ACTION-FOR-HEALTH

Situation analysis and Needs assessment in seven EU-Countries and regions

Reducing Inequalities in Health

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Situation Analysis and Needs Assessment in Seven EU-Countries and Regions

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Project ACTION-FOR-HEALTH aims to improve the health and quality of life of European citizens by tackling health inequalities with means of health promotion and use of structural funds. The project connects partners from 10 EU countries including: National Center of Public Health and Analysis – NCPHA (Bulgaria), Institute of public health of Medimurje county – ZZJZ MŽ (Croatia), Estonian-Swedish Mental health and Suicidology Institute (Estonia), National Institute for health and Development – OEFI (Hungary), Institute of Hygiene – HI (Lithuania), CBO (Netherlands), University of Trnava – TU (Slovakia), University de la Laguna – ULL, University of Brighton – UoB (United Kingdom) and Institute of public health Murska Sobota – ZZV MS (Slovenia).

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Content

Preface

This publication is the first of four publications within the project Reducing Inequalities: Action for Health. Action for Health is an EU co-funded project within the framework of the Health Programme. Its aim is to strengthen the capacity of health promotion workers in the region to tackle health inequalities through the promotion of health across Europe by developing action plans within seven regions in seven EU countries: Bulgaria, Croatia, Estonia, Hungary, Lithuania, Slovakia and Spain. The project work is based on experiences gained from a previous Slovenian project for reducing inequalities on the regional level through the promotion of health, performed by the Institute of Public Health Murska Sobota.

Socio-economic inequalities in health pose a major challenge to health policies. Those socio – economic health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups (WHO definition) (1). Health inequalities can be perceived as systematic and preventable differences in health status between populations, where the poor suffer from poorer health than the rich. Health inequalities exist on the supra-national level (between countries), on the national level (between regions in the same country), and within regions (between different local groups).

The importance of tackling those health inequalities on the national and regional levels is that a part of the inequalities is systematic and preventable by reasonable measures (2). It is unethical to let people live in poor health if it can be prevented. On the other hand, health inequalities cause a system-wide preventable economical burden in the EU. Poor health affects EU citizins health care costs, capacity to work, to learn and their the income level negatively.

In order to effectively reduce inequalities in health, a strategic plan is required, which would identify the key aims and objectives for politicians (on the local, regional and national levels) and other stakeholders to contribute to the reduction of health inequalities as well as strategies for achieving these objectives and indicators to monitor progress.

An initial step in developing the strategic plan is a systematic analysis of the current state of health and health inequalities in the regions as well as the current state and needs of the policy environment with regard to resolving health inequalities. For that reason, situation analyses and needs assessments have been implemented in the 7 countries and regions in question. Both the situation analyses and needs assessments provided insight into the strengths, weaknesses, opportunities and threats of health status, socio-economic factors and organisational factors such as available knowledge, manpower, resources (time, money, goodwill), internal and external networks, methods, policy and leadership (3).

This publication shows the results of these situation analyses and needs assessments carried out with the support of project partners in all 7 countries. Beginning with the results of these outcomes, strategic action plans will be developed in all 7 countries. Furthermore, this publication offers various promising practices in the field of tackling inequalities.

I Health & Health Inequalities in the EU

Health inequalities caused by differences in social status exist in all European countries. Differences are also seen within the countries (4, 5).

Health inequalities have been defined as differences in several health aspects such as mortality, morbidity, life style, access to health careacross subgroups of the population, which may be based on biological, social, economic or geographical characteristics (6).

Health inequalities are influenced by a variety of factors. The main determinants of health are shown in the figure below (7).

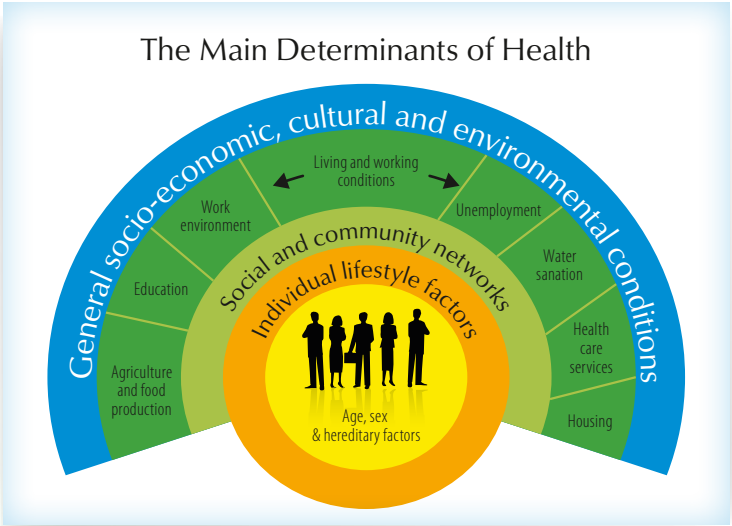


Figure 1 *Diagram by Whitehead M and Dahlgren C, in "What can be done about inequities and health?" The Lancet, 338, 8774, 26 October 1991, 1059-1063.*

A portion of those factors shown in figure 1, such as sex, age and heredity factors, cannot be influenced. Others, such as life style factors and socio-economic factors (education, poverty, employment and poverty) can be influenced, for example, by public policies. Health inequity within a population can be caused by differences in those factors. When those differences are not caused by free choices or biological variety, but by factors outside an individual's control it becomes unjust and unfair. Health differences caused by factors which can be influenced by public policy are called health inequalities (2;8). According to the European

Health Report 2012, the social determinants of health contribute to 50% of all health inequalities and comprise political, socioeconomic and environmental factors. Another influencing determinant on health inequalities is, according to this report, access to effective health services. At least 25% of health inequalities (differences found within a country's population) are associated with a lack of access to effective health services. This percentage increases if differential access to basic public health interventions such as access to safe water is included (9).

Health inequalities that can be avoided should be tackled as should interregional health inequalities and differences in the health status of populations in different regions. Not only because inequalities are unjust and unfair, but because they place an economic burden on society. Poor health leads to high health care costs. Additionally, people in poor health are less able to work and learn, affecting the human capital's ability to contribute to the economy. Structural funds aim to reduce regional disparities in terms of income, wealth and opportunities and as a result, disparities in health and health inequalities.

This publication gives an overview of the general health situation and needs to tackle health inequalities in seven European regions together withexamples of promising practices. This knowledge will be used to develop an action plan to tackle health inequalities in these regions through health promotion and structural funding.

II Methods Used

Situation analysis

In order to develop an action plan that focuses on health inequalities, insight in the determining factors that cause these health differences in the in various regions is needed. In other words, what are the factors contributing to avoidable differences in health. A situation analysis was implemented to analyse the current situation and assess those factors. Theoretical models and theories were used to determine and specify the underlying mechanisms for health inequalities (based on Dahlgren and Whitehead (1991), Albeda (2001), Dahlgren and Whitehead (2007), The Marmot Review 2010 and The European Health Report 2012). According to these theories, socio-economic factors (education, income, poverty), environmental- and cultural factors have a direct influence on health and health inequalities. On the other hand, a person's social position may be influenced by poor health. For example, educational opportunities affect job prospects and income levels (10). A lower income subsequently, could influence the type of house one may live in and its surroundings. Poor housing and environmental conditions in turn are associated with poor water, sanitation and air. All these conditions affect a person's health. Those complex mechanisms can be translated into entry points for tackling health inequalities. According to Whitehead (8), a typology of actions to reduce health inequalities comprises:

1. the strengthening of disadvantaged individuals: e.g. empowerment, health literacy,
2. the strengthening of the community: e.g. building social cohesion and mutual support to promote healthy behaviour,
3. the improvement of working and living conditions: e.g. education, income,
4. the promotion of healthy macro-policies: health policy, social benefit, structural funds.

These principles have been translated into online questions regarding geographical background, socio-economic determinants (income, (un)employment, education, and poverty), health status (life expectancy, healthy life years, mortality/morbidity rates, hospital admission) and health determinants (lifestyle factors, environmental and social conditions, contextual factors).

The member countries included in this project sought information regarding these factors for both the national level and for one chosen region. EUROSTAT, the HEIDI data tool, national and regional statistical databases and reports were used as sources. The outcomes of the situation analyses are summarized in 7 country reports and are part of this publication.

Needs assessment

In order to tackle health inequalities in the seven regions it is insufficient to merely know the health status and determinants of health

inequalities in one region. One must also obtain insight on the strengths, weaknesses, opportunities and threats regarding health status, socio-economic factors and organisational factors such as the availability of knowledge, manpower, resources (time, money, and goodwill), internal and external networks, methods, policies and leadership. A needs assessment was established for this reason. This needs assessment is based on the Dutch Health Promotion Framework (3), a quality tool for developing health promotion programmes in which health equity is an important long-term goal. See the figure below: column 1, organise, contains the organisational aspects which should be taken into account when developing a regional action plan for health.

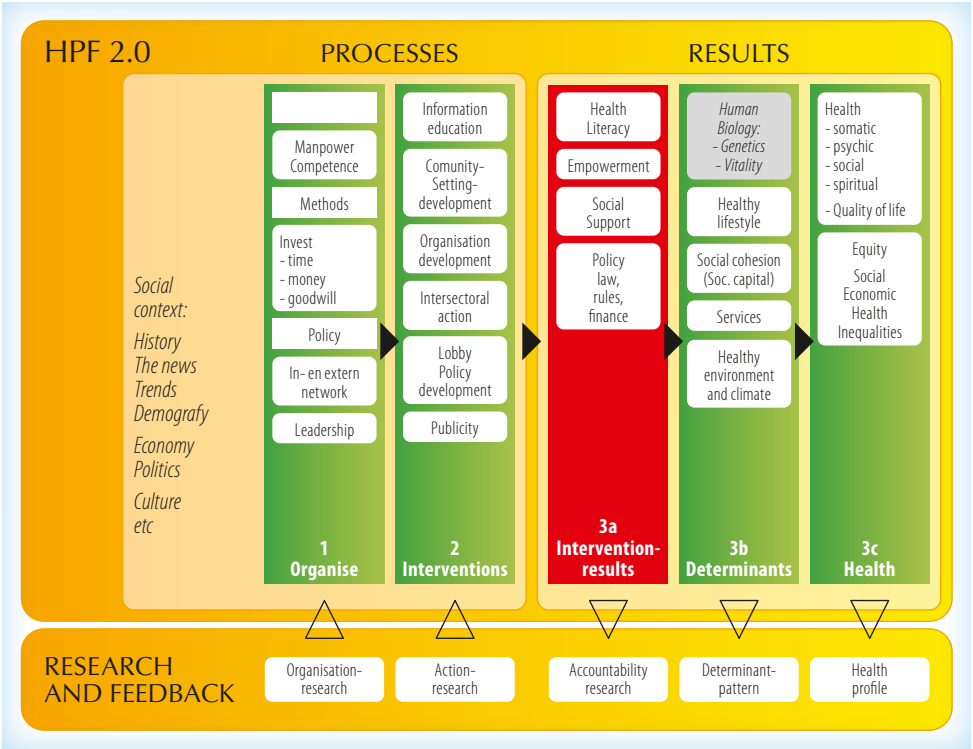


Figure 2 *Health Promotion Framework. Saan en De Haes, 2005, 2007, 2010.*

**A questionnaire surveying the needs of relevant stakeholders in the regions was developed and used in focus groups or interviews. The assessment results have been entered into an online database and summarized in this report. The results of both the situation analyses and the needs assessments represent the basis for the action plans of the seven European regions. The country reports including a summary of established needs are given in the following chapter. Finally, all partners were asked to find examples of promising practices, which are included in this publication as well.*

III Country Reports

1. Bulgaria, Lovech

General data

Bulgaria has a population of 7,327,224 inhabitants (2011) of which 51.3% are women and 48.7% men (1). Main trends regarding the population size are a permanent reduction in the population and aging. The primary causes for this trend include a low birth rate, increased mortality and significant youth emigration. Despite the overall prevalence of women in the total population, there are fewer women than men in the lower age groups, leading to low demographic reproduction. The increasing urban population and reduced population in rural areas are another ongoing trend. Nearly 72.7% of the total population live in cities with only 27.3% living in rural areas. A steady trend involving the depopulation of settlements, mainly villages in border regions (northwest and the southeast border) can be seen. This has given rise to a serious problem in economic development, as well as a future challenge for the state and regional government, indicating a widening gap between the conditions of life and work in cities and villages.

