



Community Health Management to Enhance Behaviour

Proceedings of the 2nd International Meeting of the Project CHANCE

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Introduction

CHANCE is a project funded by the EU-programme GRUNDTVIG/ “Lifelong Learning Programme” conducted from December 2007 to November 2009 (www.community-health.eu). Partners from the participating countries presented their individual project results at the 2nd international meeting on June 12th 2009, in Fulda, Germany.

CHANCE describes new pathways to enhance and support people in the long term to be well-informed and to take responsibility for their own health.

The focus of the project was based on the following questions:

- What resources are offered by the community to live healthy or healthier and what are the barriers that need to be resolved?
- Are there cultural differences in health behaviours and in the perception of health information?
- What health information is perceived in general and by whom?
- What information and health interventions are required?

CHANCE shows how people in different European cities and communities live, perceive information with regard to health and process it. The inhabitants of the communities were motivated to participate actively in the improvement of local interventions with regard to consumer education in health. The community approach aims to reach socially, culturally or economically disadvantaged groups such as elderly people, migrants and single parents.

In order to seek answers to the questions from a participative perspective, appropriate communities were identified by the participating partners in cities across six European countries:

- Fulda, Germany – Südend und Kohlhaus
- Jelgava, Latvia – RAF (**R**iga **A**utomobile **F**actory)
- Liverpool, United Kingdom – South Central Liverpool
- Timisoara, Romania – Dumbravita
- Uppsala, Sweden – Eriksberg
- Vienna, Austria – Schneiderviertel/Simmering

An inspection of local structures and a survey among the inhabitants were used as techniques to receive an impression of the specific situation in the community. For this reason, the inhabitants were supported to look actively into the subject of health in their community and to utilise and expand their local network. Together with the local provider of consumer health education specific offers were developed with regard to the selected communities. At the end of the project (October/November), guidelines relating to Community Health Management will be developed. In the future, these guidelines can be used for the implementation of similar projects in other interested communities.

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Austria

Schneiderviertel in the 11th district of Vienna

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1 Profile of health information systems

The political system in Austria provides a division of work between the federal government, the governments of states and authorized civil society organizations in the health care sector. The Austrian state delegates competencies to membership-based insurance associations and service providers which operate in the form of self-governmental organisations.

1.1 Institutions

Institutions of Health Information in Austria
Federal Government Federal Ministry of Health Federal Ministry of Labour, Social Affairs and Consumer Protection Federal Ministry of National Defence and Sports Federal Ministry of Women and Public Services Federal Ministry for Education, Arts and Culture Federal Ministry of Agriculture, Forestry, Environment and Water Management
Governmental (controlled) Services, (Research) Institutions Public Health Service State departments for health, health platforms/agencies, specialized bureaus and regional transfer units for health promotion and prevention “Gesundheit Österreich GmbH” with its three sub-organisations FGÖ, ÖBIG and BIQG aks austria Supreme Health Board (Bundesgesundheitsagentur) The Austrian Agency of Health and Food Safety (Österreichische Agentur für Gesundheit und Ernährungssicherheit – AGES) Federal Drug Forum
Non-governmental Institutions Networks for health promotion (boroughs, schools, hospitals) Private providers Different organisations like NGO’s or self-help groups Social insurance companies Health profession associations
Economy/ Industry Nutrition, Food, pharmacologic industry
Media Internet, TV, Radio, Newspaper/ Magazines

Due to the legislative separation of organizational and financial structures in the health care system, in connection with the increasing availability of services and the increasingly demand, an enhanced cooperation between all stakeholders has become necessary. Cooperative instruments of the federal

state (agreements according to Federal Constitution Article 15a B-VG¹) have been employed since the end of the 1970s which enable the federal government to have controlling influence, especially in the in-patient care sector (Hofmarcher MM, Rack H-M, 2006). By latest health reform main features of a new structure of the health system, particularly in hospital financing and connection between in- and out-patient health care, are arranged (Schwamberger H, 2007). As a result the Austrian Structural Plan of Health (Österreichische Strukturplan Gesundheit - ÖGS) was developed in 2005. After revision and supplement ÖGS 2008 was constituted in 2009

(<http://www.bmg.gv.at/cms/site/standard.html?channel=CH0716&doc=CMS1136983382893>, 2009)

With the Health Structural Plan only basic plans are decided on federal level. This allows states, hospital owners and social health insurance funds more scope for design within the plan of details on regional level. This is the first step of dislocation between the sectors of the health system and that is why the ÖSG is a base for conversion and further steps of health care reforms (Bundesministerium für Gesundheit, 2009)

1.2 Strategies and distributions

Major players are the national and the federal councils, the Federal Ministry of Health and social insurances. The federal government retains an important role in policy-making, as a supervisory authority for the enforcement of law and the education of health professionals. Almost all areas of the health care system are the responsibility of the federal government, except for the hospital sector for which the federal government is responsible for enacting basic law, while legislation on implementation and enforcement is the responsibility of the states.

The Ministry of Health is supported by partly subordinate institutions and committees, with regard to public health services and is active in licensing issues and legal responsibility. For example, the field of the Healthy Austria Fund (Fonds Gesundes Österreich) ranges from setting-orientated health promotion (increasing resources) to primary behavioural and circumstantial prevention and health information and education. Further institutions are the Supreme Health Board (Bundesgesundheitsagentur), the Austrian Federal Institute for Health (Österreichische Bundesinstitut für Gesundheitswesen – ÖBIG) and the Austrian Agency for Health and Food Safety (Österreichische Agentur für Gesundheit und Ernährungssicherheit – AGES).

The states and the local communities are very important in establishing, implementing and monitoring the various aspects of the public health service, but they are bound to the framework legislation of the federal government and nationwide planning and specifications. [HOFMARCHER MM, RACK H-M, 2006]

¹ 15a B-VG-conventions are conventions under constitutional law between federal and states governments. It is introduced if a complex problem is in the area of responsibility of federal and states legislation. Both enact laws with equal content (Schwamberger H, 2007).

1.3 Media

Health information is basically offered by the Federal Ministry of Health, but the Federal Ministry of Labour, Social Affairs and Consumer Protection, Federal Ministry of National Defence and Sports, Federal Ministry of Women and Public Services, Federal Ministry for Education, Arts and Culture and Federal Ministry of Agriculture, Forestry, Environment and Water Management also deal with this topic. [HOFMARCHER MM, RACK H-M, 2006] Health information is offered nationwide by the “Gesundheit Österreich GmbH” with its three sub-organisations, FGÖ, ÖBIG and BIQG², the Supreme Health Board, the AGES, the Federal Drug Forum, public corporations like the chamber of labour, public television and radio, and different organisations like NGO’s (Caritas...) or self-help groups. On the states level this is done by the governments, health platforms/agencies, specialized bureaus and regional transfer units for health promotion and prevention, aks austria³ and addiction prevention programmes. Furthermore, some health insurance companies, networks for health promotion (boroughs, schools, hospitals) and private providers are working in the field of health information. [DÜR W, 2007]. According to the providers of health information, the variety of health data is enormous. Therefore health information is often perceived differently.

2 Community profile

The project area is located in the 11th district of Vienna and is called “Schneiderviertel”. The 11th district is called “Simmering” and it is mainly a labour district. The area of investigation is a part of an urban area where the urban renewal office (GB 11) is active. The urban renewal office implements quarter management on the “Schneiderviertel”, which aims to motivate the residents for participation in quarter development.

2.1 Description

About 4012 people live in the project area, on 20 km². That amounts to a total of 1765 households that include 1.600 employees and 331 unemployed people. Compared to the Vienna average the percentage of employees in the CHANCE-area is medial, the percentage of unemployed people is high.

The project area is defined as a housing area in a quarter with low infrastructure. The structure of buildings is characterized by the fact that the houses were built as multi-level houses in the beginning of the last century. Furthermore there are 3 buildings of social housing. The CHANCE-area is located in an urban renewal area with middle to high requirement of urban regeneration. The quarter is densely populated. The only public green space is Hyblerpark in the south of the project area but there are also semi-public green areas in the middle of the social housing buildings.

² BIQG = „Bundesinstitut für Qualität im Gesundheitswesen“ – Federal Institute for Quality in Public Health [www.goeg.at]

³ aks austria = Forum of Austrian Health Working Committee which is working in six states [www.aksaustria.at]

29% of the residents are immigrants; compared to the Vienna average the percentage of immigrants in the CHANCE-area is high. 13% of the inhabitants are elderly which is low compared to the Vienna average.

2.2 Health related resources

The project area is characterized by a great variety of living spaces. Both, medium and high quality spaces are available. The whole housing area is a transition space for local use with a very high percentage of parked cars, which defines the city shape. In the quarter, the infrastructure regarding local food suppliers is insular at best and this problematical situation was addressed in the interviews. The streets and pavements are significantly wider than down town so that the individual sphere of operations (movement) is also bigger. The public spaces are occupied by migrants.

Other spatial areas are the public and semi-public green spaces. The Hyblerpark in the south is a high quality recreational space. The park is divided in two parts: rest area and sports area. Both areas are used by a high percentage of immigrants and elderly and the sports area is used by children and pupils. In general, there is little conflict between the users, just between dog owners and young persons in the evening. The courtyard of the social housing buildings offer generously proportioned green areas.

The infrastructure site Simmeringer Hauptstrasse has to be considered a space of its own. It is a traffic junction both for public transport and individual motor car traffic, essential for regional mobility. The Hauptstrasse handles a high volume of traffic every day. It is also an infrastructure site for daily food, retail industry and gastronomy, and thus ensures basic provisions for the CHANCE-area.

3 Profile of households

3.1 Type of households

In the quantitative and qualitative survey, the individuals were chosen by random-route-method by inclusion of all streets. The households had been informed by flyers being delivered to every house entrance. In the sample, some of the groups overlap.

Qualitative interviews were carried out in 20 households. The interviews were recorded using a dictaphone and transcribed. We had four interviewers. The interviews were conducted in the flats of the interviewees. A few interviews were conducted at the Hyblerpark. Mostly, we interviewed elderly (female) people with an Austrian background. The implementation of the interviews was often difficult; in the majority of cases, households with immigration background were not prepared to give an interview. The main problem was the language barrier, because particularly women in immigration households (especially Turkish households) often do not speak German well. At this time, we had only

a Croatian native speaker. The questionnaires were distributed by female students of nutritional sciences.

The quantitative study includes 254 participants.

Of the 254 participants, 32.3% are younger than 31 years, 57.5% range between 31 and 60 years, and 10.2% are at least 61 years old. 63.4% of participants are women and 36.6% men. On average, all participants are normal weight: the mean BMI of women is 25.3 kg/m² (min=17.1 kg/m²; max=40.4 kg/m²), the average BMI of men is 26.3 kg/m² (min=17.2 kg/m²; max=43.3 kg/m²).

More than two thirds of the interviewees have a graduation level of upper secondary school (76.0%), whereas 23.2% are less educated (2 missing). Nearly every second person (40.2%) works full time, 14.2% part time, 5.5% of study subjects are students, 11.4% are housewives, 10.6% are unemployed, and 15.0% retired. One person studies and works part time, and one woman is a housewife and works part time (0.4% each). Two subjects did not answer this question (0.8%).

28% of participants are immigrants; their mean educational level is similar to the Austrian. However, immigrants make up more than accident in the group with the lower education level. 29.5% earn less money than average, 51.6% average, and 16.1% above average. Although in the mean immigrants do not state they earn less money than average, more than one third of immigrants earn less and only 6.9% more than average; 19.4% of Viennese participants have a higher income than average.

About 22.4% live alone, 24.8% with a partner, 29.5% with partner and children, 8.7% with their children, 7.1% with others and 6.3% indicate another living situation like “with parents”. Immigrants make up highly significant more than accident in the group which is living together with their partner and children and underrepresented in the group which is living alone. In contrast, Austrians make up more than accident in the group of single households and are rarely represented in the group which is living with their partner and children.

3.2 Perception of health information

In terms of people's health, no mean difference between Austrians and immigrants is observed for the question about the importance of their individual health (very important: 64.6%; important: 31.9%; neither/nor: 2.8%; not at all important: 0.8%) and for their individual health status (very good: 22.0%; good: 59.1%; neither/nor: 12.2%; bad: 5.5%; very bad: 0.8%; missing: 0.4%). Asked how they think their health will be in three years, a significant mean difference between Austrians and immigrants is recognized: while Austrians think that their health status will not change (improve: 28.6%; remain the

same: 68.6%; worsen: 2.3%; missing: 0.6%), immigrants display a positive perspective towards the future (improve: 44.4%; remain the same: 50.0%; worsen: 4.2%; missing: 1.4%).

There are no mean differences between Austrians and immigrants concerning the offer of necessary information in the neighbourhood (very true: 38.2%; neither nor: 48.4%; not at all true: 12.6%; missing: 0.8%) and the understanding of doctors' advice (very true: 79.9%; neither nor: 18.5%; not at all true: 1.2%; missing: 0.4%). However, immigrants consider health information significantly more confusing than Austrians. Most of the participants, especially elderly people, get their health information from their doctor (70.5%), who is also mentioned by the majority as their most important source of health information (22.4%), followed by media like TV (42.9%), newspaper (36.6%) and internet (35.0%), as well as pharmacy (37.4%), family (35.8%), and friends (34.3%). Schools (7.9%), food industry (6.7%), neighbours (6.3%), institutions/unions (3.9%), district/city council (3.5%), state/government (2.4%), and other sources than mentioned (9.1%) above play a minor role. The only significant differences of distribution regarding the sources of health information are found for the internet and for neighbours. Immigrants make up more infrequently than accident in the internet using group and they make up more than accident in the group which mentioned neighbours as a source for health information. No significant difference in the ability to transfer health information into everyday life is observed between Austrians and immigrants (very true: 11.8%; true: 48.0%; neither/nor: 13.8%; less true: 24.4%; not at all true: 1.2; missing: 0.8%).

3.3 Daily life

All interviewed households define health as a very important issue in their lives. Health is mostly defined by absence of illness. Handling the daily life has priority; healthy nutrition and sports are 'luxury' topics. Healthy nutrition and sports play a role after severe illness.

Asked for the correct meaning of "5 a day", a significant difference of the knowledge between Austrians and immigrants is observed. While immigrants are underrepresented in the group that knows the right answer (five portions of fruits and vegetables a day), Austrians make up in this group more than accident. Immigrants answered "I do not know" more infrequently than accident.

The outcome concerning the knowledge of the durability of minced meat shows the following trend: Austrians are better informed about the reduced durability than immigrants.

Austrians get significantly more exercise than immigrants.

Concerning food frequency questionnaire immigrants eat significantly more fruits, vegetables, vegetable oil, and less meat than Austrians.

3.4 Resources and barriers and social networks

About 80% of interviewees like their house/home, feel safe, well and can recreate in their home. More than half (57.1%) feel safe. 22% are in contact with their neighbours, but 14.2% do not even know their neighbours. 25.2% report that the traffic noise is too loud. Only one quarter (25.2%) mentions that their district is healthy and that the air in Simmering is pure (28.0%). Significant differences between Austrians and immigrants are found at following points: immigrants often live more crowded than the mean, think more often that they live in a healthy area, and feel safer in their neighbourhood.

Immigrants have a stable family network. The relationship to (Austrian) neighbours is distanced. There is no interchange between the social groups. For the Turkish immigrants, the mosque plays a very important role in getting in contact with other immigrants. The family and mosque help in health aspects, but people need a professional person to ask questions concerning health without having to consult an institution.

The elderly are occasionally involved in civic activities. In the majority of cases, they want to stay in their familiar homes. They are interested in more consumption of healthy topics in the neighbourhood but they are neither mobile nor motivated to change their habits.

4 Interrelation of the community's structure and people's knowledge

At the end of April 2009, we started to distribute our information leaflets to those who wanted further information after the first survey in summer 2008 and on the blackboards in every house of the district. Furthermore, we approached our target groups directly in the Hyblerpark by one person only or in Nordic walking groups.

At the beginning of May 2009, after expanding our Turkish events, we were able to distribute our Turkish information folder.

We used the following multipliers for distribution of both leaflets:

1. adult education center (Volkshochschule) Simmering
2. urban renewal office (Gebietsbetreuung) Simmering
3. kindergarten Rinnböckstraße and kindergarten Dopplergasse
4. local pharmacy (Adler Apotheke)
5. local shops and local service companies, e.g. hairdresser
6. local restaurants and cafés
7. local caretakers
8. internet courses for elderly and people with immigration background (Turkish) offered by „Fonds Soziales Wien“
9. local Islamic, catholic, and evangelic denominations, e.g. Babycafé, Seniorencafè, organized by the denomination
10. local club for elderly people organized by the Kuratorium Wiener Pensionisten-Wohnhäuser,
11. the local culture club (Centro Once)
12. the local physician (oculist)

Most of the multipliers were informed in face-to-face talks and discussions. They got information about the main goals of the project, the intervention, and the target groups.

To present the project in the community, nutrition and health information were provided at the European Neighbour's Day (Nachbarschaftsfest) at Hyblerpark on the 26th of May, 2009, and at the Simmering Street Festival (Simmeringer Strassenfest) on 6th of June, 2009. At the Neighbour's Day, free fresh fruit and vegetable juices were prepared after some sport activities like Nordic walking or yoga. At the Simmering Street Festival, a quiz on nutrition and sensory tastings were organized.

Seniormedia ges.m.b.h. has been presenting information about the project on its homepage (<http://www.seniorkom.at>) since 20th of May, 2009. Since the 26th of May 2009, people are being informed about intervention courses via (<http://www.wien.gv.at>) (official Homepage of Vienna).

5 Conclusions

For the residents in the community the only public green space the “Hyblerpark” followed by educational and social services play a very important role for their quality of life. The majority of interviewees like their house/home, feel safe, and can recreate in their home. Main resources of health information are the doctor as well as friends and family. Health interventions have to be done on community level in consideration of disadvantaged groups like immigrants, elderly people and single parents.

References

HOFMARCHER MM, RACK H-M. Austria: Health system review. Health Systems in Transition, 2006; 8(3):1-247]

TÁLOS E. Das politische System in Österreich, Bundeskanzleramt, Bundespressedienst, 2000

<http://www.bmi.gv.at/wahlen/wahlberechtigung.asp> (Stand 7.4.2009)

http://www.bmi.gv.at/wahlen/nationalratswahl_ueberblick.asp (Stand 7.4.2009)

ADAMOVICH LK, FUNKE BC, HOLZINGER G. Österreichisches Staatsrecht, 2 Bände, Wien, 1998

DÜR W. Visionen für die Gesundheitsförderung in Österreich. 9. Gesundheitsförderungskonferenz. 4.6.2007. Präsentation: <http://lbimngs-archiv.lbg.ac.at/present/04062007.pdf> (Stand 30.5.2009)

PELINKA A. Gesetzgebung im politischen System Österreichs In: Gesetzgebung in Westeuropa. EU-Staaten und Europäische Union, Ismayr W. (Hrsg.), 1. Auflage, Verlag für Sozialwissenschaften, Wiesbaden, 2008, 431 – 463

http://www.ess-europe.de/europa/kvsys_oesterreich.htm (Stand 14.4.2009)

SCHWAMBERGER H. Das Gesundheits- und Pflegewesen im österreichischen Bundesstaat In: Gesundheits- und Pflegewesen im Umbruch. Ein euroregionaler Rechtsvergleich. Gamper A, Fraenkel-Haeberle C (Hrsg.), Facultas Verlags- und Buchhandels AG, Wien, 2007

<http://www.bmg.gv.at/cms/site/standard.html?channel=CH0716&doc=CMS1136983382893>

(Stand 15.4.2009)

BUNDESMINISTERIUM FÜR GESUNDHEIT (Hrsg.). Österreichischer Strukturplan Gesundheit 2008. ÖSG 2008 (inkl. Großgeräteplan) gemäß Beschluss der Bundesgesundheitskommission vom 6. März 2009;

http://www.bmg.gv.at/cms/site/attachments/1/0/1/CH0716/CMS1136983382893/oesg_2008_-_gesamt.pdf (Stand 15.4.2009)

Germany

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1 Profile of health information system

In Germany a number of different governmental and non-governmental institutions exist communicating health matters. There are at least five main important categories of institutions making decisions on the content and way of providing health information on the national, regional or local level.

1.1 Institutions

Institutions of Health Information in Germany (extract)
Governmental Institutions National Ministry of health National Ministry of Nutrition, Agriculture and Consumer Protection National Ministry of Education and Research National Ministry of Family, Elderly, Women and Youth ... as well as corresponding county ministries and other cross-sectional institutions; Consumer session of the Lower House of the German Parliament
Governmental (controlled) Services, (Research) Institutions Public Health Service Health Insurance Companies 4 National Research Institutes - Julius Kühn-Institute (Culture Plant Research) - Friedrich-Loeffler-Institute (Animal Health Research) - Max Rubner-Institute (Nutrition and Food Research) - Johann Heinrich von Thünen-Institute (Rural Area, Forestry, Fishery Research) National Institute of Risk Assessment Robert-Koch-Institute National Centre of Health Information German Institute of Medical Documentation and Information Independent public institutions
Non-governmental Institutions National Centre of Consumer Associations Profession Associations of Health Professions Specific Associations (e.g. German Association of Nutrition, German Association of Home Economics) aid – Information Service Consumer Protection, Nutrition Agriculture National Association of Health BAGSO German Olympic Association
Economy/ Industry Nutrition, Food, Pharmacologic Industry
Media Internet, TV, Radio, Newspaper/ Magazines

The structure of the health information system in Germany is characterized by the specific role of the social and health insurance companies. Their offers on e.g. nutrition, physical activity and health information in general are based on the German social law. That is why 38% of all preventive and health promoting activities are initiated by health insurance companies and more than 50% of total

financial support for those matters is due to them, followed by nearly 25% governmental money. Altogether 1-5% of the total state health budget is spent for health promoting activities. Since 2008 the consumer information law gives more responsibility to the nutrition economy, which has to communicate product (health) information of the produced food to the consumer. Regulation (EC) No. 1924/2006 on nutrition and health claims made on food, establishes rules for the use of claims in the labelling and advertising of food.

1.2 Strategies and distributions

Government sets the frame for different national activities e.g. by the “National Action Plan suitability of living situation for children in Germany 2005-2010” and the “National action plan on nutrition and physical activity 2008”. National health targets, national strategies, education and health (information) programmes show the tendency of supporting lifestyle matters in a sustainable way and community based concepts. There are not only national campaigns, but also regional and local support centre (e.g. “social knots”, “Networking Agency for school meals”).

From the regional perspective of Hesse, health information strategies, programmes and activities are more detailed, with slightly different focus and supported by regional working groups. Health targets are putting more emphasis on disease prevention. On the regional level there is also a wide range of protagonists with more abilities in the practical support of health information strategies. Networking activities concentrate on the settings City and school. Further research is needed on the practical level of implementation of health programmes and projects.

The media are also included into the process and reminded on their helpful and responsible information policy. Besides involving “classic” media like newspaper, magazines and radio there exist also first attempts to install edutainment concepts on TV. More and more networking via internet is utilized by multi-sectional stakeholders to secure the quality of health information in Germany (e.g. www.gesundheitsinformation.de, www.afgis.de, www.gesundheitlichechancengleichheit.de).

1.3 Media

There are different ways of getting an impression of how health information is noticed and put into practice by German people: regularly governmental supported national reports on topics like health in general (2006), nutrition (2008) and consumer affairs (2008) are published in different media and available for everybody who is interested. Scientific national studies provide recent data like the National Nutrition Survey (MRI, NVS II, 2008). Those studies do not only allow insight into people’s nutrition and health status but also into the social situation and information behaviour. In addition a recent study on consumer affairs conducted by the food industry demonstrates changing information policy in economy by giving more attention to consumer’s quality expectance, time management, daily nutrition and health values.

2 Community profile

The district Südend (Southend) is located south of the inner city of the Middletown Fulda. The name shows, that Südend has no tradition as a self developed neighbourhood or local community. It is just the housing scheme in the south/ east of the outward road to Frankfurt. This is important for all attempts to install a local network of stakeholders and to mobilize the inhabitants for the interests of “their” neighbourhood and community.

