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Community Health Information in Europe

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I Introduction

Health information – research and interventions on the community level

Barbara Freytag-Leyer and Monika Alisch

In health sciences, there is a broad consensus that even simple information on health maintenance rarely reaches those population groups that are economically and socially disadvantaged (see Homfeldt / Sting 2006). Even though there has been a broad spectrum of projects and publications, for example, on nutrition issues developed in the last two centuries, nutrition scientists recognise that concepts and materials seem to predominantly reach such population groups that are already informed about, for example, eating disorders, overweight and malnutrition (see Heindl 2007: 35; Nutbeam 2004).

The campaign "5 A DAY" has for many years been advising people to eat five portions of fruit and vegetables daily. Yet this is an example of how such advice is acted upon by those groups that already have good nutrition knowledge and habits and practice the type of lifestyles that the intended behaviour fits with (ibid.).

Heindl (2007: 33) argues that lifestyle-relevant areas of health are a question of communication and education in western countries. She points to Wilkinson who in comparing highly developed countries, argues that the healthiest countries are not necessarily the richest, but those with the least income differences and socio-economic disparities (see Wilkinson 2001: 129ff). Alternatively, the most equal societies appear to be the healthiest: They are characterised by a stronger social cohesion, closer communal life, and a high rate of social capital (ibid.; Putnam 2000). Eventually, this is the origin of participative approaches to community-based health promotion yet have only been developed in a few European countries.

In certain circumstances, health is not valued as important, but becomes less of a priority. Furthermore, it is argued that the period of time in poverty declines interest and perception of health messages. Research of poverty with regard to nutrition and activity behaviour demonstrates that

the gap between recommendations from experts and the understanding of laypersons has grown over the last 25 years (see Feichtinger 1995). Hence, approaches that strive to promote health information and integrate diverse populations are regarded as the way forward. Furthermore, pathways are explored with regard to the perception of information and chances to implement information during everyday life (living environment perspective). Appeals to the individual to change behaviour are only one pathway in health promotion. Influencing the environment we live in offers another way: for example providing health education classes in schools or extending safe cycle tracks and improving adequate green spaces. Physical education need not be bound to rules of any particular sport or game, but rather can just conform that it is fun to be active. With this perspective, social environmental conditions, structures of the neighborhood and living accommodations as a place of social community come to the fore.

Referring to medical anthropological investigations which emphasise the non-professional private sector of health care as relevant, Heindl (2007: 36) assumes that the aetiology and maintenance of health (salutogenesis) as well as coping with disease significantly occur in the everyday life and not within professional care systems. So, she argues that (2005; ibid.: 38) communication and education that recognises social inequalities may be more affective in the maintainance of a salutogenetic environment. In this process, it is necessary to strengthen systematically the lay perspective on health (empowerment); to make the aetiology of health (not disease) a subject of public discussion and thereby, to develop a culture of telling positive stories of healthy living (e.g. stories of nutrition and physical activity biography), as well as to start learning processes for good health behaviour early in life (see ibid.; Naidoo / Wills 2003).

In health promotion, the so-called "setting approach" is well established. According to its definition, the Federal Centre for Health Education of Germany (2007) describes a setting as an "area in which people follow their everyday activities and/or conduct their social life". This complies with the idea, also distinguished by social work and health sciences, in which human beings are no longer seen as objects of professional health services, but rather as an acting and creating subjects acting autonomously (see Gerber / von Stünzner 1999: 52; Alisch 2009: 11).

The organisation of social space and the community in its functional and territorial dimension determine the opportunities for getting informed about health, for perceiving and anticipating such information.

Based on this assumption, the interdisciplinary project "Chance – Community Health Management to Enhance Behaviour[1]" selected six European cities of various sizes, and culture and further identified specific communities as local space structures to develop and test health-promoting action approaches and measures on the basis of the respective local background. In the spectrum of the European Lifelong Learning Programme, the project is based on the approach of 'community-building' that is designed to initiate processes of interaction in a local community tailored to the specific social space circumstances and beyond counselling and education campaigns. The project is illustrated in the articles which are presented in this issue.

While this approach is known and applied in various contexts in space-related scientific and practical discourses and the setting-oriented health promotion, this action level in social space and the local community needs to be explained in the context of interdisciplinary cooperation of natural and social sciences. In the more natural scientific perspective of Nutrition Sciences, 'space' is more dealt with as a 'location' for interventions, a rather exchangeable setting for quasi-experimental data gathering of health sensitivities (see Alisch 2009: 11). In the urban sociology and social work, space has long been perceived as a social product where the social organisation and space are mutually dependent. Justifications for methods, which are designed participatively and according to the local space-society relationship, are derived from this (see e.g. Riege / Schubert 2005). In the confrontation of the social scientific social space research and the natural scientific health and nutrition research arises the question of lay competences (community residents) and experts in designing "correct" projects this is unclear. So, the Chance project's approach is also an experiment – with ambitious questions:

1 Lifelong Learning Programme, Sub-Programme Grundtvig, project no. 134240-2007-DE-GRUNDTVIG-GMP. Project coordination: Prof. Dr. B. Freytag-Leyer; Fulda University of Applied Sciences, Department of Nutritional, Food and Consumer Sciences. Duration 12/2007 – 11/2009. www.community-health.eu.

For example what structures promote health? What impact has the cultural embedding and the social networking in a community on perceptions of health information? In addition to that, we will discuss how different health systems Europe-wide affect the perception and transformation of health information and how these different forms of health services are recognisable among socio-cultural, economical and urban neighborhoods.

1. Chance: Lifelong Learning and the idea of a "Community Health Management to Enhance Behaviour"

The lifelong learning project 'Chance' was founded on the approach of "community-building", which is beyond counselling and education campaigns designed for the social and environmental circumstances and aims to initiate the build-up of networks and local communities. On the one hand, the needs of the inhabitants in a local community resp. neighbourhood are look at. On the other hand, circumstances and structural aspects the people are exposed to, are examined[2].

The Europe-wide research project, 'Chance' looks to provide resources with the aim of enhancing and supporting people to be well-informed and to take responsibility for their own health in the long term. During the period of the project, selected communities from six European partner countries focused 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?

2 The participating cities across six European countries were Fulda, Germany; Jelgava, Latvia; Liverpool, United Kingdom; Timisoara, Romania; Uppsala, Sweden; Vienna, Austria. Institutional partners were Fulda University of Applied Sciences, (Coordination); Latvia University of Agriculture, Jelgava; Liverpool John Moores University; Technical University Vienna; University of Vienna; Uppsala University; West University of Timisoara. German National Association of Senior Citizens Organisations e.V. (BAGSO e.V.); German society of home economics e.V. (dgh e.V.); Consumer Centre Hesse (VZ Hessen e.V.), Germany.

- What health information is perceived in general and by whom?
- What information and health interventions are required?

The project showed how people in different European cities and different local communities live, regard information with respect to health and how they may process it. The inhabitants of the communities were asked to participate actively in the improvement of local interventions with regard to consumer education in health. New networks and project-oriented cooperation were developed, are currently in the course of formation, or available networks were expanded. The project aims to reach socially, culturally or economically disadvantaged groups, who may be bound by the circumstances of their local and/or social space, or who may not necessarily be reached by the official information system offered by the health system.

For the development of concrete interventions, the partners involved local intermediate organisations. At the end of the project, Chance developed a manual or guidebook which aims to support agencies, organisations and health promotion networks to tie the available resources in a local "Community Health Management" system and to develop a holistic view on questions to maintain health during everyday life. The objective of Chance was the encouragement of a collective learning process in a local network with regard to lifelong learning.

Project aims were formulated on different levels and it was intended at first that the specific resources and needs of local communities in different European cities would be analysed (the local community level is an innovative resource for examining health behaviour). Second, the partners analysed the different European health information systems and compared these health information systems on the European level. In six case studies, the health knowledge and the perception of health messages were analysed and related to the local community's structure. Parallel local networks were established. These local networks could be a new pathway to help adults to improve the knowledge and competences because of the planned community-related health interventions. Finally, specific community-related promotions for health information and health education were designed and implemented.

The aims at the European level concerned the development of a social area analysis instrument and the testing of its capability by applying it in

different European countries and cultures to determine the resources of a community, the perception of health messages, and the specific requirement of interventions promoting health information. Finally, the potential of a "Community Health Management" system or process has been tested, compared and promoted, paying particular attention to cultural diversity.

These aims have been fulfilled in one local community of each country to find out best practice in conveying information about healthy lifestyle and in initiating a "Community Health Management" as a means of health promotion. The project especially wanted to reach specific excluded and disadvantaged groups, namely older singles, migrants and incomplete families.

Structure of the Project

The Chance project methodically consists of three phases: First, it was necessary to analyse the national health information system because there are different types of systems in Europe: Organisations providing information, their interrelation, the kind of information offered and the way the information is published, differ from country to country.

Secondly, the local community's structure (Part A) referring to health had to be examined: The social, ecologic, economic and urban structure was analysed in this step. This analysis needed a community-related analysis instrument which had to be culture-adequate and needed to consider the specific circumstances of the local community in question. Therefore, the consortium did not use one common instrument for the social area analysis, but one instrument in each community.[3]

3 To ensure the common dissemination of the analysis and the comparability of the data, the project started with a kick-off meeting. There, we provided a guideline of how to conduct the analysis phases. It included the categories and questions that should be examined.

Figure 1: Analysis instruments

	Part A	Part B	
Target	community's structure	households' resources	perception of health information
Target group	local institutions	adult inhabitants / households	
Research method	qualitative research	quantitative and qualitative research	
Result	local network community's resources	households' resources households' barriers need for information	conclusion to the perception of official health information in a community

The analysis of the households' resources and the perception of health information in a community (Part B) consisted of two research phases: firstly, how selected official health messages are perceived in the local community were examined and secondly community households profiles were established. In addition to a survey in each community (about 200 each), we used qualitative interviews with households in each local community to examine people's idea of health, their lifestyle and their idea of the associations between community and health.

The standardised questionnaire and the guideline for the qualitative interviews recorded statements concerning everyday life, labour and family situations whilst also revealing some the burden of social networks and the social spatial relationships within the community. Thus, it is directly connected to the concept of health of the World Health Organisation as well as to the setting approach (see Paton et al. 2005). Furthermore, issues in everyday life also became apparent via questions on, for example, diet. Of course opinions regarding the accessibility of health information were voiced along with ideas and suggestions concerning the development of the social space within the context about the meaning of the term 'community'. In all the following areas were covered:

- *Lifestyle*: Questions about nutrition and shopping behaviour and habits; the neighbourhood the place of working and living; own ideas about healthy living, health awareness, sources of information.
- *Empowerment:* Interest in health information; requirements on health services; willing to take part in local working groups on health or community affairs, clubs or initiatives.
- *Residential environment:* Individual social networks, contacts in the neighbourhood (what are you doing together with others? with whom? what kind of activities?), supporting network in case of an emergency, regular contact to social institutions; knowledge and personal impression of the neighbourhood; knowledge on using meeting places, locations of fear etc.

2. The articles

The research results of the Chance alliance are presented in three analysis steps: The articles of the first part form a framework where the local studies and interventions related to health information were initiated. Based on the Chance project's core thesis, which is the close relationship between the resources of social space and the opportunities of developing healthy behaviour patterns in everyday life, the first article of the urban sociologist *Monika Alisch* addresses the relevance of *Social space and the local community*. It summarises the current social scientific discourse concerning space and presents models of systematising social space and social space analysis. On this basis, it becomes clear which dimensions of space and community a targeted strategy of local health information can refer to in order to implement needs-oriented interventions.

In the first instance, the Chance consortium dealt with the comparability of the different health and health information systems of the participating European countries and with the question of how such differences would impact upon the implementation of concrete interventions on the community level. The investigation results were spread in the partner cities and especially to the involved local institutions in the form of proceedings in 2008. *Monika Alisch's* article *Health systems and the relevance of health information in Europe* is an editorial work of the country profiles. After a short introduction into health policies of the relevant countries, the health information of the

respective national, regional and local institutions are presented, strategies and distributions are comparatively explained, and the role of medicine in health information in the participating countries is discussed.

The following article takes up another essential relationship in the concept of community-based health promotion and health information which is the aspect of education and collective learning processes. The ecotrophologist *Barbara Freytag-Leyer* and the business economist *Thomas Berger* open the action area of lifelong learning, which has not only been the funding framework for the Chance project, but also particularly emphasises the education-initiative requirement of health promotion. Herein, it becomes clear on the one hand that community-based health information intervention targets groups of different ages and on the other hand, that learning processes in the meaning of lifelong learning can be well applied to learning processes in everyday life and this may sustainably change health behaviour. They will give a short overwview about the basis and the development of the conceptions of Lifelong Learning in Europe, especially of the European Union. In Chance the main aim was the learning process of the stakeholders. With regard to health this should include new approaches and participation of several disadvantaged groups.

The next part of this issue presents six country studies with their respecttive and specific prerequisites and project approaches: The research team from Liverpool from the Centre for Tourism, Consumer and Food Studies *Allan Hackett, Pauline Lybert, Mark Meadows, Jackie Richards* and *Leo Stevenson* focuses their article *Scouse nouse: empowerment of carers in Liverpool* on the role of carers in influencing health behaviour for the cared for, and their role as processors of specific health information and education. The authors implemented their investigation in a highly-condensed working class district of South Central Liverpool. They were able to build on an existing working relationship with an intermediate partner who was instrumental in carrying out the intervention.

The study at the Swedish University City Uppsala of the microbiologist *Ingela Marklinder* and the dietist *Margaretha Nydahl* places its focal point on the everyday life of older residents in a suburban district. *Health knowledge and behaviour among residents in a Swedish city district – designing health information for the public,* where it was also possible to count on existing structures which have already had access to the target group.

In the western-Romanian city Timisoara, the starting situation was considerably different: Against the background of only very limited local social and commercial institutions, the case study of the psychologist *Mona Vintila* especially dealt with *Creating a local network and implementing public health activities in Romania*. On the one hand, she had to consider that there is no tradition of community-related action of the local authorities or even the health system. There is great scepticism towards advice, especially by doctors, related to everyday life modifications. Here, as a reliable mediator between expert knowledge and local residents of the relevant suburban housing areas she found that the local church, was able to integrate the various ethnical and religious groups.

The Latvian case study laid its focus on the everyday life in a housing area for the employees of a car factory which developed in the 1970s, and still bears the factory's name *RAF: Public Health prevention in a former company housing estate in Latvia* outlines the circumstances of the study of *Aija Eglite*. The selected urban area has a series of centrally controlled and located commercial, social, and health infrastructures, this being typical of large housing areas. The living in high-rise buildings and the social living in a district's centre strongly diverges. Social places, where health promotion projects can be sustainably implemented, are missing and have to be created, so that the RAF's residents can be reached

In the sartorial quarter ("Schneiderviertel") in Vienna, the circumstances were considerably better: The Austrian partner chose a district originated at the end of the 19th century ("Gründerzeit") which has had a district office in the context of Local Agenda 21 for several years, where all activities of the area were coordinated and interrelated. *Health factor 'neighbourhood': A participatory project with inaccessible socially disadvantaged groups in Vienna* is the article's title of the nutrition scientists *Petra Rust* and *Elizabeth Höld*, as well as the city planner *Wencke Hertsch*.