The region of Lovech is situated in north central Bulgaria. The Lovech region has a population of 139,609 people, of which 49% are males and 51% females (1), accounting for 1.9% of the country's total population. The decreasing population in the area – by an average of 1.0% annually, is identical to the country level trend. The Lovech region consists of eight municipalities. The largest is the Lovech Municipality has a population of 49,045 while the smallest – the Municipality of Apriltsi – has a population of 3,285. Analysis of the three age groups (0-17, 18-59 and over 60 group) shows a very low percentage for the first age group (less than 20%) and a very high percentage for the third group (40%), demonstrating the aging population structure in the Lovech region.

Socio-economic factors

Total income per household member in the region of Lovech is 804.68 BGN per trimester, equalling 412.65 euros per trimester, which is 10% lower than the country's total (886.48 BGN or 454.60 euros per trimester), making Lovech a more deprived area. According to a recent study by the European Commission, the risk of poverty in the EU is highest in Bulgaria. The percentage of people at risk of living under the poverty line in Bulgaria is 21.8% (2010) (1). The proportion

of the population estimated to be living on the poverty line is even higher for the Lovech area, namely 23.9% (males 24.3%, females 23.6%) (1). According to AROPE's definition, 66.6% of the population (69.9% of the men and 63.8% of the women) are at risk of poverty or social exclusion in Lovech (1), which is higher than the national average (49.2% of the population, males 47.3% and females 50.9%). The unemployment rate in the Lovech district is close to the national average or 11.2% (2011). The unemployment rate on national level by gender shows a percentage of 12.7% for males and 10.1% for females. The national unemployment rate of the active population under the age of 25 is 24.6%.

The total population with an upper secondary education in 2012 in Lovech is 61.6% compared the national percentage of to 43.4%. Recent data of NIS 2011/2012 shows 18.56% drop-outs from general and special schools at the country level versus7.01% for the region of Lovech (1). Although the educational level is above average, Lovech is still a deprived region.

Health and Health inequalities

Life expectancy at birth in Bulgaria in 2011 was 73.9 years (males – 70.7 years, females – 77.8 years). Healthy life years (HLY) for women were 65.6 years and for men 62.1 years. Life expectancy at birth is slightly lower in Lovech, namely 73.53 years (males – 70.12, females – 77.20) (1).

The top three health problems at the national level according to disease-specific mortality rates were: cardiovascular diseases (67.0%), cancer (15.7%) and respiratory system diseases (3.7%). Morbidity rates show that cardiovascular diseases (CVD) (14.9%), respiratory diseases (11.3%), and malignant cancers (3.6%) were the leading causes of hospitalization (1). According to data from 2011 (1), all three health problems are found more often in the north-western and north central regions of Bulgaria.

The leading causes of mortality in Lovech are consistent with those for the country. The CVD-specific mortality rate is significantly higher than the national average, comprising 80.7% of the total regional mortality rate in 2011. The cancer-specific mortality rate is lower than average. Negative demographic and health trends in Lovech persist and most (socio-economic) indicators are less favourable than the national average.

Needed Action(s) for Health

An aging population, unemployment and deteriorated social status are factors that directly affect health status and increase chronic non-communicable diseases, both at local and national levels. The leading risk factors for these diseases are lifestyle factors, e.g. smoking, low physical activity, alcohol consumption, unhealthy nutrition, obesity and aging.

Lovech is one of the demonstration areas that has been participating in the CINDI program in a series of studies and activities aimed at reducing the harmful effects of multiple risk factors for human health for more than 10 years (since 1995). An association was established in 2004 called the `Public Health Initiative`. This public coalition supports programme implementation. A child component was added to the CINDI program in 2008. The positive results and trends observed over the 10-year period are promising and help

focus efforts primarily on those risk factors characterized by greater stability – smoking, alcohol and low physical activity. A good prospect for this program would be to integrate health services into a broader intersectoral commitment to promote healthy living habits and a health-supportive social environment.

The Lovech action plan will focus on the prevention of smoking. Lovech has the highest smoking rate amongst adults (44.3% males, 33% females) and adolescents (33.7%) out of all the municipalities. The Roma population in Lovech numbers 5705 persons or 4.38% versus 4.87% at the country level (1). More information on the life style habits and health literacy of the Roma population is needed. Implementation of activities related to health promotion and disease prevention should be included in the Lovech Regional Strategy for Roma Integration (2012-2020), which was developed in cooperation with various stakeholders, in particular with Roma NGOs (3). Greater consistency and coordination between all institutions involved in the Roma Integration Regional Strategy is still required.

The Regional Health Inspectorate possesses more comprehensive data about the Roma community in the region, such as employment and educational levels, routine examinations and immunizations as a result of regional strategy monitoring activities. These data could be of assistance in developing and implementing the action plan for reducing health inequalities.

Challenges that should be considered when implementing the Action Plan include the organization and coverage of the Roma population and the assurance of a sufficient number of health mediators for the Roma population in municipalities. The network of health mediators should be expanded so as to comprise at least one mediator for each municipality. Barriers comprise uncertain funding, lack of mechanisms for involving physicians in the Action Plan and insufficient coordination between institutions.

Facilitating factors for the action plan are the existence of the current Regional Strategy for Roma Integration (2012-2020), existing expertise, good training practices, commitment, and the presence of NGOs in the Roma community. The active participation of the municipalities and sufficient financial resources are needed to realise the action plan.

2. Republic of Croatia – Međimurje County

General data

According to the latest population census (2011), Croatia has a population of 4,284,889 inhabitants living predominantly in four of the twenty counties and in the City of Zagreb (1). Međimurje is a county located in the northern part of the Republic of Croatia. (Figure 1). The Međimurje County (Međimurje) is the smallest county with 113,804 inhabitants (55.601 men and 58.203 women). It is the second most densely populated county in Croatia (156.11 inhabitants per sq. km). The county is administratively divided into three towns and twenty-two municipalities. The capital of Međimurje is Čakovec (2).

Socio-economic factors

Although Croatia is, according to the International Monetary Fund, an emerging economy, socio-economic inequalities do exist between and within the counties. In Croatia 21.1% of the population is at risk of living under the income-poverty line of 60%, of which 20.0% are men and 22.1% are women (3). In 2010, men earned 9.8% more than women in Croatia (4). Međimurje has a less favourable position with respect to income, (un)employment and educational level and could therefore be seen as a deprived county in Croatia. Since poor socio-economic factors often go hand in hand with poor health and health inequality, Međimurje will be the region of focus for the Action Plan.

The lowest average net income recorded in 2010 in Croatia was registered in Međimurje, and was 584 euros (with an average of 617.45 euros for men and 541.34 euros for women and national average of 737 euros) (5). While the total unemployment rate in Međimurje (16.4%) is lower than the national average (18.3%), unemployment in the under 25 years of age group is somewhat higher (23.1% versus 20.5% of the unemployed under 25 years of age in 2011) (6). Data regarding professional qualifications show a less favourable position. With 51.3% had Međimurje the lowest percentage of secondary education in the 15 years and over age group while the percentage was 58.5% for the country (7). Inequality exists between rural and more urbanised areas and between groups. For example, the share of women who died from cardiovascular diseases in the municipalities of Međimurje County, between 2006 and 2010 and who had not finished a primary education is statistically considerably lower than in the cities – 53.65% vs 59.3% (8). Inequality between groups is reflected in the Population Census of 2011; 16,975 Roma people live in Croatia, of which 5,107 of the total live in Međimurje

(4.4% of the total population in Međimurje). About 90% of the Roma people who live in Međimurje are unemployed and 82% receive social benefits (1; 9;10).

Health and Health Inequality

In Međimurje the average life expectancy at birth in 2008/2009 was 76.0 years, which is just below the national average of 76.1 years. The life expectancy for women in Međimurje was 79.8 years, which was 7.7 years higher than for men (11). HLY in Croatia for women was 60.7 years and for men 57.3 years (12).

The three main causes of death in the Međimurje County as well as in Croatia in 2010 were: cardiovascular diseases (46% and 49% respectively), cancer (28.8% and 26.3% respectively) and injuries and poisoning (6.1% and 5.7% respectively)(13). These were also the leading causes for hospital admissions (13).

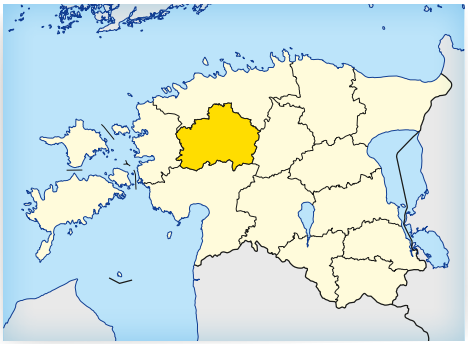
Apart from age and sex, lifestyle and environmental factors play an important role in the onset and progress of cardiovascular diseases in Međimurje (14): Professional stress was a possible risk factor among 15% of men in the continental part of Croatia, the place where Međimurje is located (15). Next to this Existential concern caused by unemployment, fear of losing a job, stress due to overwork, insufficient income, poor housing, lack of friends or family support plays a role (15;16). A total of 20.2% men and 12.1% women in Croatia reported unhealthy dietary habits. The number of respondents with unhealthy dietary habits in the northern region is higher than the Croatian average (24.4% of the men and 16.53 of the women) (17). In Međimurje a growing trend exists away from traditional foods and towards more saturated fats, more salt-cured products and less fruit and vegetables (18). A total of 28.9% men and 31.9% women in Croatia are considered physically inactive. The male respondents of the northern region had a greater prevalence of physical inactivity (37.7%men) (19). A lack of knowledge and information, lack of accessible and affordable recreation and sport facilities, lack of time (due to tasks at home and work) and motivation or self confidence (when unemployed) and an insufficient number of bike and pedestrian paths play a role in physical inactivity in the Međimurje County (16). Average alcohol consumption in Croatia is 12.3% for men and 0.7% for women. The respondents in the northern region had a greater prevalence of alcohol consumption than the Croatian average (13.12% men and 1.45% women) (17). Međimurje is a wine-producing region and the consumation of alcohol is therefore socially accepted. Underage drinking is prohibited by law but not followed up; advertising of alcohol is allowed and media marketing is influential (17). Although the lowest frequency of smokers in both genders was recorded in the northern region (for men 24.1% and for women 10.5%) according to WHO, 30-40% of all deaths are attributed to smoking (21;22). Health care services are not equally accessible due to costs or distance in all parts of Croatia. In 2012, a new Emergency Medical Services (EMS) unit was established in the Međimurje County. Also the number of staff has increased and included in the Croatian percutaneous coronary intervention network. Those factors have improved health care quality and reduced both the distance and time required to obtain medical intervention in the event of acute

coronary syndrome (23). The combination of all these factors will be the focus of the Action Plan for Health in the Međimurje County for tackling CVD among young adult and middle-aged men as well as middle-aged and older women who are less educated and financially dependant.