2.1 Description

The housing in Southend is located between a bad frequently used road and the main railway tracks. The housing areas are surrounded by an industrial and business zone with small and medium sized companies in the production and service sector. The railway tracks and the industrial zone divide the district Südend into several small neighbourhoods. The whole area is built as a mixture of three to four stories high tenement houses. The rate of houses managed by one of three big housing associations is high. In 2006, 4.688 inhabitants lived in Südend. This equals an inhabitants density of 15.9/ha. Compared to the city of Fulda the rate of Migrants is high (18.3% vs. 13.0%). The main ethnic groups are Turkish and Russian people. Furthermore, the proportion of children is low and the rate of elder people is high compared to the city of Fulda. The proportions vary between the five neighbourhoods of Südend. These neighbourhoods are defined by the housing structure, the homeownership structure of these quarters and spatial barriers like streets, railway tracks and industrial zones. Due to the fact, that Südend is a statistical district (a part of the inner city) and not a self developed community, there is no local mayor, no social-spatial centre or infrastructure. In Kohlhaus, the adjacent district, there is a mayor. The children of Südend and Kohlhaus visit one school together (Sturmiusschule). In Fulda-Südend reside 4.688 inhabitants and in Fulda-Kohlhaus 1.160 inhabitants.

Tab 1: Age-groups in Südend, Kohlhaus and Fulda 2007 in percent

Age-groups	Südend	Kohlhaus	Fulda
1 – 17 years	15,6	17,8	18,4
18 – 20 years	3,6	3,6	3,9
21 – 64 years	53,8	62,1	57,7
65 – 79 years	15,5	11,3	14,3
80 – 89 years	9,2	4,8	5,0
90 years and older	2,4	0,4	0,7

Source: Stadt Fulda, Statistikstelle, 2008

2.2 Health related resources

Health related resources are more than medical services. The resources of the community can be divided into spatial resources, infrastructural resources, civic resources and household resources.

Spatial resources:

The elementary school, with its yard and sports grounds is located in the middle of Südend. The sports ground of the local Turkish sports club is located right beside the school building. In the other neighbourhoods there are sports areas as well, but they are not opened for the public yet. West of the big outward road the recreation area “Fuldaauen”, the meadows of the river Fulda, abut on. The traffic is an important barrier to use this area especially for children and elder people. Südend is located north of Kohlhaus, a former village with established structures of clubs and citizens’ involvement. In Südend, there are 2 kindergartens, the AWO (Worker’s Welfare Association) is running a youth club in the basement of the school and the organisation PRISMA helps young people to get a job. In Addition, several church communities do social work for special target groups in Südend. Südend has a little shopping centre including a bank, a pharmacy, super market and bakery.

A somewhat bigger shopping centre, influenced by the regional sphere, is located in the west of Südend. Except the Turkish sports club (which has German members as well) there are no ethnic economy or social infrastructure in Südend.

Economic structure:

Südend is surrounded by companies of different branches. Some of the local companies are working together in a local Promotion Association (Werbegemeinschaft Kohlhäuser Feld). There are producing companies as well as service companies with little connection to the urban district. However, Südend is not the home of the employees. Some of the companies are active in workplace health promotion. There are companies with an own employee cafeteria. Several companies are interested in a broader contact with local organisations and are willing to support local health projects.

3 Profiles of households

3.1 Type of households

With qualitative interviews three disadvantaged social groups that are dependent on the local community in a special way were identified: households of migrants, families with little children and elder people. In the sample the groups are overlapping. The Households have been contacted by local stakeholders.

In the quantitative survey the individuals were chosen through random sample on two methods. One part was selected according the random-route-method by inclusion of all streets (Raithe, 2006, 57). The households had been informed through the local press and a paper in each private post box in

Südend. The individuals were interviewed in their own households; students completed the questionnaires. Each third individual, who was ringed, was interviewed by students (92 individuals). Another part of the questionnaires was given to local groups in Südend and Kohlhaus (e.g. parents in kindergarten and schools, patients of a doctor, Turkish sports club). They completed the questionnaire by themselves (103 individuals). Here the cluster sample was used. From the 195 questionnaires 186 could be analysed.

3.2 Perception of health Information

Migrants: The interviewed migrants think that they are well informed. But none of them could designate a concrete Health Information or a concrete source of information except the doctors. There is a big suspicion about the doctors. Migrants are afraid that they misunderstand the medical advice and they are under the impression that doctors are always short of time.

Families: All interviewed families defined Health as a very important issue in their life. There were no differences between German and migrant families in the knowledge about healthy living. We found a reflected consciousness of health. Almost all families are actual or formerly affected by diseases, concerning the children or important experiences in dramatic diseases in the family.

3.3 Daily life

Selected results of the questionnaires:

- 87 % of the respondents report that if they have health problems they ask the doctor. 44 % talk to their families, 29 % to their friends. 27 % use internet. Only a small group of 10 % is active LOHAS (Lifestyle of Health and Sustainability) enrolling in a health course, visiting a lecture.
- A little more than one of three knows what “5 a day” means.
- More than 95% say that their health is “very important” or “important”.
- Only 11.5 % think that their health status is very good. 60.7 % suppose that their health status is good.
- Only 5 % think that their health status will become worse. But 30 % hope it will become better. 55 % are convinced that they are able to implement health information in their life.

3.4 Resources and barriers and social network

Migrants: Migrants have constant family networks that help in health aspects esp. in nutrition questions. The social network is not localized. The relationship to (German) neighbours is distanced. Mothers with migration background wish to get more in touch with others in the neighbourhood. And they miss a person point of contact, to ask questions concerning health without consulting an institution, a medical practice etc. They are interested in participating in local projects – if others make the first step.

Elderly People: The Elderly are not involved in clubs and civilize activities anymore, not active sports. They want to stay in their familiar homes and therefore they are very interested in more consumption

and medical infrastructure in the neighbourhood. The trust in the doctors is great. Elderly are burdened by physical restrictions, influencing daily life (going shopping, managing stairs or taking part in sports, other leisure time activities or civil, voluntary activities). Elderly people refer to restricted mobility and motor skills, exhaustion, bad muscularity, overweight, mental fluctuations und cognitive dissipation.

Families: The supply of the children and the shift-work of their partner structure daily life. The woman is responsible for the main proportion of family work. Most of them work part time or support other members in the wider family. The families cook at home and they try to eat the meals together. The interviewed families appreciate fresh ingredients.

Exercises are is denoted as very important. Some of the interviewed adults and almost all children are members in the local sports clubs. But some of the parents have to refuse because the burden of both work and family organisation increases. For some of the families going for as walk the main sport activity

The families are very interested in health information. The topics are very different due to the actual situation of the family (special information on a certain disease, information about healthy food etc.). The sources of information are also very different. The families develop individual strategies of research (e.g. the „Apothekenrundschau“, TV shows, internet).

Family and neighbourhood networks are central in organizing daily life and the healthy lifestyle at home.

4 Interrelation of community's structure and people's knowledge

4.1 Participation of the inhabitants

We are working on two levels and with several steps. At first the inhabitants participated in the quantitative and qualitative research. So we find out the situation of the special target groups, the perception of health information, and the special needs for the local situation. On the other side, we made continuous networking and networking forums with the stakeholders for Fulda-Südend and Kohlhaus (Fuldaer Stadtteilforum Südend/Kohlhaus). This included several groups like sport clubs, esp. a Turkish sport club, the elementary school, several kindergarten, labour welfare organisation, senior clubs and staffs of the community Fulda esp. for elderly and seniors as the official partners catholic adult education, the local consumer centre Hesse and the housewives society Hesse as two health insurances.

On the basis of the results of the quantitative and qualitative research, we planned together with these forum and the partners single and common actions and projects. Access to target groups is easier over existing societies, groups like parents in the kindergarten or school, members of religious groups. We went the way over these groups and the way for the whole population. The activities must be needs oriented and with low barriers.

4.2 Local activities

The first common activity was a health day “Fit in the spring” in the end of February in the elementary school. This was the start of information and presentation of the offers by all stakeholders and included several forms of health information, moving actions and general information for elderly and parents.

The second common activity is a summer event around health on 13th of June for all target groups on the open-air ground of elementary school. Similar stakeholders and some new stakeholders presented their offers which included health information, some more moving actions and a programme on a little arena with music, dance of seniors, children`s theatre of a kindergarten. A special eco racer will be an attraction especially for men/fathers.

Special actions were made by the housewives` society Hesse like “Cooking for Turkish women” and healthy breakfast for children and parents in an evangelic kindergarten. The consumer centre Hesse offered lectures about care at home for catholic elderly and a group of stakeholders. A course of this organisation about nutrition is planned for kindergarten workers. The staff of the community Fulda offered in the primary school information for parents with education problems and general information for aid of elderly.

The primary school looks about health and healthy nutrition and includes these points in the official school programme. A playing and sporting day will take place on 17th of June for the children in this school connected with information of the parents. Students of the University of Fulda are engaged. In the secondary school nutrition concepts for children and parents are planned.

5 Conclusions

With the available networks in both communities it was possible to reach the target groups of elderly people, migrants and (single) parents and their children. With qualitative interviews the needs of the inhabitants with regard to the community and their daily routine were determined. The desire for low threshold offers was identified. Furthermore, frequent information and counselling offers were requested by households with migration background. In addition, families were identified as important resources for migrants. Projects, with the objective to reach this group, should tie in with this aspect. Numerous projects enabled the activity and participation of the inhabitants and will be repeated.

References

MRI (Max Rubner-Institut) (2008) (Ed): Die Nationale Verzehrsstudie II

Raithel, Jürgen (2006): Quantitative Forschung. Ein Praxiskurs. Lehrbuch. Wiesbaden: VS Verlag für Sozialwissenschaften

Stadt Fulda (2008): Statistikstelle

www.gesundheitsinformation.de

www.afgis.de

www.gesundheitlichechancengleichheit.de

Zimmerer, Silvia (2008): Wahrnehmung von Gesundheitsinformationen in der Bevölkerung eines Stadtteils am Beispiel des Projektes CHANCE. Masterthesis Public Health Nutrition, Fulda (unpubl.)

Latvia

RAF⁴ - District of Jelgava City

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1 Profile of health information system

In Latvia numerous different governmental institutions are responsible for the distribution of health matters. Twelve ministries and a total of 60 subordinate institutions are engaged in designing and introducing the Public Health Strategy (Informational Report on the Public Health Strategy Action Program by the 2005 to 2006, 2007).

1.1 Institutions

Institutions of Health information in Latvia
Ministry of Health and subordinate institutions
Public Health Agency
Health Compulsory Insurance State Agency
Board of Nutrition
Ministry of Economics and subordinate institutions
Consumer Rights Protection Centre
Consumer Rights Protection Association
Ministry of Education and Science
Ministry of Agriculture and subordinate institution
Food and Veterinary Service
Ministry of Regional Development and Local Government
Local governments
Republican cities
Districts and district towns
Amalgamated local municipalities
Civil parishes

The Latvian Ministry of Health and their subordinate institutions are responsible for the development and implementation of state policy by ensuring public health in a healthy environment, promoting prevention, popularizing a healthy life style and creating conditions where the inhabitants would benefit from cost effective, physically accessible, and high-quality health care services.

1.2 Strategies and distributions

Health education is a planned learning system to provide knowledge, to shape attitudes, skills and acquirements, to develop abilities required for maintaining health by using inferences of several sciences (Rubana I.M., 1997). The three main tasks for health education in Latvia are to provide knowledge on health and factors influencing it, to create a positive attitude to an individual's health and to that of others, and to develop skills for taking care of one's own health and that of others (Velša Z., 2005).