Here two aspects of a well-functioning community-related health promotion were examined. On the one hand, the authors emphasise in their article the relevance of a stable and well functioning local neighbourhood as a factor for a healthy living in the sense of a holistic health related to the WHO. On the other hand, they point to the quality of social spatial work with the means of a participative approach of project implementation. The Vienna study also concentrates primarily on migrants from mainly Muslim countries, whom are, at least in the

German speaking European countries, considered to be hard to reach for campaigns concerning health promotion.

Likewise, the research team of the German middle-sized city Fulda in Hesse could use facilitating preliminary work: On the one hand, the University of Applied Sciences Fulda had already started establishing a local network concerning health so that social and health promotion-related organisations were already known. Some preliminary research work had already been done in the districts. On the other hand, approaches of a community-related support are embedded in national and regional policies which have strived for a local interrelatedness and integrative cooperation since the 1990s. But, the selected investigation area in Fulda just did not correspond to the idea of a deprived district and had not been funded by respective programmes so far. Even though, the authors *Monika Alisch* and *Barbara Freytag-Leyer* started again at general community-related action approaches, and discuss in their article *Turning a "community of space" into a "community of interests": Local health networks in Germany*. The focus in this analysis therefore lies on the question how common interest could be organised and how to help the non-organised residents to articulate their needs. The aspect of institutional networking indicates a demand for a sustainability of such local interventions.

The last section of this issue comprises the conclusions of our international Chance-project. Two articles summarise the essential results so that the interdisciplinarity becomes visible again, as well as the very different paradigms of researching health behaviour and the practical advice for an effective Community Health Management system.

The article *Results and comparison of the quantitative date* by *Barbara Freytag-Leyer* and the nutrition psychologist *Christoph Klotter* of depicts an overview of the essential results of the standardised interviews from the six partner cities. This should also clearly reveal that the nature of the Chance project is less one of research but one of a development project in the framework of lifelong learning. This also means that the interviews' results should mainly be used as a communication instrument in order to strengthen the sensitivity for questions of everyday life – on the side of the districts' residents (which requires an adequate translation in a language for everyday use) as well as on the side of the local stakeholders who's profession is primarily just not people's health

(priests, politics, kindergarten teacher, youth club operator etc.). The final article of *Monika Alisch* and *Barbara Freytag-Leyer* is a conclusion with the character of action advices*: How to initiate a community- based health information system* is based on the guidelines which were published by the Chance consortium in different languages in winter 2009. The article itself again focuses on three aspects that are valid within cultural, political, and social differences of the involved countries: a) The meaning of space and community, b) the target groups of community-based health information (Bauer / Bittlingmeyer 2006), c) networking and institutional resources, d) the nature of projects, and e) the evaluation and sustainability standards[4].

References

Alisch, M. (ed.) (2009): Lesen Sie die Packungsbeilage …?! Sozialraumorganisation und Gesundheitsinformation. Opladen / Farmington Hills: Barbara Budrich Verlag.

Bauer, U./Bittlingmeyer, U.H. (2006): Zielgruppenspezifische Gesundheitsförderung. In: Hurrelmann, K./Laaser, U./Razum, O. (eds.): Handbuch Gesundheitswissenschaften. Weinheim: Juventa Verlag. pp 781-818.

Bundeszentrale für gesundheitliche Aufklärung (BZgA) (2007): Kriterien guter Praxis in der Gesundheitsförderung bei sozial Benachteiligten. Ansatz – Beispiele – weiterführende Informationen. http://www.bzga.de/.

Feichtinger, E. (1995): Armut und Ernährung im Wohlstand: Topographie eines Problems. In: Barlösius, E. et al. (eds.):Ernährung in der Armut – gesundheitliche, soziale und kulturelle Folgen in der Bundesrepublik Deutschland. pp 295. (AG Public Health).

Gerber, U./von Stünzner, W., (1999): Entstehung, Entwicklung und Aufgaben der Gesundheitswissenschaften, in: Hurrelmann, K. (ed.): Gesundheitswissenschaften. Berlin, Heidelberg, New York: Springer. pp 9-64.

Heindl, I. (2005): Gesundheit und soziale Zugehörigkeit – Probleme der Vermittlung in Bildung und Beratung. In: Heseker, H. (ed.): Neue Aspekte der Ernährungsbildung. Frankfurt /a. M: Umschau Verlag. pp 24-28.

Heindl, I. (2007): Ernährung, Gesundheit und soziale Ungleichheit. In: Aus Politik und Zeitgeschichte. Heft 42/207. pp 32-38.

Homfeldt, H.G./Sting, S. (2006): Soziale Arbeit und Gesundheit – Eine Einführung. München / Basel: Ernst Reinhardt Verlag.

Naidoo, J./Wills, J. (2003): Lehrbuch der Gesundheitsförderung. Hamburg: G. Conrad.

4 We thank Martina Metz, Allan Hackett, Mark Meadows and Pauline Lybert fort he support with translation.

Nutbeam, D. (2004): Getting Evidence into Policy and Practice to Adress Health Inequalities. Health Promotion International. 19, 2, München, Basel. Reinhardt-Verlag. pp 137–140

Paton, K./Sengupta,S./Hassan, L. (2005): Settings, Systems and Organisation Development: the Healthy Living and Working Model. Health Promotion International, 20, 1. pp 81–89.

Putnam, R.D. (2000): Bowling Alone. The Collapse and Revival of American Community. New York: Simon & Schuster.

Riege, M./Schubert, H. (2005): Einleitung: Zur Analyse sozialer Räume – Ein interdisziplinärer Integrationsversuch. In: Riege, M/Schubert, H. (eds): Sozialraumanalyse. Grundlagen – Methoden – Praxis. Opladen: Leske + Budrich. pp. 7-60.

Wilkinson, R. (2001): Kranke Gesellschaften. Soziales Gleichgewicht und Gesundheit. Wien, New York: Springer Verlag.

Social space and the local community

Monika Alisch

1. Introduction

Since the 1990s, social sciences and different policy areas have extensively discussed and published about the concept of space European wide, especially about the social space[1] ('spatial turn'). Until today, the various space-oriented disciplines (such as urban and regional sociology, geography, spatial planning, spatial economy and social work) have discussed different concepts of social space. And similarly, the way of working concerning space in the various professional action areas of social and health policies as well as urban and regional sociology are very different: The respective concepts of space are based on fundamentally different perceptions of space reaching from the idea of a "container", or a 'location', as 'spatium' up to a relational concept of space or a space of "storage" (see Alisch / May 2008: 7).

According to the urban sociologist Jens S. Dangschat (2007: 25), more recent space-oriented social research aims to explain and understand the different ways of appropriation, utilisation and design of space integrating the interactions with social behaviour of individuals and groups as well as the functions of institutions. Therefore, space is not considered as a carrier of "objective characteristics" (the euclidean, isotropic or infinite space, see Lefevbre 1991: 1). The Frenchman Henri Lefebvre and his script „Production of space" influenced all practice relevant concepts of space: His key sentence that social space is a social product (Levebvre 1991: 30) lately penetrates all social science attempts of systematising social space (see Alisch 2010: 105; 2011).

1 For a comprehensive discussion of space-theoretical approaches and space concepts see Pierre Bourdieu (1991) concerning the physical, social and occupied space, Henri Lefebvre (1991) about the „Production of space", for the German language discourse Martina Löw (2001) on a „Sociology of space"; Michael May (2008a) on social space aspects in practical social work and the history of scientific analysis of social space (2008b).

According to Lefebvre, space consists of three factors: a) the *spatial practice* as production and reproduction of space (perception and its derived everyday routines), b) the *cognitive construction* of space ("representations of space" as the ultra-planned space, the space conceptualised by science and technique), and c) the *symbolic representation*, which Lefébvre relates to the images and symbols that complement spatial practice and thoughts (Löw / Sturm 2005: 37).

This is what most conceptual and theoretical considerations concerning the concept of (social) space are based on when space is analysed from the perspective of *structures*. As an example might serve space as a "decoder matrix („Matrixraum") of the urban economist Läpple (1991) who's four dimensions also appear in similar space models which focus on their applicability in practice.

- The *"material substrate"* of a community or an urban area is established by a bordered area and its containing people and properties (use of nature, artefacts) (see Hamm 1982: 17; Läpple 1991).
- The *"institutional"* dimension of space refers to the network of interactions and its associated positions, roles, status, and rules for the use of an area (Hamm 1982: 17).
- In the *„semiotic"* dimension, a community has a name and an appearance which illustrate "feeling at home" and a "symbolic site-relatedness" (Hamm 1982: 17).

In Läpples definition of space (1991: 196f.), further components of space emerge which are relevant in steering for example health information:

- The material-physical substrate of societal conditions (*places*);
- The societal structures of action and interaction (societal practice of production, use of the material space: *acquisition* of space);
- System of regulation (mediation between the material-physical substrate and the societal space practice (*urban policy, administration*)
- System of signs, symbols and representation (*architecture*).

He concludes that a societal space has to be explained in the context of its societal production, application and acquisition concerning its material substrate. Läpple points out that space will only develop its societal character in the context of the societal practice of those people who are

living in it, using and reproducing it (1991 197). Also the space-theoretical approach of the urban sociologist Jens S. Dangschat (2007) is based on this basic concept of a "relational" space: He positions his space concept between a structural production and an individual construction (ibid. 24) and differentiates between "space" as a theoretical concept and "territory" or "place" as a statistically describable and definable material characteristic (ibid.).

In his multilevel model Dangschat allocates these "social spatial products"' to the "meso level". The "macro level" of space contains all forces which are established from places/territories by the network (steering, institutional construction, stakeholder and the structures of communication among one another, ibid.). The perceptions of space and its evaluations, as well as space relevant behaviour patterns (acquisition, utilisation, mobility etc.) are allocated to the micro level. The action space, which results in the model from the material and social structures of place as well as the locally bound political and social cultures, is produced with individual cognitive behaviour elements. Even this space model claims to be able to capture, describe and analyse the socio-spatial structures and processes on different aggregation levels, as well as the interactions between places/territories.

Besides these theoretical discourses, it is also attempted to capture the term "social space" more practical concerning action in such a way so that it is applicable in different practice fields (especially social planning, social work in the sense of community work and health promotion) (see Alisch 2009).

Adapted to the respective situation and coalition of interest, definitions and interpretations of concepts have developed. These lead to the creation of elaborated, enhanced or new concepts especially in interdisciplinary discourses aiming at differentiating from the "concept alterations" in the practical routine or to differentiate the discussion processes of empirical issues and normative concepts (see Alisch 2007: 309). The problem is that by excluding semiotic interpretations, it has to be assumed, that different dialogue partners speak about the same content only by chance (see Jung / Schönwandt 2006: 375).

The educational scientist Michael May (2008b: 64ff) offers a suggestion of how to systematise all these theoretical and practical applications of

social space without evaluating them. He differentiates the *territorial, functional and categorical* dimension of social space, derived from the tradition of community work as concept of social work. All three dimensions exist in practice concurrently. They do not stand against one another, but they can help to find a position in the respective field (e.g. community based public health).

a) The *territorial* dimension refers to social space as a space of planning and administration. This dimension deals with space as a space of sway and decisionmaking, configuration and intervention (see e.g. Hinte 2007). In this dimension, social space is identical with 'urban area' or district.

b) The *functional* dimension of social space concerns the space of constitution and refers to the living conditions and the reproduction facilities. Healey (1997) called this form of space constitution "place-making": "A social process, which is determined by individuals, who are institutionally bound, and who interpret the stationary social situation in their way" (Dangschat 2007: 28)[2].

c) The third *categorical* dimension of space, introduced by Michael May, refers to the number of people in a society sharing certain characteristics, e.g. age, a certain problem situation, social origin, etc., without the need for a relationship between them. Here, it is where the community work starts, which focuses on the interests and needs of target groups (see ibid. 67).

All dimensions of the social space exist in parallel: Within the practical work of town authorities, intermediate organisations of health promotion, social work etc., one refers to these three dimensions of space differently. This is relevant for the conception of a social-space-analysis and for the role played by elements of participation in it.

2 Both dimensions have their origins in the double meaning of „community" as a geographical and functional community (see May 2008b: 68). Understanding social space in this way implies the risk that space is again perceived as a continuous, for itself existing space in the sense of a fixed container (Kessl / Reutlinger 2007: 23).

2. Social Space Analysis

In the space-oriented spheres of activity, the methodical and theoretical roots of the analysis of social spatial relationships lie in the Chicago of the 1920s. Today, both methodological approaches of the so called "Chicago-School of Sociology" are relevant for concepts of social-spatial-analysis: on the one hand, the quantifying and categorising approach (in the origin especially Burgess, later Duncan, Shevsky / Bell), and on the other hand the ethno-methodological, understandingly approach, in the tradition of Robert E. Park, based on the experiences of the journalistic inquiry[3] (see Dangschat / Frey 2005: 150f.).

In this second approach of the Chicago School, the dense, qualitative description of urban lifestyles and their spatial implications played a major role. It was about the behaviour of metropolitan inhabitants in their societal and urban-structural change (ibid.: 151).

One assumed that people in their social spatial actions on the one hand developed cognitive structures due to their involvement in social groups and social spaces, but on the other hand also had an individual scope (ibid. 151). Here, the theoretical concepts of *appropriation* and *construction* of space are set up.

In this idea of social space, the urban space becomes an urban mosaic of different local communities, whose distribution in the city results from the competition of social groups for space and resources. On the methodological level, the predominantly quantifying programme of the Chicago School has coined the social-space-analysis for the means of policy advice even in West-Europe since the 1960/70s. Several concepts have developed to receive social space related information:

First, the *social area analysis*: This archetype of a systematic space analysis assumes homogenous spaces dependent on the standard of living, lifestyle, and ethnic background (natural areas). The structural social behaviour was analysed based on statistical indicators: a) *social position,* deter-

3 Primarily, the social-ecological approach in its categorising form was the basis of the studies on segregation. Its model of illustrating social inequalities, where space was at first not more than a container for urban planning strategies, was based on statistical-mathematical procedures (see e.g. Dangschat / Frey 2005: 149).

mined by employment status, level of education, maintenance, persons per room, heating system; b) *urbanisation*, as measured by age, sex, ownership, house type, and the number of household members; c) the degree of *segregation* captured by race and origin, native country and nationality (see Shevky / Bell 1974). These structural space analyses were only possible by means of comprehensive data sets.

