of the public and easy access to independent information. No such framework and criteria—which may be likened to Wilson and Jungner's screening criteria—have hitherto been available.

Based on two ethical principles the Health Council of the Netherlands developed an assessment framework: (i) the population should be protected optimally and (ii) benefit should be fairly distributed across population groups on the basis of need. Seven criteria for inclusion of candidate vaccinations into public programmes were formulated, covering the burden of disease, effectiveness, acceptability, efficiency and urgency.

It will be shown how the criteria may be applied in different epidemiologic situations. The framework and the seven criteria allow a systematic assessment of the value of vaccination. They urge one to be very specific about the goal of vaccination and the target group, and make gaps in knowledge explicit.

Using the criteria may help to make decision making more transparent, set priorities and retain public confidence. In the discussion we will focus on the feasibility of developing an international set of criteria.

Discordant immunization schedules can complicate vaccine evaluation for Europe

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Although vaccine licensure can be centralized through the EMEA, immunization recommendations are established at the national levels, reimbursement policies vary widely, ranging from regional to national, from private to public, and the lag time can be long between licensure and eventual introduction into a national immunization program. An example of this discordance is the pediatric combination vaccines. Young infants in some EU countries receive a whole-cell pertussis vaccine, in a three- to five-vaccine combination ('DTPw | IPV | Hib'). Acellular pertussis vaccines have been introduced over the last decade in many other EU countries, with four- to six-vaccine combinations ('DTPa | IPV | HBV | Hib'). Either of these combinations may be administered with a '3 + 1' schedule, with the first dose between the ages of 2 to 3 months, a spacing of 1 to 2 months between doses and the final (booster) dose usually given at anywhere between 12 and 24 months of age, but in a handful of countries as late as the age of 3–5 years. By contrast, a '2 + 1' schedule is applied in some countries for the 'DTPa | IPV | Hib' or 'DTPa | IPV | HBV | Hib' vaccines: first dose, three-months old; spacing, two months between doses; final (booster) dose, 11–14 months of age. Most of the world's vaccines are produced in Europe. Nonetheless, piecemeal national policies in the EU may have led to delays in the introduction of the newest vaccines (e.g. pneumococcal conjugate, meningococcal conjugate, rotavirus, influenza, varicella-zoster, etc.), which must be shown to be compatible with the various infant immunization programmes across Europe. This could lower the likelihood, in some EU countries, of the public health advancements that these new vaccines can provide. Furthermore, this discordance might eventually make Europe less attractive for future vaccine research and development. Harmonization of vaccination schedules might rationalize vaccine development, streamline the introduction of novel vaccines into the national immunization programmes and facilitate the evaluation of the impact of new vaccines in Europe.

F.3. Workshop: Social and cultural resources for health: local level approaches

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Resources play a key role in health promotion. The focus of this workshop is on local level approaches to support social and cultural resources for health. Local level approaches mentioned in the papers include communities, schools, hospitals and religious institutions. Social and cultural resources for health include capacities for health promotion in different settings and their measurement, religion in the service of families' mental health promotion and socio-economic school district factors and their impact on alcohol drinking onset in adolescents. The workshop will start with a theoretical paper on capacity building (Krajic), followed by a paper on a new approach to measure community capacity development (Trojan *et al.*). Furthermore we will discuss how a cultural variable such as 'religious practice' (Benkö *et al.*) and a social variable (housing type, Stock *et al.*) might be integrated into the broader concept of community capacities.

Building capacities for health promotion in settings: the case of professional, people-processing organisations

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Background

Capacity building as strategy reacting on deficits in implementation of health promotion has been introduced mainly in the Australian and Canadian context, but is gaining ground also in scientific research. The Health Promotion Glossary (Smith/Tang/Nutbeam 2006) defines capacity building as development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organizations, and the development of cohesiveness and partnerships for health in communities This concept can be complemented by adding a 'societal systems level' (VicHealth 2004, also Catford 2005).

Methods

Theoretical proposal developed on the basis of a systematic reconstruction of the capacity building discussion, utilizing a social-systems approach. This project is part of a 7-year research programme on health promotion in schools, hospitals and long-term care.