Needed Action(s) for Health

A number of different strategies and plans could contribute towards the successful execution of the Action Plan in Međimurje. In the Long-term County Health Plan 2008-2012, County Health Care Plan 2010 (25) and Development Strategy of the Međimurje County 2011-2013 the main topics of the upcoming Action Plan for Health Inequality are designated priorities (24;26). Following the country's entry into the EU, Međimurje will have the possibility of using EU structural funds. Programming of the financial perspective 2014-2020 in Croatia is currently in progress, and will be coordinated with the National Health Care Development Strategy 2012-2020 (28). Since one of the development priorities in health care, i.e. intensifying prevention, is a part of this strategy, it is believed that these different programmes on the regional, national and EU-levels will offer opportunities for strengthening a healthy lifestyle related to CVD in Međimurje. Cooperation across a number of sectors is of importance in realising this goal (29; 30). What is also needed according to the relevant stakeholders in Međimurje is the building of professional capacity regarding health promotion, social determinants of health and health inequality. Expertise on the topic of CVD spanning beyond the existing knowledge of secondary and tertiary prevention is also required. Current expertise should be expanded and awareness raised both on the professional and political levels to enable the continuation of activities sufficient time and funding. An important condition for the Action Plan is that health promotion becomes a separate official task for public health services, with separate funding and capacity. In this way, EU tasks or other projects regarding health promotion will not compete with the regular tasks of public health services (31). Formalising the current network would additionally strengthen the existing agencies and institutions and others that deal with health promotion which are willing to take the lead in the Action Plan. This, and the conditions and factors mentioned before will be taken into consideration when developing the Action Plan for tackling health inequalities in Međimurje.

3. Republic of Estonia – Rapla County



General data

Estonia is a state in the Baltic region of Northern Europe with a population of 1,286,479 in January 2013 (1). It is a democratic parliamentary republic divided into 15 counties. The Rapla County (Rapla) is situated in the north-western part of Estonia and includes 10 rural municipalities (2). The total population was 34.442 in 2013 of which 48.2% was male and 51.8% female (3). The population of Rapla County constitutes about 2.7% of the total population of Estonia (4).

Socio-economic factors

Estonia has the highest gross domestic product per person among the former Soviet republics (5).

It is listed as a "high-income economy" by theWorld Bank and identified as an "advanced economy" by the International Monetary Fund. It is a member of the Organisation for Economic Cooperation and Development. Although it is a high-income economy, 17.5% of the people lived below the poverty line in 2011 (6). A gender-gap exists with regards to income distribution (27% in 2008) as well as a 5.3-fold income gap between the lowest and highest income groups (7). Rapla County is a county where aspects of inequalities, lower educational levels and lower income, are more prominent than at the national level (11). The experience gained in the Rapla County with respect to tailored approaches for specific target groups and psychosocial interventions will aid in tackling health inequality.

Rapla County is a rural area. Building, transport and agriculture are the primary industries there (8). Public administration, schools, health and social service play also an important role. Although the unemployment rate in Rapla County increased in 2012 (8.7%), it is still lower than average (10.2%) (9). The number of people at risk of living under the poverty line of 60% in the Rapla County equalled the national average of 17.5% in 2011. This may be due to the lower average income of 534 euros in 2011 compared to the national average of 672 euros (10). A lower average income often reflects a lower educational level (11). In 2011, 50.5% (aged 15-74) had an upper secondary education in the Rapla County, which is much lower than the national average of 88.9% (aged 25-64) (12;13). This may explain the lower average income in the Rapla County. This inequity in income and educational levels compared to the national average are socio-economic factors which need to be taken into account when tackling health inequality.

Health and Health Inequality

The life expectancy at birth was 75.73 years in the Rapla County in 2010/2011, which is slightly lower than the national average of 76.28 years (14). The life expectancy of women in the Rapla County is 81.0 years, which is 10.6 years longer than for men (15). The

number of these expected life years lived in good health is not known for Rapla County. Nationally, the figure is 57.3 years for women and 52.9 years for men (15).

The three main causes of death in Estonia in 2011 were cardiovascular diseases (53.7%), cancer (24.2%) and injury or poisoning (7.4%) (16). The percentage of people who died of cardiovascular diseases is lower in the Rapla County than the national average (48.9% versus 53.7%). The percentage of people who die of cancer is 1.1% higher for the Rapla County compared to the national average of 24.2%. Estonia has the highest mortality rates due to injuries in the EU (17; 18). The rates for injury and poisoning are slightly higher (9.4%) in the Rapla County than the national average. Various causes of injury and poisoning exist in the different stages of life. Between 2006 and 2009, an average of 161 young people (aged 0-18) per 1000 inhabitants suffered traumas and 123 middle-age people (aged 19-64) per 1000 inhabitants suffered traumas and 71 older people (aged 65+) per 1000 inhabitants (20). Injury mortality is a problem, especially among men; in 2011, 36 men and 5 women died due to injury and poisoning in the Rapla County (16). Poisoning and suicide rank first in death by injury in males in the 20-60 year age group. Suicide is strongly linked to emotional health and psychological conditions (20). Poisoning can be caused by poisoned water, alcohol poisoning and drugs. Alcohol also plays a very important role in death by injury among men. The majority of middle-aged suicide attempters (82%) were alcohol abusers. Also, most people who died due to fire were found to be intoxicated (20). Alcohol consumption and drug abuse play an important role in the injury rates of youth and adolescents. In Rapla County a study on alcohol consumption implemented in 2010 showed that out of all eleventh grade students aged 17-19 years old, 45% of the boys and 35% of the girls consumed hard liquor every month and 20% of the boys and 8% of the girls consumed hard liquor every week. In Rapla County the percentage of eighth graders who had tried drugs had decreased by almost 7% from 2008 to 2010 (from 17% to 10%); the percentage of eleventh graders who had tried drugs had grown by 9% from 2008 to 2010 (from 28% to 37%) (20). The foundations for health awareness and healthy behaviour are paved in childhood. Promotion of the physical and mental health and social development of children and young people should therefore begin in their youth. Family and the general environment play an important role in improving children's health. The priority actions should therefore be: 1. Promotion of the physical and mental health and social development of children and young people. 2. Prevention of injuries and violence among children and young people. 3. Prevention of chronic diseases and their risk factors among children and young people (22).

Needed Action(s) for Health

Prevention of injuries and alcohol poisoning is more effective if access to alcohol is limited. Rapla County introduced one of the first bans on the retail sale of any kind of alcoholic drinks at night in Estonia in 2003. All municipalities of Rapla County had fixed restricted alcohol sales from 10 p.m. to 8 a.m. by 1st January 2008. Since the summer of 2008, the ban on the retail sale of any kind of alcoholic drinks at night has enforced throughout Estonia. Moreover, in Rapla County,

preventive activities related to alcohol are always combined with prevention of other addictions (e.g. smoking, drug abuse) (23; 24).

Rapla County has obtained immense experience regarding health promotion, especially injury prevention, e.g. Rapla County Health Profile (2005, 2011), Rapla County Injuries Profile (2010) and Rapla County Safe Community Program 2004-2009. A very strong network structure and a highly co-operative team for health promotion are in place. All partners have their own budgets for prevention. However, barriers still exist. Rapla County has insufficient knowledge and other resources for implementing situation analyses and evaluating the effectiveness of programmes. Although it possesses some experience in analysing environmental factors which affect injuries, a greater capacity is needed for the impact assessment of mental health as a determinant of injuries (e.g. stress, mental health problems, suicide and related alcohol and drug consumption). The team should be trained in the field of suicide and mental health; risk factors and risk groups should be identified; children in trouble need recognition and professional help. A national injury registry is required to support all this. Hence, the capacity for recognizing and solving mental health problems/disorders and suicide attempts should be established. The ERSI (Estonian-Swedish Mental Health and Suicidology Institute) is willing to play the key role in this field in cooperation with local health promotion specialists and practitioners in Rapla County. Unstable financing support and legislations that don't encourage "grass" level health promotion will be obstacles for building a network organization on this level (24). To be able to do so consistently, it is imperative that national political attention will be placed on injuries and damage and their cost (more than 3 million euros per year) (17; 24). Those needs and the beneficial factors should be taken into account when setting up an action plan for health for the Rapla County.

4. Hungary – Sellye

General data

In January 2012, the population of Hungary was 9,957,731 and spread over seven statistical administrative regions in Hungary (1). All regions in turn, consist of counties; there is a toal of 19 counties. The counties are further subdivided into 175 sub-regions ("kistérségek"). One of the counties is Baranya, which is situated in the southern part of Hungary on the border with Croatia (2). The Sellye sub-region lies within the Baranya County. This sub-region had 14,181 inhabitants in 2011 (3).

Socio-economic factors

The Hungarian economy is medium-sized andstructurally, politically, and institutionally

open and part of the EU common market. Its economy is highly dependent on foreign investment (luxury vehicle production, renewable energy systems, high-end tourism, information technology) and vulnerable to economic crises. Although already recovering from the economic crisis, economic reform measures such as health care reform, tax reform, and local government financing are still being addressed by the present government (4;5). This is reflected in its poverty rate (AROPE definition); every third person (approximately 3 million individuals) lives below the poverty line in Hungary today with 1.2 million of them living in extreme poverty (6). Despite the economic difficulties, the inequality between socio-economic groups is low compared to the other countries described in this publication, namely 3.9% (7). However, a gender income inequality of 18% exists in favour of men (8). Poverty is prevalent in Hungary as well as in Sellye. Sellye is a very deprived region where poverty, low levels of education and income are prominent socio-economic factors. Those aspects are related to health inequality and for Sellye being the sub-region of focus.

Sellye is one of the most disadvantaged sub-regions in the country. The unemployment rate is 27.3%, far above the national average (10.9%). The rate of unemployed persons as a percentage of the economically active population was 43.8% in 2012 (9). This is reflected in a lower average income of 296 euros compared to the average national income of 483 euros. People in Sellye earn their income primarily through agricultural activities and small businesses. Lower incomes and employment types often relate to education levels. With respect to education, 65% of the population over 7 years of age had a primary school education in 2001 with 21.74% of the population possessing a secondary education (the national average was 82.1%). A total of 80% of children attending kindergarten and primary school were socially disadvantaged (entitled to regular child protection allowance) with approximately 40% of them multiply disadvantaged (socially disadvantaged children whose parents only have a primary school education and/or who are under long term state care). The rate of children entitled to regular child protection allowance in this region is 75.7%. This means that the population of the Sellye sub-region has multiple disadvantages (income, unemployment, poverty, education), which are more often prevalent among Roma people. The rate for the Roma population is 32.8% (9). All these factors greatly impact health in this region and should therefore be taken into account when setting up an Action Plan for Health.

Health and Health Inequality

In Sellye, the life expectancy at birth was 72.87 years in 2010 (11), which is lower than the national average of 75.1 years in 2010 (12). With a life expectancy of 75.95 years, women live 6.21 years longer than men (11). HLY expectancy on the country level is 57.6 years for men and 59.1 years for women (12).

The three greatest causes of mortality in Hungary in 2011 were cardiovascular diseases (49.9%), cancer (25.8%) and digestive diseases (5.7%) (13). The 3 most common diseases based on the register of family physicians in 2009 were: hypertension, locomotor disorders and ischemic heart disease (13;1). According to the WHO's Burden of Diseases 2004

– Updated Study, the 3 major health problems identified at the national level were cardiovascular diseases, cancer and injuries (14). On the local level, in Sellye in 2011, the most common regional health problems based on the rate of mortality were cardiovascular diseases (41.8%), cancer (30.8%) and respiratory diseases (10.4%) (15). The main health problems among children under 14 years were allergies, asthma, orthopaedic diseases and malnutrition. The Action Plan will focus on children with respiratory diseases (allergy, asthma and other respiratory diseases) and malnutrition. Medical treatment is unaffordable for most families. Poor housing also plays an important role in children's health status. For example, 33% of the flats in this area are without sufficient comfort and there is no tap water in 15% of the flats. The sanitation rate is only 17%. Health care services for children and persons in need of care and nursing are insufficient (9). Those conditions affect health and subsequently, the ability to fulfil school requirements (16).