Second, the *human activity systems:* Here, the pure structural perspective was replaced by a behavioural perspective. It includes the construction of space on two levels: a) the *character level*: Motivation and mentality as predispositions of behaviour, roles and individual characteristics are decisive for behaviour; b) the *level of space*: This is about the availability of opportunities and the perception of their quality – linked with the assumption that both influence the behaviour of space (see Riege / Schubert 2005: 249).

The programmatic perspective of human-ecological research (see Quinn 1950) attempted to illustrate this interrelationship of the social and spatial organisation in three dimensions, which can today be called the standard of social-space-analyses:

- *Study of sub-social relations:* Here, the inhabitants' basis of existence in a geographical space are analysed (e.g. the economic perspective or the competition of groups for social space).
- *Study of social-cultural areas:* This means the analysis of social processes and social spatial structures.
- *Study of spatial distributions*: This dimension marks again the structural perspective, which is based on the characteristics of certain indicators, and which allows comparisons of the whole city and subspaces, of cities, urban sub-spaces in their interrelatedness, or at different times (see Hamm 1984).

Finally, Riege / Schubert (2002; 2005) identify four methodological strands, which are empirical and practical applied in all action areas and, from their point of view, should be interwoven even in the ideal case:
Besides the structural (social area analysis and study of spatial distributions) and behavioural (social activity systems and study of social-cultural areas) analysis procedures of human ecology, Riege / Schubert (2005) also see the methodology of the '*Lebensweltanalyse'* (analysis of the lived-in world) according to Husserl and the sociography method as further historical roots of analysing social spaces:

The *‚analysis of the lived-in world'* also derived from the critics of the objectifying and quantifying approaches, that human ecology applied on the description and analysis of social spaces, and that abstract from the individual living environment with its moral concepts and perceptions. From a phenolmenological perspective, the analysis of the lived-in world deals with affairs (phenomena) of everyday experience (intentionality and sense) of people in the social space (Riege / Schubert 2005: 250). From the empirical perspective, the space to be analysed is the space as it is given each individually or group specifically (ibid.).

Sociography is a method of social-space-analysis, which has been developed by means of the Austrian study "The unemployed of Marienthal" in the 1920s. It is the attempt to depict a relative narrow area, which was enclosed originally geographically and later also concerning its problem area, by means of as many perspectives as possible and with different methods (Jahoda et al. 1975: 132).

To figure something out of the social relationships, habits and coping strategies of "The unemployed in Marienthal", the observing role of the researcher was partly disclosed and embedded into concrete, meticulously documented community work - without the necessity to declare it as action research. This is because it was not the aim to practically change the determined problem areas, but one can rather identify a methodological and also historical connection to the community studies[4]. Because of their plenty of material concerning structural elements and subjective estimations, these were perceived as a social science way of research, which depicts the complexity of social processes interdisciplinarily.

Riege / Schubert (2002: 46) assume that action research in the meaning of community work allows to grasp social relationships and habits in the space as it is even relevant for determining health behaviour in a neighbourhoods's everyday life.

4 This multidimensional understanding of the social space has been later on picked up in the environmental psychology and in the milieu focused space observation (Riege / Schubert 2005: 251). Today, it plays an important role in social-space-analyses which target different patterns of a cultural and ethnical acquisition of space (ibid.).

This would be an "activating method to survey subjective utilisation perspective of social space, where it is not the research aim to prove theoretical statements" (ibid), but which target the practical change, where the "questioned" and "observed" participate in target discussion, data survey and analysis, and where even the researcher's role adapts: The researcher becomes an acteur (of social or planning work), but also vice versa, the social working people become action researchers in the professional interest.

3. The meaning of the local community

Within these attempts to grasp the social space on a conceptual level, it is striking that sometimes the reference quality is 'space', and in earlier concepts also 'community', for the almost same systematic. This concept of community makes a reference to the connection between social community and locality (or local community). Within the scientific discussion, this association had an impact on the so called *community studies,* which represent the ethnical / qualitative arm of the systematic social-space-analysis from a historical and methodological perspective, and which dealt with the connection of space, social structures, and culture (see Kronauer 2002: 135ff.).

This community approach has appeared political and in the activities of organisations and institutions in different European and national programmes since the 1980/90s. Especially the urban area as an action area has been used in such policies so far, that focus on deprived areas. Andrew Wallace (2010: 5) refers to the „common belief at the ‚high' policy level of the need to prescribe area based policy measured to 'treat' poor areas and address the conditions of those who reside in them."

Such programmes known in Europe as "URBAN I and II", in Great Britain as "New Deal for Communities", or e.g. in the Netherlands as "Bouwen voor de Buurt" (Renewal in the neighbourhoods) aim at a crisis management and combine „some physical re-development with improvements in local service delivery to encourage ‚participation', ‚partnership' and 'empowerment'" (Wallace 2010: 5).

Below, the social science approaches to explore 'community' will firstly be presented and subsequently, the application of the community approach in different action areas is following.

3.1 Modern community studies

While e.g. in Germany, community studies ('Gemeindestudien') have only shortly raised the research interest on the social and spatial interrelationships (see Kronauer 2002: 135), the programmatic of *community studies* with their combination of space, social structure, and culture has already developed in the tradition of the Chicago School of sociology since the 1920s.

The urban sociologists Häußermann / Siebel (2004: 78) remind of that eventually, the whole empirical social research in the USA has only developed in the form of community studies at first. One assumed that such processes which are abstract and affect the whole society could be studied in limited areas thoroughly (ibid.). Therein is reflected the *community's* function as the essential basis of the American society, whereby in this concept, society, and the community as a political community, as well as the geographically identifiable city resonates in its meaning. The concept of community therefore did not stand for a synonym of city or village, but for a local *community*, which has been suggested in small cities as a motor of cohabitation for a long time.

Especially because of the claim that the empirical examination in and of a local community or town supplies a kind of "laboratory setting" for the whole society, community studies in the USA were criticised at the latest when the wider structures of society and its effects on a community became noticeable: public regulation, national and international interdependencies of economy, supra-regional interest groups, and a technological progress, which brings the world into the community.

The view on the community as one with social spatial interrelationship remained systematically and methodologically essential. Such interrelationships were described by Kronauer (2002: 135) as the territorial unit within which people in their everyday living practice interact, and specific group connecting and separating patterns of perception and attitude are determined.

In an analysis of all community studies, three main meanings of community became apparent: community as an urban area, social ties, and social interaction. It is not necessarily the space or the geographical place in focus, but studies can be differentiated related to interest groups *(community of interests)* and settlements *(community of space)* (see Alinsky 1972). Here, social relationships refer to a wide spectrum of regular and regulated relationships and interactions (ibid.: 136), which also refer to such social relationships that convey power or are constituent for social stratification.

Having this perspective on social spatial phenomena and processes, it was possible even to make the concept of community fruitful for the investigation of large cities' development. Community studies of the 1960s contributed to recognising and understanding the specific lifestyles as well as the social and economic recreation strategies in urban subareas: Gans (1965) defined „*urban villages*" as such urban neighbourhoods, where - similar to the provincial and rural communities – local identities and communities are visible and tangible.

Increasingly, new forms of such community studies are purposely used as science based preparation or monitoring work (see chapter 3.2). The action areas "community work", "community organizing" or "community development" of social work reflect the close relationship of community and professional action (see chapter 3.3).

3.2 The community approach critisised

The attempt to recreate and support the community, controlled in planning, has affected all concepts of integrated programmes from the field of social urban development, even district related health promotion, over local business development, up to community psychiatry European wide until now.

The urban sociologist Jens S. Dangschat (2009: 26) critically asks in his pleading for a necessity of the community approach, whether it is an innovative solution for complex societal problems, only a temporary fashion, or a current 'vanishing point' that is picked up in science, politics, and economy (ibid.). So, he points to the risks to discuss totally different concepts of community concerning motivation and content in

parallel, and to indiscriminately use the lowest common denominator of a "community feeling" and group identity as a demand for all social groups and opportunities.

Dangschat adds examples from very different fields of application. So, the concept of ‚content community management' means such (virtual) communities of private people who join under a certain topic, or communities of companies and professional nets, which are established to "retain" (potential) customers (ibid.: 25).

Kohlberg (1984) conceives ‚just communities' as communities in educational institutions for the moral development; with reference to the communitarianism, Dangschat designates the movement of civil societal associations in the sense of grass-root-democracy. Last but not least, the area based policies could here be allocated, which aim at the constructional as well as social development in the district.

In his discussion of a growing relevance of the community approach since the 1990s, Jens Dangschat perceives two basic expectations which are linked to the approach: a) civil societal aims which are positively evaluated (e.g. also in the concept of the Chance project concerning the community related health promotion), and b) aims deriving from a helplessness of previous intervention strategies. Besides the geographical manageability of urban areas and the unity of such areas regarding urban development, the community approach also refers to the relevance of the place as 'neighbourhood':

Since the 1960s, neighbourhood as a resource, as a social net and as an opportunity of solidarity and support has been relatively irrelevant for most social groups in large cities. Dangschat points to Wullkopf (2008) who examined that friendship, acquaintance and the net of solidarity in the neighbourhood became fragile, and that the private welfare services (neighbourly help) were reduced.

Concurrently, employment and family as reliable identification lose relevance, whereby the identification with the residential location gains importance especially for the elderly (see Lemme 2009). Dangschat explains this by the fact that the materiality and immobility of home (in connection with the law of rent and ownership) promises 'security' (2009: 32). He adds that neighbourhood offers familiarities in many

ways, be it the persisting neighbourly relations or relations to the local retailer, services and manufactures in the community (ibid.).

In this ambivalent meaning of „neighbourhood" as a good prerequisite for an integrative community (ibid. 37f), Dangschat points out that a community approach in this sense strongly depends on whether the inhabitants have the feeling of being 'at the right place' and are living there voluntarily (ibid.). As well, it is relevant whether they can identify themselves with the neighbourhood (shopping facilities, gastronomy, open spaces, urban developmental form, and the social composition resp. social milieu of neighbours as well as the city's image) (ibid.). They can fully exploit the available *resources of place*, but furthermore, they have the opportunity to develop and use additional '*us-resources'*.

The mobilisation of resources for a positive local (neighbourhood) development is an important task in all action approaches which focus on community. Proceeding from the concept of 'social capital' (Putnam 1993), three closely related resources can be distinguished (Frey 2009; Dangschat 2009): *Individual resources*, like knowledge and own skills of how to deal with social relations, are distinguished from group related resources (*us-resources*), which also relate to social relationships of a community's group members, e.g. the district's inhabitants. The *resources of place* are such resources, which could arise from the place's specific circumstances, its function, location, power structure, and interests.

3.3 Community work and community organizing

While the political action approaches concentrate on the "revitalisation of community", on the recollection of social community values, neighbourhood and solidarity, the community approaches in the social work aim to support existing local communities in a way that common interests can be articulated and implemented.

The origin of this community work lies in the community organizing of Saul Alinsky who refused to analyse the problem structures in deprived urban areas any longer in the 1930s (as practiced by the Chicago School of Sociology that he belonged to). But, he wanted to solve the problems himself together with the people involved in the urban areas.

In the sense of the *Chicago School of Sociology*, Alinsky captured *community* as an ensemble of relationships, organisations and institutions enabling the elderly to articulate their needs (see 1972). A consistent *community* that is only defined as territory was hardly manageable. This understanding of community was called *physical community*. It maintained the idea of community that he assumed to be necessary to facilitate a fair cohabitation (see Rammé 2007: 17). For this reason, he contrasted the *physical* with the *integrated community*: This should be a community where people cooperate across racial and religious barriers, and common interests can be pursued.

Alinsky assumed that all underprivileged firstly have to be able to satisfy their basic needs concerning food, living and clothing. In this context, work and employment are central interests because they are prerequisites for meeting the needs (income and access to health). All people could agree with this, said Alinsky. It would be the foundation for a c*ommunity of interests* (see Szynka 2006; Rammé 2007).

The term ‚organizing', included in the instrument 'community organizing', is deliberately derived from the corresponding verb: I points out that a "community of interest" only develops when the inhabitants have clarified their interests, and when they prevent that targets are imposed on them (parties, clubs), but also public organisations are not organisations in this sense (ibid.), they should also participate if they have interests inside the community. But, they should *participate* and not *decide* (Rammé 2007: 18).

From this context, the claim derives of participation in the community based measures of the different programmes in terms of revitalisation of deprived districts. But, this is also the starting point for a basic paradigm shift which means the mobilisation of common interests and the participation in decision making affecting the individual life not only in times or regions of crisis, but even there, where the organisation of everyday living should be changed in a healthy way sustainably.

References

Alinsky, S. (1972): Anleitung zum Mächtigsein. Ausgewählte Schriften (Deutsche Übersetzung von Reveille for Radicals). Göttingen: Lamuv Verlag.

Alisch, M. (ed.) (2009): Lesen Sie die Packungsbeilage ?! – Sozialraumorganisation und Gesundheitsinformation. Beiträge zur Sozialraumforschung, Band 3.. Opladen/Farmington Hills: Barbara Budrich Verlag.

Alisch, M. (2010): Sozialraummodelle im arbeitsmarktpolitischen Kontext – Ein unvollständiger Überblick über die sozialwissenschaftlichen Diskussion(en) zum Sozialraumbegriff. In: Bundesamt für Bauwesen und Raumordnung (Eds.): Bildung, Arbeit und Sozialraumorientierung. Informationen zur Raumentwicklung, Heft 2/3.2010. pp 103-110.

Alisch, M. (2011): Sozialräume im Stadtquartier: Analyse und Praxis von Prozessen der Sozialraumorganisation. In: ILS & Kulturgeographie (RWTH Aachen) (Eds.): Das Quartier – Forschung aus raumstruktureller, sozialer, symbolischer und ökonomischer Perspektive.

Alisch, M./May, M. (2008): Einleitung: Kompetenzprofil Sozialraumentwicklung und Sozialraumorganisation. In: Alisch, M. / May, M. (eds.): Kompetenzen im Sozialraum. Sozialraumentwicklung und -organisation als transdisziplinäres Projekt. pp 7-18.

Alisch, M. (2008): Von der Gemeinde zur Großstadt und zurück: Methodologische und systematische Traditionen der Analyse sozialer Räume. In: May, M. / Alisch, M. (Eds.): Praxisforschung im Sozialraum. Fallstudien in ländlichen und urbanen sozialen Räumen. Beiträge zur Sozialraumforschung, Band 2. Barbara Budrich Verlag. Opladen / Farmington Hills. pp 21 – 44.

Bourdieu, P. (1991): Physischer, sozialer und angeeigneter physischer Raum. In: Wentz, Martin (Hrsg): Stadt-Räume. Frankfurt a.M./New York: Campus Verlag.

Dangschat, J.S. (2007): Raumkonzept zwischen struktureller Produktion und individueller Konstruktion. In: Universität Hamburg. Institut für Ethnologie (Eds.): Ethnoscripts. Jahrgang 9/Heft 1., pp 24-44.

Dangschat, J.S. (2009): Zur Bedeutung des Community Ansatzes. In: Alisch, M. (ed..): pp 25-44.

