be strengthened by implementing national obesity prevention strategies.

An exploration of the tensions experienced in developing an obesity strategy and service within a UK Primary Care Trust

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The aim of this presentation is to provide the basis of an informed discussion of how to link public health approaches for the prevention and management of obesity to short term priorities for treatment and service development.

The process of developing a public health strategy for obesity and commissioning of services taken from a Primary Care Trust in the UK will be used as a case study.

Attention will focus on the magnitude of the problem, evolving tensions between evidence based national guidelines for commissioning of specialist procedures (including surgery and drug therapies) without ring fencing of resources, and competing professional and popular values.

The conclusions reached from the case study are that obesity is a public health priority and needs to be addressed within a coherent framework for action at a European level. The case study demonstrates that local action plans have limited potential for making sustainable changes to the levels of obesity within the population. Emphasis must be given to the need for interpretation of evidence of clinical effectiveness. The commissioning of services should be informed by a wider debate of public health issues.

Workshop 4: EUPHA section on health promotion: the role of health promotion in tackling inequalities

Reducing health inequalities through health promotion

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Issue/problem

Although social inequalities in health can to some extent be addressed through improved access to health care, reducing health inequalities also requires the use of health promotion strategies specifically targeted at the socio-economically disadvantaged. While it is recognised that traditional methods of health education to influence health-related cognitions or attitudes are ineffective with these groups, it is essential to develop more effective strategies which bring about structural or organisational changes to create a health-enhancing environment, and which enable disadvantaged groups to take control of their own health.

Description of project

A two-year research project was carried out in collaboration with the European Network of Health Promotion Agencies (ENHPA). The project involved the participation of 13 EU countries plus Norway. A combination of systematic literature survey and a key informant approach was used to identify existing health monitoring systems and indicators related to health inequalities, as well as examples of interventions and policies to reduce health inequalities.

Lessons learned

A descriptive inventory of good practices and policies was composed and subsequently submitted to a qualitative analysis, resulting in a series of recommendations for policy makers. These recommendations were discussed at an international expert seminar organised at the European Parliament, and reduced to a set of 8 consensus-based policy recommendations.

Conclusions

To reduce health inequalities through health promotion, policies should focus on policy development (identification of national health inequality targets, integrating health determinants in other policy areas, and supporting community development approaches), access to health care and preventive services, and building a strong evidence base (monitoring, health impact assessment, evaluation and dissemination).

Responding to inequality in the health of elderly people: a national collaborative programme of health promotion (UK)

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The paper describes, analyses and evaluates the content and methodology of national programme of health promotion planned and delivered by a three-way partnership of a large University, a national charity, a government-sponsored research team and a number of health care trusts. Through this delivery and partnership network, a long-term evidence base for defining effective strategies to maintain health, well-being and independence has been identified, and for preventing or delaying the onset of frailty and the need for long-term or acute care. The Manchester Metropolitan University as knowledge-transfer agency receives government funding to support a research team including a doctoral student. They establish base-line data and work with the national charity (Age Concern) and its linked health care providers to plan, implement and evaluate social, physical and psychological initiatives/activities among elderly people. This health promotion initiative has been identified as an example of excellence which subsequently will be disseminated nationally. The paper offers critical appraisal of the programme's aims, outcomes, organisation and processes, with particular emphasis on the health promotion strategy as viewed by the service users and service providers.

Health inequalities in Hungary – challenges in training health promoters

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Economic and social inequalities play an important part in the formation of health inequalities. A Hungarian national representative empirical study on social stratification (Kolosi, 1986) has phrased three categories that are in correlation with social inequalities: financial state, education, distribution according to regions and settlements. In those regions where the GDP is low the proportion of the lowly educated is high. The average life expectancy at birth is 66,32 years for men, and 75,13 years for women (Central Statistical Office, 1998). There are about 4 year differences between the life expectancy of people living in farms and small villages, and of those living in middle-sized or big cities. The number of deaths due to diseases of the circulatory system is high. The responsibilities of Health Promoters and their educators are enormous.

The target domain of the presented multidisciplinary and intersectoral project is higher education (postgraduate) and it has been working under continuous monitoring and on a high standard since 1992. The aim was to train educators and those in the helping profession to become multiplicators. The first stage of the project was a 30 hours sensitising training, leading to the need of developing a 2 years long postgraduate diploma course called "Health Promoter and Mental Health Promoter Master's Degree Course". Around 1600 professionals are trained already. The definite aim was to choose participants representing the above inequality factors, which aim could be partially fulfilled. The project has developed into a national network and into undergraduate and Master degree courses.