Results

In organizational settings, capacity building is a strategy to increase the likelihood of integrating health promotion in core processes and management decision making. The paper outlines a model for health promotion capacity building for professional people-processing organizations. Capacities are to be developed for organizations and their relevant societal environment and comprise of four levels: (i) individual level (competencies and skills of professionals, health literacy of users), (ii) organizational level (supportive structures, processes, cultures, management tools), (iii) local communities (supportive partnerships) and (iv) societal regional, national or supra-national level (networking strategies, legal, financial

and institutional frameworks, professional standards development). The main focus of the paper is the organizational level.
Conclusions
The model developed on the basis of the capacity building debate will form an important element in analysing experiences, developing implementation tools and evaluating their implementation in schools, hospitals and long-term care in the next years.

Capacity building in communities—first results and assessment of a research instrument

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Aims
Capacity Building is regarded as an intermediate outcome and a success parameter for community health promotion. The aims of the study were the development and examination of a tool to measure capacity building in the context of a programme of health promotion for children and parents in a socially disadvantaged quarter in Hamburg (about 3000 residents, 60% with migration backgrounds).
Methodology
A survey was carried out with 27 professionals from the health and social field. The dimensions of the instrument were: citizen participation, local leadership, existing resources, networking and co-operation, support of residents. In order to validate the instrument results were compared with a survey of some residents. Additionally they were discussed in a workshop by professional experts.
Results
The result of the project, next to its practical use in the quarter, consists of the generation of a psychometrically tested instrument to measure capacity building, and the fact that important experiences were obtained on how to conduct such a study. A comparison of the situation in 2006 with the situation in 2001 showed considerable improvements on all dimensions of capacity building in the quarter.
Conclusion
We mainly attribute the overall positive picture over five years to the generally positive climate of development in the quarter as well as to the strong and continuous commitment of individual persons involved. However, establishing the instrument on a long-term basis calls for more intensive examination of not only the chances, but also the limitations of the tool.

Religion in service of families' mental health promotion—experiences of a transnational empirical research of families in Hungary, Poland, Czech Republic and Slovakia (2005–07)

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Background
Religion in our pluralistic society means a way of self-realization and a social regulatory system (Tomka, 1999). It is a compound phenomenon that consists of five dimensions (Glock and Stark, 1968): belief, religious practice, religious feelings, religious knowledge and everyday religiosity. Practising ones religion has been proven to promote better physical and mental health, less depression, more community ties and less health-damaging behaviour. The WHO's life-quality definition also emphasizes spiritualism. The present research explores the state of religiosity in the families of the Visegrad countries, with special focus on Hungary, how modernity affects people's religiosity and how can it be a resource for a healthier life.
Methods
Our research methods are theoretical (analysis of relevant concepts) and empirical (structured assisted questionnaire/interview) in nature, referring to a community based representative sample, among 500 families/households (one adult member) from the administrative territory of Szeged (Hungary), Rybnyk (Poland), Hradec Králové (Czech Republic) and Nitra (Slovakia) each. Data were analysed with the help of SPSS; national and transnational comparative analyses were performed.
Results
69.9% of the transnational sample was reported to be religious (HU-76.0%; PL-98.8%; CZ-23.8%; SK-83.6%). In Hungary religiosity is the highest (79.2%) in the age group 41–65 years. According to family types, the rate is high in case of one-parent families (77.9%). The rate of church goers is high among young people (20.7%) and in the eldest age-group (20.0%). The same pattern appears in finding consolation in religion (0–25-year olds-67.9%; 66 years and older-78.6%).
Conclusions
The spiritual nature of belief, its spiritual, mental experience and the practical experience of it (e.g. going to church) is a life-cycle phenomenon that comes into the foreground in youth and in old age. When concerning public health impact, the positive relationship between religion and health results in a healthy future labour-force when young people are concerned and a healthier elder population, relieving somewhat the health insurance system from the financial burden of medication and hospital care.

Socio-economic school district factors and their impact on alcoholdrinking onset in Danish adolescents

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Background
Area-level socio-economic factors are significantly related to a population's health. That is, the social status and level of resources of a particular region, neighbourhood or community have an effect on the health and health behaviour of its inhabitants above and beyond that of the individual's socio-economic status. This study investigates how school district level factors affect the individual health behaviour of Danish adolescents.
Methods
A sample of 12 511 pupils in the 7th grade from 422 schools across Denmark was used from the 'Ungeshverdag' Study's data collection in the year 2005 for the outcome of variable drinking onset and the predictors gender, parental behaviour, peer behaviour, performance at school and satisfaction with school. Geographical neighbourhoods were constructed around schools based on school district borders. Aggregate-level school district variables were created for education, employment status, household savings and housing situation using the Conzoom data from Geomatics.
Results
Mixed-effects logistic regression with random effects for school districts showed that the individual level predictors for drinking onset were male gender, socio-economic status of the family, a lower performance at school, peer group drinking and the drinking style of the father. Housing type was the only school district level variable significantly associated with drinking onset. In school districts with a higher percentage of single houses and farm houses adolescents were more likely to initiate alcohol consumption than in school districts with a higher percentage of apartment housing.