Dangschat, J.S./Frey, Oliver (2005): Stadt- und Regionalsoziologie. In: Kessl, Fabian / Reutlinger, Christian / Maurer, Susanne / Frey, Oliver (Eds.): Handbuch Sozialraum. Wiesbaden: VS Verlag. pp 143-164.

FOCO (eds.) (2003): Forwards to the Roots. Community Organiszing in den USA – eine Perspektive für Deutschland? Bonn: Stiftung Mitarbeit.

Frey, O. (2009): Die amalgame Stadt. Orte. Netze. Milieus. Wiesbaden: VS Verlag für Sozialwissenschaften.

Gans, H.J. (1965): The Urban Villages. Group and Class in the Life of Italian-Americans. New York.

Hamm, B. (1982): Einführung in die Siedlungssoziologie. München: Beck.

Hamm, B. (1984): Aktuelle Probleme sozialökologischer Analyse. In: Kölner Zeitschrift für Soziologie und Sozialpsychologie. Jg. 36., pp 277-299.

Häußermann, H./Siebel, W. (2004): Stadtsoziologie. Eine Einführung. Frankfurt a.M./New York: Campus Verlag

Healey, P. (1997): Collaborative Planning. Shaping Places in Fragmented Societies. Houndsmills / London.

Hinte, W. (2007): Das Fachkonzept „Sozialraumorientierung". In: Hinte, W. / Treeß, H. (Eds.): Sozialraumorientierung in der Jugendhilfe: Theoretische Grundlagen, Handlungsprinzipien und Praxisbeispiele einer kooperativ-integrativen Pädagogik. Weinheim/München. pp 15-130.

Jahoda, M./Lazarsfeld, P.F./Zeisel, H. (1975): Die Arbeitslosen von Marienthal. Ein soziographischer Versuch. Frankfurt a.M.: Suhrkamp. (Erstveröffentlichung 1933).

Kessl, F./Reutlinger, C. (2007): Die Rede vom Raum und die Ordnung des Räumlichen. In: Kessl, F. / Reutlinger, C. (eds.): Sozialraum: Eine Einführung. Wiesbaden: VS Verlag. pp 7-56.

Kohlberg, L. (1984): Der „Just Community"-Ansatz der Moralerziehung in Theorie und Praxis. In: Oser, F.; Fattke, R. / Hoffer, O. (Eds.): Transformation und Entwicklung: Grundlagen der Moralerziehung. Frankfurt am Main: Suhrkamp. pp 21-55.

Kronauer, M. (2002): Die Aktualität von „community studies" für die soziologische Ungleichheitsforschung. In: SOFI-Mitteilungen Nr. 30. pp 135-142.

Läpple, D. (1991): Essay über den Raum. In: Häußermann, Hartmut / Ipsen, Detlev / Krämer-Badoni, T. / Läpple, D. / Rodenstein, M. / Siebel, W. (Eds.): Stadt und Raum. Soziologische Analysen. Pfaffenweiler: Juventus.

Lefebvre, H. (1991) The production of space. Oxford.

Lemme R. (2009): Älter werden im Quartier: Raumaneignung als Gesundheitsressource. In: Alisch, M. (ed.): pp 119-138.

Löw, M. (2001): Raumsoziologie. Frankfurt a.M.: Suhrkamp.

Löw, M./Sturm, G. (2005): Raumsoziologie. In: Kessl, F./Reutlinger, C./Maurer, S./Frey, O. (eds.): Handbuch Sozialraum. Wiesbaden: VS Verlag.pp 31-48.

May, M. (2008a): Begriffsgeschichtliche Überlegungen zu Gemeinwesen und Sozialraum. In: Alisch, M./May, M. (Eds.): Kompetenzen im Sozialraum. Sozialraumentwicklung und -organisation als transdisziplinäres Projekt. Opladen/Farmington Hills: Barbara Budrich Verlag. pp 19-38.

May, M. (2008b): Sozialraumbezüge Sozialer Arbeit. In: Alisch, M./May, M. (Eds.): Kompetenzen im Sozialraum. Sozialraumentwicklung und -organisation als transdisziplinäres Projekt. Opladen / Farmington Hills:: Barbara Budrich Verlag. pp 61-84.

Putnam, R. (1993): Making Democracy Work: Civic Traditions in Modern Italy. Princeton. Princeton University Press.

Quinn, J.A. (1950): Human Ecology. (Neuauflage 1970) Hamden. Connecticut.

Rammé, A. (2007): Community Organizing und Gemeinwesenarbeit. Unveröff. BA Arbeit an der Hochschule Fulda. Februar 2007.

Riege, M./Schubert, H. (2002): Einleitung: Zur Analyse sozialer Räume – Ein interdisziplinärer Integrationsversuch. In: dies. (eds.): Sozialraumanalyse. Grundlagen – Methoden – Praxis. Opladen: Leske + Budrich. pp 7-60.

Riege, M./Schubert, H. (2005): Konzeptionelle Perspektiven. In: Kessl, F./Reutlinger, C./Maurer, S./Frey, O. (eds.): Handbuch Sozialraum. Wiesbaden: VS Verlag. pp 247-259.

Shevky, E./Bell, W. (1974): Sozialraumanalyse. In: Atteslander, P./Hamm, B. (eds.): Materialien zur Siedlungssoziologie. Köln: Kiepenheuer & Witsch.

Szynka, P. (2006): Theoretische und empirische Grundlagen des Community Organizing bei Saul D. Alinsky (1909-1972). Akademie für Arbeit und Politik der Universität Bremen

Wallace, A. (2010): Remaking Community? New Labour and the Governance of Poor Neighbourhoods. Ashgate.

Wullkopf, U. (2008): Gemeinschaftliches Wohnen in einer sich wandelnden Gesellschaft. In: Schader-Stiftung / Stiftung trias (eds.): pp 23-27.

II Political parameters: Health systems and EU funding strategies

Health systems in Europe and the relevance of health information

Edited by Monika Alisch

In light of an European health policy that tries to implement a holistic model of health in Europe across the various health systems, we will try to give an overview of the health and health information systems of the countries involved in the Chance-project[1]. We will follow with some discussion concerning European health policy and then provide a comparison of the relevant countries' health systems, the strategies and distributions, and the role of media in health information systems.

It is clear however that the organisation of health systems are very different across national boundaries. For example in Austria and Germany, there exist many federal and regional institutions because of the number of statutary organisations. A high number of NGOs further increases the complexity and of course all institutions utilise all available media such as internet, television, radio, newspaper and magazines to get their messages out to interested parties.

To begin with Sweden, here there is a highly developed health system on a national level comprising different institutions. However, often civic and non-civic institutions on a local level offer health promotions. The civic institutions are responsible for disease prevention and the regulation of food quality. In Austria, responsibility is split between the federal and regional governments and authorised civic organisations within the health sector. The federal government deputes competences to selected self-organised and democratic social insurance companies, based on membership. The federal ministry of health and different governmental organisations are responsible for planning and observation. In the United Kingdom, the consumer is overwhelmed with health information,

1 Data on the respective systems were collected by the partners during the project to be presented in the proceedings at the EACEA. Here, they are newly and comparatively compiled (see http://fulldok.hs-flda.de/volltexte/2010/40/.

however, most of the information does not come from official sources. When official messages are analysed, it can be determined that recommendations for diets have not changed a great deal over the last 40 years. In the future, more responsibility will be delegated to the national health system (NHS). Existing campaigns have been designed on a short time scale and many different organisations need to be involved. In addition, all four countries of the United Kingdom are responsible for establishing their own health policy. In Latvia, numerous ministerial departments are responsible for dealing with health matters, this being in addition to local government.

The mass media are of course important. For example in Romania the decentralisation of state services is on going and whilst private health insurances currently still have low market density this may be set to change. Consumers have a lack of health knowledge and they know less about prevention. Television plays an important role in this process.

In general, the health system influences the perception of health information and health behaviour. In the Chance project, we were confronted with different health systems in different countries. In Sweden, a coherent health system guarantees high life expectancy. A less coherent health system is correlated with a lower level of health. In Germany especially, many institutions and organisations are part of the health system, and there is no systematic cooperation.

1. European health policy

"Good health for everybody" is the slogan that the European Union uses on its website to promote health policy in Europe. Without reference to its origin it is stated that "Health is a priority for Europeans and therefore for the European Union" (Communication Department of the European Commission, www.europa.eu/pol/ health/index_en.htm).

The list of societal goals connected to health immediately shows an inherent normative direction with the initial expectation "to be protected against illness and disease". This is followed by aims related to sustainability represented by the aspiration that "We [the Europeans] want to

bring up our children in a healthy environment", added that "We are entitled to a safe and hygienic workplace" this on the basis of the fundamental principles that "When travelling within the European Union, we need access to reliable and high-quality health advice and assistance" (see http://europa.eu/pol/health/index_en.htm).

This normative European health policy is well aware of its limits and suggests that "each EU country is free to decide on the health policies best suited to national circumstances and traditions" (see http://europa.eu /pol/ health/index_en.htm). The now concluded Chance-project, whose results are presented in this issue, demonstrates that these circumstances are extremely different, and questions concerning comprehensive knowledge on health and health behaviour in everyday life could only be answered referring to the national, regional, and local practices and policies[2].

Thus, even the EU-political appeal is in essence a mission statement notwithstanding the plea for the "right of everyone to the same high standards of public health and equity in access to quality health care" (see http://europa.eu/pol/health/index_en.htm) has to be implemented European-wide. In light of this, the EU produces strategies for cooperating "on common challenges" (http://europa.eu/pol/health/index_en.htm) which are "ranging from ageing populations to obesity. The EU is also committed to taking the implications for health into account in all its policies" (http://europa.eu/pol/health/index_en.htm).

To meet these "common challenges", the "EU is spending more than €50m annually on activities to improve health security, to promote good health – including reducing inequalities, and to provide more information and knowledge on health" (see http://europa.eu/pol/health/index_en.htm). Despite this however we do demonstrate how on an European level little information from this level reaches its target groups, especially and tellingly deprived social groups (see the introducing article by Freytag-Leyer/Alisch).

2 A comparison of strategies of health promotion in the 15 "old" European countries and case studies in six countries show the differences in understanding the terms health promotion, health prevention or health impact assessment (HIA) and in their implementation (see Weinbrenner et al. 2007).

Simultaneously, the EU oversees cooperation in crisis situations according to its supranational responsibility, and claims that "When a pandemic threatens, the EU draws up a coordinated response plan as it has done, for example, for avian influenza" (see http://europa.eu/pol/ health /index _en.htm). The "European Centre for Disease Prevention and Control" headquartered in Stockholm co-ordinates and "pools and shares knowledge on current and emerging threats, and works with its national counterparts to develop Europe-wide disease surveillance and early warning systems"(see http://europa.eu/pol/health/index_en.htm). The sustainability goal to protect the environment because of its capacity to improve the health of all is also dealt with in an EU-plan: "A strategy within the European Commission's Environment and Health Action Plan is tackling the links between environmental factors and conditions such as asthma, allergies, respiratory diseases, cancer, and neuro-developmental disorders, such as autism and speech problems" (see http://europa.eu/pol/health/index_en.htm).

Altogether, the EU health policy appears as both a medicine and technology-related health policy which in reality is not necessarily able to mirror the comprehensiveness of full social, psychological, and physical health. It rather emphasises the prevention or therapy of diseases.

Due to "the emergence of new challenges and priorities in the field of health […] it is necessary to develop a new strategy" (see http://europa.eu/legislation_summaries/public_health/European_hea lth_ strategy/c11563_en.htm). This strategy has been developing since 1998 and with the experiences and findings of previous action programmes. The strategy consists of the two main elements (ibid.):

- "a new framework for action in public health ("public health framework"), which includes the adoption of a Community action programme in the field of public health (2001-2006);
- the development of an integrated health strategy. As a result of the Treaty provision which stipulates that a high level of health protection must be ensured in the definition and implementation of Community policies, health protection concerns all key areas of Community activity. This new strategy contains specific measures to incorporate health protection into all Community policies" (see http://

europa.eu/legislation_summaries/public_health/european_ health_ strategy/c11563_en.htm).

The current EU health policy should comprise three strands of action:

- improving information for the development of public health (a structured and comprehensive Community system should be developed for collecting, analysing and disseminating information on general trends in the population's health status and health determinants and on developments concerning health systems);
- reacting rapidly to threats to health (creating Community surveillance, early warning and rapid reaction mechanisms to meet the threats to health);
- tackling health determinants through health promotion and disease prevention (strengthening individuals' ability to improve their health, including social, economic and environmental conditions, and the many activities linked to prevention). (e.g. http://europa.eu/legis lation_ summaries/ other/c11560_en.htm).

2. Institutions of health information in the participating countries

The political system in *Austria* provides a division of work between the federal government, the governments of states and authorised civil society organisations in the health care sector. The Austrian state delegates responsibilities to membership-based insurance associations and service providers which operate in the form of self-governmental organisations. Due to the legislative separation of organisational and financial structures in the health system, in connection with the increasing availability of services and increasing demand, enhanced cooperation between all stakeholders has become necessary. Cooperative instruments of the federal state (agreements according to Federal Constitution Article 15a B-VG[3]) have been employed since the end of the 1970s which enable the federal government to have controlling influence, especially in the in-

3 The conventions are bilateral conventions under constitutional law among federal and state governments. It is regulated if a complex problem lies in the responsibility of federal or state legislation. Both enact laws with equal content.

patient care sector (Hofmarcher / Rack 2006). The latest health reform's main features set up a new structure of health provision, particularly concerning hospital financing and the integration of in- and out-patient health care (Schwamberger 2007). As a result, the Austrian Structural Plan of Health (Österreichischer Strukturplan Gesundheit - ÖGS) was developed in 2005. After its revision and adaption, ÖGS 2008 was constituted in 2009 (Bundesministerium für Gesundheit, 2009) The Structural Plan of Health only allows for basic strategy at the federal level. This gives states, hospital owners and social health insurances a broader scope for designing within the detailed plan on a regional level. So, there is a separation of the sectors within the health system which is why the ÖSG is a basis for health care reform (Bundesministerium für Gesundheit 2009).

In *Germany,* there exists a number of different governmental and non-governmental institutions communicating health matters. There are at least five separate bodies making decisions on the content and way of providing health information on the national, regional or local level. The structure of the German health information system is characterised by the specific role of social and health insurances. Their provision of, for example, nutrition education, physical activity and health information in general are based on German social law. That is why 38% of all preventive and health-promoting activities are initiated by health insurances, which also carry more than 50% of total financial support for such initiatives, followed by nearly 25% governmental funding. Altogether, 1-5% of the total state health budget is spent for health-promoting activities. Since 2008, consumer information law gives more responsibility to the food industry, which has to communicate product (health) information of the food to the consumer. Regulation (EC) No. 1924/2006 on nutrition and health claims made on food establishes rules for the use of any claims in the labelling and advertising of food.