According to our international experiences, the project could be well adapted to all countries of Europe, with special regard to countries with similar indices (Eastern–Central Europe). As a conclusion we can state, that in Health Promotion the congruity between the micro- and macro society – law, education, health care – are important.

Promoting health in poor and noninformed social groups – adequate access to health services at practitioner level

Project proposal for encouraging healthy eating at different ages and different social status

Laurentia Mihaela Andronache

There is a clear link between poverty and illness. Practitioners need to clarify how poverty can influence people in adopting unhealthy behaviours. The study focuses on unhealthy eating. The assumptions are that:

- there is not a direct correlation between social status and healthy eating;

- the level of education is not directly connected with the social status and the correct information;
- people at risk belong to all social categories.

This presentation includes a case study analysis indicating possible activities which can promote healthy eating in poverty, beginning with children and ending with the elderly .

In the first part there are mentioned the efforts made to identify the main elements which affect people's basic needs and behaviours, not allowing them to attend a minimal living standard for everyday life. The main elements discovered are: lack of money, depression, family problems.

Risky eating behaviours are induced by cultural and economic factors. They are perceived and accepted as wrong by the patient after the discussion with the practitioner. The client tries to make efforts to change his life style, understanding the benefits of healthy eating.

The study tries to encourage people's participation in assessing living needs, targeting and financing health and social services. Effective health promotion should reduce inequalities resulting from economic, social and communicating deficiencies through appropriate services, focusing on client defined issues and personal problems.

If social-economic factors cannot be quickly changed, health and social services are the solution for educating and advising people at risk.

The non governmental organizations should cooperate stronger in order to compensate the lack of state resources, financing health promotion activities focused more on concrete human needs.

Conclusions

Even now we are not able to answer the following questions:

Is health the result of unhealthy life styles? Or of the social and economic conditions in which people live?

Proposals

Interventions at school level in reducing health information inequalities:

Domains which should be included in the school curriculum;

– the school-home-community interaction; increase in teacher's and parent's knowledge on health;

– development of school health promotion services (promoting healthy breakfast);

– development of healthy school physical environment;

– development of proper school policy health promoting strategies.

Interventions at elderly level

– social and health promotion educational programs;

–screening for cardiovascular and metabolic diseases (clinical exams) and counselling.

Evaluation of the Recent National Child Labour Prevention Projects of Turkey from the Point of View of Health Promotion

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Issue

Child labour is a problem of underdevelopment and poverty. Employment of children often cause them to be deprived of education and their mental and physical development to be retarded bringing about negative social effects.

Project

However, in today's reality, if it can be understood that the poor families have to have working children, and this cheap labour is in demand by the market forces, and because of this strong demand, child labour can be removed from labour market only with long term infra structural changes, but until then they can be protected with short and medium term effective measures, and since these children need this help right away without any further delay, it is possible to start a movement which will mobilize all the relevant agencies and resources today.

Lessons-learned

Preparing a National Plan is a sign of political will towards stopping child labour and the protection of working children. But, exercising this political will depends on whether the plan is consistent with the realities of the country, small and medium sized industries, and the realities of the working children and drawing up a realistic action plan.

Conclusions

Of course the mere fact that a policy and action plan is ready and being implemented is not sufficient to reach our goal. It is equally important that this policy be adopted as a national policy and be carried on by changing political parties in power, equalization of income distribution, increased employment, and be supported by economical and social measures which favours the expansion of social security. On the other hand, the process of globalisation and the rules of the new economic order makes the implementation of any policy difficult because in general they have to be against the market dominating labour relations as is realised today in Turkey.

The 'Romsås in Motion' study: Promoting physical activity in a multi-ethnic urban district in Norway

Anne Karen Jenum

Background

Despite existing and increasing health inequalities in Norway, awareness has been low and this issue has not received much attention until recently. In the capital Oslo, life expectancy at birth differs by 11 years for men and 7 years for women, between geographic regions, and mortality rates correlate strongly to socio-economic status (SES) and behavioral risk factors.

Design

The 'Romsås in Motion' is a community-based intervention trial promoting physical activity to reduce the burden of obesity and diabetes in a multi-ethnic district in Oslo with high mortality rates. The intervention started in 2000 after a baseline survey in two low SES districts where one district is the control, collecting data from questionnaires, physical examination and blood-tests from 2950 respondents. In 2003 a new survey will evaluate the effect of the intervention.

Objectives

1) To study diabetes prevalence and associated risk factors at baseline and in 2003. 2) To increase the level of physical activity both within a general adult population and a group of individuals with diabetes/high risk for diabetes. A specially designed program is set up for the high-risk group.

Methods

There is an urgent need for effective community based interventions to complement hospital-based clinical trials showing convincing effects of lifestyle interventions. The methods used in this trial are based on theoretical models hypothesizing that behavior is influenced by intra-personal factors, social *and* physical environment. The intervention consists of a set of orchestrated strategies tailored for groups with varying motivation and readiness to change their physical activity.

Learning objectives

At the end of this session the participants should be able to

1) Understand the conceptual framework of an evidence based multi-level community intervention to increase physical activity.

2) Identify with type 2 diabetes as a marker for health inequalities in the age group 40–60 years.

3) Recognize the 'Romsås in Motion' study as a strategic preventive effort to reduce health inequalities and the high prevalence of type 2 diabetes.

4) Appreciate the importance of community based interventions as an advocacy tool for policy and decision makers in order to prioritize and mobilize the need for more comprehensive preventive efforts.

Healthy Cities in Germany – Claim and Performance: a comparative examination and a proposal for quality improvement (Healthy-Cities-Barometer)

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Background

The overall goal of the WHO *Healthy Cities Project* was to put some key points of the Ottawa Charter of Health Promotion (1986) in practice such as building healthy public policies, create supportive environments, strengthen community action through active public participation (empowerment of communities) and equity in health at the local level. These should be anchored within the local political administrative system (PAS), which means health should be put on the agenda of policy makers in all sectors.

Aim

To figure out how far this has been reached after almost 15 years of healthy cities movement in Germany – and in view of the still increasing number of member cities within the German *Healthy Cities Network* – was the central point of the first questioning of the local project-coordinators.

Methods

A written questionnaire containing 128 items has been developed in collaboration with the Healthy Cities Network-Coordinator. The

questionnaire consists of 78 standardised questions and some (23) open-ended questions for more specific qualitative information. Also included were 27 ten-point-rating-scales to evaluate the co-ordinators' view of some aspects of their healthy cites work and to assess its progress. 47 (90%) project-coordinators from a list of 52 took part in the first German *Healthy Cities* survey 2002.

Results

We will present results based on six quality dimensions of the Healthy Cities work: *Programme Equipment* and *Commitment* (Structure), *Concept Quality* and *Integration within the Network* (Process), *Self reported Success* and *Integration within the City/Municipality* (Outcome) in an East-West-Comparison. Weak points of the *Healthy Cities* work are the following:

– Programme Equipment and Concept Quality;
– Commitment (9-point-programme) as a steering instrument;
– Integration within the Healthy Cities Network (HCN) and within the Cities and their political administrative system (PAS);
– Documentation and Evaluation.

Derived from the six quality dimensions we will present a monitoring-model *(Healthy-Cities-Barometer)* which can also be used for strategic controlling (benchmarking) within the German *Healthy Cities Network*. Based on the data we have identified 13 Cities at an A-level *(excellent)*, 22 Cities at a B-level *(satisfying)* and 12 Cities at a C-level *(inadequate)*.

Conclusion

The *'Healthy-Cities-Barometer'* provides a surveillance instrument that – if constantly used over several years – could offer data for a longitudinal analysis of the *Healthy Cities'* development. With its help the *Healthy Cities Network-Coordinator* could gain more information for a better performance and a continuous quality improvement process of the local *Healthy Cities* projects.

Systematic implementation of a sex education curriculum in lower levels of Dutch secondary schools

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Background

Implementation is an underscored issue in research on school health interventions. Even if effective interventions become available, adoption and implementation on the part of school personnel often fails. This suggests that the intervention's acceptability is hardly promoted by referring to arguments derived from the evidence based medicine paradigm.

Aim

This presentation is about a quantitative evaluation of a systematically designed innovation strategy that was applied to promote teachers' adoption and implementation a sex education curriculum, Long Live Love, that had proven to be effective on the student level when correctly applied. Health professionals of the Municipal Health Services (MHSs) actually applied the pre-designed innovation strategy in their regions. The target group was teachers in the lower levels of secondary education in the Netherlands, since their students appear to be at a relatively high risk for STD/AIDS and unplanned pregnancy. The theoretical and empirical basis for the applied innovation strategy and the outcomes will be presented.