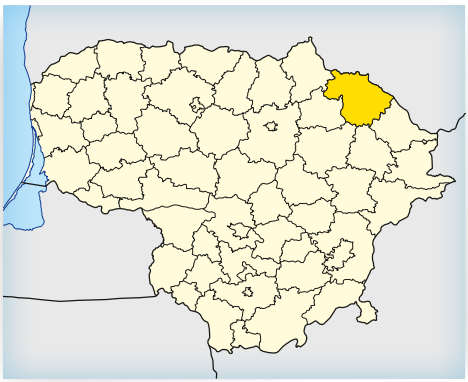
Needed Action(s) for Health

The basis of the Action Plan for the Sellye sub-region is supported by data gathered within the Social Renewal Operational Programme of the New Hungary Development Programme (9). The data represented a professional and methodological foundation for the national extension of the Chances for Children Programme and was commissioned by the Hungarian Charity Service of the Order of Malta in 2012. It helped assess the socio-economic and health status of the sub-region. The knowledge, local expertise and manpower of these programmes can be used to realise a local Action Plan for Health Promotion to tackle upper respiratory diseases and malnutrition among children. Data from the experiences of other EU-funded projects implemented at the local level can also be used.

Within the New Hungary Development Programme, most of the applications in Sellye were submitted within the the South Transdanubia Operative Programme and the Social Renewal Operative Programme. The "Integrated Regional Programs for the Social Inclusion of Children and their Families" within the Social Renewal Operative Programme (S.R.O.P 5.2.3) aims to reduce and prevent poverty, particularly child poverty. The programme "Everything has a solution" – a complex family assistance programme with prevention aims (SROP-5.3.5-09/1) focuses on debt management and preventing further debts for people living in Sellye. A sub-regional outpatient care centre was established in Sellye within the Social Investments Operative Programme (2.1.2-07/1). The main objective of the project was to develop a sustainable regional outpatient care centre that would contribute to equal access to health services. Several civil society organisations – besides the Hungarian Charity Service of the Order of Malta – work for children and other vulnerable groups in various parts of the region (9). Better access to health care and sanitation is an important tool in reducing health inequality. Lack of access to clean water, poor housing, lack of education, malnutrition and upper respiratory problems are issues that still need to be addressed. A comprehensive intersectoral regional action plan is needed and a policy

for health promotion (17) such as, for example, a healthy school approach – e.g. provision of school meals also in the summer time, a healthy respiratory environment within schools, safe play grounds, promotion of water consumption in schools, results in better school achievements. This school-oriented health approach is a good example of an integrated local health promotion programme which could contribute significantly to children's' health in the Selly sub-region. Based on several local workshops with local experts, decision makers, care and social welfare professionals and representatives of target groups, an appropriate action plan to address the lack of access to clean water, poor housing, and lack of education, malnutrition and upper respiratory problems will be set up.

5. Lithuania, Rokiskis



General data

A total of 2,993,534 people live in Lithuania (average annual population in 2012). Roskiskis is a district in the northeast corner of Lithuania with 33,851 inhabitants (46.5% male, 53.5% female)(1). Around 16,000 people live in the city of Rokiskis (2). Rokiškis is well known for its cheese. "Rokiškio sūris" is one of the largest cheese manufacturing companies in Lithuania. The company is a very important employer in the region and also an important supporter of community initiatives (2).

Socio-economic factors

The net average monthly wage in Lithuania was 461.83 euros in 2011. The gender pay gap was 11.9% in 2011 and income inequality 5.8% (1). The total population aged 25-64 for the whole country possessing at least an upper secondary education was 92.9%, while the percentage of early school leavers was 7.9% in 2011. The unemployment rate in 2012 was 11.7% (14.6% male, 10.6% female) (3). The percentage of the unemployed population aged 15-24 years old was quite a bit higher, namely 27.5% (1). Despite these facts, the percentage of the total population at risk of living under 60% of the income-poverty line in 2011 is quite high, namely 20.0%. Poverty and social exclusion are significant problems in Lithuania.

The monthly net average income for the Rokiskis district was 533.47 euros, which is slightly more than the national average (1). A total of 12.8% of the population in the Rokiskis district are unemployed, which is higher than the national rate. No information regarding the educational levels of the population in the region is available. However, Rokiskis is one of the disadvantaged regions in terms of unemployment and poverty.

Health and Health inequalities

Life expectancy at birth at the national level is (73.8 years (total) – 68.1 years for males and 79.3 years for females) (4). Healthy life years at birth are slightly higher for women (62.1 years) than for men (57.1 years). The main health problems at the national level are cardiovascular diseases. Of the 41,037 people who died in 2011, 56.3% died of cardiovascular diseases (47.7% males, 65.1% females). The second major health problem is cancer with 19.8% of people dying as a result of cancer (21.5% males, 17.9% females), followed by mortality due to external causes (9.1% – 13.5% males, 4.4% females). The three most frequent diseases based on prevalence in 2011 were hypertensive diseases, acute upper respiratory infections and influenza and diseases of the digestive system (5). The highest prevalence of cardiovascular diseases by age group in Lithuania in 2011 was observed in over 64 year-old age group. Females were affected more by cardiovascular diseases and the figures were higher in the urban population.

Cardiovascular diseases represent the biggest health problem in the Rokiskis district municipality and in the country. This problem is distributed unequally among the age groups and by gender. There is no certain area where prevalence or mortality of cardiovascular diseases would be especially high – the rates mostly depend on the age structure of the population and social conditions.

The main social determinants affecting cardiovascular diseases in Lithuania are age, gender, marital status, place of residence and lifestyle. Prevalence among females and older people (65 and over) is higher than among males and youth (6). Malnutrition (especially high intakes of salted food and fats) are strongly related to a high prevalence of cardiovascular diseases. According to a 2007 study for the period 1989-2001, cardiovascular diseases (CVD) contributed most to excess mortality of never married and divorced men, as well as all unmarried groups of women (7). According to a 2002 study for the period 1990-2000, mortality from cardiovascular diseases was higher amongst the rural population than amongst urban dwellers (8).

The following data regarding the main health problem of CVD on a regional level is known:

The standardized mortality rate for cardiovascular diseases in the Rokiskis Municipality in 2011 was 519.3 / 100,000 pop. (739.1 / 100,000 pop. for males; 360.7 / 100,000 pop. for females).

Prevalence of cardiovascular diseases in the Rokiskis municipality in 2011 was 25,798.0 / 100,000 pop. (19,269.8 / 100,000 pop. for males; 31,533.7 / 100,000 pop. for females). Prevalence of hypertensive diseases was 20,642.2 / 100,000 pop. (14,534.4 / 100,000 pop. for males, 26,008.6 / 100,000 pop. for females) (8). A total of 31.9% of the urban population and 31.53% of females are affected more than the rural population (20.5%) and males (19.27%) in the Rokiskis municipality (9). The most affected age group were aged 64 years and over (70,414.2 / 100,000 pop). The main personal factors affecting cardiovascular diseases in the Rokiskis municipality were identical as for the whole country – age, gender, marital status, place of residence and lifestyle.

Needed Action(s) for Health

Prevalence and incidence of cardiovascular diseases and death could be changed with policies and intervention as well a low physical activity, malnutrition, smoking and alcohol consumption. Physical activity can be influenced by creating better cycling infrastructure, improving conditions for physical activity in green areas and creating new ones. Malnutrition can be influenced by creating better conditions for buying healthy food and reducing prices of healthy food (making a healthy choice an easy choice). Smoking can be reduced by creating more non-smoking areas and increasing the prices of tobacco products. Alcohol consumption requires special attention because there are a lot of illegal sources for obtaining alcohol products in the country.

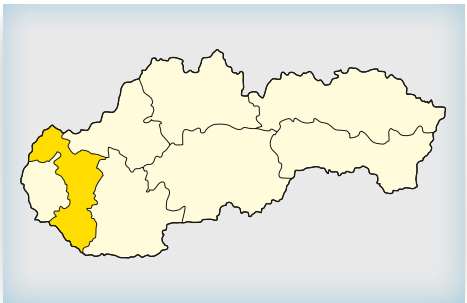
Physical activity and nutrition should be tackled first. Low physical activity and malnutrition is a complex problem and causes not only a high prevalence of cardiovascular diseases, but also other diseases.

The Statutory Health Insurance Fund is the main source of financing for health programs in Lithuania. The High Cardiovascular Risk Primary Prevention Programme was financed by this fund and significantly affected mortality caused by cardiovascular diseases in Lithuania. EU Structural Funds (European Social Fund, Cohesion Fund and the European Regional Development Fund) are available for financing programs involving local development, quality and accessibility of public services and environmental quality and energy efficiency that are intended to influence the major health problems in Lithuania.

However, the infrastructure of health care institutions in Lithuania does not meet the necessary quality requirements nor do they meet communal needs sufficiently. Great differences regarding the availability of services exist in smaller municipalities and/or rural areas. Modern technologies and treatments demand greater funds for health care. The problem of the lack of human resources in some areas due to the migration of specialists also exists. The lack of good monitoring systems to observe whether services meet the needs of patients also hinders optimization of these services.

The Action Plan of Lithuania will focus on the prevention of cardiovascular diseases for the entire population and the accessibility of the health care system for all social groups. In order to reach this challenging goal, advanced training skills and an exchange of good practices in and between organisations are required. Greater support for health politics in the Rokiskis district will also be needed. Enough staff is available. Nevertheless, improved skills of health care workers and the increased competence of health monitoring methods will be needed. Furthermore, financial and political support is also essential for success. Finally, a real challenge will also be the undertaking of efforts to obtain more support and leadership for health improvement and the tackling of inequalities in health through health promotion!

6. The Slovak Republic – Trnava region



General data

The Slovak Republic had a population of 5,404,322 in 2011 (1). Slovakia is subdivided into 8 regions. The Trnava is a region in the west of Slovakia. It is the smallest and second most densely populated region in Slovakia, with 554,765 inhabitants in July 2011 (2,709,305 males, 2,838,365 females) (2; 3). The town of Trnava, the 'capital' of the Trnava region has the most inhabitants of the region.

Socio-economic factors

Slovakia is an advanced economy with one of the fastest growth rates in the European Union and the OECD (4). The country joined the European Union in 2004 and the Euro zone in January 2009. Even in a country with such fast growing rates, inequalities do exist between and within the regions and counties. The country had a gender pay gap of 20.5% in 2011 (5). The inequality of income distribution was 3.8% in 2011 between the lowest and highest SES groups (6). A total of 13% of the population lived under the 60% income poverty line in 2011 (7).

The Trnava region is quite productive in both industry and agriculture. Its proximity to the capital Bratislava is an asset as many of the region's residents commute to work there on a daily basis. The main industries in the Trnava region are: automotive, metallurgical, electrical and chemical engineering (2). Productivity in the Trnava region is reflected in lower unemployment rates compared to the national average of 2011 (10.6% in the Trnava region vs. 13.5% nationally) (1). The risk of living under the 60% poverty line is less prevalent in this region (9.5% here versus 13% in Slovakia (2011)) (3). A total of 40.3% of the population possess at least an upper secondary education compared to the national average of 43.4% (8). The average net income of 639 euros in Trnava lags slightly behind the national average income of 665 euros (3). Overall, Trnava is a region in which most socio-economic factors do not differ significantly from the national average. The percentage of people with an upper secondary education is low at both the national and regional levels, compared to other European regions. Poor education is closely linked to poor health and health inequality and it is therefore important that both areas be improved (see introduction and methods). For this reason, education will be an important priority in the regional action plan.

Health and Health Inequality

Life expectancy at birth was 75.7 years in the Trnava region in 2011, which is slightly higher than the national average of 75.4 years. Women in Trnava live to the age of 79.4 years or 7.0 years longer than men (2).

The main causes of death in Slovakia and in the Trnava region were respectively,

cardiovascular diseases (CVD) (52.6% vs. 50%), cancer (23% vs. 25.4%), diseases of the digestive system (6.3% Trnava) and injuries (5.4% Slovakia). The three main causes of death in Trnava were: CVD 19.8%, cancer 21.6% and digestive system diseases 20.8% (1). Data regarding underlying health determinants for morbidity and mortality rates due to cardiovascular disease is available at the national level but could give an indication for possible risk factors for CVD in the Trnava region and will therefore be covered discussed.

In Slovakia, more women die of circulatory diseases than men (55% of the 27,306 CVD deaths in 2011) (1). Underlying factors are the prevalence of physiological factors such as hypercholesterolemia (46.2% in 2011), obesity (61.8%) and hypertension (21.1%) (11). Several behavioural factors are also of influence. The prevalence of daily smokers in Slovakia, which was in 2009 19.5% (27.1% males, 12.5% females), occasional smokers 9% (10.3% males, 7.7% females) and those who have never smoked 71.5% (62.6% males, 79.8% females) (13). The prevalence of smoking has been decreasing since 1993 (11) and is lower than in most other EU countries. A trend in eating habits within the Slovak population which enhances these risk factors for cardiovascular disease is the increased energy intake and high consumption of animal fat and protein. A difference in energy intake was shown with ageing and between the sexes. The intake of energy, animal fat and proteins is higher among men than women between 19-56 years. Older women (age group 35 to 54) consumed more animal fat and proteins. In older men, an increase in obesity was reported. In younger man, high cholesterol levels were twice that of younger women which is directly linked to their diet (high energy intake, high intake of fat and protein) (12). Data on whether and how drinking water plays a role in the Slovakian diet was not available, but in 2005, 84.9% of the Slovak population had access to clean water from the public water supply as did 84.7% of the Trnava population (14; 15). According to the Slovak Environmental Agency, a decreasing trend in the consumption of drinking water from public water supplies has been reported in the Slovak Republic; a growing number of people prefer water from their own wells or bottled water. A total of 14% of the population uses water from individual sources (wells) however 80-85% of these sources do not meet hygiene and taste standards and are possible hazards to health (16). Factors mentioned above should be considered in the Action Plan.

Needed Action(s) for Health

Two national programmes tackling cardiovascular diseases were implemented in the Slovak Republic. The project MOST (One Month about Heart Topics) has been implemented in recent years (17). This could be perceived as a promising practice that increases people's knowledge of cardiovascular diseases and their prevention. The National Programme on Cardiovascular Diseases was also implemented during the period 2009-2012 (18). Objectives within the Slovak National Health Promotion Programme have also been prepared to tackle cardiovascular diseases (19). However, there seems to be a gap between political and policy rhetoric and practice. This is one of the reasons why CVD needs

to be addressed and an intervention performed to tackle the burden of CVD on society.

To be able to develop an action plan for health, data from the Trnava region is needed such as information on health determinants which could explain the prevalence and incidence of cardiovascular disease in the Trnava region. Education and health are closely linked and could be key priority in the action plan for health in te Trnava region. A life course perspective is accepted as good practice in public health and health promotion research and practice (20) and should be used; it is an effective way of targeting specific geographic populations at different stages of life in addressing the risk factors for CVD. Intersectoral policy-making and programming could be a possibility and should therefore be explored. The creation of goodwill for health is cross-sectoral and should be enhanced. One policy which could support this cross-sectoral approach is the current plan to build a cycling stadium in Trnava which will greatly enable people's access to the sport's arena; additional similar centres could be facilitated and supported through future structural funds. A team with the right knowledge, skills and different roles to carry out the action plan could be established. There are many promising practices available from previous national programmes on CVD. Quite a few health and non-health sector professionals are motivated to be involved in a possible network, interested in lifelong learning and in being involved in an international project. This expertise should be incorporated into a network to facilitate the action plan. On the other hand, capacity building in the Trnava City in the area of health determinants for CVD, intersectoral collaboration, creation of goodwill to support cross-sector activity and structural funds are required. These conditions and factors will be taken into account and will be subject of the Action Plan for Health in Trnava.

7. Spain, Canary Islands

General data

Spain has a total population of 47,265,321 (male 23,298,356; female 23966, 965) inhabitants.

The Canary Islands, one of 17 autonomous regions of Spain, consists of 7 larger islands and 6 smaller islands. The islands are located off the north-western coast of the mainland of Africa, more or less 100 kilometres west of the coast of southern Morocco. The total population of the Canary Islands in year 2012 was 2,118,344 (male 1,056,240; female 1,062,104) (1). As visible in the map (2), the Canary Islands are located rather far away from the mainland of Spain and are quite isolated. This has an effect on the social and economic position of the islands.

Socio-economic factors

The average annual income per person in 2011 was 9321 euros. The annual income per household in 2011 was 24,609 euros according to data from the National Statistics Institute (1). According to an ADECO report published in 2013, the average salary in Spain per month in 2012 was 1,639 euros while in the Canary Islands, it is less than 1400 euros (3). However, the minimum salary is established by the government at 645 euros per month. The gender pay gap was 16.2% in 2011 (4).

The total population with at least an upper secondary education on the mainland was 53.8% (1). In 2011 the school dropout rate was 26.5%. With respect to education, the total population with at least an upper secondary education is 34.8% (2011) which is less favourable than the rate on the mainland. In 2011 the school drop out rate was 30.4% (8).

Spain scores rather high with respect to the rest of Europe with regard to the unemployment rate. The total percentage of unemployed people in Spain increased to 27.1%, which is 6,202,700 people (male 26.8%, female 27.6%) in the first three months of 2013. The unemployment rate increased to 34.27% on the Canary Islands (1;5), by gender 34.73% for males and 33.72% for females.

The unemployment rate of people under 25 years is even higher, namely 57.2% in the first trimester of 2013 (1;7). Recent figures for 2013 (7) show the unemployment rate for the population under the age of 25 to be 70% on the Canary Islands.

A total of 21.8% of the population of Spain is at risk of living under the income poverty line in 2012. People under 16 displayed the highest rate of risk of poverty with 25%, followed by the population aged 16-64 with 19.3% and those over 65 8.5% (1). The percentage of people at risk of living under the poverty line is higher for the Canary Islands: 33.8% (1).

In the last five years, the Canary Islands have ranked below Spain in terms of average income per person and per household. An analysis of income per capita shows that 39% of the population earned less than 500 euros per month per person, indicating the deprived situation in the Canary Islands. The data for the Canary Islands shows the disadvantaged the socio-economic position of this region, which together with the ongoing economic crisis, had resulted in serious problems for people's daily lives and consequently, for their health.

Health and Health inequalities at national level

Life expectancy at birth in Spain is 82.5 years, 79.4 years for males and 85.4 years for females (1). Life expectancy on the Canary Islands is similar to that of Spain (5). The score of healthy life years indicator for males is 65.4 years and for female 65.8 years, meaning that women have about 20 unhealthy life years, although their life expectancy is rather high.

Total life expectancy on the Canary Islands is slightly lower at 81.43 years (78.5 years for males; 84.3 years for females) while the total number of healthy years is 54.5 years (9).

With respect to mortality rates in Spain, according to the National Statistic Institute (2010) the 3 major health problems are: cardiovascular diseases (31.2%), cancer (28.1%) and respiratory diseases (10.5%) (1). With respect to cardiovascular diseases, women are more often affected than men, and with respect to cancer men are more affected than women. All these diseases have a higher prevalence on the mainland in the regions of Cataluña, Madrid and Andalucía. The 3 major health problems in the Canary Islands region based on mortality rates are (1) cancer (differing from the mainland where CVD are the first cause of death), (2) cardiovascular diseases and (3) respiratory diseases.

Except for heart attacks, women are more affected by cardiovascular diseases then men.

Smoking is the leading avoidable risk factor related to cardiovascular diseases in Spain comprising 21.5% of the women and 31.5% of the men over 16 years of age who are daily smokers. But in terms of age groups, this pattern changes and the prevalence of smokers is higher among women in the 16-24 age group: 28.8% of women compared to 25.0% of men. Alcohol consumption in the last 12 months before the survey was 68.6% (80.2% of males and 57.5% of females). A total of 37.1% of the population displayed slight obesity and 15.4% signs of serious obesity. Men are more often overweight than woman (45.1% of men versus 30.4% of women) and obesity is more or less comparable in both sexes (10). Almost half the population of Spanish children (45.2%) is overweight, with 26.1% overweight and 19.1% obese. A total of 54.1% of children have a healthy weight and 0.7% are considered thin in relation to their age and size. If the results are analysed by gender, little difference in terms of overweight among children are seen (boys 26.3% and girls 25.9%),while the obesity rate shows a six-point higher frequency rate in boys compared to girls (22% and 16%, respectively) (11).

Obesity and severe obesity are a serious health problem on the Canary Islands and the rates of prevalence are higher than on the mainland of Spain and are still growing. Smoking and obesity are important risk factor

for numerous diseases. Health professionals attempt to discover the reasons for the increasing tendency in overweight of 36.8% of the adult population (42.1% of males and 31.7% of females) and obesity (18.5% of the adult population) The percentage of women who are obese (19.24%) is higher than the percentage men (17.92%), in contrast to the percentages of overweight men and women (13). Special attention is needed for children as the prevalence of overweight and obese children is higher on the Canary Islands than on the mainland.

Being aware of these data and the need for special attention for children with respect to the prevention of obesity, the focus of the action plan in Tenerife will be on this health problem. The prevention of obesity depends significantly on the policy agenda, however, effective evaluation of the existing health promotion programs and interventions is lacking, so the effectiveness of those actions is unknown.

Gender and socioeconomic status are key social determinants for obesity in Spain and, consequently, need to be addressed when developing preventive activities (15). Factors influencing obesity in the Canary Islands are education, lifestyle, religion, cultural beliefs and family environment (16). Another problem is access to quality food. Food is expensive on the islands as most of it needs to be imported. Determinants to be tackled first are diet (increased knowledge), physical activity and behaviour & attitudes.

Needed Action(s) for Health

Initiatives already in place on the Canary Islands include the Circle of Life project for the entire population and the PIPO program for children (also for families and schools). The PIPO programme focuses on a healthy diet and physical activity. One of the main obstacles for most activities (at this moment) is financial support. All the budgets have been cut (due to the economic crisis), making it very difficult to implement any strategy or programme. Another obstacle is the lack of an intersectoral approach. Most of the actions are taken by the Public Health Institute without too much involvement from other sectors. There is enough goodwill from stakeholders and politicians to support the action plan focusing on child obesity and sufficient knowledge and experience by professionals. Furthermore, there are materials available from other initiatives (e.g. PIPO, SEEDO, DELTA) which could be used in the action plan, such as the Paediatric Guide, healthy menus, nutritional information based on the food pyramid and a physical activity guide.

However, the economic crisis and its consequences on the labour force (e.g. lower salaries, higher taxes and increased working hours) are barriers and challenges at this moment. Therefore, it will be important to show all stakeholders that participation in the action plan is part of the work they are already doing (not asking for a lot of extra time and effort) and that an intersectoral approach will bring more benefits than individual work.

IV Promising practices partner countries

Promising practice in Bulgaria

Health mediator – a key element of a systematic approach to reducing health inequalities for disadvantaged persons of minority descent.

The history of health mediation in Bulgaria began in 2001 when the Ethnic Minorities Health Problems Foundation developed the concept of health mediator and successfully introduced this new occupation in the Roma neighbourhood of "Iztok" of Kyustendil. The Ministry of Health implemented the PHARE project "Ensuring Minority Access to Health Care" in 2004, which aims to improve Roma people's access to health services in 15 pilot cities, one of which was Lovech. The experience which all the pilot municipalities have gained and the consistent national policy for Roma integration allows municipalities to develop Action Plans for Roma integration and integration of persons living in a situation similar to that of the Roma, with one of these Action Plans prepared for the Lovech Municipality (2012 – 2014).

Following the adoption of the Health Strategy for Disadvantaged Persons of Minority Descent in 2005, a new occupation – health mediator was institutionalized and included in the National Classification of Occupations with a relevant job description adopted. A training program for health mediators was developed and two medical colleges were licensed to carry out training for a fee.

The National Network of Health Mediators was founded in 2007. Further training and qualifications, workshops and conferences for the exchange of experience have been implemented repeatedly since then. The most recent training took place in January 2013. Institutions at the national level – the Parliamentary Health Committee and National Council for Cooperation on Ethnic and Integration Issues of the Council of Ministers of the Ministry of Health strongly support health mediation and mediators. The Bulgarian experience of implementing health mediation is considered one of the most successful in the region. The National Strategy for Roma Integration 2012-2020 also gives the health mediators an important role at the implementation stage.