In *Latvia,* numerous different governmental institutions are responsible for the regulation 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 2005 to 2006, 2007). 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, popularising a healthy lifestyle and

creating conditions where the inhabitants would benefit from cost-effective, physically accessible, and high-quality health care services.

Health care in *Romania* is generally poor compared to European standards, and access is limited in certain rural areas. The report "*Empowerment of the European patient, options and implications*" published in Brussels in March 2009, sees Romania in 30th place with regard to health information. It also argues that Romania offers its citizens very poor information and knowledge about health; even poorer than other East European countries (Health Consumer Powerhouse AB 2009). The state-owned health care system was a campaign to decentralise state services. The system has been funded by the National Health Care Insurance Fund, to which employers and employees make mandatory contributions. The private health insurance sector has developed slowly. Because of low public funding, about 36% of the population's health care spending is out-of-pocket (Library of Congress/Federal Research Division 2006: 10).

In *Sweden,* most public health work is undertaken at the local level by the county councils, the municipalities and non-governmental organisations. Preventive and population-oriented health care has been integrated into primary health care provision. The Ministry of Health and Social Affairs is responsible for health care, health, and social issues/insurance, with the Ministry of Agriculture also providing information about health issues. Today, there are three authorities responsible for public health information in Sweden. The SNIPH[4] works to promote health and prevent ill health and injuries, 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 organisations. The NFA (National Food Administration), 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, undertakes a wide range of activities and duties within the fields of social services, health and medical services, environmental health, communicable

4 Swedish National Institute of Public Health (SNIPH) which is a state agency under the Ministry of Health and Social Affairs.

disease prevention and epidemiology. One of the latest publications is the seventh environmental health report issued in 2009.

In *Great Britain,* 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: 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 poor numeracy skills.

3. Strategies and distributions

The main organisations in the *Austrian* health information system are the national and the federal councils, the Federal Ministry of Health and social insurances. The federal government retains an important role in policy, as a supervisory authority for the enforcement of law and the education of health professionals. Almost all areas of the health care system are in the responsibility of the federal government, except the hospital sector for which the federal government is only responsible for enacting basic law, while legislation on implementation and enforcement is the state's responsibility.

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 / Rack 2006).

The Government sets the frame for different national activities in *Germany*:, 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 centres (e.g. "social knots", "Networking Agency for school meals").

From the regional perspective of Hesse, health information strategies, programmes and activities are more detailed than national programmes, with a 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 providers with more focus in the practical support for health information strategies. Networking activities concentrate on the settings of for eaxmple 'city' and 'school'. Further research is needed on the practical level of implementation of health programmes and projects.
Health education in *Latvia* is a planned learning system to provide knowledge, to shape attitudes, skills and acquirements, to develop abili-

ties required for maintaining health by using advice and evidence from several desciplines (see Rubana 1997). The three main tasks for health education in Latvia are to provide knowledge on health and the factors influencing it, to create a positive attitude to the individual's and the others' health, and to develop skills for taking care of one's own health and that of others (see Velša 2005).

The Public Health Agency determines public health problems, develops proposals for policy and creates effective solutions of problems in the field of public health. The main target of the Health Compulsory Insurance State Agency is to implement state policy for the availability of health care services and to administrate the state compulsory health insurance resources. The Board of Nutrition is responsible for promoting and implementing 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 the development and implementation of policies with regard to education, science, sports, and national language, promoting sustainable growth for welfare of the citizens of Latvia is the responsibility 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 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 a development strategy to organise 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 for the provision of accessibility of health care as well as for encouraging people to follow a healthy lifestyle.

The most visible *Romanian* campaign nationally concerning health education is promoted via Romanian TV channels. There are some TV spots to highlight and raise awareness of various issues of health: "The excessive consumption of salt, sugar, and fat is bad for health", for example.

All *Swedish* 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 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 sources of health communication for Swedish people regarding issues like diet and health. Further, communicating via computer, internet, and 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 relatively weak success of such efforts.. Advertisement (e.g. for food, alcohol, and tobacco) does however also exist.

In *Great Britain,* 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. Also, many manufacturers and service providers use 'health' as a lever to market their products, for example motor cars, vacuum cleaners, textiles, insurances, 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 of institutions involved 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.

4. Health information and the media

In *Austria,* health information is provided not only by by the Federal Ministry of Health, but also by the Federal Ministry of Labour, Social Affairs and Consumer Protection, the Federal Ministry of National Defence and Sports, the Federal Ministry of Women and Public Services, the Federal Ministry for Education, Arts and Culture, and the Federal Ministry of Agriculture, Forestry, Environment and Water Management (see Hofmarcher / Rack 2006). Health information is offered nationwide by the "Gesundheit Österreich GmbH" with its three sub-organisations, FGÖ, ÖBIG and BIQG[5], the Supreme Health Board, the Austrian Agency for Health and Food Safety (AGES), the Federal Drug Forum, public corporations like the chamber of labour, public television and radio, and different organisations like NGO´s (Caritas etc.) or self-help groups. On the state level, health information is provided by the government's, health platforms/agencies, specialised bureaus and regional transfer units for health promotion and prevention, aks austria[6] and further addiction prevention programmes. Furthermore, some health insurances, networks for health promotion (boroughs, schools, hospitals) and private providers are working in the field of health information (see Dür 2007). According to the providers of health information, the variety of health data is enormous. Therefore, mirroring the situation in the U.K. health information is inevitably perceived differently by different social groups.

The media in *Germany* are also included in the process and often praised for their helpful and responsible information policy. Besides involving "classic" media like newspaper, magazines and radio, there also exist first attempts to install edutainment concepts on TV. More and more networking via internet is also being utilised by multi-sectional stakeholders to secure high quality health information (e.g. www.gesundheitsin formation. de, www.afgis.de, www.gesundheitliche chancen gleichheit.de).

5 BIQG = „Bundesinstitut für Qualität im Gesundheitswesen" – Federal Institute for Quality in Public Health [www.goeg.at]; FGÖ (Fund for Healthy Austria, (http://www.fgoe.org /welcome-to-fond-gesundes-oesterreich?set_language= en& cl=en); ÖBIG (Östereichisches Institut für Gesundheitswesen; Austrian Health Institute).

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

There are different ways of getting an impression of how health information is noticed and then put into practice by German people: regular governmentally 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. Scientific national studies provide recent data like the National Nutrition Survey (MRI 2008). Those studies do not only allow insight into people's nutrition and health status but also provides background demographic and behavioural information of respondents.

Public education on health issues in *Latvia* is organised and disseminated in collaboration with the mass media and the insurance institutions listed in section 1. Cooperation with the media is assured through regular press conferences on topical issues and by bringing the latest information of institution's web pages under the section "News". Public health officers regularly give interviews to the media. Varieties of interactive discussions are organised on topical issues such as smoking, etc. in Latvian portals. In collaboration with schools, a variety of health related activities and competitions are organised, where students need to be knowledgeable in health matters; the results are published in the media.

The newspapers have separate sections allocated for specific health-related themes, with television and radio also broadcasting such issues. The participating institutions regularly prepare and publish reports on public health research results, as well as industry statistics, and these are also available to the media. Public education of health issues is organised in collaboration with mass media and the institutions involved in the health system.

In *Romania*, 87% of people between 15 and 60 years old declare themselves interested in health information. Such information is found by 38% on the Internet (specialised sites), 31% find it on TV, in magazines, journals, and newspapers. Only four percent ask for health information at specialised resources (general practitioners or specialised magazines). Women between 45 and 60 years old, with a high educational level and professional careers are the most interested in obtaining health information. Their resources are: specialised magazines, specialised columns in newspapers and their general practitioner. Most of the people interested in health information prefer to find this information (one to four 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.

In Romania, national surveys examine the population's health as well as the perception of health information. Mediums of distribution of health messages are the TV, radio, newspapers, journals and national or local campaigns and advertisement. The consumer health education domain needs to develop various approaches that offer more sustainable results and advice. Despite the fact that knowledge of what a healthy behaviour and a healthy lifestyle has became better, this knowledge – promoted as an official message – only reaches a minority of the population. Romania is well known for "abundant" and unhealthy nourishment, for the sedentary lifestyle, as well as for the lack of preventive health behaviour. Poor eatings habits are, unfortunately, well established.

Swedish people who are responsible for information on healthy diets believe that because of the current information environment, there are difficulties in disseminating such information,. However, they argue that the responsibility for an individual's health is ultimately within 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 (unpublished data).

The World Health Organisation (WHO) has had a marked influence on national policy with regard to health in *Great Britain*. 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.

References

Acheson, D. (1998): An Independent Inquiry into Inequalities in Health. TSO: London.

Adamovich, L.K. / Funke, B.C. / Holzinger, G (1998): Österreichisches Staatsrecht, 2 Bände, Wien.

Bundesministerium für Gesundheit (2009) (eds.): 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_-_gesa mt.pdf (Stand 15.4.2009)

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].

Dür, W. (2007): Visionen für die Gesundheitsförderung in Österreich. 9. Gesundheitsförderungskonferenz. 4.6.2007. Präsentation: http://lbimgs-archiv.lbg.ac.at/ present/04062007.pdf (Stand 30.5.2009)

Health Consumer Powerhouse AB (2009): The Empowerment of the European Patient 2009 - options and implications. http://www.healthpowerhouse.com/files / EPEI-2009/european-patient-empowerment-2009-report.pdf

Hofmarcher , M.M./Rack, H.M. (2006): Austria: Health system review. Health Systems in Transition, 2006; 8(3): pp. 1-247.

Hochschule Fulda, Community Health Management to Enhance Behaviour, Proceedings of the 2nd International Meeting of the Project CHANCE: 12.6.2009 Fulda Germany http://Fuldok.hs-fulda.de/volltexte/2010/140/

Informatīvais ziņojums par Sabiedrības veselības stratēģijas Rīcības programmas ieviešanu 2005.-2006.gadā (2007): (Informational Report on the Public Health Strategy Action Program by the 2005 to 2006) Riga, 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.

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

LR likums. Par Latvijas Republikas administratīvo teritoriju izveidošanu un apdzīvoto vietu statusa noteikšanu (1991): (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.

MRI (Max Rubner-Institut) (2008) (ed.): Die Nationale Verzehrstudie II.

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

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. S. 484-99.

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

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.

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

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=14627epslanguage=SV.

SLV (2007c). Livsmedelverkets 5 kostråd. Available at: http://www.slv.se /templates/SLV_Page.aspx?id=13873&epslanguage=SV

SLV (2008), Matförgiftningar. Available at: http://www.slv.se/ templates/ SLV_Page.aspx?id=2569&epslanguage=SV

Tálos, E. (2000): Das politische System in Österreich, Bundeskanzleramt, Bundespressedienst.

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

Veselības ministrija. Definīcijas (Definitions). In Latvian available at: http://www. vm .gov.lv /index.php?top=117&id=120, 20.08.2008

Weinbrenner, S. / Wölz, M. / Busse, R. (2007): Gesundheitsförderung im europäischen Vergleich. Frankfurt a.M. KomPart. Verlag.

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

World Health Organisation (1946): Constitution: Basic Documents. Geneva: WHO.
World Health Organsiation (2003): Diet, nutrition and the prevention of chronic disease: 2003. World Health Organization Technical Report Series 916.

Conceptions of "Lifelong Learning" in the EU

Barbara Freytag-Leyer and Thomas Berger

The Chance project was supported by the Grundtvig programmme for adult education in the framework of the European Lifelong Learning Programme. This chapter aims to provide a brief overview about the history of Lifelong Learning as well as current and future aims and programmes for Lifelong Learning in the European Union. Three sample projects illustrate the practical implementation of different European programmes.

Introduction

Education is a human right according Article 26 of the UN Universal Declaration of Human Rights on December 10, 1948:

"1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.
(2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.
(3) Parents have a prior right to choose the kind of education that shall be given to their children" (UN http://www.un.org/en/documents/udhr/index .shtml#a26).

The elementary education will be offered worldwide, although it may be in different specifications. However, lifelong learning – education throughout the whole of life – didn´t become a value in all states.

In Anglo-Saxon countries, lifelong learning has a longer and different tradition. It was a liberal and pragmatic conception as *"recurrent education"* on the basis of the OECD (1973) (Nuissl, 2010:205). Equality in

education and innovation in educational management were two main axes. One of the projects was "recurrent education as a strategy for lifelong learning" (OECD, 2008: 1).

A report entitled "*Permanent Education* – a framework for recurrent education" was presented at the Standing Conference of European Ministers of Education. "The ministers emphasised that a valid system of permanent education needed to embrace all sectors of education, formal and informal, vocational and non-vocational. A long-term project was conducted by the Council of Europe from 1967 to 1979 in an attempt to define the characteristics of a coherent and integrated educational system covering the various stages and all spheres of life." (Council of Europe w/oyear.).

For developing countries "*lifelong education*" was important for the cultural and national identity and coverage of poverty – reported from the UNESCO (Nuissl, 2010: 205). Knoll pointed out that the so called "Faure report" from 1972 – "Learning To Be" – was the beginning of the discussion of lifelong learning in the UNESCO (Knoll, 2002:16).

The key words of the report were lifelong education and learning society. "The approach was based on the idea of osmosis between education and society, and sought to steer clear of a number of misconceptions, such as the ideas of education as a 'sub-system' of society, of instruction as a tool for solving all individual and social problems, and of the compartmentalization of life into 'learning time' and 'time for living'." (UNESCO, w/oyear: 35ff). Learners (not teachers or educational institutions) were the most important groups for personal development and the outcome of the learning process (UNESCO, w/oyear: 35ff): "Education and teaching are described in it as dimensions that are subordinate to the learning process. School and out-of-school activities (formal, non-formal and informal education) are treated without hierarchical distinction, and the importance of basic education for all and of adult education is taken as a premise: 'learning is a process that lasts a lifetime, both in its duration and in its diversity'." (ibid).

At the end of 20th century the UNESCO edited a task force for the education, "Education takes place throughout life in many forms, none of which ought to be exclusive. We must start to think about education

in a more all-encompassing fashion. Likewise the four pillars cannot stand alone. Without all the four pillars education would not be the same" (UNESCO 1999). The four pillars include:

- Learning to know,
- Learning to do,
- Learning to live together,
- Learning to be.

The UNESCO activities can be seen as a reaction to socio-cultural and socio-economic developments, described as dissolution of boundaries, which influence the individual, organisational and social dimension of learning (Kirchhöfer 2004). According to Kirchhöfer, this process can be described with the following interrelated factors (ibid.):

- *Time*: learning takes place across all stages of life;
- *Space*: digital technologies enable learners to construct their learning spaces independent from institutions such as schools, universities;
- *Resources*: digital technologies allow almost unlimited access to learning resources;
- *Content*: Competences (including meta-competences such as ability to learn and to maintain and develop competences) gain importance at the expense of the importance of knowledge;
- *Social Form*: the process of self-directed learning dissolves the separation of the social functions of learning and teaching;
- *Institution*: traditional institutions have to deal with new forms of learning (e.g. accreditation and recognition of formal and informal learning);
- *Biography*: after school the degree of freedom to decide about content, time, and duration of learning increases.

These factors can help to explain and describe ongoing change processes often related to the term lifelong learning.

Lifelong Learning in European Tradition

In the first decades after World War II the focus lay on economic affairs. Education was absent. In the midst of the 1970's then a first community action plan on education (non-binding resolution) identified

six priorities for action: educating the children of migrant workers; closer relations between education systems in Europe; the compilation of documentation and statistics; higher education; the teaching of foreign languages and equal opportunities. Many pilot projects started and experiences could be obtained but it was not until the Maastricht Treaty in 1992 that education and training were given a legal basis in the European Union. European Parliament and Council were responsible. They introduced a separate Directorate General of the European Commission for Education and Culture. Two programmes were applied: Socrates for Education and Leonardo da Vinci for Vocational training. "The concepts of 'knowledge based society' and 'lifelong learning' were coined and became increasingly well-known" (European Commission/1 2010).

On the basis of the Lisbon Strategy in 2000, laying out the economic, social and environmental strategy for the EU up to 2010, education and training were brought "to the forefront in its aim of achieving a Europe of knowledge" (European Commission/1 2010).

At first a single programme for Lifelong Learning was established besides a new youth programme. The programmes were more and more successful. Over 1 percent of the community budget was provided in the period 2007 to 2013 (European Commission/1 2010). Since 2007 the Lifelong Learning Programme has been integrated as a new umbrella for all European educational and training initiatives. "The objective of the programme is to enable individuals at all stages of their lives to pursue stimulating learning opportunities across Europe" (European Commission/2 2011).

There are four sub-programmes for 2007 to 2013 which fund projects at different levels of education and training:

- Comenius for schools,
- Erasmus for higher education,
- Leonardo da Vinci for vocational education and training,
- Grundtvig for adult education (European Commission/1 2011).

The transversal action part of the programme comprises areas such as applied language learning, information and communication technologies (ICT), policy cooperation and dissemination and exploitation of project

results (European Commission/1 2011). Furthermore the Jean Monnet programme, which supports educational and research activities in the area of European integration is integrated in the Lifelong Learning Programme.

The European Commission bears the responsibility for the programme, the management for some parts is done in the Education, Audiovisual & Culture Executive Agency (EACEA) in Brussels and national agencies of the EU member states. The national agencies are responsible for some decentralised actions (European Commission/2 2011).

What is happening in the moment in Europe?

Adult learning is now important in EU education policies. All groups, especially the most disadvantaged, should be included. "It is essential to competitiveness and employability, social inclusion, active citizenship and personal development across Europe" (European Commission/4 2011). Five central main aims are in the spotlight:

- "To reduce labour shortages due to demographic changes by raising skill levels in the workforce generally, and by upgrading low-skilled workers (80 million in 2006);
- To address the persistently high number of early school leavers (nearly 7 million in 2006), by offering a second chance to those who enter adulthood without any qualifications;
- To reduce poverty and social exclusion among marginalised groups. Adult learning can both improve people's skills and help them achieve active citizenship and personal autonomy;
- To increase the integration of migrants in society and labour markets. Adult learning should offer tailor-made courses, including language learning, to help the process. Adult learning can help migrants to secure validation and recognition of their qualifications;
- To increase participation in lifelong learning, particularly to address the decrease in participation over the age of 34. With the average working age rising across Europe, there should be a corresponding increase in adult learning by older workers" (European Commis
- sion/4 2011).

Five priority actions are in the spotlight:
- "Analyse the effects of reforms in other educational sectors on adult learning;
- Improve the quality of provision and staffing;
- Increase the possibilities to achieve a qualification at least one level higher;
- Speed up the process of assessing and recognising non-formal and informal learning for disadvantaged groups;
- Improve the monitoring of the adult learning sector." (European Commission/4 2011).

The *Comenius programme* is oriented on all levels of school education from pre-school to secondary schools and relevant to mainly pupils, teachers, local authorities, NGO's, teacher training institutes and universities (European Commission 5/2011).

Erasmus is the "flagship education and training programme" (European Commission 4/2010). It supports students for studying abroad, professors and business staff for teaching and receiving training abroad, hosting student placements, academic networks and multilateral projects (European Commission 5/2011).

The *Leonardo da Vinci programme* funds practical projects for the vocational education and training from individual work-related training abroad to large-scale co-operation efforts. Projects are funded which will develop innovative policies, courses, teaching methods and materials (European Commission 3/2010).

The *Grundtvig sub-programme* especially provides practical support for the implementation of adult learning policies. It gives opportunities for learners, teacher, trainer, staff and organisations in this sector as relevant associations, counselling organisations, NGO´s, voluntary groups and research centres.

The aims are:

- "increase the number of people in adult education to 25,000 by 2013, and improve the quality of their experience, whether at home or abroad;

- improve conditions for mobility so that at least 7,000 people per year by 2013 can benefit from adult education abroad;
- improve the quality and amount of co-operation between adult education organisations;
- develop innovative adult education and management practices and encourage widespread implementation;
- ensure that people on the margins of society have access to adult education, especially older people and those who left education without basic qualifications;
- support innovative ICT-based educational content, services and practices" (European Commission 2/2010).

In this programme many activities, e.g. exchanges, networking and partnerships between organisations, in different countries support for travelling abroad for learning experiences (European Commission 2/2010).

Examples

In the following three sample projects are presented; at first Chance as an example of Grundtvig, than Nutgecs as an example of Leonardo da Vinci and in the end Uni-key as an example of Erasmus. The University of Applied Sciences Fulda has been a member or coordinator of the respective project consortia.

a) CHANCE as a Multilateral Project - Example of the Grundtvig Programme

Chance (community health management to enhance behaviour) was a European project funded within the framework of the Grundtvig-Lifelong Learning Programme with a duration from December 2007 until November 2009 (www.community-health.eu). It provided the framework for an interdisciplinary team to enhance and support people in the long term to be well informed and to take responsibility for their own health.

Under the leadership of the Department of Nutrition, Food and Consumer Science (Ecotrophology) and the Department of Social Work of the Fulda University of Applied Sciences, Germany, six universities and

three German NGO´s were partner in this project:

- Department of Nutritional Sciences of the Faculty of Life Sciences, University of Vienna, Austria
- Department of Spatial Development, Infrastructure and Environment Planning, Centre for Sociology (ISRA) of the Faculty of Architecture and Spatial Planning Vienna University of Technology, Austria
- Department of Economics from Latvia University of Agriculture, Jelgava, Latvia
- Faculty of Sociology and Psychology from Universitatea De Vest Din Timisoara, Romania
- Department of Food, Nutrition and Dietetics of Uppsala University, Uppsala, Sweden
- Centre for Tourism, Consumer and Food Studies of Liverpool John Moores University, Liverpool, United Kingdom
- and
- German National Association of Senior Citizens Organizations, Germany (BAGSO Bundesarbeitsgemeinschaft der Senioren-Organisationen e.V.)
- German Association of Home Economics (Deutsche Gesellschaft für Hauswirtschaft e.V.) Germany
- Consumer Centre Hesse (Verbraucherzentrale Hessen e.V.) Germany.

The universities were especially responsible for the needs analysis; the qualitative and quantitative research. Together with local partners in Germany, and in a similar way in the other countries, they developed specific offers and interventions in the field of consumer health education and implemented them in each community (see the different country studies in this book).

Three international meetings were reasonable to get to know each other and to discuss results, experiences and best practices. Emails, Skype and an internal internet platform were used for the on-going general communication. Some general results e.g. the guidelines, the proceedings and the website are available for stakeholders in all European countries.

The interdisciplinary cooperation of social and natural sciences and urban planners with regard to health, led to an intensive exchange of experiences and mutual trust. The development of intercultural mutual understanding and intercultural appreciation was an important side effect of this project.

b) Nutgecs as a Partnership Project - Example of the Leonardo da Vinci Programme

Some of the Chance partners participate in a new project: Nutgecs – a Nutrition Guide for Early Childhood Active Stakeholders, during 8/2010 – 7/2012. Five universities for higher education work together:

- Faculty for Vocational Education of Selcuk University, Konya, Turkey as project coordinator;
- Department of Nutrional Sciences of the Faculty of Life Sciences University of Vienna, Austria;
- Department of Nutritional, Food and Consumer Science, Fulda University of Applied Sciences, Germany;
- Department of Economics from Latvia University of Agriculture, Jelgava, Latvia;
- Faculty of Sociology and Psychology from Universitatea De Vest Din Timisoara, Romania.

The aims of the project are to increase quality and usage of vocational education, focusing on typical techniques for vocational education. Furthermore, it is aimed to create collaboration with related sectors to improve awareness for nutrition in early childhood, to increase quality of life and to contribute to forming and improving awareness among stakeholders of the importance of nutrition education in the preschool period (see: www.nutgecs.eu).

The analysis of surveys on the nutritional status of pre-school children and health promotion projects for pre-school children in each country, qualitative interviews of pre-school teachers and the analysis of needs of the stakeholders and responsibilities for nutrition in kindergarten are applied methods.

The integration of a Turkish university demonstrates farsightedness and new possibilities for intercultural exchange and experiences. Mobility activities are requested by the Leonardo programme. In seven meetings active cooperation and transfer of knowledge will increase between the partners in the project. A guidebook offering descriptions and solutions for sustainable nutrition and nutrition education which can be used by all stakeholders of children in early childhood will improve vocational training.

c) Uni-Key as a Multilateral Project - Example of the Erasmus Programme

This project was selected for funding in 2011 and is already influenced by the future European Strategies in the area of Lifelong learning, which are presented at the end of this chapter. The project promotes university-enterprise cooperation in order to address entrepreneurial skills as a "European key competence for lifelong learning" (European Parliament, Council 1/2006).

Consequently the project consortium consists of enterprises, universities and research institutes and intermediate organisations such as enterprise associations and a Chamber of Commerce.

The following project partners are coordinated by the Fulda University of Applied Sciences as the leading organisation:

- Institute of Interdisciplinary Research Fulda, Germany;
- Belgian-Italian Chamber of Commerce, Brussels, Belgium;
- CONSORZIO C.E.S.A.F. S.c. (adult education organisation), Santa Vittoria d'Alba, Italy;
- WOW GROUP S.A. (software company), Marousi, Greece;
- Jeunes Entrepreneurs de l'Union Européenne (Young Entrepreneurs Association), Brussels, Belgium;
- University of Aveiro, Aveiro, Portugal;
- Anne Fox (consulting company), Nimtofte, Denmark;
- Instituto Tecnológico de Canarias, S.A. (Public Research organization), Las Palmas des Gran Canaria, Spain;
- Kruger to Canyons Biosphere (non-profit civil society organization), Hoedspruit, South Africa.

The main aims are a) an exploitation of the potential of practical training and study phases abroad (e.g. Erasmus and Leonardo placements) for the development of both entrepreneurial and intercultural skills for strategic career planning, b) the identification of key situations during a placement period in order to turn them into key entrepreneurial learning situations, i.e. entrepreneurial skill training is situated to practical situations each student experiences before, during and after being abroad; c) a valorisation of placements periods for university-enterprise knowledge transfer, research and innovation; hereby students shall develop to "transfer agents"; d) the exploration of formats of "entrepreneurial

placements", i.e. placements in young and micro enterprises (e.g. University spin-off companies) and e) the support of access to digital learning environments through mobile devices (e.g. smartphones).

What is planned for the future?

In 2009 the European Commission and the EU member states strengthened their cooperation with a strategic framework "Education and Training 2020 - ET 2020" (European Commission 3/2011).

For the EU, lifelong learning needs have priority. A high quality on all levels of education (pre-primary, primary, secondary, higher and vocational education and training) are very important for the changes in the future.

The main strategic aims are:

- Making lifelong learning and mobility a reality;
- Improving the quality and efficiency of education and training;
- Promoting equity, social cohesion and active citizenship;
- Enhancing creativity and innovation, including entrepreneurship, at all levels of education and training" (European Commission 3/2011).

These aims are reflected in the so called "Flagship Initiatives" (European Commission /6) of the Europe 2020 Strategy of the European Commission. The following four initiatives are of particular relevance from the perspective of lifelong learning:

- an Agenda for new skills and jobs (European Commission 7/2011) – aiming to match education and labour market needs;
- Youth on the Move (European Commission 8/2011) – aiming to promote mobility of learners;
- Innovation Union (European Commission 9/2011) – aiming to promote a triangular relationship and mutual stimulation of education, research and innovation (in products, services and business models);
- Digital Agenda for Europe (European Commission 10/2011) – aiming to promote digital literacy among all groups of society (Pillar VI) and the digital economy in general .

An integrated education, training and youth programme will follow the Lifelong Learning Programme for the period 2014-2020 (European Commission 11/2011).

The brief overview about the history of the concept of "Lifelong Learning" in Europe shows that changes have occurred continuously. Changes have been based on results of the evaluation of European programmes and new framework conditions. For researchers and stakeholders those changes result into a continuous challenge to deal with the diversity of European Lifelong Learning funding programmes and rules of participation in those programmes.

References

Arnold, R./Nolda, S./Nuissl, E. (2010): Wörterbuch Erwachsenenbildung. 2. Aufl., Bad Heilbrunn.

Council of Europe (w/oyear) Forty years of European Cultural Co-operation. http://www.coe.int/t/e/cultural_cooperation/commun/40cceng.asp#P94_21503 access: 14.6.2011.

European Commission 1/2010 (13.1.2010) History of European co-operation in education. http://ec.europa.eu/education/more-information/moreinformation294_en.htm. access: 12.8.2011.

European Commission 2/2010 (2.6.2010) Grundtvig. Practical learning for adults.http://ec.europa.eu/education/lifelong-learning-programme/doc86_ en .htm. access: 12.8.2011.

European Commission 3/2010 (30.9.2010) Leonardo da Vinci Programme. http://ec.europa.eu/education/lifelong-learning-programme /doc82 _en. htm. Access: 12.8.2011

European Commission 4/2010 (8.6.2010) The Erasmus Programme – studying in Europe and more. http://ec.europa.eu/education/lifelong-learning-programme /doc80_en.htm. Access: 12.8.2011.

European Commission 1/2011 (24.5.2011) The lifelong Learning Programme: education and training opportunities for all. http://ec.europa.eu/education /lifelong- learning-programme/doc78_en.htm, access: 14.6.2011.

European Commission 2/2011 (31.5.2011) Our Mission. http://ec. europa.eu /education/who-we-are/doc324_en.htm. access: 12.8.2011.

European Commission 3/2011 (17.2.2011) Strategic framework for education and training. http://ec.europa.eu/education/lifelong-learning-policy/doc28_en.htm. Access: 12.8.2011.

European Commission 4/2011 (12.5.2011) Learning for all. http://ec.europa.eu/ education /lifelong-learning -policy/doc58_en.htm. access: 12.8.2011.

