi/

National Bio bank of Finland

To guarantee the top level of expertise in modern genetic and biological analyses, we have built an infrastructure that facilitates the collection of genome-wide information on the genetic background of diseases as well as functional information on the molecules that are critical in the disease process. Furthermore we have established the necessary storage, database and computational resources for the expert analyses of the massive amount of collected biological information. Our scientific expertise, technology platforms and large nationwide sample collections facilitate a highly competitive environment for research and education in molecular medicine of the 21st century.

The bio banking wet lab effort is concentrated to KTL/Biomedicum Large scale DNA extraction and storage facility. The facility presently houses DNA from more than 200 000 individuals and is co-ordinated by National Public Health Institute. It is equipped with state of the art bar coding system for sample tracking, an automated Gentra DNA extraction equipment, liquid handling robots, storage facilities, and tailor made data management tools for optimal confidentiality and quality control.

ROMANIA – Annexes 1 and 2

[i] Life-styles are acquired in the early life years, policy therefore has to focus on children and young people, who can not determine their living environment, nutrition and housing themselves and are susceptible to outside influences.

For this reason, the National Health Education Program was initiated in 2001, by a joint initiative of the Ministry of Education and Research (MoER) and the Ministry of (Public) Health (MoPH). At that time, the specific educational offer was quite considerable with respect towards NGOs' activity, but insufficient in order to address the needs of students at national level, following an integrated and organized approach. At this point, the program is coordinated by the MoER, with the aim to achieve the introduction of Health Education in all Romanian schools, both as an optional curriculum (and/or classes included in other disciplines) and as an extra-school activity.

The program is addressed on long-term to the school students, aged 7-18/20 years old (2.900.000) for curricular, extracurricular and extra-scholar activities. Regarding students' involvement, the starting point as population to address is of 2.900.000. The first two years of the project reached 48.78% (1.463.544) of them, the objective for the next three being of yearly maintaining a constant number of beneficiaries. After two years of piloting (2001-2003) and other 2 years of implementation under the GF (2004-2005), there are significant results to consider, not only regarding the impact on students' knowledge, but also in terms of transformations of the educational system. Out of the 215.000 teachers involved in the pre-universitary system, 12.977 develop health education classes and 8.785 of them already had benefit of specific health education training .

[ii] The Ministry of Public Health has taken some initiatives for reducing poverty-related inequalities in health, such as offering incentives for family doctors to locate themselves in isolated rural areas (setting up bonuses, modernization of practices), training Roma representatives as health mediators to facilitate contact between health personnel and Roma communities, hiring Roma health mediators at DPHAs, training community nurses as a link between primary health care

practices and community social services, and offering free medical services for deprived population groups.

The Millennium Development Goals Report mentions targets to be achieved by 2010. The universal goals were adapted to the Romanian situation because of the relatively higher level of the country's development needs. The report indicates as priorities for resource allocation the assurance of a minimum income; development of systems to deal with child abandonment, trafficking of human beings, juvenile delinquency, child abuse and neglect; halving the mortality rate among children under five years by 2015; and halving the maternal mortality rate by 2010 (Section 1.4). Law 202/2002 on equal opportunities for women and men aims to exclude all possible gender-generated inequalities.

The approach to inequalities in health in recent years has focused on access to health services, while outside the health sector the main priority has been the development of a social work system. The latest development in social work has been quite significant. In the early 1990s, social services mainly took the form of local initiatives in the NGO sector, with local authorities subsequently developing some services. In 2001, a social work law was developed to provide a legal framework for these services. As a result, national agencies were established for disabled persons, child protection and adoption, and violence prevention and family protection. All these agencies have a health component that aims to facilitate access to health services of marginalized or at-risk people.

A remaining challenge is the further development of the national social work system and its links with the health system. Usually marginalized people are not registered with a family doctor (7% of the population was not registered in 2005) and consequently they cannot benefit from any public health services.

Discussion and debates are taking place around the issue of establishing structures to provide directly social services within the health system or within the social work system, around the financing of those structures, and around the link between the two systems.

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[iv] A study of avoidable mortality in Europe with data extracted from WHO mortality files for the period 1990–2000 compared avoidable mortality for men and women in 20 European countries (Newey et al., 2003). In both 1990 and 2002, Romania had the highest level of treatable mortality (followed closely by Bulgaria), and Romania is the only country that does not show improvements in treatable mortality over the ten-year period for men, although slight improvement for women can be seen. Moreover, over 40% of all-cause mortality in both time periods could be attributed to treatable diseases. Analyses of preventable deaths (from lung cancer, motor vehicle and traffic accidents and cirrhosis of the liver) show similar patterns. Romania has the second highest rate of preventable deaths for men and women, followed by Hungary. Rates of preventable deaths increased for both men and women; for the latter this is a trend in most countries (attributed in large part to the increase in prevalence of smoking among women; Tyczynski et al., 2004) and not unique to Romania.
These findings overall suggest that significant health gains can be achieved through improved access to effective health care and public health policies.

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This project has been funded with support from the European Commission. This publication [communication] reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein.