

Situation analysis and Needs assessment in

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

Reducing Inequalities in Health

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Preface

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

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



Health Report 2012, the social determinant and unfair, but because they place an economic burden on society. Poor health leads to high health care costs. Additionally, people in poor economic and environmental factors. Another health care cost is, according to this report, access to effective health services. At least 25% of health inequalities (differences found within a country's population) are associated with a lack of access to effective health services.

This publication gives an overview of the general health situation and needs to tackle health inequalities in seven European regions together with examples of promising practices.

Health inequalities that can be avoided should be tackled as should interregional health inequalities and differences in the health status of populations in different regions. Not only because inequalities are unjust

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1. Bulgaria, Lovech



General data

of the population estimated to be living on the poverty line is even higher for the Lovech area, namely 23.9% (males 24.3%, females 23.6%) (1). According to AROPE's definition, 66.6% of the population (69.9% of the men and 63.8% of the women) are at risk of poverty or social exclusion in Lovech (1), which is higher than the national average (49.2% of the population, males 47.3% and females 50.9%).

The leading causes of mortality in Lovech are consistent with those for the country. The unemployment rate in the Lovech district is close to the national average or 11.2% (2011). The unemployment rate on national level by gender shows a percentage of 12.7% for males and 10.1% for females. The national unemployment rate of the active population under the age of 25 is 24.6%.

The total population with an upper secondary education in 2012 in Lovech is 61.6% compared to the national percentage of 43.4%. Recent data of NIS 2011/2012 shows 18.5% drop-outs from general and special schools in the Lovech region. Although the educational level of Lovech is above average, Lovech is still a deprived region. Health and Health inequalities

Life expectancy at birth in Bulgaria in 2011 was 73.9 years (males 70.7 years, females 77.8 years). Healthy life years (HLY) for women were 65.6 years and for men 62.4 years. Life expectancy at birth is slightly lower in Lovech, namely 73.53 years (males – 70.12 years, females – 77.20) (1).

The top three health problems at the national level according to disease-specific mortality rates were: cardiovascular diseases (67.0%), cancer (15.7%) and respiratory system diseases (3.7%). Morbidity rates show



focus efforts primarily on those risk factors: community in the region, such as employment characterized by greater stability – smoking, and educational levels, routine examinations, alcohol and low physical activity. A good-prosperity and immunizations as a result of region. A key objective for this program would be to integrate a strategy monitoring activities. These data health services into a broader intersectoral could be of assistance in developing and implementing commitment to promote healthy living habits, complementing the action plan for reducing health and a health-supportive social environment. inequalities.

The Lovech action plan will focus on the Challenges that should be considered when prevention of smoking. Lovech has the highest in implementing the Action Plan include the or smoking rate amongst adults (44.3% males, organization and coverage of the Roma population 33% females) and adolescents (33.7%) out of all and the assurance of a sufficient number all the municipalities. The Roma population of health mediators for the Roma population in Lovech numbers 5705 persons or 4.38% in municipalities. The network of health mediators versus 4.87% at the country level (1). More indicators should be expanded so as to comprise information on the life style habits and health literacy of the Roma population is needed. At least one mediator for each municipality. Barriers comprise uncertain funding, lack of implementation of activities related to health promotion and disease prevention should be included in the Lovech Regional Strategy for

Facilitating factors for the action plan are developed in cooperation with various stakeholders, in particular with Roma NGOs (3). for Roma Integration (2012-2020), existing Greater consistency and coordination between all institutions involved in the Roma Integration Regional Strategy is still required. The active participation of the Regional Health Inspectorate possess municipalities and sufficient financial resources more comprehensive data about the Roma are needed to realise the action plan.

2. Republic of Croatia – Međimurje County



General data

According to the latest population census (2011), Croatia has a population of 4,284,889 inhabitants living predominantly in four of the twenty counties and in the City of Zagreb (1). Međimurje is a county located in the northern part of the Republic of Croatia. (Figure 1). The Međimurje County (Međimurje) is the smallest county with 113,804 inhabitants (55,601 men and 58,203 women). It is the second most densely populated county in Croatia (156.11 inhabitants per sq. km). The county is administratively divided into three towns and twenty-two municipalities. The capital of Međimurje is Mursko Središće (2).