Health mediators emerged as a key element in effectively tackling the greatest health inequalities, particularly those of disadvantaged persons, including minorities. The health mediator is a coordinator, a bridge between people of minority communities and groups on the one hand, and health and social services, on the other hand. He/she facilitates the overcoming of cultural barriers in communications and maintains a dialogue with institutions,

participates in the optimization of preventive programs and health awareness campaigns in Roma communities, accompanies illiterate Roma to health and social services and advocates the rights of patients and others.

An overview of the productivity of this approach is provided by the following data of the Dobrich Municipality, which managed to preserve 25 mediators, trained while the first projects for health mediators training were being implemented.

Three mediators, appointed via employment contracts with the Health and Social Policy Department of the Dobrich Municipality, work in the primary health centre based on a GP serving mainly the Roma people.

In 2012, in addition to its main function of providing relevant and culturally-appropriate health information to the community, mediators assisted in:

- 2400 immunizations for children and adults,
- 1600 screenings,
- resolution of 455 health cases,
- 558 cases of a social nature,
- 20 events involving disease prevention which included 120 persons,
- provision of advice and support for family planning and sexual health to 50 persons,
- patronage of risk groups – multiple home visits to 50 pregnant women and young mothers, 15 large families and 70 chronically ill and disabled persons.

Each of the appointed mediators prepares his/her competent, consistent and respected assistants in the community, taking into account traditional family and social roles, extending adequate cultural specific access to health communication and monitoring and interacting with Roma community. This is crucial for the sustainability of the system of health mediation now that financial constraints do not allow all municipalities to appoint all of the mediators they need. The municipality and RHI, as the second part of this sustainable cooperation, create a supportive environment for the activity of mediators and initiate future ones.

A Health Education Program for Disadvantaged People of Minority Descent was developed in the Lovech Municipality within the framework of the National Action Plan for the Decade of Roma Inclusion 2005-2015 for the third consecutive year. The Regional Health Inspectorate of Lovech conducted a campaign which including training and events aimed at the Roma population.

The implementation of health classes in schools, the teaching of children from minorities, establishment of "Health Messengers" clubs, where Roma students are trained to be peer educators, and the "Health Mail" initiative which allows targeted distribution of tailored health information materials through paper media, are activities of great importance. Health mediators' active participation in these activities completes the cycle of a sustainable process of health mediation as a model for reducing health inequalities.

In general, the best practice of using health mediation in the Lovech Municipality includes the following steps:

1. Informing the accessible part of the Roma community of health problems and a healthy lifestyle through the initiative "Health-Mail".

2. Reaching students from the community through health classes, establishment of "Health Messengers" clubs, where volunteers are trained to be peer educators with all activities carried out with the participation of a health mediator.
3. Provision of financial and organizational support from the municipality and NGOs:
   - for students from minority backgrounds who intend to study for occupations in the health field,
   - for Roma high school graduates willing to qualify as health mediators,
   - for those who have achieved a mediator's qualification prior their appointment as such by municipalities – meal vouchers and phone vouchers.
4. Involvement of actual students in mediations and medical practice in the relevant community, municipal health centres or mobile centres provided by the Ministry of Health.
5. Provision of assistance, if needed, to all members of the Roma community qualified as mediators and medical professionals to enhance their skills as cultural mediators.
6. Support for membership in the National Network of Health Mediators and assistance in regional networking.

Promising practice Spain

Introduction

Coordinated by the Public Health Directorate of the Canary Islands Health Service, the Ministry of Health of the Canary Islands offers a new health promotion policy called "Circles of Life", which claims to act on multiple aspects influencing health and the prevention of chronic diseases in a coordinated manner.

The new program and strategy "Circles of Life" originates from:

1. The campaign of World Diabetes Day 2011, which is set as the starting point.
2. A high-level meeting of the United Nations (19 and 20 September 2011) which aims to adopt an international strategy for preventing non-communicable diseases.
3. The report of the World Health Organization (17 November 2011) which provides performance targets for the prevention and control of non-communicable diseases.
4. The European Union's approach to combat chronic diseases and high prevalence, which aims to integrate actions on risk factors and strengthen the health systems for better prevention and control.

Circles of Life consists of a series of recommendations to reduce the impact of determinants of non-communicable and/or chronic diseases, and promote healthy lifestyles. From this perspective, the different recommendations converge in concentric circles as though they were a dartboard with a central point/bull's eye, representing HEALTH.

The new program and strategy, Circles of Life, calls for a "take care of your health, and

always win" approach. This slogan metaphorically represents the concept "health", and highlights the importance of the "point" in the middle of it.

Objectives

The promotion of health through educational interventions at the community level in the areas of nutrition, physical activity, stress and relaxation, sexual health, tobacco consumption and alcohol are all contained in the Circles of Life. The purposes of each of these areas are:

- to raise awareness-health promotion in children, adolescents and the adult population,
- to promote the advantages of a healthy lifestyle,
- to teach about health risks and improve the perception of them,
- to teach about the main determinants of health,
- to prevent health risks.

http://www2.gobiernodecanarias.org/sanidad/scs/contenidoGenerico.jsp?idDocument=4d7d0d3e-a8c5-11e1-a270-87db0c674047&idCarpeta=cc8a68ff-98de-11e1-9f91-93f3670883b5

http://www.youtube.com/watch?v=ay6B0Grqkd4

Promising practice Lithuania

Mental health care access for children with mental, behavioral and emotional disorders in Lithuania

Health inequalities across socioeconomic groups are a health and public policy concern in all countries, being considered a measure of the performance of health care systems. Health inequalities are preventable and inequities in health status are experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. Health inequalities are not only apparent between people of different socio-economic groups – they also exist between genders and different ethnic groups [1].

Health care services require appreciable conditions of health care with secured economic, communicative and organizational accessibility of health care for individuals and the community. The quality of health care depends on its accessibility and performance, i.e. whether services for patients are provided or not, and if given whether they are accredited or not. [2].

Analysis of the quality of health care services based only on the assessment of the professional qualifications of medical staff and statistical indicators of population health (mortality, morbidity, complications, disability, frequency of sick leave) is insufficient. Patients' views on health care service quality have become an integral part of evaluating the quality of health care. Patients' evaluations may be used to expose weak links in the health care system, an area which health care managers and politicians should pay more attention [3].

Quality of health care services, satisfaction of patients, etc. are analysed in different studies. However, there is a lack of assessment of services for children's mental health in Lithuania.

Purpose:

To evaluate the accessibility of primary mental health care to children (aged 0-17) with mental, behavioural and emotional disorders in Lithuania in 2008-2010.

Methods:

To describe and evaluate personnel providing primary mental health services for children with mental, emotional and behavioural disorders in different regions of Lithuania in 2008–2010. Indicators were calculated (prevalence, number of employees, child psychiatrist workload) using data from the Health Information Centre of the Institute of Hygiene and State Mental Health Centre database.

Access to the Primary Mental Health Centre (PMHC) was evaluated via the subjective opinion of respondents (parents/caretakers of children with mental, behavioural and emotional disorders). Two PMHCs (one from the city, another from a rural area) were selected randomly in each of the ten regions. A sample was formed by consecutively enrolling approximately 25 parents/caretakers of children with mental, behavioural and emotional disorders in each PMHC. The sample size totalled 369 respondents.

Findings:

Overall in Lithuania, the number of child psychiatric staff per 100,000 children had risen from 5.6 in 2008 to 5.9 in 2010. The morbidity rate of children with mental, behavioural and emotional disorders decreased during the past 3 years in Lithuania, but the trend was very different in rural regions. The distribution of prevalence of children with mental, behavioural and emotional disorders was particularly unequal. The highest prevalence in 2010 was observed in the Kaunas (22 / 1000 children with disorders per year) and Marijamole (18 / 1000 children with disorders per year) districts, where the prevalence rates were higher than the Lithuanian average (13 / 1000 children with disorders per year). The smallest number of children's psychiatric staff employed was found in the Kaunas and Marijampole regions (2.4 per 1000 patients in 2010). The number of employed children's psychiatric staff per 1000 patients showed a difficulty of access to a PMHC in the Kaunas and Marijampole districts. A total of 30% of PMHC psychiatrists worked part-time, e.g. at least 3.6 hours per week in the Neringa district. Over 40% of the respondents admitted that they usually went to a PMHC by themselves without a referral, while 28.7% asked their general practitioner for a referral to a PMHC. The waiting time didn't pose a big problem for them, with 38.4% reporting that they didn't wait at all while 45% of the respondents having to wait up to 15 minutes until they got to the doctor's room. The consultation usually took up to 40 minutes for 47.2% of the respondents with about 31% finishing their visit in less than 20 minutes.

In general, the services provided by PMHC and the attention given to the patient were evaluated as good and excellent by most respondents. Private psychologists visited 11.1% and private psychiatrists 6.4% of the respondents. Organizational and communicative

accessibility in PMHC were assessed as good despite the type of residence (urban or rural) with distance not posing a problem in obtaining services.

Conclusions:

Inequalities were identified between the number of staff (especially child psychiatric staff) and workload in the various regions of the country. In some mental health centres there was no child psychiatrist, but medical services for children were provided. Availability of services in PMHC were considered adequate by the respondents although it was shown that some organizational aspects would have to be adjusted to improve accessibility. Organizational and communicative accessibility in mental health centres were considered to be good, irrespective of the place of residence (city or district) of the patients with distance not considered an obstacle for access to services. Following this study in 2000, the Ministry of Health of the Republic of Lithuania issued Order no. 730 "Description and performance principles of requirements for children's and adolescent psychiatry and psychotherapy services" which specifies in Annex 1 that children's and adolescent health care teams are to be organized in PMHCs which do not have a child psychiatrist, clinical psychologist, mental health nurse or social worker.

To reduce inequalities, the Ministry of Health of the Republic of Lithuania issued Order no. V-943 in 2005: "Primary ambulatory health care services organization and payment arrangements and primary ambulatory health care services and basic price list mounting" (Žin., 2005, Nr. 143-5205) which specifies that 20,000 patients instead of 40,000 patients shall be serviced by one full time psychologist in primary health care centres.

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Promising practice Croatia

"Together we are stronger – the education project of peer assistance in addiction"

Risky behaviour in connection to the use of addictive substances is becoming an even more prominent public health problem in Croatia, as well as in the Međimurje County. After the "Picture of Health of the Međimurje County" was implemented, excessive alcohol consumption and smoking were chosen as one of five priority problems in the county. In 2007, the task group dealing with the aforementioned problem initially carried out a qualitative research on alcohol consumption among children and youth entitled "Youth and alcohol", followed by a quantitative research called "Attitudes, habits and use

of addictive substances among youth in the Međimurje County". The survey carried out on a randomly selected group of pupils in the seventh and eighth grades of primary school and second grade of secondary school showed the beginnings of alcohol consumption to be shifting to a younger age – many of our respondents had been drinking alcohol regularly since the seventh grade. By the second grade of secondary school, 66.3% of the boys and 47.7% of the girls had experienced drunkenness, which is considered risky behaviour. The fact that 12.3% of the boys in the seventh and eighth grades are smokers (daily and periodically) is alarming, while 8.4% of girls of the same age group could also be categorised as smokers.

Alcohol consumption and smoking appear to be the most common examples of the use of addictive substances among children and youth in the county, and the results of the research that confirm this statement have been presented and published. The survey did not show significant differences in these habits between the pupils of urban and rural schools.

The association ''SMILE" with the goal to help children and youth, which is active in Međimurje County, has designed and carried out the project: ''Together we are stronger – the education project of peer assistance in addiction" between 1 August and 31 December 2011 in cooperation with primary schools of Međimurje, the Institute of Public Health of the Međimurje County and school prevention programs.

Ten experts of various profiles took part in the project's implementation: pedagogues, social pedagogues, psychologists and specialist of school medicine, together with some twenty volunteers.

The project was financed by the Ministry of Families and Intergenerational Solidarity within the programme of financing the projects of associations which contribute to the fight against drugs and all other forms of addiction in the Republic of Croatia (financial support from lottery income in 2011).