Method

The study was carried out in spring 2001. Teachers in the intervention group (89) received training and personal guidance on how to use Long Live Love, while teachers in the control group (20) did not. Teachers in both groups filled out a questionnaire about curriculum-related beliefs, interactive context and teacher characteristics before they carried out Long Live Love. Teachers in the intervention group also filled out this questionnaire after the initial training. Besides, teachers registered the learning activities of the curriculum they had actually implemented in their classrooms.

Results

Training and personal guidance during the stages of adoption and implementation had a significant effect on teachers' curriculum-related beliefs (especially outcome beliefs, subjective norms, perceived social support and teachers' efficacy expectations). Outcome beliefs and teachers' perceived instrumentality of the curriculum also appeared to be the strongest predictors of the extent of use of the curriculum. Moreover, teachers in the intervention group carried out significantly more of the prescribed learning activities than teachers in the control group ($t=2.3$; $p=.03$).

Conclusion

Teachers' innovation decision making does not fit a rational planning model such as promoted by the paradigm of evidence based medicine. Teachers' adoption and actual use of an effective health education program is best promoted by innovation strategies that are theoretically and empirically tailored at the determinants of teachers' planning behaviour.

Health promotion significance of subjective social status

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4) University of California, San Francisco

Background

There is a social gradient in self-rated health and mortality. Subjective social status might be an important new concept in inequality research.

Aim

We examined the relationships between subjective and objective socioeconomic status (as measured by income and education) in relation to male/female self-rated health and middle aged mortality rates across counties in Hungary.

Methods

Cross-sectional, ecological and individual-level analyses were performed. 12,643 people were interviewed in the 'Hungarostudy 2002' survey, representing the Hungarian population according to sex, age and county. Self-rated health and self-rated disability were assessed. Independent variables included subjective social status, personal income and education. For ecological analyses, gender-specific mortality rates were calculated for the middle-aged population (45–64 years) and for the total population in the 20 counties of Hungary. For individual-level analyses, we examined self-rated health as the outcome.

Results

In ecological analyses, self-rated health and self-rated disability were significantly associated with middle age mortality, with male mortality being more closely connected with self-rated health. Subjective social status was an important predictor of mid-aged mortality both among men and women, but subjective social status of women was an important predictor of mortality among middle aged men as well. At individual level, subjective social status was associated with better self-rated health both among men and women, independently of income and education.

Conclusions

In tackling inequalities in health it is important to take into consideration the subjective social status. There are important interactions between male and female self-evaluation of social status and its health consequences.

Inequalities of Social Capital and Collective Efficacy in Hungary: Cross-sectional Associations with Middle-Aged Female and Male Mortality Rates

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Background

Social capital, collective efficacy, and religious involvement have each been linked to lower mortality rates.

Aim

We examined the socioeconomic differences in measures of social capital, collective efficacy, religious involvement and male/female mortality rates across 150 sub-regions in Hungary.

Methods

Cross-sectional, ecological study was performed in 150 sub-regions of Hungary.12,643 people were interviewed in the 'Hungarostudy 2002' survey, representing the Hungarian population at the sub-regional level. Social capital was measured with three indicators: lack of social trust, reciprocity between citizens, and membership in civil organisations. Additionally attitudes towards competition was also measured. Collective efficacy was measured by 10 items from the Project on Human Development in Chicago Neighbourhoods Community Survey. Religious involvement was measured by church attendance. Socio-economic status was measured by educational

attainment and taxable income. Daily cigarette smoking and spirit consumption were included as co-variates. Gender-specific mortality rates were calculated for the middle-aged population (45–64 years) in the 150 sub-regions of Hungary.

Results

Among men, socio-economic status, collective efficacy, social distrust, competitive attitude, reciprocity, and membership in civic organisations explained 67.6% of the sub-regional variations in mortality rates but years of education alone explained 61.8%. Among women the same variables explained only 29% of the variance in mortality rates. Collective efficacy was the most important social capital predictor of mortality, both among men and women. Collective efficacy and religious involvement showed opposite connection with socioeconomic status than social trust and participation in civic organisations. Religious involvement was found to be protective among women, while competitiveness emerged as a significant risk factor for mortality among men.