The Public Health Agency determines public health problems, develops proposals for policy making and creates effective solutions of problems in the field of public health. The main target of the Health

⁴ RAF is a district of Jelgava for the former employees of Riga Automobile Factory

Compulsory Insurance State Agency is to implement state policy for the availability of health care services and administrate the state compulsory health insurance resources. The Board of Nutrition is responsible to promote and implement nutrition policy, analysing public health problems related to nutrition and suggesting solutions for solving these problems. The Ministry of Economics and subordinate institutions are responsible for consumer health and safety protection, which includes the protection and fostering of other economic interests of consumers, consumer information and education. To ensure development and implementation of policies with regard to education, science, sports and state language, promoting sustainable growth of welfare of the citizens of Latvia, is target of the Ministry of Education and Science. The food surveillance concept “from the field up to the table” is the most effective project to protect the consumer right to receive safe and harmless food. This is commissioned by the Ministry of Agriculture and subordinate institutions and conducted by the Food and Veterinary Service within the framework of the food surveillance concept. The Ministry of Regional Development and Local Government aims to coordinate the elaboration of development strategy, to organize and coordinate the implementation of laws and regulations in the area of regional policy, spatial planning, habitation policy, development and performance of local governments. Finally, local governments are responsible to provide the accessibility of health care as well as to encourage people to follow a healthy lifestyle.

1.3 Media

Public education of health issues is organized in collaboration with mass media and the institutions insuring that are listed in section 1.1. Cooperation with mass media is assured through regular press conferences on topical issues by bringing the latest information of institutions' web pages under the section "News". Public health officers regularly give interviews to the media. Varieties of interactive discussions are organized on topical issues such as smoking, etc. in Latvian portals. In collaboration with the schools, a variety of health related activities and competitions are organized, where students need to be knowledgeable in health matters; the results are published in the mass media. The newspapers have allocated separate sections for specific health-related themes, also television and radio broadcast these issues. The participating institutions regularly prepare and publish reports on public health research results, as well as industry statistics, which are also available to the mass media.

2 Community profile

Jelgava is the fourth largest city in Latvia. It is located in the Southern part of Zemgale plain. The total territory is 60.3 km² and 66 thousand inhabitants are living there. There are several inner cities within the cities, which are named after companies located there. RAF is the name of the inner city of Jelgava. RAF means Riga Car Manufacturing Company located in Jelgava.

2.1 Description

RAF inner city was built in 1970s when it was necessary to build living premises/houses for the manufacturing plant employees. Initially mainly RAF employees were living in the community. The inner city is located in the North Eastern part of Jelgava, on the banks of river Lielupe, only 3 km from the centre of Jelgava towards Riga, capital of Latvia. The inner city microdistrict with an area of 0.3 km² in-between Riga Street, Pernava Street, Loka Magistrale and Old Road was chosen for the research.

Tab 2: The main figures about RAF, Jelgava, Latvia in 2008

Indicators	RAF	Jelgava	Latvia (Country)
Inhabitants (in thousands)	4.520	65.804	2276.282
Area (km ²)	0.3	60,3	64.589
Density (inhabitants/km ²)	15066	1096	35.2
Employed (in %)	no data	no data	70.3
Unemployed (in %)	no data	3.9	4.9

In the RAF communities, there are multi-unit apartment houses: five-story and nine-story block houses. The houses were built in times of the USSR, in order to create possible apartments in the future. Within the last few years, special measures were performed in order to improve the quality of the apartments (e.g. heat insulation of buildings). Improving the quality of these apartments will help to attract more inhabitants to the area from the centre, where apartments are of equal quality but more expensive. The possibility to reach Riga conveniently is equally important both to employers in Riga and to employees living in Jelgava. The majority of RAF apartments are privatized.

2.2 Health related resources

The community offers one school - Jelgava Secondary School No 6 (Russian secondary school with 647 pupils), 1 kindergarten, 4 food stores, a bakery, a market place, a flower shop, a hardware store, 3 shopping malls, 1 dinner and fast food restaurant, a post office, 2 pharmacies, one dentist and general medical practice office, one library, 3 casinos, 3 children playgrounds, a dry cleaner's and Laundromat, a shoe repair shop, petrol and gas stations and a car repair shop.

Traffic: between RAF and the city centre, public transportation is regularly offered. On the route to Riga and from Riga, the intercity buses stop at RAF station.

Leisure: there are several opportunities to exercise (e.g. swimming, football etc..). A weight lifting hall is located on the top of the mall. The library can be considered as one of the cultural centres of RAF microdistrict, as well as a social integration centre. Currently, there are 3 playgrounds for children.

Green area: on the other side of Loka Magistrale, a forest is located. The forest lies near RAF ex-plant and RAF multi-unit apartment complexes. Through the forest, Old road stretches -previously Jelgava-Riga road, which is a popular hiking route. Near the forest, there are guarded car parking garages, a cemetery monument store and Berzi cemetery. There are no churches in the area; this is due to the fact that the RAF living area was built in the soviet times.

Along with the collapse of the USSR in 1991, the manufacturing plant was liquidated. In the area of the plant, warehouses were constructed. In 2007, the first stage of NP Jelgava Business Park reconstruction works was completed. "NP Properties" Ltd, which is one of the largest developers of industrial parks in Latvia, has invested 1 Million Euro in that project. This will be the largest reconstructed industrial park in the Baltics.

3 Profiles of households

3.1 Type of households

There are 21 multi-apartment houses in the territory chosen for the project, in which 1562 households reside. The average size of households is 2.89 people, which is much larger than the average indicator for Latvia. Empirical information was gained by conducting a quantitative questionnaire survey of RAF microdistrict's residents in Jelgava in May of 2008 and 20 qualitative interviews and one interview of focus groups in the summer and autumn of the same year.

There were 255 (169 women, 85 men) respondents in the quantitative survey. Of them, 44 respondents were aged 61 and over. Young people (aged 21-30) and individuals of preretirement age (51-60) mostly live in two-person households, people aged 31-50 mostly live in 3 or 4 person households or in the phase of "full family". In Jelgava, pensioners live mostly alone (43%) or in couples with a partner or a child (38%), while the rest of them live in many-person households. Of the respondents, 70% are home owners and only 7% are subtenants. The size of apartments is mostly less than 80 m². If a household has 3 persons, there is a greater possibility that its apartment size is less than 60 m² rather than larger. The size of apartments belonging to 52% respondents is less than 60 m², 35% respondents own apartments with a size range of 61-80 m². As to a language used for conversation at home, 121 respondents said they talk Latvian, 132 – Russian, but 3 used both languages, however, the native language of 129 respondents was Latvian, 117 - Russian. 211 respondents (83%) were born in Latvia.

3.2 Perception of health Information

In terms of physical exercises and nutrition, the majority of the respondents believe that they are well informed about healthy lifestyles. However, the majority is only partially informed about the feeling of social and mental comfort. The main source of health information is television, followed by friends, the press, the family, and Internet, the doctor, and neighbours. The pensioners gain information about

healthy lifestyles from television, the second place is shared by the doctor and friends. To the Latvian pensioners, the family accounts as the fifth most important source of health information. For the pensioners of RAF microdistrict, the most important institutions of infrastructure are the market place, health services, the green zone, food stores, and social care.

3.3 Daily life

A typical resident of RAF is well informed about healthy lifestyles from the point of view of physical exercises and diets and partially informed about the feeling of social and mental comfort. The main source of information is television; it is watched on average 1-2 hours a day. He/she believes that only sometimes it is easy to use information on a healthy lifestyle in everyday life. If he has a problem, usually it is solved by himself. Problems of food, physical exercises, and health are solved in the family, in serious occasions a doctor is visited. In acute occasions, he goes straight to a hospital.

A typical resident of RAF lives together with a partner in an apartment owned by him, the size of which is less than 60 m². However, he does not consider his apartment is small. At home, he feels well and safe where it is possible to have a rest in peace and quiet. He likes the apartment that was furnished by him. In most cases, the neighbours are known and sometimes he, one can say, has the best neighbours ever could be. He spends more than 3 hours a day outside the home and is engaged in physical exercises for 1-3 hours a week, doing it outside. He feels safe in his microdistrict and does not want to live in another part of the city. He believes that he lives in a health-friendly microdistrict with unpolluted air and he is not bothered by traffic noises. The greatest value, mentioned by the residents, is, first of all, the green zone, doctor's office, food stores, school, and kindergarten. The shopping centres, sports ground, sports hall, market place are important as well, while their social organisations, church (that is not available), sports club, swimming pool, and social care are less important.

A typical resident of RAF goes shopping on weekdays and cooks himself. He does not need help with household work. When shopping, sometimes he reads information about ingredients and nutritional value of food. He drinks water, tea, or coffee several times a day (mostly tea rather than coffee). At least once a day he eats a hot meal. Every day he consumes wheat bread and vegetables as well as vegetable oil. Every day he eats fresh fruits, meat, milk, curds, butter, and sweets. Several times a week he eats potatoes, rice or pasta, cheese, sausages, yogurt (in Latvia yogurt is considered as a sweet product made of sour milk, which is a relatively expensive food), as well as cakes and biscuits. Rarely or almost never a typical resident of RAF consumes beer, wine, cereals, lemonade, coca-cola, nutritional supplements and vitamins, fat fish, margarine, full-grain bread, lean fish.

A typical resident of RAF cares about his health. He believes that his health is quite good and nothing will change over the next years. He knows nothing about what “5 a day...” means. To be healthy, it is important to a resident of RAF to wash the hands after being to a W.C., walk, not to smoke, to eat fruits and vegetables every day and to store food products in a proper way.

3.4 Resources and barriers and social network

The family is the most important value of life. Environmental protection is also important for the residents of the RAF, followed by the career; more money is spent on healthy food. Physical activity is important as well as to participate in decision-making in the microdistrict.

NGOs do not exist in the microdistrict. There was an English club existing for a while, but it was relocated to the city centre. Nevertheless, the residents get engaged in various neighbourhood improvement and backyard cleanup activities. In addition to the residents, entrepreneurs and local government representatives were invited to the focus group interview, but there was no local NGO to invite. The implementation activity was developed on the basis of the ideas of the empirical studies.

4 Interrelation of community’s structure and people’s knowledge

4.1 Participation of the inhabitants

In the spring of 2008, results of the questionnaires done in RAF municipality were collected. Based on the results and suggestions given by respondents, we have developed a special educational and informative program for people living in this community.

1. The two local schools were involved in a health project – contest “Be Healthy at Home”. Sixty students in teams developed a formula of healthy lifestyle. The following tasks were asked to be done:
 - To study the literature about healthy lifestyle (no more than 10 written pages)
 - Explore the habits of own family and neighbours and its accordance to healthy lifestyle (attachment to first task)
 - On bases of the first and second tasks, create a group formula of healthy lifestyle
 - Prepare a creative presentation of the “formula” in semi final and in final.
2. A second activity was done with a focus group interview in which different social groups of the local community such as entrepreneurs, teachers, and students participated. It was done in order to get a deeper understanding of the needs and structure of the local society.

4.2 Local activities

The main activity, in which around 3000 inhabitants were involved, was the “Marathon of Health”. The event was open for every person interested. Two weeks before, there was an information campaign organized to inform people about the project. In order to cover the needs of all age groups (children, students, middle generation and retired people) the following program was developed:

- Morning exercises for seniors;
- Students' presentations of "Formulas" of healthy lifestyle;
- The marathon of health for families with 10 different tasks in the forest led by association of athletics;
- The market of healthy farm products;
- Diagnostics of health for free: teeth, sugar level in blood, heart, CO level in breath of smokers;
- Information about reproductive health;
- First aid "school";
- Consultations with a sports doctor;
- Auto ergonomics and auto sport.

At the same time to the activities outside, a set of lectures given by professionals was offered:

- Ecology of consciousness;
- Foll's Diagnostics – diagnosis of health condition using active energetic points of the human body;
- How to become healthy without using medicines;
- Life without tobacco;
- Apiculture products for improvement of health.

This event was all day long and was supported by 16 organisations related to health and 15 farmers who supplied their products. Furthermore, the government of the city has shown support of the project idea and is willing to develop it as a sustainable activity for citizens.

The RAF area has poor health facilities for local people. The local inhabitants are mainly connected by themselves to the whole city and are using offers of the centre. There is a swimming pool in RAF, but advertised effectively. Since it is located at the local school, it is mostly used by families who have children in school. There is a modern sports hall in the other school of the community but which is mainly used for educational purposes.

There is a local health centre where health information can be received. Unfortunately, information is not spread out of the centre. Health promotion in RAF community needs to be developed and activated by the involvement of all possible stakeholders.