Socio-economic factors

Although Croatia is, according to the International Monetary Fund, an emerging economy, socio-economic inequalities do exist between and within the counties. In Croatia 21.1% of the population is at risk of living un

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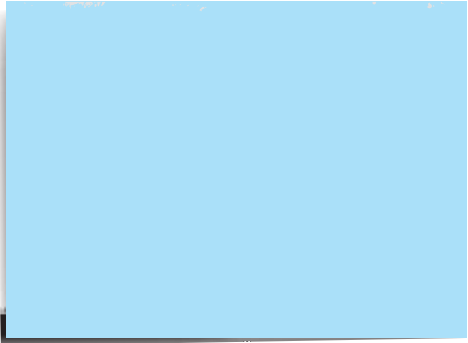


coronary syndrome (23). The combination of all these factors will be the focus of the Action Plan for Health in the Meimurje County for tackling CVD among young adult and middle-aged men as well as middle-aged and older women who are less educated and financially dependant.

Needed Action(s) for Health

A number of different strategies and plans could contribute towards the successful execution of the Action Plan in Meimurje. In the Long-term County Health Plan 2008-2012, County Health Care Plan 2010 (25) and Development Strategy of the Meimurje County 2011-2013 the main topics of the upcoming Action Plan for Health Inequality are designated priorities (24;26). Following

3. Republic of Estonia – Rapla County



a county where aspects of inequalities, lower educational levels and lower income, are more prominent than at the national level (11). The experience gained in the Rapla County with respect to tailored approaches for specific target groups and psychosocial interventions will aid in tackling health inequality.

Rapla County is a rural area. Building, transport and agriculture are the primary industries there (8). Public administration, schools, health and social service play also an important

General data

Estonia is a state in the Baltic region of Northern Europe with a population of 1,286,479 in January 2013 (1). It is a democratic parliamentary republic divided into 15 counties. The Rapla County (Rapla) is situated in the north-western part of Estonia and includes 10 rural municipalities (2). The total population was 34,442 in 2013 of which 48.2% was male and 51.8% female (3). The average income often reflects a lower education level (11). In 2011, 50.5% (aged 15-74) had an upper secondary education in the Rapla County, which is much lower than the national average of 88.9% (aged 25-64) (12;13). This may explain the lower average income in the Rapla County.

It is listed as a “high-income economy” by the World Bank and identified as an “advanced economy” by the International Monetary Fund. It is a member of the Organisation for Economic Cooperation and Development. Although it is a high-income economy, 17.5% of the people lived below the poverty line in the Rapla County in 2010/2011, which is slightly lower than the national average of 27% in 2008) as well as a 5.3-fold income gap between the lowest and highest income groups (7). Rapla County is 10.6 years longer than for men (15). The

Socio-economic factors

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Health and Health Inequality

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number of these expected life years lived in the injury rates of youth and adolescents. good health is not known for Rapla County. In Rapla County a study on alcohol consumption. Nationally, the average is 57.3 years for women and 55.9 years for men (15). In all eleventh grade students aged 17-19 years old,

the three main causes of death in Estonia in 2011 were cardiovascular diseases (53.7%), cancer (24.2%) and injury or poisoning (7.4%) (16). In Rapla County 45% of the boys and 35% of the girls consumed hard liquor every month and 20% of the boys and 8% of the girls consumed hard liquor every week. In Rapla County the percentage of eighth graders who had tried drugs had decreased by 1.1% higher for the Rapla County compared to the national average (48.9% versus 53.7%) (16). In most 7% from 2008 to 2010 (from 17% to 10%); the percentage of eleventh graders who had tried drugs had grown by 9% from 2008 to 2010 (from 28% to 37%) (20). The foundations for health awareness and healthy behaviour are EU (17; 18). The rates for injury and poisoning paved in childhood. Promotion of the physical and mental health and social development of children and young people should therefore begin in their youth. Family and the general environment play an important role in improving children's health. The priority actions should therefore be:

1. Promotion of the physical and mental health and social development of children and young people. 2. Prevention of injuries and violence among children and young people. 3. Prevention of chronic diseases and their risk factors among children and young people (22). Injury and poisoning exist in the different stages of life. Between 2006 and 2009, an average of 161 young people (aged 0-18) per 1000 inhabitants suffered traumas and 123 middle-aged people (aged 19-64) per 1000 inhabitants suffered traumas and 71 older people (aged 65+) per 1000 inhabitants (20). Injury mortality is a problem, especially among men; in 2011, 36 men and 5 women died due to injury and poisoning in the Rapla County (16). Poisoning and suicide rank first in death by injury in males in the 20-60 year age group. Suicide is strongly linked to emotional health and psychology. Rapla County introduced one of the strictest conditions (20). Poisoning can be caused by alcoholic drinks at night in Estonia in 2003. All municipalities of Rapla County had restricted alcohol sales from 10 p.m. to 8 a.m. by the 1st of January 2008. Since the summer of 2008, the ban on the retail sale of any kind of alcoholic drinks at night has been enforced through sumption and drug abuse play an important role in Estonia. Moreover, in Rapla County,

Prevention of injuries and alcohol poisoning is more effective if access to alcohol is limited. Rapla County introduced one of the strictest conditions (20). Poisoning can be caused by alcoholic drinks at night in Estonia in 2003. All municipalities of Rapla County had restricted alcohol sales from 10 p.m. to 8 a.m. by the 1st of January 2008. Since the summer of 2008, the ban on the retail sale of any kind of alcoholic drinks at night has been enforced through sumption and drug abuse play an important role in Estonia. Moreover, in Rapla County,



preventive activities related to alcohol are also should be trained in the field of suicide and mental health; risk factors and risk groups should be identified; children in trouble need recognition

Rapla County has obtained immense experience regarding health promotion, especially required to support all this. Hence, the capacity for recognizing and solving mental health problems/disorders and suicide attempts should be established. The ERSI (Estonian-Swedish Community Program 2004-2009. A very strong network structure and a highly cooperative team for health promotion are in place. All partners have their own budgets for prevention and practitioners in Rapla County. Unstable financing support and legislations that don't encourage "grass" level health promotion will be implementing situation analyses and evaluation of the effectiveness of programmes. Although it possesses some experience in analysing environmental factors which affect injuries, a greater attention will be placed on injuries and damage and capacity is needed for the impact assessment of mental health as a determinant of injuries (e.g. stress, mental health problems, suicide and related alcohol and drug consumption). The team

4. Hungary – Sellye



administrative regions in Hungary (1). All regions in turn, consist of counties; there is a total of 19 counties. The counties are further subdivided into 175 sub-regions ("kistérségek"). One of the counties is Baranya, which is situated in the southern part of Hungary on the border with Croatia (2). The Sellye sub-region lies within the Baranya County. This sub-region had 14,181 inhabitants in 2011 (3).

General data

In January 2012, the population of Hungary was 9,957,731 and spread over seven statistical

Socio-economic factors

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



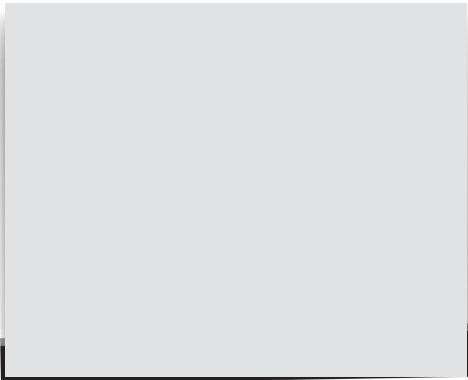
– Updated Study, the 3 major health problems identified at the national level were cardiovascular diseases, cancer and injuries (14). On the other hand, among children. Data from the experiences of local level, in Sellye in 2011, the most common EU-funded projects implemented at the regional level can also be used. The rate of mortality were cardiovascular diseases (41.8%), cancer (30.8%) and respiratory diseases (10.4%) (15). The main health problems among children under 14 years were allergies, asthma, orthopaedic diseases and malnutrition. The Action Plan will focus on children with respiratory diseases (allergy, asthma and other respiratory diseases) and malnutrition. Medical treatment is unaffordable for most families. Poor housing also plays an important role in children's health status. For example, 33% of the flats in this area are without sufficient comfort and there is no tap water in 15% of the flats. The sanitation rate is only 17%. Health care services for children and persons in need of care and nursing are insufficient in Sellye. A sub-regional outpatient care centre was established in Sellye within the framework of the Social Investments Operative Programme (16).

Needed Action(s) for Health

The basis of the Action Plan for the Sellye sub-region is supported by data gathered within the Social Renewal Operational Programme of the New Hungary Development Programme (9). The data represented a professional and methodological foundation for the national extension of the Chances for Children Programme and was commissioned by the Hungarian Charity Service of the Order of Malta in 2012. It helped assess the socio-economic and health status of the sub-region. The knowledge, local expertise and manpower of these programmes can be used to realise a local

for health promotion (17) such as, for example, a healthy school approach e.g. provision of school meals also in the summer time, several local workshops with local experts, decision makers, care and social welfare professionals and representatives of target groups, an appropriate action plan to address the lack of access to clean water, poor housing, and lack of education, malnutrition and integrated local health promotion programme. Upper respiratory problems will be set up.

5. Lithuania, Rokiskis



General data

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

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

Socio-economic factors

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

gap was 11.9% in 2011 and income inequality 5.8% (1). The total population aged 25-64 for the whole country possessing at least an upper secondary education was 92.9%, while the percentage of early school leavers was 7.9% in 2011. The unemployment rate in 2012 was 11.7% (14.6% male, 10.6% female) (3). The percentage of the unemployed population aged 15-24 years old was quite a bit higher, namely 27.5% (1). Despite these facts, the percentage of the total population at risk of

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Health and Health inequalities

Needed Action(s) for Health

energy efficiency that are intended to influence the prevalence and incidence of cardiovascular diseases and death could be changed with policies and intervention as well as physical activity, malnutrition, smoking and alcohol consumption. Physical activity can be encouraged by creating better cycling infrastructure, improving conditions for physical activity in green areas and creating zones. Modern technologies and treatments depend on great and greater funds for health care. Improving better conditions for buying healthy food and reducing prices of healthy food (making healthy choice an easy choice). Smoking can be reduced by creating more non-smoking areas and increasing the prices of tobacco products. Alcohol consumption requires special attention because there are a lot of illegal sources for obtaining alcohol products in the country.

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

The Statutory Health Insurance Fund is the main source of financing for health-programs in Lithuania. The High Cardiovascular Risk Primary Prevention Programme was financed by this fund and significantly affect the increased competence of health monitoring methods will be needed. Furthermore, financial and political support is also essential for success. Finally, a real challenge will also be the undertaking of efforts to obtain more support and leadership for health improve local development, quality and accessibility of public services and environmental quality and through health promotion!



the capital Bratislava is an asset as many of the region's residents commute to work there on a

General data

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

The town of Trnava, the 'capital' of the Trnava region has the most inhabitants of the region.

Socio-economic factors

Slovakia is an advanced economy with one of the fastest growth rates in the European Union and the OECD (4). The country joined the European Union in 2004 and the Euro zone in January 2009. Even in a country with such fast growing rates, inequalities do exist between and within the regions and counties.

The country had a gender pay gap of 20.5% in 2011 (5). The inequality of income distribution was 3.8% in 2011 between the lowest and highest SES groups (6). A total of 13% of the population lived under the 60% income-poverty line in 2011 (7).

The Trnava region is quite productive in both industry and agriculture. Its proximity to

cardiovascular diseases (CVD) (52.6% vs. 50%), cancer (23% vs. 25.4%), diseases of the digestive system (6.3% Trnava) and injuries (5.4% Slovakia). The three main causes of death in Trnava were: CVD 19.8%; cancer 21.6% and digestive system diseases 20.8% (1). Data regarding underlying health determinants for morbidity and mortality rates due to cardiovascular disease is available at the na



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

To be able to develop an action plan for health, data from the Trnava region is needed such as information on health determinants which could explain the prevalence and incidence of cardiovascular disease in the Trnava region. Education and health are closely linked and could be key priority in the action plan for health in the Trnava region. A life course perspective is accepted as good practice in public health and health promotion research and practice (20) and should be used; it is an effective way of targeting spe

7. Spain, Canary Islands



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

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

Being aware of these data and the need for special attention for children with respect to



The history of health mediation in Bulgaria began in 2001 when the Ethnic Minorities Health Problems Foundation developed the concept of health mediator and successfully introduced this new occupation in the neighbourhood of "Iztok" of Kyustendil. The most recent training took place in January 2013. Institutions at the national level – project "Ensuring Minority Access to Health Care" in 2004, which aims to improve Roma people's access to health services in 15 pilot municipalities, one of which was Lovech. The experience which all the pilot municipalities have gained and the consistent national policy for Roma integration allows municipalities to develop Action Plans for Roma integration and-integration of persons living in a situation similar to that of the Roma, with one of these Action Plans prepared for the Lovech Municipality (2012 – 2014).

Health mediators emerged as a key element in actively tackling the greatest health inequalities, particularly those of disadvantaged Minority Descent in 2005, a new occupation – health mediator was institutionalized and included in the National Classification of Occupations with a relevant job description adopted. A training program for health mediators was developed and two medical colleges were licensed to carry out training for a fee.

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always win” approach. is slogan metaphor t to promote the advantages of a healthy ically represents the concept “health”, and lifestyle, highlights the importance of the “point” in t to teach about health risks and improve the the middle of it. perception of them,

Objectives t to teach about the main determinants of

e promotion of health through eduea health, tional interventions at the community level int to prevent health risks.

the areas of nutrition, physical activity, stress and relaxation, sexual health, tobacco consumption and alcohol are all contained in the Circles of Life. e purposes of each of these areas are:

t to raise awareness-health promotion in children, adolescents and the adult population,

Promising practice Lithuania

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

Health inequalities across socioeconomic groups are a health and public policy concern in all countries, being considered a measure of the performance of health care systems. Health inequalities are preventable and inequities or not. [2].

health status are experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. Health inequalities are not only apparent between people of different socioeconomic groups – they also exist between genders and different ethnic groups [1].

Health care services require appreciable care. Patients' evaluations may be used to expose weak links in the health care system, an area which health care managers and politicians should pay more attention [3].



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

Purpose:

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

Methods:

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

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

accessibility in PMHC were assessed as good. “Psychotherapy services” which specifies in Annex 1 that children’s and adolescent health care teams are to be organized in PMHCs which do not have a child psychiatrist, clinical psychologist, mental health nurse or social worker.

Conclusions:

Inequalities were identified between the number of stations (especially child psychiatrists) and workload in the various regions of the country. In some mental health centres there was no child psychiatrist, but medical services for children were provided. Availability of services in PMHC were considered adequate by the respondents although it was shown that some organizational aspects would have to be adjusted to improve accessibility. Organizational and communicative accessibility in mental health centres were considered to be good, irrespective of the place of residence (city or district) of the patients with distance not considered an obstacle for access to services. Following this study in 2000, the Ministry of Health of the Republic of Lithuania issued Order no. 730 “Description and performance principles of requirements for children’s and adolescent psychiatry and

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 2. Law on health insurance of the Republic of Lithuania. Valstybės žinios. 1996; Nr. 55-1287;
 3. Kaladin R., Petrauskienė J., Bankauskaitė V. Lithuania issued Order no. 730 “Description and performance principles of requirements for children’s and adolescent psychiatry and

Promising practice Croatia

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

Risky behaviour in connection to the use of addictive substances is becoming even more prominent public health problem in Croatia, as well as in the Međimurje County. In 2007, the task group dealing with the aforementioned problem initially carried out a qualitative research on alcohol consumption among children and youth entitled “Youth and alcohol”, followed by a quantitative research called “Attitudes, habits and use