European Commission 5/2011 (5.5. 2011) Comenius: Europe in the classroom. http://ec.europa.eu/education/lifelong-learning-programme/doc84_en. Htm. Access: 12.8.2011.
European Commission 6/2011 (17.8.2011) Europe 2020 – Flagship initiatives for smart, sustainable and inclusive growth. http://ec.europa.eu/ europe2020/ tools/flagship-initiatives/index_en.htm. Access: 27.8.11.
European Commission 7/ 2011 (27.8.11) European Commission – Employ ment, Social Affairs & Inclusion: New Skills for New Jobs. http://ec .europa .eu/ social/main.jsp?catId=822&langId=en. Access: 27.8.11.
European Commission 8/2011 (25.8.11) Homepage – Youth on the move – European Commission. http://ec.europa.eu/ youthonthemove/ index_en .htm. access: 27.8.2011.
European Commission 9/2011 (27.8.11) Home page - Innovation Union - European Commission. http://ec.europa.eu/research/innovation-union/ index_en.cfm. access: 27.8.2011
European Commission 10/2011 (26.8.11) Europa - Information Society - Digital Agenda for Europe. http://ec.europa.eu/information _society /digital-agenda/index_en.htm. access: 27.8.2011.
European Commission 11/2011 (11.7.2011) European Commission - Press release: Extra funds for education, youth and creativity will boost jobs, says Commission. http://europa.eu/rapid/pressReleasesAction. do?refe rence=IP/11/857&format=HTML&aged=0&language=EN&guiLanguag e=fr. access: 27.8.2011.
European Parliament, Council 1/2006 (18.12.2006) Recommendation of the European Parliament and of the Council of 18 December 2006 on key competences for lifelong learning. http://eur-lex. europa.eu/LexUriServ /LexUriServ.do?uri=CELEX: 32006 H0962: EN:NOT. Access: 27.8.2011.
Kirchhöfer, D. (2004): Lernkultur Kompetenzentwicklung: Begriffliche Grundlage. Berlin: Arbeitsgemeinschaft Betriebliche Weiterbildungsforschung..
Knoll, J. (2002): Einheit der Welt – Vielfalt der Kulturen. In: UNESCO-Institut für Pädogogik, Auf dem Weg zu einer lernenden Welt-50 Jahre UNESCO-Institut für Pädagogik. Hamburg.
Nuissl, E. (2010): Lifelong Learning. In: Arnold, R./Nolda, S./Nuissl, E. (ed.), Wörterbuch Erwachsenenbildung. 2. Aufl., Bad Heilbrunn.
OECD (2008): OECD´s Centre for Educational Research and Innovation – 1968 to 2008, http://www.oecd.org/dataoecd/19/44/40601796.pd access: 14.6.2011.
UN, Universal Declaration of Human Rights. http://www.un.org /en/ docu ments /udhr/index.shtml#a26. access: 14.6.2011.
UNESCO (1999):UNESCO Task Force for the Twenty-first Century. http:// ww w.unesco.org/delors/index.html 13.12.1999. access: 16.6.2011.
UNESCO (w/oyear) 5o years Main Thrust. http://www.unesco.org /education /educprog/50y/brochure/maintrus/35.htm. Access: 16.6. 2011.

University of Salford (ed.) (2009): Mentoring for 21st century skills- it´s all about learning. http://www.inter-research.eu/images /stories/ VITAE-Mentoring_for_21st_century_skills.pdf.

III Community based health information: The European case studies

Scouse Nouse: empowerment of carers in Liverpool

Allan Hackett, Pauline Lybert, Mark Meadows, Jackie Richards and Leo Stevenson

It was decided to focus the Liverpool strand of the Chance project on carers. This was because there are a huge number of unpaid carers in the UK, the number is likely to grow, the health needs of carers are often neglected and "carers need better and timely access to information" (HM Government, 2010). In addition the impact of one campaign with very limited resources could be maximized by affecting the health of the carer and the cared for. Finally by working in partnership with a local social enterprise organization ('Local Solutions') which supports carers, a window of opportunity was ready made. Some communities in Liverpool can be very 'tight knit' and particularly wary of any hint of officialdom, to collaborate with a community from scratch would have taken much time to build the trust required.

1. Liverpool

Liverpool was once a thriving city but declined dramatically in the years following World War 2 and about thirty years ago the city entered a second period of decline with the introduction of neoliberal policies and the deregulation of social housing. This 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 (Department of Health 2007). Indeed, health inequalities in Liverpool can no longer be generalised to any particular geographical area or parliamentary ward which makes data acquisition, and interpretation, more problematical when attempting to study people from a particular social background and refine it to a specific location. Until recently, regeneration had been accelerating at an astonishing rate with more than £3 billion invested in major projects as part of the city being 'Capital of Culture' 2008 which has changed the

face of the city. Nevertheless Liverpool still has among the highest morbidity and mortality rates with one of the lowest levels of life expectancy in the country as well as the very highest levels of deprivation in the UK. As in the 19th Century, there remains a stark contrast in health experience between the rich and poor.

The table summarises this social disadvantage, in terms of employment, in Liverpool compared to the wider setting of North West England and the country as a whole. The poor employment prospects for black and ethnic minority (BME) residents is particularly apparent.

Employment Rate 50y to 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
	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
	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
	63.5%	67.0%	67.3%	72.1%	74.5%
BME Employment rate, July 2007- June 2008					
	Liverpool	**Merseyside**	**City Region**	**North West**	**GB**
All Persons	13,700	21,900	22,800	185,500	2,518,200
	55.6%	58.6%	59.0%	55.0%	61.0%

Source: Liverpool City Council 2009

1.1 Description of target locality

South Central Liverpool is a roughly east-west band of the city beginning about two miles south along the river Mersey from the city centre and is home to some 81,000 people (Liverpool First 2009). The area targeted is a 'neighbourhood management area' but straddles six electoral wards. The area was built at the height of Liverpool's prosperity and has a unique urban character. Its communities are the most diverse

in the city representing a range of cultural backgrounds and faiths, including the majority of Liverpool's long established and newer BME residents. In some parts deprivation is acute and poor housing, health inequalities, low income, crime, discrimination, poor educational attainment and worklessness adversely affect the lives of many residents. Very detailed information on the factors listed for the wards composing South Central Liverpool is published annually in the City Council's 'Ward Profiles' (Liverpool City Council 2011).

Health is a major issue across South Central Liverpool with some areas having very high standard mortality rates (SMR) well above the national average for a variety of disorders, notably cancers (lung) and cardiovascular disease. Some progress has been made, for example during the period 2001/2003 and 2002/2004, SMR for cancer and heart disease have decreased by 13.3% and 8.3% respectively and the SMR for strokes has also seen a reduction of 9.4%. However, although Liverpool male life expectancy has risen by 2.1% since 1998 and the average is now 72.7 years and female life expectancy has also risen, but only by 0.6% with an average of 77.7 years, these are still well behind national expectations and are the lowest in the country for women and second lowest for men (UK average approximately 77y for males and 82y for females).

2. Results from the Chance questionnaire

2.1 Profile of households

Six hundred Chance questionnaires were distributed to residents of the South Central Liverpool area and 170 were returned and used for analysis. The low return rate is typical and may reflect apathy and cynicism concerning 'yet another' initiative. In addition the questionnaire was suitable only for literate individuals but as many as 20% of adults in the UK are functionally illiterate (cannot read or write) thus potentially disenfranchising them from many community development initiatives. Most respondents were women (70%) and 28% were aged 20-40y; 33% 41-60y and 39% over 61y. 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). Forty two per cent were retired and 9.7% un-

employed (15% of those not retired) and a further 10.4% were 'home-makers'. Only 6% described their income as 'above average' compared with their 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. Most respondents therefore had deep associations with Liverpool but those not answering may have felt uncomfortable

2.2 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 an indication of lack of self-efficacy (only 3% claimed to be usually unable to think of a solution to problems) which may well simply reflect the biased nature of the sample.

About 29% felt they needed help with cleaning and 24% with shopping but only 13% with their caring role. 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. Bearing in mind the biased nature of the sample, the findings suggest a lifestyle which is constrained to some extent by physical problems (including the environment) but the community exists primarily as an informal entity. Attempts to organize / develop / engineer a 'community' might well be resisted.

2.3 Perceptions of health

Most respondents thought their health to be good or very good (68.7%) and 14.9% thought their health poor or very poor. But 19.4% answered that they did not know suggesting a need to develop greater self-awareness. Few respondents admitted to not feeling well informed about health issues, for example physical activity (7.5%) and nutrition (8.2%)

but a further 14.2% and 20.1% respectively did not express an opinion. The perception of being informed was not challenged or verified. A very substantial minority expected their health to deteriorate in the next three years (24%) and only 19.4% expected improvement. Most (73.9%) claimed to read nutritional information at least sometimes. A substantial minority gave responses indicative of poor knowledge about basic food hygiene. There was clearly scope for activities to promote health literacy.

2.4 Qualitative Data

Twenty interviews were completed with carers, 18 of these were women. Two were from BME groups, this being broadly representative of the ethnic profile of South Central Liverpool. Most thought they were generally well informed about health and used a range of media to access information, for example books, magazines and TV.

The internet was also used to access specific information for the individual. No clear judgements were made as to the quality or relevance of information from such sources yet scepticism was apparent in relation to how health promotion messages change over time or did not reflect actual experience. Nevertheless, despite the range of information that was accessible, most considered *common sense* and past experience just as valid, and in many cases, more so.

The range of comments suggested a commonality of experience and this was particularly apparent in that whilst the carers had the responsibility of caring, and as such were the key decision makers, such decisions were taken with the person that was being cared for as the primary driver of these decisions. Thus it was the outcome for them that was the most important factor. Indeed many carers put their own needs to one side in order to care for their loved ones and this was reported as having a negative impact upon their own quality of life. Disrupted sleep patterns, lack of opportunity for exercise, social isolation, limited career prospects and financial hardship were all mentioned as consequences of their caring role.

Such outcomes would of course have influence upon the overall sense of wellbeing one may have and this was apparent in the way in which a number of the carers recognised the benefits of being able to socialise

and/or to attend, for example, short courses. Such courses had positive outcomes over and above the instrumental value of the course itself and therefore clearly had the potential to enhance confidence and emotional well-being, and in some cases even increased the perceived sense of safety they felt within the community.

In relation to the support carers received there was a general feeling this was quite limited. There was a general level of agreement that much more should and could be done and this clearly led to a sense of isolation. Family and friends were of course seen as a source of support but there was also recognition that such support could only be offered within the context of the ability to offer it. Time, distance, family and work commitments were all offered as reasons as to why family and friends may not be able to offer the levels of support either they or the carer would like. Limited support was available to some within the community but this was, at best, patchy and clearly something not many of the carers were comfortable relying upon. Such support was very much seen on being an '*if needs be'* basis.

2.5 Summary of issues from qualitative research

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

3. Scope for intervention

3.1 Participation of the residents

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. As expected the response rate was low (28%). It is likely that the results are optimis-

tic, 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 and promote health. There seemed to be unmet needs, possibly a limited sense of community and limited positive health related behaviours.

3.2 Food hygiene as a focus for health development

Focusing on food hygiene appeared to provide a good opportunity to improve one health related behaviour (and contribute to health literacy), not least since there is increasing interest in the role of consumer behavior in managing food safety closer to the moment of consumption (Jacob et al., 2010; Fischer et al., 2007). 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 our partner 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 necessary qualification required by law for anyone working with food thus improving employment prospects). 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 an appropriate intervention for carers, not least since there has been concern in the UK in recent years over an increase in the incidence of food borne disease in older and vulnerable groups (particularly listeriosis) (Advisory Committee on the Microbiological Safety of Food, 2009); but participants also 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.

The first attempt to deliver the Chance aim of 'community building', the food hygiene course, found that the opportunity for building social capital or social networking was limited due to the scatter of the population, the expense and low participation. However, the organisation delivering this intervention 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 but a formal 'course' had very limited capacity to reach the community as a whole.

3.3 Scouse Nouse[1]

A second strategy was tried to deliver health literacy through food hygiene which involved making a short film for wide, free distribution as a DVD. In this way it was hoped to reach the 'hard to reach' who either would not, or could not join a training programme. It was also decided to be as inclusive as possible by consciously avoiding an 'academic' approach to the topic. Enabling carers to be instrumental in identifying an area of need and providing training is empowering by incorporating some 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 (and people born in Liverpool are known as 'scousers'). The local relevance of the DVD was further emphasized by

1 Scouse refers to the people of Liverpool and Nouse is an informal word approximately meaning 'common sense'.

the recognizable exterior visual images used, the music (a very local song still part of children's games), the accent of the main presenter (unmistakably Liverpool an accent referred to as 'Scouse'), the food (Scouse is a dish distinctive to Liverpool) and the visual interior shots (of an 'ordinary' home). The style of filming was 'cinema verite' and the quality of filming was consciously kept 'amateur' to stress the relevance to the viewers. A story was told, using humour, with a beginning, a middle and an end complete with a message. Story-telling is one of the oldest means of transmitting information and changing behaviours. The film is short, about 15 minutes, and it is hoped that it would be watched once out of curiosity and because it is local and amusing it will then be handed on with 'have you seen this?'

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.

The DVD was evaluated. Copies were distributed at a city-wide event for carers which included a questionnaire and a prepaid envelope. Three hundred copies of the DVD were distributed and 23 questionnaires were returned. The majority of respondents (91%) enjoyed the DVD and found it interesting (95%) and easy to understand (96%). Most learned something new (61%) and shared what they had learned with other (59%) and a half (50%) passed the DVD on to others. This last finding is especially noteworthy and indicates considerable 'added value' especially relevant in community settings. The respondents were aged 51-60y (44%), 61-70y (17%) and 71-80y (13%) and over 80y (17%) indicating that DVD technology is appropriate for older members of the community. Perhaps the most impressive feedback was unsolicited. A phone call was received at the university from a man who was concerned that someone should be shown leaving a toilet without washing his hands. In addition the presenter of the film was stopped by two boys in his local park and asked if he was the man in the film and if this was his dog called 'Harry'. This shows that substantive information from the DVD had been internalised by some people to the extent of recognising a person and remembering a minor detail. Clearly local films have potential for impact.

4. Conclusion – what next?

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.

Making the film was fun. It would be feasible for community groups to make their own films, each telling a different story highlighting an aspect of health promotion: giving up smoking, taking more exercise or preparing a low cost healthy meal etc. The process of working together would be empowering and new skills would be developed. Some professional advice would need to be at hand and some technical expertise would also be needed. Local involvement would give the film greater 'currency' – that is, another reason to watch it and the presence of recognisable members of the community ('powerful others') conforms to the Theory of Reasoned Behaviour / Social Learning Theory.

"Medicine is a social science, and politics nothing but medicine at a larger scale"
Rudolph Virchow 1821-1902 (Mackenbach 2009).