5 Conclusions

The people in the community start to think about their health and become aware of its importance when health problems emerge. The feeling of comfort in the apartment, in the backyard, stairway, street and sidewalk and in the nearest surroundings is important to the residents of multi-apartment houses. If the residents of RAF identify themselves with the microdistrict of RAF, it associates them with a comfortable place of residence having a large green zone and forests, but not with joint festivities with their neighbours.

References

Informatīvais ziņojums par Sabiedrības veselības stratēģijas Rīcības programmas ieviešanu 2005.-2006.gadā (Informational Report on the Public Health Strategy Action Program by the 2005 to 2006) Rīga, 29.01.2007., In Latvian, Available at:

http://www.sva.lv/svm/svmz/doc/Zinojums_RP_2006_uz%20VM_ar%20papild.pdf, 19.08.2008

LR likums. Par Latvijas Republikas administratīvo teritoriju izveidošanu un apdzīvoto vietu statusa noteikšanu (Latvian Law on the administrative territory of the Republic and the establishment of settlements status determination), VSIA "Latvijas Vēstnesis", 06.06.1991.ar grozījumiem, 25.10.2006.

redakcija, In Latvian, Available at: <http://www.likumi.lv/doc.php?id=67938>, 17.08.2008

LR Reģionālās attīstības un pašvaldību lietu ministrija. Latvijas nacionālais attīstības plāns 2007.-2013.gadam (Latvian National Development Plan 2007 to 2013, 2006, In Latvian, Available at:

http://www.nap.lv/lat/nacionalais_attistibas_plans/iesakam_izlasit/?doc=1001, 24.08.2008

Rubana I.M. Veselības izglītības pamati (Health Education Basics), Raka, 1997, 23.lpp. In Latvian. Veselības ministrija. Definīcijas (Definitions). In Latvian, Available at:

<http://www.vm.gov.lv/index.php?top=117&id=120>, 20.08.2008

Velša Z. Veselības izglītības jautājumi (Health education issues), ISEC, 2005, 1-9.lpp., In Latvian,

Available at: <http://isec.gov.lv/pedagogiem/metmat/veseliba.pdf>, 16.08.2008

Romania

Community of Dumbravita

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1 Profile of health information systems

In Romania health care is generally poor by European standards, and access is limited in certain rural areas. The EU report “*Empowerment of the European Patient, Options and Implications*” published in Brussels in March 2009, places Romania in 30th place with regard to health information. The report considers that Romania offers his citizens very poor information and knowledge about health; even poorer than other East-European countries.

1.1 Institutions

Institutions of Health information in Romania	
Ministry of Health	
-	Public Health Institutes from Bucharest
-	Public Health Institute “Prof. Dr. Leonida Georgescu” from Timisoara
-	National Sport Medicine Institute from Bucharest
-	National Centre for Organizing and Assuring the Informational and Informatics System in Health Domain from Bucharest
-	Medical Sciences Academy Bucharest
-	National Mental Health Centre from Bucharest
Ministry of Work, Social Solidarity and Family	
-	National Department for social assistance and family politics
National Health Insurance Funds	
-	42 regional District Health Insurance Funds
National statistic Institute	
General direction of Public Health	
National Authority for handicapped people	
National School for Public Health and Sanitary Management	
House of Health Insurance	
Numerous Medical Societies	
Media	
Internet (specialised sites)	
TV	
Magazines and newspapers	
Specialised resources (general practitioners or specialised magazines)	
Physician	
Doctor	
TV	
Chemist’s shop	

The state-owned health care system was a target of the campaign to decentralize state services. The system has been funded by the National Health Care Insurance Fund, to which employers and employees make mandatory contributions. Private health insurance has developed slowly. Because of low public funding, about 36 percent of the population’s health care spending is out-of-pocket (Library of Congress/Federal Research Division, 2006, p 10). The health system suffers from practical problems and a negative mentality impacts the quality of its service.

1.2 Strategies and distributions

The most important national campaign concerning health education is made through the Romanian TV channels. There are some TV Spots to highlight and raise awareness of various issues about health: “The excessive consumption of salt, sugar and fat is bad for health”.

In Romania, 87% of people between 15-60 years old declare themselves interested in health information. This information is found by 38% on the Internet (specialised sites), 31% find this information on TV, magazines, journals and newspapers. Only 4% ask for health information specialised resources (general practitioners or specialised magazines). Women between 45-60 years old, with high educational level and top jobs are the most interested in obtaining health information. Their resources are: specialised magazines, specialised columns in newspapers and the physician. Unfortunately, most of the people interested in health information prefer to find this information (1-4 times a month) on TV shows and specialised sites on the Internet. On local levels, health information is distributed through national or local campaigns (e.g. blood pressure, blood sugar measuring). In addition, people receive health information by specialist doctors, general practitioners and school campaigns.

1.3 Media

In Romania, national surveys examine the populations’ health as well as the perception of health information. Media to distribute health messages are the TV, radio, newspapers, journals and national or local campaigns and their advertisement. The consumer health education domain needs various approaches for the society with stronger effects on the long run. Despite of the fact that the knowledge of what a healthy behaviour and a healthy lifestyle mean, is better, this knowledge – promoted as an official message – does not reach most of the population. Romania is well known for the „abundant” and unhealthy nourishment, for the sedentary life-style, as well as for the lack of preventive health behaviour. Nourishment habits that are unhealthy are maintained for many years and are noticed to be a barrier at the level of those patterns.

2 Community profile

Romania has chosen Dumbravita as the community to investigate for the information and the assessment of the education level on health as well as to implement the intervention program. Dumbrăvița is a community in Timiș, a west County from Romania. It was founded in 1892 by Hungarian settlers from Szentes, its original name being Hungarian: *Ujszentes* (New Szentes). It is located near Timișoara, in the northern part. As result of the city development, many people from Timișoara have built homes in Dumbrăvița, which has the tendency of becoming a quarter of Timișoara. This development has divided Dumbravita in two different areas: the old part of the community, which is functioning as a village and the residential part with very high life standards. This new area has increased the socio-economical status of Dumbravita.

2.1 Description

Dumbravita has an area of 18.99 km² from which 112 497 m² is residential area. It also owns a lake and a forest. The socio-demographic data shows a number of 2915 inhabitants living in 1417 households, which equals a density of 153.5 inhabitants/km².

In the analysis of the Romanian population, the target group identified being disadvantaged was the group of the elderly. Dumbravita has about 400 persons aged over 65. The elderly truly belong to the disadvantaged category in Romania. Their difficulties are many: economical, social, cultural, including information accessibility. Nutrition is also problematic, partly because of low economic resources, and partly because of the raising resistance to change and the increased tendency to maintain traditional nutrition habits, which are pleasant, but not always healthy. Often, their ideas of health, transmitted to younger generations, contain expressions such as: “healthy means having round, red cheeks”. If in the past, fat nutrition represented an efficient method of dealing with physical effort, present conditions turn these nutrition habits into toxic ones. Low physical effort, sedentary lives, even the lack of activity and social involvement, which so well characterize our elderly people, deteriorate their health state much more than their chronological age would justify. The lack of social participation, either due to exclusion, or due to economic limitations, decreases their access to efficient information about health. Often, adopting unhealthy nutrition habits, which are familiar, may represent a form of resistance in the inter-generation conflict, a form of keeping alive a world that could be a match for the modern society that does not fit them. Low life expectancy, decreasing self-esteem, the feeling of being useless, the lack of encouraging social contacts, the lack of the will to live (let us take into account the fact that, for many of Romania’s elders, retirement is equivalent to social death, since the necessary means that allow an active life are missing) greatly affect their health status.

Not least, migration makes many old people remain lonely in the country. Most people lack emotional support of the younger generations, or they are loaded with nephews whose parents work in different countries. Unfortunately, there are only a few institutions with the purpose to maintain elderly people’s quality of life. Consequently, this population category needs a much more careful approach from society, as well as discovering adequate means to solve their specific problems.

The community has a great ethnical and religious diversity. About 54% of Dumbravita’s inhabitants are Romanians, 36.15% Hungarians and 1.16% Germans. The main religion is Orthodox (47.13%), but the Catholics (20.51%) and Protestants (17.28%) represent also an important part in the community. There are also 3.91% Pentecostals and 0.85% Greek Catholics. Although there are few natives, culture and habits didn’t suffer because people moved here from places nearby. Regarding households, we can mention that most of Dumbravita’s inhabitants live in houses (over 50% of them with more than 100m²) and just a few in small apartment houses. More than 90% of them own the

houses they live in. The rate between the number of persons living in a house and its rooms is max. 2/1.

2.2 Health related resources

The most valued parts of the house are the garden, the yard and the kitchen, which is considered the centre or the “soul” of the house. In most of the houses there are 2 or 3 generations living, which is a common pattern in Romanian culture. From the economical point of view, it is important to note, that the rate of unemployed people is very low with 0.37%. Most of the people moved to Dumbravita when they were young, because of the abundance of work places that can be found. The statistical data show a number of 135 economical agents in Dumbravita.

Most of the people from Dumbravita are pleased and happy when they talk about their area and its mayor. In contrast with other localities Dumbravita is valued for its beautiful surroundings and its clean air (forest, lack, parks), for the fact that it has all the necessary utilities (gas, water etc.) and the side roads are in good shape. Also the main local institutions are very active in the community making the place safe, calm and prosperous.

The educational system is well represented by the high equipped schools and the active teaching staff. Dumbravita has one school with primary and secondary level where are learning 162 students and one kindergarten with Romanian and Hungarian classes with 112 children.

An important place in the community is the church. In Dumbravita there are 3 churches representing the three main religions in the local area.

The sanitary system in Dumbravita does not respond to the inhabitants needs. There is only one medical office where two physicians work in shifts only for few hours a day. In addition, there is one dentist. There are no clubs or voluntary services in Dumbravita.

3 Profile of households

3.1 Type of households

The qualitative research analysed 20 households. The quantitative research was conducted on 200 people, 90 elderly (60-85 years) and 110 people aged between 18-60 years. From the whole sample, there were 112 are female and 87 are male, 96 are pensioners and only 73 are working fulltime.

3.2 Perception of health information

The quantitative results show a lot of similarities between the whole sample and the elderly. Those similarities allow the assumption that elderly have not adapted their health behaviour to their age.

Furthermore, changes from one generation to another are scarce, and influenced by mentalities and traditions.

More than 50 percent of our research group think that they are well informed about healthy behaviour concerning physical activity, nutrition, mental wellbeing and social wellbeing. Contrariwise, almost 80% of them do not know the meaning of “5 a day” and about 20% think that they can keep minced meat in the fridge for 7 days. About 95.5% of the participants consider that in order to be healthy it is important to wash hands after using the toilet and to keep the fridge at the right temperature.

About 66.5% of the whole group and 74.4% of the elderly receive health information from the doctor, 63% of people from both groups from TV, only 14% of the whole group and 19% of the elderly get information about health from the chemist’s shop. An important aspect is that not even one person mentioned the local administration as a provider of health information. Most of the people (about 80%) from the research refer to their doctor if they have a problem regarding health, about 40% turn to their family for help and only 1-2% attends a meeting or a lecture.

Only about 30% of both groups claim that it is easy to implement health information in their daily life. An explanation could be the fact that almost 40% of them think that they have to spend more money for healthy food.

3.3 Daily life

Regarding physical activity, 39.5% of the whole sample and 49% of the elderly do exercises (e.g. walking, cycling and swimming) more than 5 hours a week. Activities take place, in private surroundings (50%) and nature (40%). Physical activity is considered to be important for a healthy life. Participants claim that they are engaged in such activities, but these are not made with the explicit goal of improving or maintaining the health status. These are actually daily activities they need to do in their house, garden or at their work. This idea is sustained by the fact that 30% of the elderly and almost 20% of the whole group disagrees with the fact that they are interested in active sports. Furthermore, the body weight of 21 persons from the entire sample is over 90 kg.

The elderly seem to have the same eating habits compared to the rest of the population. More than 50% of both research groups eat bread several times a day, rice and cakes are consumed by 40% of the participants several times per week. Potatoes are consumed several times a week by 50% of the whole sample. More than 50% of the participants eat fresh fruit and vegetables daily. They seldom or never eat/use whole grain bread, cereals, oil, butter, organic products, mineral, vitamin supplements or wine. About 20% seldom or never eat cheese or drink milk. Seasonal aspects may have influenced the

findings with regard of the fruit and vegetable consumption (the research was conducted during summer when fruit and vegetables are available in the people's garden).