Goals of the project:

- Prevention and reduction of alcohol and cigarette consumption and the abuse of other addictive substances by creating a system of values in the local community and at schools, teaching that the use of addictive substances is a form of unacceptable behaviour, raising general awareness and informing the public on the adverse effects.
- Reduction of morbidity, mortality and the burden of diseases connected to addictive behaviour, reduction of the number of accidents, especially traffic accidents.
- Reduction of the incidence of social disorders, family breakdowns and domestic violence; joint training and presentations for peers and their parents have contributed to the rejection of prejudices and stereotypes, which is the precondition for the continuation of cooperation and activities within the local community.
- Health care for youth by promoting healthy lifestyles and mental health.
- Integration of the participants in primary schools; the youth of the Roma minority have felt a sense of togetherness, belonging and acceptance through joint educational activities with youth of Croatian nationality,

which has additionally strengthened their confidence and sense of worth.

- Reduction of health inequalities by brining together rural and suburban schools and schools with a greater number of pupils of Roma minority.

Intervention measures:

Following preparatory meetings, in which the representatives of the participatory schools were informed, pupils were selected to take part in the education program, followed by the actual ''School of educators''. The school was led by psychologists, pedagogues, social pedagogues and school medicine specialists, while some 30 pupils of the seventh and eighth grades from the Primary Schools of Macinec, Pribislavec, Strahoninec and Štrigova trained, eight of whom were pupils of the Roma population.

The educated pupils held lectures and presentations in their schools and were also guest lecturers in other schools, holding presentations on the harmful effects of alcohol and smoking for their peers, i.e. pupils of the sixth, seventh and eighth grades. The lectures were attended by about 260 pupils in the aforementioned schools. The educational part was accompanied by entertaining activities which enabled the pupils from different schools to meet and socialize.

The educators also held a lecture regarding the harmful effects of alcohol for the parents of the seventh and eighth grade pupils at their schools.

After concluding the activities in schools, a final meeting of the pupil educators was held at the Institute of Public Health of the Međimurje County, in which they shared their experiences and impressions with regard to the lectures. The media was also informed of all the activities, a part of which was then presented to the public.

The well-informed parents and school children are now expected to transfer their knowledge and positive attitudes within their community, which is especially important among the Roma parents, because excessive alcohol consumption is quite prominent in Roma communities and leads to poverty, domestic violence, neglect and child abuse.

We are aware of the fact that it takes a long time to reduce health inequalities – years and even decades. We raise public awareness by informing people about the harmful effects on health and healthy lifestyle promotion from the earliest age, in all population groups, especially those that are regarded as the most vulnerable (children and youth, members of the Roma minority) and find it to be a good approach which leads to the ultimate goal.

Promising practice Hungary

"Promoting Sure Start" Project – Social Renewal Operative Programme 5.1.1.-09/9

The project was implemented in Northern Hungary, in Sárospatak, a small region of Borsod-Abaúj-Zemplén County. Due to the disadvantaged situation of the small region (ageing and a declining population, an unemployment rate of 20.8% which is higher than the national and county average) and complex health problems, it became necessary to raise awareness on health promotion and lifestyle change, especially in families living in multi-disadvantaged environments. The rate of the Roma population is 10-15% in the small region which includes 17 cities.

Goal: Enhancement of social cohesion and prevention of exclusion from society by educating the disadvantaged population and providing them with employment.

Aim: To provide practice by educating long-term unemployed, particularly Roma women (health educators, social care training) in obtaining work experience (health education tasks) and promoting further employment of registered unemployed people.

The project was implemented with the support of the European Union and co-financed by the European Social Fund: Social Renewal Operational Programme (SROP) 5.1.1.-09/9. The project leader was the Equal Opportunities Foundation (established in 2003). The head of the Family Support and Specialised Education Service was involved as an external expert, who became the professional leader of the project.

The project was performed during the 2009-2011 period.

Short description of project:

The project focuses on training and employment opportunities for 18-45 year old disadvantaged people, especially Roma women, in order to improve the health of people living in settlements.

Elements of the project:

Settlement health educators – training: long-term unemployed and disadvantaged young Roma people with primary education attended a 5-months training. After completing the training, they became able to change their lifestyle and set a good example for their environment. One of the purposes was to arouse the need for learning and employment and to strengthen self-confidence.

Training elements:

1. Health education and health promotion (e.g. first aid, mental health, lifestyle programs, drugs);
2. Communication, learning and employment skills development;
3. Development of skills for integration and re-integration into work;
4. Citizens' rights and obligations (e.g. public safety, basic traffic laws, crime prevention);
5. Household management, employment, independent work (e.g. labour law, tax law, health insurance);
6. 5 months of practical work under the supervision of a mentor (weekly case and problem discussion) with the aim of enabling them further work in their living environment.

Practical program of trained health educators:

The mentors helped the independent work of trained health educators during the training period.

The members of the target group conducted activities related to the organization and management of "Health Days" in their own settlements. They participated in health education tasks with the guidance of health visitors and assistance of social workers. To raise awareness of the importance of lung screening, they contacted the population personally, disseminated leaflets and helped organize screenings in screening buses. Thus, they assisted the care service system. They gained experience regarding the care system not only as clients, but also as actors.

Some of the members of the target group had the opportunity to attend social care-training, which provided a certificate of the National Qualifications Register (NQR).

After the completion of the program, contact was kept with participants. They received support in finding work with their employment continuously monitored and quarterly round-table discussions organized. Consultations took place with the Mayors of 16 settlements belonging to one Multipurpose Small Region Association, involving the office manager of this Association. The consultation aimed to promote employment opportunities for young people with social-care qualifications in their own settlements, thereby helping the social work activities of the local governments.

Results

The project supported the lifestyle change and integration of the Roma people. Through the effects of the project, tolerance intensified, living conditions improved and household income management became more efficient (through prioritization). School and regional segregation decreased. The participation of women in training promoted the improvement of gender equality. Results suggest that the health educator's training, acquisition of work experience and social care training were successful. A total of 90 people applied for the local health educator training with 78 people completing the preliminary training. Another 78 people also applied for the acquisition of work experience out of which 73 established working relationship. A total of 23 people applied for social care training of which 20 successfully passed the NQR exam. After the training, they obtained further employment.

Sustainability of the program: The activity can be implemented in all settlements. The good practices can be adapted from the methodological, coordination and technical aspects. The project is still being implemented in one of the small regions' settlements and involves health educators and includes and invites the most disadvantaged people living in slums to health education lectures.

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Promising practice Estonia

Project EAAD (European Alliance against Depression) the train-the-trainers 2-day workshop in Estonia

The EAAD (European Alliance against Depression in English or Eesti Depressioonivabaks in Estonian) project is a EC public health project (2004-2008). The main aim of this 4-level community-based intervention program was to prevent suicidal behaviours through the development of a sustainable network to increase public awareness about depression and to disseminate knowledge for the early recognition and treatment of depression. The 4 intervention levels of the EAAD project were:

1. Co-operation with GPs (training sessions, videos, phone hotline);
2. PR activities (posters, flyers, brochures, media campaigns, cinema spots, web-site);
3. Training sessions for multipliers (school personnel, social workers, priests, police, media, etc.);
4. Special offers for high risk groups and self-help activities.

ERSI as the project partner coordinated all activities during the two EAAD stages in Estonia:

- EAAD I 2004-2005
  Regional implementation in the defined catchment area (Tallinn).
  The target groups of the 4-level EAAD intervention were approached directly by ERSI.
- EAAD II 2006-2008
  National dissemination of the EAAD project.

For national dissemination, the ERSI organized train-the-trainers 2-day workshops in different counties of Estonia (including the Rapla Municiaplity) so as to create anational network of trainers and further disseminate the ideas and products of the EAAD project. On the first training day, the participants obtained knowledge about depression and suicide prevention, e.g. depression, suicide epidemiology, suicide risk and protective factors, suicide process, suicide risk evaluation, suicide crisis, suicide prevention strategies, etc. On the second training day, interactive video training was organized for participants to develop their skills as trainers.

After the project ended, the ERSI continued dissemination as a member of the international EAAD Society (*www.eaad.net*). In addition, the idea of the EAAD was further developed within the EC FP7 project OSPI-Europe (Optimizing Suicide Prevention Programs and their Implementation in Europe; *www.ospi-europe.com*) and the EC public health project PREDI-NU (Preventing Depression and Improving Awareness through Networking in the EU; *www.predi-nu.eu*), where ERSI participates as a partner.

Depressive disorders often start at a young age. At its worst, depression can lead to suicide. Europe-wide, suicide is the second highest cause of death for young men and the third highest for young women. Nationally, in co-operation with the Estonian National Agency for Youth, the EAAD Society supported the Youth in Action program activity “High Five for a Happy Life” (7 days in Pärnu, Estonia).

The aim was to disseminate concepts on how to cope with negative emotions, how to prevent youth depression and how to raise awareness about this disease among youth.

Promising practice Slovakia

In 2011, 105,738 people who identified themselves as members of the Roma community lived in Slovakia (SOSR, 2013a). The Roma community (hereafter referred to as Roma) is the third most common nationality in the Republic (80.7% Slovaks, 8.5% Hungarians, 2% Roma). Compared to an earlier census conducted in 2001 (89,920 – 1.7% Roma) the number of Roma had increased by 0.3% (ibid.). Although official estimates put the number of Roma closer to 250,000, Roma cultural and political activists claim this number to be higher with 350,000 to 400,000 Roma people living in Slovakia (Kállayová and Bošák, 2012).

Concentrations of Roma populations differ between regions in Slovakia. According to the census of 2011, the highest concentration of the Roma population was in the eastern and central parts of the country, namely in Prešov (5.3%), Košice (4.6%) and Banská Bystrica (2.4%) (SOSR, 2012b).

Different inequalities (in health status, mortality, morbidity, income, education, and so on) exist within regions of Slovakia with disparities between the majority population and disadvantaged groups significantly increasing. Roma living in separated and segregated settlements are the most vulnerable group. This population group is characterized by low income, low education, fewer employment prospects and inadequate living environments which result in poor health, more frequent sick leave, disabilities, hospitalizations and so on, ultimately resulting in higher costs of health care to society in general and a poorer quality of life for the Slovak minority.

The reduction of health inequalities through health policy and health promotion strategies targeted at the most vulnerable groups is one of the public health priorities in Slovakia (National Authority of Public Health, 2008a). To achieve this goal, many countries use the "Roma Health Mediation (RHM)" approach. In Slovakia, the RHM program is implemented on two levels: on the national level and through NGOs (Kállayová and Bošák, 2012).

This Slovak example of promising practice in the area of reducing health inequalities focuses on the RHM program at the national level was implemented under the auspices of the Health Promotion Program for Disadvantaged Communities in Slovakia from 2007 to 2015.

The program was divided into two phases. The first phase took place from 2007 to 2008 with the aim of improving health and increasing health responsibility in disadvantaged Roma communities. The program was coordinated by the Public Health Authority of the Slovak Republic (PHA SR) and ten regional public health authorities which participated in the implementation of the program (RPHA).

Roma health mediators (about 30 community workers) worked for four days in the community and one day in the office of the RPHA.

The RHM's work was focused on health education, medical assistance, monitoring of lifestyle and health status, cooperation with local schools and stakeholders and organization of sport activities (MHSR, 2007; Kállayová and Bošák, 2012; National Authority of Public Health, 2008b).

The implementation of educational intervention activities in the eastern part of Slovakia, respectively in the Olšovce-Kecerovce micro-region, is a practical example of the program's first phase of application. In this region, selected community workers carried out educational activities under the professional guidance of the Department of Health Education in cooperation with primary schools, kindergartens and community centres. Activities in the Roma settlements were primarily focused on finding leaders and young people who had a desire to change their lives, intense and repeated communication with household members, teaching basic hygiene habits, explaining the principles of good care especially for infants and young children, raising awareness throughout the community about health care, a proper diet and lifestyle, patient's rights and responsibilities and guiding families to better health through discussions, lectures and physical activities (Kollárová, et al. 2008).