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

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

e association "SMILE" with the goal to help children and youth, which is active in Me imurje County, has designed and carried out the proj27(r)-(08(t)-37(y)f6(o)3(n)-20(s)-10(u)-29(m)(o b)-8(ee)-10(e)-2(n e)-19(1(r)-11(i.o

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Promising practice Hungary

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

The project was implemented in Northern Hungary, in Sárospatak, a small region of Borsod-Abaúj-Zemplén County. Due to the disadvantaged situation of the small region (ageing and a declining population, an unem

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

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

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

After the completion of the program, contact was kept with participants. They received support in finding work with their employment continuously monitored and quarterly round-table discussions organized. Consultations



The EAAD (European Alliance against Depression in English or Eesti Depressioonivabaks in Estonian) project is a EG public health project (2004-2008). The main aim of this 4-level community-based intervention program was to prevent suicidal behaviours through the development of a sustainable net

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

Promising practice Slovakia

In 2011, 105,738 people who identified themselves as members of the Roma community lived in Slovakia (SOSR, 2013a). The Roma community (hereafter referred to as Roma) is the third most common nationality in the Republic (80.7% Slovaks, 8.5% Hungarians, 2% Roma). Compared to an earlier census conducted in 2001 (89,920 – 1.7% Roma) the number of Roma had increased by 0.3% (ibid.). Although official estimates put



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

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

The implementation of educational intervention activities in the eastern part of Slovakia, respectively in the Olšovce-Kecec

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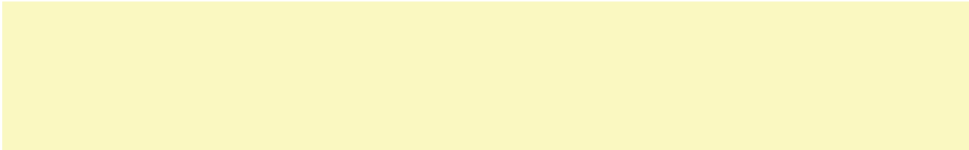
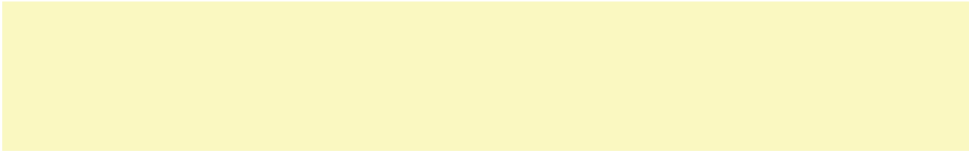
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Low income levels do not necessarily reflect countries. Regional percentages of people at risk for living under the poverty line are generally lower than the national average in the participating countries. In the AROPE rates (used in the EU 2020 report on poverty), data shows that Spain has the highest average net income among the seven countries, but also one of the highest AROPE rates (used in the EU 2020 report on poverty), data shows that Spain is established at € 645.30 in 2013 (see Table 1). The proportion of the population at risk for living under the poverty line in 2011 ranged from 13.0% to 21.8% between the risk of poverty.

Country Level	Monthly Income	Unemployment	Secondary Education	At risk of Poverty (income) 2011 (%)	(AROPE)
Bulgaria	€ 454.60 (2011)	12.4% (2012)	43.4% (2012)	22.3% (2011)	49.1%
Croatia	€ 737.00 (2010)	18.3% (2011)	58.3% (2011)	21.1% (2010)	32.7%
Estonia	€ 672.00 (2011)	10.2% (2012)	88.9% (2011)	17.5% (2011)	21.7%
Hungary	€ 483.00 (2012)	10.9% (2012)	82.1% (2012)	13.8% (2011)	31.1%

Country Level	Life Expectancy	HLY	NHP1 (mortality rates)	NHP2 (mortality rates)	NHP3 (mortality rates)
Bulgaria	73.9 years (2011)	65.6 m 62.1 f			



issues for specific target groups (e.g. Roma people). Other needs consisted of support in building networks, strengthening partnerships and support for an intersectoral approach in



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