Coffee and cigarettes are a part of daily nutrition for most of the people interviewed. There are no specific rules for meals. Most of the participants eat 2 or 3 meals per day, with irregular snacks in-between depending on mood (appetite).

Health is considered to be very important and is evaluated mainly with 10 points. At the same time, people think that health is very much related with everyone's destiny. There are people who are sick and others who are healthy. Furthermore, health is related with youth, and therefore cannot be expected after the age of 50 years. An interesting idea about health is that elderly think that it is easier for those who are young to keep themselves healthy, because life is not as difficult nowadays as it was when they were young. Despite the fact that elderly do not trust themselves being able to improve their health, those who have children and grandchildren show great interest in health education. This aspect was used as a resource for the intervention.

For most of the participants being sick means to go and see the doctor or to stay in bed. On the other hand, a healthy man is able to work and does not have to take any pills. For most of them taking care of their health means to keep themselves away from anything that makes them sick, especially food, to keep their shape by working and to be careful with their hygiene.

Evaluating their health status, show that mainly 8 points were given. Surprisingly, some of the persons who were diagnosed with diseases evaluated their health status higher than those who were apparently healthy. Blood pressure was not mentioned as a disease and people diagnosed with it do not respect a treatment because most people think it is very expensive or because they are not even convinced they are sick, as several doctors give different diagnoses or treatments to the same patient.

3.4 Resources and barriers and social network

The interest and the implication of the local administration for the community health are very low. Furthermore, the community cohesion is limited and people do not think that the administration should do something to improve the community health. A very low percentage of people is implicated in clubs or organisation and practically no one tries to get health information or help from the local administration. The general interest in health education is low even when the availability is presented, people prefer a passive implication. The people are not prepared to work together to improve the situation.

The social network in the community is under-developed. The social contacts in the neighbourhood are limited to the extended family and very close friends so that the social cohesion is low and even lower in the new residential part. Less than 50% of the people from Dumbravita think that it's important to make shared decisions in the community.

4 Interrelation of community's structure and people's knowledge

4.1 Participation of the inhabitants

In order to assure the participation of inhabitants in the development and the initiation of local Health Information projects:

- specific intervention methods were designed and considered to be helpful for the community of Dumbravita
- participation of different local institutions and firms to the intervention program (as sponsors and partners) were obtained
- support of the local mayor and the local administrative council for our actions was obtained and supported by offering the space for the meetings and they expressed their availability to sustain the development of a local network for promoting the health behaviour in the community
- support of the local churches and the interest of the local medical network was obtained
- support of the local schools was obtained, in order to disseminate the intentions and the information about the project and about the meetings was obtained; the teachers also supported us in the organization of the special meetings for improving knowledge of healthy eating behaviour at children
- information letters were used to announce the meetings program, for all the inhabitants

Between January and May 2009, these intervention methods in the community were implemented by taking into consideration that the direct connection of the local inhabitants improved the success of the intervention as a whole.

4.2 Local activities

The intervention program consisted in 5 meetings with inhabitants from the community. Our purpose was to offer information about healthy eating behaviour and to stimulate the interest and the participation of all members of the community in developing a local network to assure the success of the intervention.

The first meeting:

- The presentation of the project: the purposes of our action and our short and long terms intentions in the community
- The presentation of the results of the quantitative and qualitative study from the first phases regarding households' resources, barriers and need for information

- General information on healthy food: advices and rules for a healthy diet, presentation of the most healthy food (with examples); the enemies of a healthy diet

The second meeting:

- The presentation of the risks of unhealthy eating habits – discussions about the most important illnesses due to an unhealthy diet: diabetes mellitus, coronary heart disease and hypertension, ulcer, colitis
- Practical activities: measurements for establish the arterial pressure and body mass index, with practical advices in order to ameliorate the difficult situations

The third meeting:

- The healthy diet is usually more expensive. So, we tried to demonstrate “how we can eat healthier at the same price” and to present alternatives of healthy eating behaviour

The fourth meeting:

- Discussions about the healthiest diet for children: the risks of an unhealthy diet for child development
- Advice for parents in order to create healthy eating habits to their children
- Practical activities with children: using games, we tried to convince them about the benefits of a healthy diet

The fifth meeting:

- The final analysis of our intervention program;
- Discussion on the possibility of initiating local projects and a network for promoting health information
- Feedback from children: a short performance presenting the advantages of a healthy diet

The results of the intervention program have been assessed through the re-evaluation questionnaire.

5 Conclusions

Due to low social contacts their perception of health information is limited. Most frequently used sources of health information are TV and family. There is no social network which allows an open discussion to gain health information.

References

Library of Congress/Federal Research Division (2006): Country profile: Romania. Available at:

<http://memory.loc.gov/frd/cs/profiles/Romania.pdf> Accessed on 04.09.2009

www.dumbravita.com

www.timis.insse.ro

EU Report: Health Consumer Powerhouse, The Empowerment of the European Patient 2009-options and implications

Sweden

Community of Eriksberg

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1 Profile of health information systems

Sweden (9,182,927 inhabitants) consists of 290 municipalities and 21 county councils. Most public health work is undertaken at the local level by the county councils, the municipalities and by non-governmental organizations. Preventive and population-oriented health care have been integrated into primary health care. The Ministry of Health and Social Affairs is responsible for health care, health, social issues/insurance in Sweden. Also the Ministry of Agriculture offers information about health issues. There are today three authorities responsible for public health information:

1.1 Institutions

Institutions of Health information in Sweden
Government
The Ministry of Health and Social Affairs
The Ministry of Agriculture
Government sponsored agencies:
Swedish National Institute of Public Health (SNIPH) which is a state agency under the Ministry of Health and Social Affairs
National Food Administration (NFA)
National Board of Health and Welfare
Professional bodies:
The Swedish Medical Association
The Swedish Dental Association
The Swedish Association of Clinical Dietitians

The SNIPH works to promote health and prevent ill health and injury, especially for population groups most vulnerable to health risks. Because most public health activities in Sweden take place at the local and regional level, the majority of the Institute's work is directed towards staff, managers and decision-makers within municipalities, county councils, larger regions and other organizations. The NFA, the central supervisory authority for matters related to food, has the task of protecting the interests of the consumer by working for safe food of good quality, fair trade practices, and healthy eating, i.e. dietary recommendations. The National Board of Health and Welfare, a government agency under the Ministry of Health and Social Affairs, has a wide range of activities and duties within the fields of social services, health and medical services, environmental health, communicable disease prevention and epidemiology. One of the latest publications is the seventh environmental health report, issued in 2009.

1.2 Strategies and distributions

All county councils have websites where information (publicly and privately provided) about health care services can be found. Special health education programmes on tobacco, diet and alcohol are all functions typically carried out by general practitioners. The municipalities are responsible for the major part of local environmental policy, including disease prevention and assessment of food quality. Health journalism plays an important role in public health. Daily papers are the most common source of health communication for Swedish people regarding issues like diet and health. Further, communicating via computer, Internet, and via various websites is common for national authorities, at the regional and local level. Leaflets are directed to specific target groups and health problems that are relevant to these groups. Campaigns are also one way to communicate, but during recent years this method has not been used so frequently due to evaluations showing the relatively weak results of such efforts. Certainly, advertisement (food, alcohol and tobacco) also exists.

1.3 Media

According to a recent master thesis (2009) results show, that those people who are responsible for information on healthy diets believe that there are difficulties in reaching out with such information, because of the current information environment. However, they all agree that the responsibility for an individual's health is ultimately with the individual. The main results from the present study show that young and old participants perceive and receive health information in a slightly different way. Younger respondents receive health information via the media and family, while older respondents receive their health information from their medical doctor, including information regarding specific issues, e.g. how to achieve a healthy diet (unpubl. data).

2 Community profile

The urban area Eriksberg is situated on a hill in the central part of West Uppsala and is located about three to four kilometres outside of the city centre. The area is surrounded by green areas and a city forest with several walking trails. The busiest location is the square *Västertorg*, which offers most of the economic infrastructure.

2.1 Description

A majority of inhabitants like living in Eriksberg and have no desire to move. Several crime incidents have been reported in the area. In spite of all this, almost everyone feels safe in the area. However, many of them don't leave their homes in the evenings.

The population in Uppsala Municipality consists of 187,511 inhabitants (in 2008), who live in an area of 2189 km² (85 individuals per km²). The population of Eriksberg is 6703 inhabitants: 46 percent males and 54 percent females (Uppsala as a whole 49% and 51%, respectively). Nineteen percent are older than 65 years (Uppsala 14%; Sweden 16%). In the urban area, 21 percent of inhabitants have a non-Swedish background (Uppsala 19%; Sweden 17%).

Inhabitants in Eriksberg are generally pleased with their homes. Of the 4077 households, 227 are small houses and 3850 are flats, some of which are found in almost eight-storey-high buildings.

2.2 Health related resources

The majority think Eriksberg is a “healthy” neighbourhood, owing largely to the Håga valley, the nearby city forest and also the fact that Eriksberg is situated on a big hill, thus supplying the area with lots of fresh air. A large allotment garden is located very close to Eriksberg. There are two main bus service lines during day time, and also one night bus that regularly goes from the area to the city centre. An important point in improving the infrastructure would be to lower the bus fares. A general wish is to decrease the traffic load. In Eriksberg, 38 percent of households own a car (Uppsala 47 percent). There are also several bicycle tracks. Another important improvement would be to increase the number of park benches in the green area and to improve forest trails, which would help the elderly get outside.

Västertorg offers a choice of local companies, e.g. two grocery stores, two banks, a pharmacy, a hairdresser, a restaurant, a bakery (temporarily closed) and a kiosk. This area is normally frequented by people who live or work in Eriksberg. The elderly would like to see a greater variety of shops.

Near Västertorg are two schools, a library, a dentist practice, a health care centre and two homes for the elderly. Further from the square, there are also four different restaurants, a kiosk, a church and yet another home for elderly people. Most people are satisfied with having two grocery stores, but many complain that they are too expensive. Elderly people who live at a distance from the square wish there were a grocery store closer to them.

3 Profile of households

3.1 Types of households

The study includes 202 participants from 21- 81+ years, with an age distribution of 21-60 yr (48%) and 61-81+ (52%), 34 percent men and 66 percent women. More than half of the informants (55%) had a graduation level from upper secondary school, whereas about one fourth (26%) had limited education. Sixteen percent of informants had a non-Swedish background. More than half of the informants (57%) reported that they were tenants, while the others (43%) owned their own housing. Almost half of the informants lived alone (47%) and a third (32%) lived together with another person. The largest household type in this study consisted of five persons (2%).

According to statistic data from Uppsala Municipality, in the urban area Eriksberg, 44 percent were single living parents (Uppsala 28%; Sweden 20%) and the mean income level in this urban area was

21,900 euro (male 23,500; female 20,400), which is in line with the average income level for the whole of Uppsala Municipality.

3.2 Perception of health information

More than half of the informants (54%) reported being able to receive all the health information they want locally. Elderly and young people got their health information from different sources. A large part of the population (79%) thought that they understood instructions on medications and health information, and more than half (53%) reported that they never get confused, while 43 percent said they got confused sometimes.

The majority of informants (84%) always or at least sometimes read the list of ingredients and nutrition information on foods, while a few (13%) never or seldom do so.

The elderly associated health information with medical doctors and diseases, not with preventive care, physical exercise or food. Further, this group said that they don't need health information, and many don't trust information from sources other than their own medical doctor. However, in the younger generations, sources such as friends, family, TV and newspaper articles contributed to the overall health information they took in. More information about foods and hygiene was desired by these informants.