The Roma Health Mediation (RHM) program, which is being implemented under the auspices of the Health Promotion Program for Disadvantaged Communities in Slovakia from 2007 to 2015 (the second phase will run until 2015 however the application of the program goals is currently suspended due to a lack of funding at the national level (Author's note)), was chosen as an example of promising practice within the country because it aims to address health inequalities using a community-based approach. The aim of this RHM programme is to ultimately bridge the gap in health inequalities between Slovak citizens – between the minority Roma community and the majority non-Roma community population. The application of the RHM programme in the Olšovce-Kecerovce micro-region demonstrates the practical applicability of the practice and the variety of activities that this endeavour adopts, mostly by developing personal skills in the community.

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V Discussion and Conclusions

In line with the aim of the Action for Health project, all seven partner countries (1) have identified health inequality issues at both the national and regional levels. Theoretical models and theories were used to identify and understand those factors which influence health and health inequalities (based on Dahlgren and Whitehead (1991), Albeda (2001), Dahlgren and Whitehead (2007), The Marmot Review (2010) and The European Health Report 2012). National and regional situation analyses were carried out based on these models. To get a better picture of the national and regional characteristics influencing people's health, data was gathered for all seven countries referring to 1. Socio-economic factors (e.g. education, income, (un)employment, risk of poverty), 2. Health (e.g. life expectancy, healthy life years, key health problems) and 3. Health determinants (geographic position, culture, sex, age, lifestyle, physical environment, social environment).

Subsequently, all partners carried out needs assessments in the chosen regions focusing on requirements for the Action Plans for reducing inequalities through health promotion. Interviews and focus groups were implemented with the relevant regional stakeholders to assess the needs. The interview topics were derived from the Health Promotion Framework of Saan and De Haes (2). (Organisational) Needs were then analysed for 7 items: knowledge, manpower/competence, methods, investment (time, money, and goodwill), policy, internal and external networks and leadership.

The situation and needs analyses provided insight into the most urgent health inequality issues in the regions and their underlying causes. They also provided information on problems that need to be addressed and opportunities for their resolution given the available organisational basis and (political) priorities in the region.

Situation analysis

Socio-economic differences which influence health inequalities exist between and within countries. Income inequalities are assessed within SES- and gender-groups in every country, both nationwide and regionally. The degree of inequality varies. In Spain, for example, income inequality varies by 6.8% between the lowest and highest SES groups, whereas in Slovakia the difference is only 3.8%. Inequalities between gender groups vary even more. The highest income gender pay gap is 27% (Estonia) and the lowest 9.8% (Croatia). The most deprived region included in the Action for Health is the Sellye sub-region where the net average wage was 296 euros in 2011 compared to a national average net wage in Hungary of 483 euros. This region also holds the least favourable position of all seven regions in terms of poverty and education.

Low income levels do not necessarily reflect poverty. For example, official data shows that Spain has the highest average net income of the seven countries, but also one of the highest percentages of people living at risk of becoming poor. In addition, the minimum salary in Spain is established at € 645.30 in 2013 (see Table 1). The proportion of the population at risk for living under the poverty line in 2011 ranged from 13.0% to 21.8% between the countries. Regional percentages of people at risk for living under the poverty line are generally lower than the national average in the participating countries. In the AROPE rates (used also in the EU 2020 report on poverty), data on the severely materially deprived or those living in households with very low work intensities were also taken into account in addition to data for the proportion of the population at risk of poverty.

Country Level	Monthly Income	Unemployment	Secondary Education	At risk of Poverty (income) 2011 (%)	(AROPE)
Bulgaria	€ 454.60 (2011)	12.4% (2012)	43.4% (2012)	22.3% (2011)	49.1%
Croatia	€ 737.00 (2010)	18.3% (2012)	58.5% (2001)	21.1% (2011)	32.7%
Estonia	€ 672.00 (2011)	10.2% (2012)	88.9% (2011)	17.5% (2011)	21.7%
Hungary	€ 483.00 (2012)	10.9% (2012)	82.1% (2012)	13.8% (2011)	31.1%
Lithuania	€ 461.83 (2011)	11.7% (2012)	92.9% (2011)	20.0% (2011)	33.4%
Slovakia	€ 655.00 (2011)	13.5% (2011)	43.3% (2011)	13.0% (2011)	20.6%
Spain	€ 1639.00	27.1% (2013)	53.8%	21.8%	27.6%

Table 1

For every chosen region, one of these AROPE factors seems to lag behind, identifying the region as a deprived or poor region (see Table 2). The unemployment rates differ in the 7 countries from 27 % (Spain) of the total population being unemployed to 10.2% (Estonia). Regional unemployment rates varied as well. The economic crisis seems to be a factor in (un) employment figures and in data on average income and poverty as well. In all regions except for Lithuania, the percentage of the population which had obtained a secondary education was lower than the national average. In three of the seven countries, the national average of people who had obtained an upper secondary education is around 80-90%. On the regional level, this varied from 21.7% (Hungary) to 51.3% (Croatia). Income, education and (un) employment are important influences on people's health and health inequality. For this reason, those factors must be taken into consideration when setting up an action plan for health.

Country	Region	Income	Secondary Education	Unemployment	Poverty (under 60%)
Bulgaria	Lovech	€ 412.65 per month	61.6%	11.2% (2011)	23.9%
Croatia	Međimurje	€ 584.00 (2010)	51.3% (2001)	16.4% (2012)	12.0% (2010)
Estonia	Rapla County	€ 534.00	50.5% (15-74 age group) (2011)	8.7% (10.2% country level) (2012)	17.5% (17.5% country level) (2011)
Hungary	Sellye	€ 296.00	21.7%	27.3% (2012)	-
Lithuania	Rokiskis	€ 533.47 (2011)	-	12.8% (2011)	-
Slovakia	Trnava	€ 639.00 (2011)	40.3% (2011)	10.6% (2011)	9.5%
Spain	Canary Islands (Tenerife)	< € 1400.00	34.8%	34.3% (2013)	33.8%

Table 2

Health Status

Substantial differences were observed in the health and life expectancy rates between the countries: Spain having the highest life expectancy (82.5 years – 79.4 for males and 85.4 for females) and Lithuania with the lowest (73.8 years – 68.1 for males and 69.3 for females). The data also show large differences between life expectancy and healthy life years, sometimes up to nearly 20 years (Spain and Estonia). This means that people may live in poor health for almost 20 years, most of the time with a gender difference of up to 7 years in favour of women (Croatia). Health differences were also observed. In all regions with data on life expectancy, the life expectancy in the chosen region was lower than the national figure.

Cardiovascular diseases (CVD) were the main health problem in all the participating countries, followed by cancer as the second most important health problem. Differences arose in the percentages of CVD mortality. In Bulgaria, for example, 67% of mortalities are caused by CVD compared to 31.2% in Spain (see Table 3).

Country Level	Life Expectancy	HLY	NHP1 (mortality rates)	NHP2 (mortality rates)	NHP3 (mortality rates)
Bulgaria	73.9 years (2011)	65.6 m 62.1 f (2011)	Cardiovascular diseases (67.0%) (2011)	Cancer (15.7%) (2011)	Respiratory system diseases (3.7%) (2011)
Croatia	76.1 years (2010)	72.9 m 79.2f (2010)	Cardiovascular diseases (49.2%) (2010)	Cancer (26.3%) (2010)	Injury, poisoning and certain other consequences of external causes (5.7%) (2010)
Estonia	76.28 71.16 m 81.09 f (2011)	55.2 t 57.3 f 52.9 m (2008)	Cardiovascular diseases (53.7%) (2011)	Cancer (24.2%) (2011)	Injury or Poisoning e.a. (7.4%) (2011)
Hungary	75.1 71.2 m 78.7 f (2010)	57.6 m 59.1 f (2011)	Cardiovascular diseases (49.9%) (2011)	Cancer (25.8%) (2011)	Diseases of the digestive system (5.7%) (2011)
Lithuania	73.8 68.1 m 79.3 f (2011)	62.1 f 57.1 m (2011)	Cardiovascular diseases (56.3%) (2011)	Cancer (19.8%) (2011)	External causes (9.1%) (2011)
Slovakia	75.4 71.9 m 78. 8 f	-	Cardiovascular diseases (52.6%)	Cancer (23.3%)	Injuries (5.4%)
Spain	82.5 79.4 m 85.4 f	65.4 m 65.8 f	Cardiovascular diseases (31.2%)	Cancer (28.1%)	Respiratory system diseases (10.5%).

Table 3

On the regional level, CVD was the main health problem in five (3) of the seven chosen regions. Bulgaria again displayed the highest CVD mortality rate at the regional level (80.7%). In one region, cancer appeared as the main health problem (Spain), while allergies, asthma and orthopaedic disease among children appeared in another (Hungary) (see Table 4). Not all the countries have chosen to address their number 1 health problem based on mortality rates. Estonia decided to tackle injuries because of the high mortality rate compared to the EU average.

Social determinants related to the health problems described above comprise: biological factors (age, gender and hereditary factors), socio-economic factors (education, income, employment) lifestyle factors and cultural and environmental factors (housing, access to sanitation, access to clean tap water, clean air). These should all be taken into account in the regional action plans.

Country	Region	Life Exp.	HLY	RGHP1	RGHP Sel.	SD
Bulgaria	Lovech	73.53 70.12 m 77.20 f		cardiovascular diseases (80.7%) (2011)	cardiovascular diseases (80.7%) (2011)	Gender (m), smoking (m), eating habits, Alcohol, PA
Croatia	Međimurje	72.1 men, women 79.8 (2008/2009)	-	cardiovascular diseases (46.0%) (2010)	cardiovascular diseases (46%) (2010)	Gender and age, less educated, insufficient knowledge and awareness, place of residence, work- related stress, unemployment, lifestyle
Estonia	Rapla County	75.73 t 81.00 f 70.44 m (2010/2011)	-	cardiovascular diseases (48.9%) (53.7% country level) (2011)	injury and poisoning (9.4%) (7.4% country level) (2011)	Alcohol consumption; drug use; stress; emotional health; psychological conditions
Hungary	Sellye	72.8 t 69.7 m 75.9 w (2010)	-	respiratory diseases (10.4%) and malnutrition (12.0%) under 14 years old (2011)	respiratory diseases (10.4%) and malnutrition (12.0%) under 14 years old (2011)	Access to health care, medical costs (low income), poor housing (air, comfort, access to clean tap water and sanitation)
Lithuania	Rokiskis	cardiovascular diseases (57.5%)	-	cardiovascular diseases (57.5%)	cardiovascular diseases	Age gender marital status place of residence and life style (physical activity and nutrition tackled first)
Slovakia	Trnava	75.5 t 72.1 m 79.4 f	-	cardiovascular diseases (50%)	cardiovascular diseases (50%)	age, gender and lifestyles , healthy social environment
Spain	Canary Islands (Tenerife)	81.4 t 78.5 m 81.4 f	54.5	cancer	cardiovascular diseases	Child obesity and overweight, gender, ses, access to quality food, healthy diet (knowledge, behaviour, attitude), physical activity

Table 4

Needs assessment

Partners gathered information on specific needs in their regions based on interviews and focus group discussions with relevant stakeholders. Available activities and experiences, good practices and the most important stakeholders were identified. Most frequently mentioned were the need for more capacity for building on health promotion issues and developing action plans and knowledge on health

issues for specific target groups (e.g. Roma people). Other needs consisted of support in building networks, strengthening partnerships and support for an intersectoral approach in the region. Due to the economic crisis, finances are an issue for everyone. Other important themes are goodwill from policymakers and other stakeholders and strong leadership.

The partners within Action for Health also faced difficulties which are implicit needs, namely: greater focus on capacity building with respect to the use of statistical and other collected data and the development of an action plan as well as the need for more information regarding structural funds (possibilities/opportunities) in general, and within the countries. All needs will be taken into account in the upcoming summer school and in the development of the action plans.

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Conclusions

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