Conclusions

Gender differences in the relative influences of socioeconomic and social factors may help to explain the differential impact of economic transformation on mortality rates for men and women in Central-Eastern European countries. These results have important implications for differentiated health promotion consequences for men and women.

Healthy Food for socially deprived young people

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Problem background

Socially deprived young males have a lower health and nourishment status than those of better socio-economic status. Neither mainstream health promotion nor nutritional advice reaches them effectively.

Description of the project

The model project 'Selbst is(s)t der Mann' intervenes where the target group can be met: in social work institutions for kids. This approach was successful in other cases of health promotion interventions for socially deprived people.

The intervention takes place in five very different institutions in northern Germany. The projects offer meals planned, organised, cooked and consumed by the boys themselves with the support of social workers or other professionals with an educational training.

Lessons learned

– 400 young people could be reached in 24 months.
– The participants were clearly deprived socially in respect to education, family and migration status.
– Not only the nutritional status but as well the health behaviour of the participants was worth improving.
– The target group is not only sporadically but continually reachable with low key approaches.
– The rate of active participation is high, because it is seen as voluntary and fun for the participants.
– The problems during the project are mainly of social work nature, no health or nutritional problems.
– The participating institutions want to continue with the approach.

Conclusions

The additional value of the project lies in:
– new ways to reach 'difficult' target groups by collaborating with social work institutions;
– using low key approaches for training health related knowledge and options and
– the chance to transfer findings from nutrition to other health related behaviour.

Workshop 5: EUPHA section on social security and health: How to assess work ability in relation to sickness certification?

Chair: Professor Kristina Alexanderson

Sickness absence is an increasing public health problem in many countries and many physicians deal with sickness certification every day. Mostly this means that the physician must certify that the person has a disease or injury that has caused a loss in function leading to such a large reduction of work capacity, in relation to the demands of that persons work, that the person can not work. Many countries have rigid regulation as to which diseases are acceptable causes for absence, but little attention has been given to the process of evaluating work capacity or functional loss. Some countries (UK, Netherlands) use structured forms for the purpose of evaluating function, while others place more responsibility on the physician to give sufficient information on function for a decision as to welfare rights.

The purpose of the workshop is to give insight and impetus for further research on the issue: What do we know of the consequences of structured forms for assessing need for sickness certification as compared with a more non-structured way of gathering these information. Some evidence based on scientific studies will be presented by speakers from UK, Norway and Finland, countries using various methods to gather information on work capacity and function. With the recent introduction of ICF, a powerful, consistent and universal model, nomenclature and classification system is now available for use.

Experiences with the Personal Capability Assessment in Great Britain

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The Personal Capability Assessment (PCA) used in the process for determining eligibility for state incapacity benefits in Great Britain was developed in an extensive programme of research and evaluation during the period 1993 to 1995. It was first introduced in 1995. It is a functionally based method of medical assessment. Functions of body and mind considered essential for the ability of a person to undertake remunerative work of some kind, not limited to the person's ability to carry out their regular occupation, have been identified. Within each functional category there are grades of disability ranging from minimal or no effect on function to severe functional loss. These are called descriptors. With the assistance of an expert panel a threshold single descriptor was selected within each functional category at or above which level of severity, incapacity benefit is granted. A formula was also developed to sum the effects of co-existing functional limitations in claimants exhibiting two or more disabilities. The PCA has been rigorously evaluated by comparison with other methods of determining medical incapacity for work, including a comprehensive reference standard. It has been in use continuously since 1995 and has stood the test of time. Practical experience in its use, together with the results of formal evaluation have confirmed its validity and reliability.

Work is now progressing on the evaluation of a 'Capability Report' as an adjunct to the PCA which documents residual functional capacity and focuses on what people can do despite functional limitations or restrictions. Information provided in the Capability Report is used by DWP Personal Advisers at work-focused interviews of incapacity benefit recipients to help provided necessary support, skills, training and advice to facilitate a return to the job market and working life. This development is in keeping with the British Government's proposals to encourage retention in work, rehabilitation and return to work initiatives.

Functional assessments to counteract sickness absence in Norway

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Background

Increasing expenditure for social benefits and growing number of persons outside the workforce pose great challenges for many welfare states. In Norway, efforts are made to counteract this development by an increased focus on the individual's residual function rather than work incapacity due to disease.