Conclusions
The impact of socio-economic variables on school district level seems to be smaller in the welfare state of Denmark than that known for other countries such as the UK or Canada. The effect of the housing factor on alcohol onset may indicate a difference between rural and urban areas and varying availability of cultural, leisure and free-time activities for adolescents.

G.3. Session: Sickness certification practice

Quality of physicians' assessment of work ability in sickness certificates in a Swedish county

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Background
In most Western Countries a person is entitled to sickness benefits if she/he has a disease or injury that results in a reduced ability to work. The professional basis for the physicians' assessment of work ability is unclear. This lack of clarity might impair the right of the person and thus lead to negative consequences for return to work. The aim of this study was to investigate the sick listing practice focusing on the quality of sickness certificates, with an emphasis on how the disease is described to influence the patient's functioning and work ability.
Methods
Information provided on all 494 sickness certificates for sick leave, received at the social insurance offices in one Swedish county during two weeks in 2007, was coded and analysed quantitatively. Qualitative content analysis of information regarding functioning and work ability was performed with the International Classification of Functioning, Disability and Health (ICF) as a theoretical framework.
Results
When sick leave was certified, musculoskeletal disorders were most common (28%), followed by mental disorders (17%). Women—pregnancy related disorders excluded—were more sick-listed than men (60 vs 40%). Preliminary results indicate that the assessment of how the disease influenced functioning and work ability was described in about 60% of the sickness certificates, mainly based on patients' statement, lacked clinical measurements and seldom complemented the diagnosis or related to the work demands. Analyses of assessments of functioning and work ability in subgroups based on diagnosis will be performed during the coming months.
Conclusions
Preliminary results confirm that the quality in sickness certificates is low and that work ability is mainly based on patients' statements.

Medical audit and action plans for handling sick-listing—a programme for development of physicians professional and administrative competence

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Background
Return to work after long-lasting illness is known to be difficult. Prolonged sick-leaves are problematic both for the individual, for health services and for the social insurance system. Medical certificates issued by physicians are essential in the eligibility process. Their responsibilities include assessment of work ability and issuing of certificates. Physicians report different problems in relation to sick-listing. The quality of certificates issued has also been questioned.
Objectives
To evaluate the effect of a programme on reducing physicians' difficulty to handle sick-listing and to describe the variety of problems. The programme combined medical audit with action plans for development of sick-listing practices. We performed a sick-listing audit with registration of patient visits in a web formula, followed by a supervised shared reflection with colleagues. Participants formulated action plans for improvement based on identified problems. A triangulated evaluation was performed with questionnaires to physicians, a competence-related deductive analysis of focus-group discussions with supervisors and a qualitative analysis of the action plans.
Results
177 physicians participated. After the audit they assessed it less difficult to handle sick-listing ($P = 0.00002$), to assess grade and duration of sick-leave ($P = 0.00003$) and to assess working capacity ($P = 0.0001$) compared to before (Wilcoxon Matched Pairs Test).
The action plans contained 167 problems. The vast majority of plans held a high quality of, and had a relevant content according to predefined criteria. The problems and actions were categorized. Important problems related to sick-listing were identified in all physician-competence dimensions.
Conclusions
Performing sick-listing issues is a complex task where physicians perceive problems related to all professional-competence dimensions. Activities aiming to improve the sick-listing process therefore have to address all these dimensions. Medical audit and action plans seem to be a useful method to handle this problem. We are now repeating the programme with new participants.

Cooperation between gatekeepers in sickness insurance from the perspective of social insurance officers

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Objective
To describe variations in how social insurance officers conceive cooperation with health-care in their daily work with sick leave.
Methods
Fifteen social insurance officers (SIOs) working with administration of sickness benefits were interviewed. They were purposefully recruited to represent different parts of the social insurance office organization, different ages, gender, education, and work experience. The interviews were audio-recorded, transcribed verbatim and analysed using the phenomenographic approach.
Results
Eleven women and four men, aged 25–65 years, with work experience ranging from 1–40 years were interviewed. Three descriptive categories embracing 11 subcategories emerged: (i) Communication channels included three subcategories;