3.3 Daily life

Of the informants, 34 and 33 percent reported consumption of fresh fruit and vegetables, respectively, several times a day, and somewhat less than half (49%) consumed these food items almost daily. More than a third knew what "5 a day" means, but among the elderly (70+), only a minority (10%) knew. According to the recommendations made by NFA, some people living in Eriksberg should increase their consumption of fruit and vegetables to 500 g a day. However, many eat fruit and vegetables regularly, and a majority of the sample (82%) agreed with the statement "to keep healthy I eat fruit and vegetables every day". Further, it was shown that those who were familiar with the message "5 a day" also reported more frequent consumption of fruit and vegetables. More than a third of informants consumed whole grain bread several times a day (34%). About half of the sample (48%) reported eating fatty fish once a week, while a fifth (20%) reported eating fatty fish several times a week. According to recommendations, these intake figures are too low. Considering the fat quality of their diet, 37 percent of responders reported an almost daily intake of oil, while only seven percent reported consuming this food item daily. A large proportion (30%) of the sample reported consuming margarine several times a day.

It was found that some people feel uncertain about food handling. More than a fourth (26%) did not understand the importance of not letting raw meat come into contact with other food items. Some (43%) failed to affirm the importance of checking the refrigerator temperature. In the qualitative study among elderly, it was shown that they were neither aware of the refrigerator temperature nor of the temperature differences on different shelves, although they did consider themselves to have sound

knowledge of how to handle and store foods. They expressed confidence in the grocery store and as such did not see the need for information.

In a separate questionnaire regarding hygiene issues, (n=249) 15 percent reported that they normally taste raw minced meat. Of this sample, 127 informants were 70+, and of these 20 percent reported that they normally taste raw minced meat. Four percent of all informants had suffered from food poisoning during the past year, which is in agreement with other Swedish studies. However, one fourth was afraid of food poisoning. A minority (12%) agreed strongly/agreed that it is boring to live a healthy life, and the majority (52%) reported that their general health is good. However, the elderly reported wanting to improve the health care system and care for the elderly. Further, this target group would like to have increased opportunities to engage in physical exercise, e.g. to open a health centre with a swimming pool or to open a gym for elderly people. Of the entire sample, 48 percent agreed/agreed strongly that they are interested in active sports.

3.4 Resources and barriers and social network

Eriksberg is surrounded by green areas, a city forest and allotment gardens nearby. Västertorg offers a variety of food stores as well as services, e.g. a health care centre, a dentist office and a drug store. Buses go frequently between the area and the city centre. Further, there is a variety of living and care systems for the elderly.

There is only one dietitian employed by Uppsala Municipality. The dietitian, employed at the primary health care centre in the urban area, deals with people who have already received a diagnosis from a medical doctor. We wish to emphasize the importance of investigating the health promotion work done by dietitians.

The qualitative interviews showed that the elderly often feel they have enough knowledge about food handling and that they don't see the need for information. Such attitudes might be an obstacle to accessing further information.

There are associations that have activities in the urban area, e.g. housing co-operatives, allotment garden activities and senior clubs. However, people living in Eriksberg often go to the city centre for their activities, such as sport clubs or various courses.

The aim of the local network meeting in the framework of the CHANCE project was to initiate a dialogue between local stakeholders and politicians in Uppsala Municipality, as well as concerned target groups in Eriksberg. A total of 25 key persons were invited. The aims of the project and results from the quantitative questionnaire were presented. The participants were divided into small groups, where they discussed results from the quantitative study as well as the preliminary idea of providing

education via a computer programme, and they concluded with other ideas about how future improvements in health maintenance could be achieved. The network meeting was concluded after the participants had documented their ideas.

4 Interrelation of community's structure and people's knowledge

4.1 Participation of the inhabitants

The intervention study was based on results from earlier studies that were part of the CHANCE project. Two kinds of health promotion programmes (PowerPoint on CDs) were developed by dietitian students in the ongoing course "Dietetics and public health" at our department. One programme focused on the "5 a day" concept, while the other concerned food safety. One suggestion from the network meeting was to build bridges between older and younger people. Therefore, part the intervention was held in the primary school in Eriksberg with the help of pupils. Recruited informants (n=92) took part in group meetings (February – April). The information was provided via computers, followed by a short group discussion. Questionnaires were filled in before, directly after and three weeks after the information.

The result illustrates a statistical significant improvement in knowledge according to the meaning of the expression "5 a day", cross contamination and the recommended storage temperature for smoked salmon and raw minced meat. However, no behavioral changes were found. For behavioral change this model must be developed. The information program together with a discussion can be a useful health information model to improve knowledge about and the meaning of "5 a day" and food safety. Further experience from this study illustrates that it is difficult to get people interested in participating in health education even if it is offered in the nearby surroundings.

4.2 Local activities

A possible strategy would be to invite different target groups, and to include these health information CD- programmes as an approach in line with the already established course material *Food classes for the elderly*, which has been investigated by our department at Uppsala University and funded by the Uppsala Municipality. Future plans are to reproduce the information programmes on CDs and to implement them in other municipalities in Sweden. This kind of computer communication can be easily and inexpensively administered and implemented at home, at health care centres, in schools, by pensioner organizations, food stores, different kinds of local networks, etc. Additional knowledge about health promotes the realization of a healthy life.

5 Conclusions

The majority of the inhabitants like living in Eriksberg and are in general pleased with their homes. Young and old participants perceive and receive health information in a slightly different way. Younger people received health information via media and family, while many old people do not trust

information from sources other than their medical doctor. During the intervention health information (CD-programmes) was provided via computers, followed by a short group discussion. The results of the current intervention illustrate a statistically significant improvement in knowledge according to the meaning of the expression “five-a-day”, cross contamination and the recommended storage temperature for identified food items; measured after three weeks of information. Within this intervention project however, no behaviour changes were identified. Experience from this study shows that:

- more effort and resources are needed in the recruitment process;
- the intervention model should be developed with a second group meeting;
- to activate participants is important and could be exemplified through a home task related to the issues;
- information and involvement of community and local area stakeholders is important to reach different target groups and to receive improved knowledge as well as promote long-term behaviour changes.

The local network meeting held in Eriksberg started a dialogue between local stakeholders and politicians in Uppsala Municipality, as well as concerned target groups in Eriksberg. One suggestion from the network meeting was to build bridges between older and younger people. In a planned intervention two more local stakeholders will be included.

References:

Redmond C E, Griffith J C. (2005). Consumers perception of food safety education sources, implication for effective strategy. *Br Food J*, vol 107, no 7; 484-99

SLV (2007a). Ett halvt kilo om dagen! Available at:

http://www.slv.se/templates/SLV_Page.aspx?id=13878&esplanguage=SV

SLV (2007b). Folkhälsoarbete-nationellt och internationellt. Available at:

http://www.slv.se/templates/SLV_Page.aspx?id=14627&esplanguage=SV

SLV (2007c). Livsmedelverkets 5 kostråd. Available at:

http://www.slv.se/templates/SLV_Page.aspx?id=13873&esplanguage=SV

SLV (2008), Matförgiftningar. Available at:

http://www.slv.se/templates/SLV_Page.aspx?id=2569&esplanguage=SV

Sandberg H. (2005). Medier en arena för hälsokommunikation. *Medie och kommunikationsvetenskap*, Lunds universitet. Available at : http://www.nordicom.gu.se/common/publ_pdf/184_027-036.pdf

Schiavo R. (2007). *Health communication from theory to practice*, jossey-Bass. ISBN:978-0-7879-8205-8

WHO (2003). *Diet, nutrition and the prevention of chronic disease:2003*. World Health Organization Technical Report Series 916

World Cancer Institute /American Institute for Cancer Research.(2007). *Food, nutrition, physical activity and the prevention of cancer: a global perspective*. Washington DC:AICR, 2007

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1 Profile of health information systems

Much health information is provided as a result of Government policy which in recent years has attempted to re-focus the National Health Service (NHS) to have a greater role in disease prevention and health promotion. Many campaigns are funded by Government but they tend to be 'ad hoc' and relatively short term (although some recur, for example the annual 'Don't Drink and Drive' campaign at Christmas). Several government departments may deliver health information, including: Department of Health, Department of Transport, Department for Environment, Food Standards Agency, Food and Rural Affairs and the Department for Children, Schools and Families, but all use known outlets, e.g. GP Surgeries, Health Centres, Sports Centres, etc.

Information is delivered at national, regional and local levels (where local can mean for example a city or a much smaller locality). A large number of organisations are involved:

1.1 Institutions

Institutions of Health information in the United Kingdom

Government

Department Health, Department of Transport, Department for Environment
Department of Food and Rural Affairs, Food Standard Agency
Department for Children, School and Families
Department for Media, Culture and Sports

Local Government

Public health
Health promotion
Sport/leisure services
Leisure centres

Government sponsored agencies

Food Standards Agency
Health and Safety Executive (workplace health)
National Health Service (primary care, secondary care, public health, health promotion including employment of health trainers and food workers)
Schools (may be private or state run)
Institutes of Higher Education (Universities)
Further education colleges

Professional bodies

British Medical Association
British Dental Association
British Dietetic Association
Royal College of Surgeons
Royal College of General Practitioners

Third sector, non-governmental organisations

Age Concern
MIND (mental health)
Heart of Mersey (very local)
Local Solutions
Sustrans

Private sector

Health sector: pharmaceutical companies; private health care organisations; clinics; therapists; licensed and unlicensed health professionals; private leisure centres

Food sector: producers; trade associations; manufacturers; and retailers

Sport/leisure sector: manufacturers; outward bound (courses & holidays)

Media

TV and radio (local and national)

Newspapers and magazines (local and national)

Internet

Posters

Not surprisingly, there is a common perception that experts on health do not agree and that health information messages constantly change. However, this is not necessarily true for information from ‘official sources’; for example, dietary advice has been remarkably consistent both over time (40 years or more) and between authoritative professional organisations. In addition there are clearly problems with health literacy in the population; about 20% of adults have very poor general literacy (effectively they can not read or write) and innumeracy skills.

1.2 Strategies and distribution

Some health information is required by law; for example, health warnings on cigarette packets and the National Curriculum in schools requires that issues related to health are addressed. In addition, specific products are accompanied by health information usually related to health and safety issues, for example food storage.

In addition, many manufacturers and service providers use ‘health’ as a lever to market their products, for example motor cars, vacuum cleaners, textiles, insurance, etc. Thus the scope for delivery of health information through the private sector is almost unlimited and a wide variety of media are employed.

The list (see above) is inevitably incomplete and suggests only the flavour of the information which besets consumers. The list also demonstrates the inherent conflicts of interest and hence the very high degree of health literacy expected of consumers to be able to make truly ‘informed choices’ on the basis of unbiased information. Health literacy, therefore, should be at the heart of government health policy since informed consumer choice is regarded as being the prime impetus to health promotion but relatively little attention has been explicitly paid to the topic. The UK population is subject to prodigious amounts of health information from a huge variety of sources, much of which is concerned with achieving commercial objectives. It is suggested that many (perhaps most) UK consumers are ill equipped to deal with this information, although there seem to be no studies to confirm this.

1.3 Media

The World Health Organisation (1946) has had a marked influence on national policy with regard to health. The WHO definition of health has been adopted, as has its prime target for health in Europe – ‘Equity in Health’. Hence addressing health inequalities is invariably a target of health initiatives at all

levels. However, government policy for nearly 30 years has embraced the free market philosophy and there are repeated references, for example in policies on health, to being a nation of ‘consumers’. Consumers in the UK are subject to a barrage of information on health. Little of this information is from ‘official’ sources and much is neither vetted nor regulated.

A key report commissioned by the Labour government when first elected was the “Independent inquiry into inequalities in health” (Acheson, 1998), known as The Acheson Report. This comprehensive review revealed the extent of the ‘health gap’ between rich and poor and concluded that these inequalities were “...fundamentally a matter of social justice...” and it pointed out that “...factors influencing inequalities in health extend far beyond the remit of the Department for Health”. This then set the prime target for the new health agenda and suggested that a more holistic approach would be required to deliver equity in health. This report was followed by the first summary of the government’s policy on health (DH, 1999). Four priority areas were identified (cardiovascular disease, cancer, mental ill-health and accidents) all of which show huge socio-economic inequalities. The policy highlighted the need to address the ‘root causes’ of ill health which were accepted to be socio-economic in nature. However, a recurring theme in government policies (which date back some 30 years) has been the emphasis placed on helping the ‘informed consumer’ to make healthy choices, encapsulated in the title of the government’s latest statement on public health policy, “Choosing Health: making healthy choices easier” (DH, 2004). For example, Tony Blair in the Preface wrote “...the responsibility that we each take for our own health should be the basis for improving the health of everyone across the nation”. Thus, collectivist notions of health promotion have been firmly set aside in favour of a consumer driven vision where ‘consumer sovereignty’ and the resulting accumulation of ‘utility’ will ensure that appropriate individual decisions are taken. Clearly for this to happen, individual health literacy is a paramount requirement.

Other factors for consideration concerning models of health behaviour include the health belief model, social learning theory, protection motivation theory, transtheoretical model and social marketing, most of which indicate the importance of ‘knowledge’ but few recognise ‘health literacy’ as such. Finally, the concept of social capital is very relevant and health literacy/health information is an important facet of a community’s ability to promote and protect health.

2 Community profile

Liverpool was once a thriving city but thirty years ago the city entered a period of decline when the introduction of neoliberal policies and the deregulation of social housing led to a greater number of rental properties being occupied by professional people in what were traditionally very working class areas. This blurring of social boundaries and the mix of people with different educational backgrounds skews statistics relating to lifestyle and health literacy. Indeed, health inequalities in Liverpool can no

longer be generalised to any particular geographical area or parliamentary ward which makes data acquisition more problematical if one is attempting to study people from a particular social background and refine it to a specific location.

2.1 Description

South Central Liverpool stretches for about two miles south along the river Mersey from the city centre. The area was built at the height of Liverpool's global prosperity and has a unique urban character. Its communities are comprised of a highly diverse range of cultural backgrounds and faiths, including the majority of Liverpool's long established and newer Black and Minority Ethnic (BME) residents. Deprivation is acute, and poor housing, health inequalities, low income, crime, discrimination and worklessness adversely affect the lives of many residents.

Employment Rate 50 - Retirement Age July 2007 – June 2008					
Liverpool	Merseyside	City Region	North West	GB	
All Persons	36,800	126,000	140,400	704,000	6,390,600
All Persons	60.8%	62.4%	62.8%	67.3%	71.7%
Worklessness – August 2008					
Liverpool	Merseyside	City Region	North West	GB	
All Persons	64,460	161,350	174,870	627,210	4,368,560
All Persons	22.6%	19.4%	19.3%	14.8%	11.9%
Working Age in Employment – July 2007 – June 2008					
Liverpool	Merseyside	City Region	North West	GB	
All Persons	177,400	551,600	604,800	3,042,000	27,276,900
All Persons	63.5%	67%	67.3%	72.1%	74.5%

Source: Annual Population Survey 2008

2.2 Health related resources

More recently, regeneration has been accelerating at an astonishing rate with more than £3 billion being invested in major projects which are changing the face of the city. It is important to note, however, that Liverpool still has among the highest morbidity and mortality rates and one of the lowest levels of life expectancy in the country and, as in the 19th Century, there remains a stark contrast in health experience between the rich and poor. What is more, as the global economic crisis continues predictions of cuts in the budgets of private and public sector industries within the United Kingdom are pessimistic and will unquestionably affect the delivery of many planned health interventions, possibly exacerbating health inequalities even further.

Local Stakeholders

Liverpool City Council
Liverpool John Moores University
Liverpool First Culture Task Group
Liverpool Hope University
Liverpool Community Network
Liverpool Charity & Voluntary Service
Forum Liverpool First for Health & Well-Being

Liverpool Primary Care Trust
Liverpool University
Liverpool Culture Company
Liverpool Environment Network
Liverpool Disability Network
Liverpool Senior Citizens
Community Regeneration Forum

3 Profile of households

3.1 Types of households

600 questionnaires were submitted to residents of the South Central Liverpool area; the majority of respondents were unpaid Carers, i.e. people responsible for providing varying degrees of care for dependents, usually relatives, within their own home. Only 25.4% were working (most of these part-time). 41.8% were retired and 9.7% unemployed and a further 10.4% were 'homemakers'. Only 6% described their income as above average compared with the community and 39.6% thought their income was below average.

Most had parents born in Liverpool, 56.7% mothers and 55.2% fathers, and 84.3% had always lived in the city. Of those 7.5% who had moved to Liverpool 4 had been here over 20 years. Only 1.5% claimed not to have always lived in the UK but a further 14.2% did not answer the question.

3.2 Perception of health information

Few respondents admitted to not feeling well informed about some health issues:

I feel well informed about healthy behaviour concerning physical activity

very true	97	72.4
don't know	19	14.2
not true	10	7.5

I feel well informed about healthy behaviour concerning nutrition

very true	84	62.7
don't know	27	20.1
not true	11	8.2

Health and Provision of Unpaid Care in Liverpool

	2001	%
People with limiting long-term illness	108,271	24.6

People of working age population with limiting long-term illness	56,787	12.9
General health: People whose health was: Good	283,339	64.5
General health: People whose health was: Fairly Good	95,521	21.7
General health: People whose health was: Not good	60,613	13.8
Provision of unpaid care:		
people who provide unpaid care	48,123	

Source: Office for National Statistics

3.3 Daily life

Most people were satisfied with their homes but far more expressed less positive views about the neighbourhoods (25% did not feel safe and a similar proportion wanted to move). However, very few respondents gave indication of lack of self-efficacy (only 3% claimed to be usually unable to think of a solution to problems).

Little time was spent outdoors with more than half of the respondents (53.7%) spending 2 hours or less outside each day. A minority claimed to take more than 5 hours exercise per week (26.9%) and a similar proportion claimed to take less than 1 hour or none (28.4%). Most (50.7%) claimed never to have attended events in the local community and only 19.4% belonged to any neighbourhood group. Most (73.9%) claimed to read nutritional information at least sometimes. A substantial minority gave responses indicative of poor knowledge about basic food hygiene.

Most respondents thought their health to be good or very good (68.7%) but 14.9% thought their health poor or very poor. A very substantial minority expected their health to deteriorate in the next three years (23.9%) and only 19.4% expected improvement.

3.4 Resources and barriers and social network

Health is a major issue across South Central with some areas having Standard Mortality Rates approaching twice the national average. Liverpool male life expectancy has risen by 2.1% since 1998 and the average age is now 72.7. Female life expectancy has also risen but only by 0.6% & averaging age of 77.7.

During the period 2001/2003 and 2002/2004, Standard Mortality Rates (SMR) for Cancer and Heart Disease have decreased by 13.3% and 8.3% respectively. The SMR for Stokes has also seen a reduction of 9.4%.

4 Interrelation of community's structure and people's knowledge

4.1 Participation of the inhabitants

The original questionnaire proved very problematic to deliver; many respondents required help to complete it and a number refused to complete the whole questionnaire, perceiving it to be too long. It is likely that the results are optimistic, firstly because of 'healthy volunteer' selection bias and secondly because of optimistic answers, but neither of these can be verified. Furthermore, many terms were used without definition, e.g. 'health', 'exercise', 'help' needed, 'mental wellbeing' and 'social wellbeing' so although most respondents answered these questions their interpretation of the terms is open to question.

As a result of both quantitative and qualitative studies relating to the health literacy of informal Carers, it became apparent that there is much scope for action in this community to improve/promote health. There seems to be unmet needs, possibly a limited sense of community and limited positive health related behaviours. Focussing on food hygiene appears to be a good opportunity to improve health related behaviour (health literacy). Consequently, a Basic Food Hygiene Course was identified as a potential health intervention. The course was delivered by a member of the Chartered Institute for Environmental Health at a social enterprise organisation, Local Solutions, which has extensive experience of working with Carers in the community. It was delivered to twenty-four participants during February 2009. On completion of the course, all participants were accredited with a Chartered Institute of Environmental Health Basic Food Hygiene Certificate

A telephone interview was conducted after two weeks to evaluate the efficacy of the Food Hygiene Course as an appropriate health intervention. Ten questions were developed in order to ascertain a subjective evaluation of the experience of taking part in the Food Hygiene Course. Five general questions were also asked in order to determine motivation for attending the course, as well as positive and negative outcomes.

Everybody said that they had enjoyed the experience and all had met new people. One of the participants had not been able to complete the course due to ill health. However, the remainder unanimously agreed that they had learned new things as a result of attending the course.

Food hygiene is clearly an appropriate intervention for Carers since the participants have a vested interest in developing best practice and enhancing the quality of care that they provide. As a consequence of this particular intervention, all of the participants claimed to have become more conscious of health and well-being and had changed their food handling, preparation and storage practices accordingly. However, caring is a demanding role and can be socially excluding and so some Carers were either unable or unwilling to attend the food hygiene course. Therefore, sensitivity to the

responsibilities and lifestyles of Carers is essential when designing future interventions and should encourage participation.

4.2 Local activities

Issues that were identified by the quantitative and qualitative research are:

- there is little provision in terms of support and health interventions;
- national voluntary organisations are considered ineffective;
- support provided by Local Solutions (our partner) is highly valued; and
- specific health information is available for the cared-for but generic information for the Carer is scarce.

In the first instance, i.e. the Food Hygiene Course, the opportunity for building social capital or social networking was lost due to the scatter of the population. However, the organisation delivering this intervention also provides other opportunities for Carers which operate very flexibly, allowing people to attend on an 'as and when' basis. They include a Carer's support group, a reading group, use of a gymnasium, and Tai Chi and other alternative therapies.

Enabling Carers to be instrumental in identifying an area of need and providing training incorporates freedom of choice and encourages lifestyle and behaviour change and potential quality of life. As a result, a DVD 'Scouse Nouse' was produced that focused on Food Hygiene pertaining to the preparation of a local cultural dish, Scouse. Consulting with Carers as to the appropriateness of the DVD provided an opportunity to contribute to the intervention and further enhance Carers' self-perception and foster a sense of authority and empowerment. Carers also benefited from an improved perception of themselves by demonstrating how much they already knew, increasing self-esteem and motivating them to engage in other events.

5 Conclusions

It is recognised that as a result of caring for another, Carers may inadvertently neglect their own health and well-being, and suffer from isolation, stress and a perceived lack of control. A more holistic approach to the management of these issues has identified several appropriate interventions which have been designed in collaboration with Carers and Professionals at the Local Solutions' Carer's Centre. A continuing programme of events has begun, commencing with a Scouse Tea Dance and Health Festival which were very well attended and followed by a Carer's Summer Walk for Health and a Pamper Day. Future interventions include:

1. Stress Management
2. Yoga
3. Relaxation
4. Basic Nutrition
5. Food and Mood

References

- Acheson D (1998). An Independent Inquiry into Inequalities in Health. TSO: London
- Department of Health (2004). Choosing Health – Making Healthy Choices Easier. TSO: London.
- Department of Health (2007). Health Literacy. [Online]
Available at:
http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Healthyliving/DH_080149
[Accessed 2.10.2008]
- Liverpool City Council. (2008). City of Liverpool Key Statistics Bulletin, 2008. [Online] Available at:
<http://www.liverpool.gov.uk> [Accessed: 14.09.2008]
- The City of Liverpool Key Statistics Bulletin Issue 4 - March 2008 [online]
Available at: <http://www.liverpool.gov.uk/Images/tcm21-120488.pdf> [Accessed: 14.10.2008]
- World Health Organisation (1946). Constitution: Basic Documents. Geneva: WHO

Summary

In the following, different experiences from each partner country are summarised:

- Health information systems differ in the six participating countries from simple to high complexity.
- The perception of health information was influenced by the complexity of health systems, community, migration background, age and gender.
- Mass media play an important role in all participating countries, the influence of physicians varies.
- Local network and analysis of the local community were necessary for specific local-oriented interventions.
- The initiation of local networks needs time. Some partners could rely on available networks, while others have to create and build up new networks.
- Needs oriented projects on local and neighbourhood level reach disadvantaged social groups better than wide-ranging interventions.
- Interdisciplinary exchange and communication were very important for the development of several instruments for dissemination.

Conclusion

Health information must be short, easy to understand, Europe-wide, published over mass media e.g. television, press, internet.

Integration of local structure, milieus and social networks are necessary for health information and promotion interventions.

Support for disadvantaged groups must be evidence-based, as well as manageable in terms of nutrition, motion and recreation in the lifelong learning processes.

Prospective interdisciplinary and local oriented teamwork for health promotion – supported by research – should take place and financially supported.

We would like to thank all partners, staff members, stakeholders and all people who came across to join and contribute the project.