The financial crisis and the change in government has produced a very uncertain public health environment. The public sector is in dramatic decline. The government's strategy for public health emphasises the importance of the informed consumer (Department of Health 2004; 2010a,b) and is taking advice from commercial organisations on how to achieve changes in health behaviours[2]. This approach has been severely criticised (Anon 2010). In addition the government wants the National Health Service to be more orientated towards disease prevention and the public health function is to be given to Local Authorities such as Liverpool City Council. General medical practitioners will become responsible for most of the rest of the health service. The government envisages that non-governmental organisations will play a much greater role in delivering health care and in providing the support needed, for example for carers, which it has termed the 'Big Society'[3] as a way of achieving the fully

2 At the new coalition government's first policy-setting meeting 18 of the 29 representatives were from the private sector.

3 "The Big Society is a society in which individual citizens feel big: big in terms of being supported and enabled; having real and regular influence; being capable of creating change in their neighbourhood." (Big Society Network 2011). http://thebigsociety.co.uk

engaged scenario' necessary to avert a public health catastrophe (from the obesity epidemic) (Wanless 2004). Furthermore the government is pursuing an agenda to encourage 'localism'.[4] The net result at present appears to be confusion and stasis and only time will tell if the government plans deliver a healthier nation. Certainly the political time is ripe for partnership working with commercial and non-governmental organisations to deliver health message and engage the population in preserving and promoting their own health. At best, this could be genuine empowerment of some of the most vulnerable least health literate sectors of society. At worst, once again the needs of the most needy will be subsumed to commercial interests and financial expediency.

References

Anonymous (2010): The UK Public Health White Paper: "just words" Editorial. Lancet 376, 1959.

Advisory Committee on the Microbiological Safety of Food (2009): *Ad Hoc* Group on Vulnerable Groups: Report on the Increased Incidence of Listeriosis in the UK. Food Standards Agency: 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 /Healthy living/ DH_080149 [Acces sed: 2.10.2008].

Department of Health (2010a): Healthy Lives, Healthy People: our strategy for public health in England. London: The Stationery Office.

Department of Health (2010b): Our Health and Wellbeing Today. London: Public Health Development Unit.

Department for Communities and Local Government (2011): A plain English guide to the Localism Bill. http://www.communities. gov.uk /documents/ localgovern ment/ pdf /1818597.pdf [Accessed: 16-03- 2011].

Fischer, R.H./De Jong, E.I./Van Asselt, E.D./De Jong, R./Frewer, L.J/Nauta, J. (2007): Food Safety in the Domestic Environment: An Interdisciplinary Investigation of Microbial Hazards During Food Preparation. Risk Analysis, 27 (4):1065-1081.

4 Localism is designed to reduce the power of central government in flavour of local decision making. The localism Bill was published in December 2010. "It set out a series of proposals with the potential to achieve a substantial and lasting shift in power away from central government and towards local people. They include: new freedoms and flexibilities for local government; new rights and powers for communities and individuals; reform to make the planning system more democratic and more effective, and reform to ensure that decisions about housing are taken locally." (Department for Communities and Local Government 2011).

HM Government (2010): Recognised, Valued and Supported: next steps for the carers strategy. A cross-government publication. http://www.dh. gov.uk /prod_consum _dh/groups/dh_digitalassets/@dh/@en/documents/ digitalasset/dh_122393.pdf Accessed 14-03-11

Jacob, C./Mathiasen, L./Powell, D. (2010): Designing Effective Messages for Microbial Food Safety Hazards. Food Control, 21: 1-6.

Liverpool City Council (2009): The City Of Liverpool. Key Statistics Bulletin Issue 6 March 2009. The City of Liverpool. http://liverpool. gov.uk/ council/key-statistics-and-data/key-statistics-bulletin/[Accessed: 14.09.08].

Liverpool City Council (2011): Key Statistics and Data. Ward Profiles. http:// liverpool.gov.uk/council/key-statistics-and-data/ward-profiles/index.aspx [Accessed: 11.05.2011].

Liverpool First (2009): South Central Neighbourhood Area Agreement 2009-10. http://www.liverpoolfirst.org.uk/what-we-do/neighbourhoods [Accessed: 12-05-11].

Mackenbach J.P. (2009): Politics is nothing but medicine at a larger scale: reflections on public health's biggest idea. Journal of Epidemiology and Community Health, 63: 181–184. doi: 10.1136/jech.2008.077032.

Wanless D. (2004): Securing Good Health for the Whole Population. Final Report. London: Her Majesty's Stationery Office.

Health knowledge and behavior among residents in a Swedish city district – designing health information for the public

Ingela Marklinder and Margaretha Nydahl

Most public health work in Sweden is undertaken at the local level by county councils, municipalities, and non-governmental organizations. Municipalities are responsible for the major part of local environmental policy, including disease prevention and assessment of food quality. Three main authorities are responsible for public health information: the Swedish National Institute of Public Health; the National Food Administration, and the National Board of Health and Welfare. Special health education programmes for tobacco, diet, and alcohol are all functions typically carried out by general practitioners. Preventive and population-oriented health care has been integrated into primary health care.

Health journalism plays an important role in public health. Daily papers are the most common source of health communication regarding issues like diet and health. Further, internet communicating is common for national authorities, as well as at the regional and local level. Leaflets target specific groups and health problems that are relevant to these groups. Campaigns are also a 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.

People responsible for information on healthy diets believe that there are difficulties in reaching out with such information, because of the current information environment (Garpe 2008). Today there is an agreement that the responsibility for an individual's health ultimately lies with the individual, but society must give everyone the opportunity to base their choices on knowledge and build supportive environments around the individual. A prevalent problem is that the principal recipients of health information are those who are already advantaged. Thus efforts must be made to reach out to disadvantaged groups, e.g. the elderly, low- educated and low-income groups.

The overall aim of the health-promoting activities in the framework of the EU project Chance was to explore the resources in a selected city district that strengthen and support individuals in keeping themselves well informed and able to take responsibility for their own health.

To analyze the resources for health promoting activities and health knowledge gaps among residents in a selected city district, a quantitative study, i.e., a questionnaire with a broad focus on several health-related issues, was performed. A total of 202 participants (21 to 81+yrs) were included. Further, qualitative studies on the same topic targeted elderly and other vulnerable groups (Enroth 2007; Lundmark 2007; Pettersson / Eklöf 2008; Pettersson 2009). Data from these studies will be presented in this chapter. Further, a computer-based intervention study (n=92) was developed and performed based on the weaknesses revealed by the quantitative and qualitative studies (Nydahl et al. 2011).

1. The profile of the municipality and the selected city district

The population in Uppsala Municipality consists of 187,511 inhabitants (in 2008) who live in an area of 2,189 km^2 (85 individuals per km^2). The selected city district is situated on a hill in the central part of west Uppsala about three to four kilometres from the city centre. The area is surrounded by green areas and a city forest with several walking trails. A large allotment garden is located close to the city district. The busiest location is the square, which offers most of the economic infrastructure. The population in the city district is 6,703 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%). Twenty-one percent of inhabitants have a non-Swedish background (Uppsala 19%; Sweden 17%). Of the 4,077 households, 227 are small houses and 3,850 are apartments, some of which are found in eight-storey-high buildings. From the quantitative study (n=202) 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%). A majority of inhabitants like living in the area and have no desire to

move. Almost 70 percent of the responders think their health is very important with even higher figures among the elderly and those of foreign background, respectively (table 2). Almost 80 percent stated their health to be very good/good and the majority believes that their health would be in *status quo* for the next three years (table 2).

Table 1: Demographic data on the participants in the quantitative study (n= 202).

		(n)	(%)
Sex			
	Women	133	65.8
	Men	69	34.2
Ages (years)			
	21-30	29	14.4
	31-40	27	13.4
	41-50	21	10.4
	51-60	23	11.4
	61-70	22	10.9
	71-80	36	17.8
	≥81	44	21.8
Age category			
	younger (≤60 y)	100	49.5
	elderly (>60 y)	102	50.5
Origin			
	Swedish background	167	83.1
	Foreign background	34	16.9
Education			
	No education	2	1.0
	Elementary/compulsory	51	25.4
	Gymnasium	37	18.4
	University	111	55.2
Occupation			
	Pensioner	93	46.0
	Full-time	54	26.7
	Student	28	13.9
	Part-time	23	11.4
	Unemployed	4	2.0

2. To explore the resources

2.1 Health information

In the quantitative study (n= 202), more than half of the study population (54%) reported being able to receive all the health information they want locally. One third of the informants stated it was a very true statement that they apply health information in their daily situations (Table 2). Elderly and young people got their health information from different sources. The elderly associated health information with physicians and diseases, not with promoting health activities nor preventive care, physical exercise, or food-related issues. Further, this group reported that they don't need health information, and many don't trust information from sources other than their own physician. 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 food and hygiene was desired by these informants. In a comparison study within the framework of the Chance project it was concluded that in Romania the level of information on health, interest in health and how to maintain it are all at a lower level than in Sweden (see Vintila et al. 2009). The most obvious differences between the groups of subjects relate to the fact that in Romania the elderly are not aware of their low level of low health information and are resistant to changing their unhealthy habits.

The majority of informants (84%) always/sometimes read the list of ingredients and nutrition information on foods, while a few (13%) never or seldom do so. A large share of the participants (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 get confused sometimes. In a qualitative study performed on five elderly individuals (83-92 years) it was apparent that food labeling was not the kind of information that reached the five elderly respondents (Enroth 2007).

"There are a lot of [various inscriptions] and I'm way too old to keep track of it, you see" (Doris 85 years)

2.2 Food consumption

The quantitative questionnaire showed that the consumption of fruit and vegetables was below recommended levels (NNR 2004). Barely half (49%) eat fruit and vegetables on a daily basis, whereas about one-third eat fruit (34%) and vegetables (33%), respectively, several times a day. However, no more than half of the respondents know the significance of "5 a day"; neither did the majority (85%) among the elderly (70+). According to the recommendations people are advised to consume 400-500 g of fruit and vegetables per day (NNR 2004). However, many eat fruit and vegetables regularly, and a majority of the sample (82%), agree 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 (34%) of informants consumed whole grain bread several times a day. About half of the sample (48%) reported eating fatty fish once a week. According to recommendations, these intake figures are too low. Only a fifth (20%) reported eating fatty fish several times a week in line with the recommendations. Considering the fat quality in their diet, 37 percent of responders reported an almost daily intake of oil, while only seven percent reported consuming this food item daily. Thirty percent of the sample reported consuming margarine several times a day. According to dietary recommendations it seems that only a small proportion of the population is able to reach the recommended figures regarding a healthy diet (NFA 2003; NNR 2004). .

In one of the qualitative study within the Chance project, performed on five individuals (83-92 years), it was recorded that with growing age the elderly, even though they used to eat a lot vegetables when young, did not consider vegetable consumption important any longer. Instead they increased the amount of butter and started a new habit of taking a whiskey in the evenings (Enroth 2007). Respondents showed on several occasions that they thought it was too late to make dietary changes.

"It' s too late to change anything. [...] Now you just wonder what you're going to die of when you're this healthy" (Doris 85 years)

"No, I do not think about health. I have given up thinking" (Elsa 83 years)

Now when they had reached this advanced age they just wanted to have a good time and not worry so much about what is healthy or not.

2.3 Food handling

The quantitative study (n=202) showed 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 a qualitative study performed on nine elderly persons (72-93 years), it was shown that they were aware of neither the refrigerator temperature nor the temperature differences on different shelves, although they did consider themselves to have sound knowledge of how to handle and store foods (Lundmark 2007). They expressed confidence in the grocery store and did not see the need for further information. In a separate questionnaire regarding hygiene issues, (n=251) performed on 123 elderly (70+yrs) and 128 younger (21-70 yrs) people, 15 percent reported that they normally taste raw ground meat. Of the 123 elderly informants 20 percent reported that they normally taste raw ground meat (Nydahl et al. 2011). Four percent of all informants had suffered from food poisoning during the past year, which is in agreement with other Swedish studies (Lindqvist et al. 2001; Marklinder et al. 2004). However, one fourth was afraid of food poisoning.

No significant correlation between the fear of food poisoning and tasting minced meat was observed, which might indicate knowledge gaps in terms of food handling. In ground meat the emerging *E.coli* bacterium pathogen VTEC is prevalent. In 2007 VTEC was classified as a serious risk to public health, especially with children below five years and the elderly from developing complications (Anonymus 2007). As VTEC has a low infection dose one should not put raw minced meat in the mouth.

Many cases of food-borne illnesses can be derived from domestic homes and be caused by incorrect storage of food. The elderly are at high risk of complications from certain food-borne infections (Anonymus 2007). The incidence of listeriosis among the elderly is increasing internationally and can be caused by the increasing availability and consumption of ready-to-eat food (Goulet et al. 2008). In a qualitative study performed on eight elderly people (77 to 95 years) it was shown that the informants

consider themselves to have a good knowledge of how to handle and store foods (Pettersson 2009). The results indicate an overestimation of their own skills which would help them prevent food-borne infections.

"I've never suffered from food poisoning ... and yet I am so old. I guess that shows that my knowledge is good enough." (Agnes 95 years)

Table 2[1]: A description how the responders apply health information and their perception of health status.

	All		Agegroups				Origin			
			Younger		Elderly		Swedish		Foreign	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
It is easy to apply health information in daily situations										
Very true	33	16.4	14	14.1	19	18.6	26	15.6	6	18.2
True	112	55.7	60	60.6	52	51,0	94	56.3	18	54.5
Neither nor	45	22.4	23	23.2	22	21.6	38	22.8	7	21.2
Less true	9	4.5	1	1.0	8	7.8	7	4.2	2	6.1
Not at all true	2	1.0	1	1.0	1	1.0	2	1,2	0	0
Total	201[a]	100	99[b]	100	102	100	167	100	33[c]	100
To me health is …										
Very important	141	69.8	61	61.0	80	78.4	113	67.7	27	79.4
Important	58	28.7	37	37.0	21	20.6	51	30.5	7	20.6
Neither nor	3	1.5	2	2.0	1	1.0	3	1.8	0	0
Less important	0	0	0	0	0	0	0	0	0	0
Not at all important	0	0	0	0	0	0	0	0	0	0
Total	202	100	100	100	102	100	167	100	34	100

[a]Data available for n=201. Internal dropouts 0,5 % (1/202)
[b]Data available for n=99. Internal dropouts 1 % (1/100)
[c]Data available for n=33. Internal dropouts 2.9 % (1/34)
[d]Data available for n=101. Internal dropouts 1 % (1/102)
[e] Data available for n=166. Internal dropouts 0.6 % (1/167)

	All		Ages				Origin			
			Younger		Elderly		Swedish		Foreign	
	n	%	n	%	n	%	n	%	n	%
Generally my health is …										
Very good	55	27.2	33	33.0	22	21.6	47	28.1	7	20.6
Good	105	52.0	46	46.0	59	57.8	87	52.1	18	52.9
Neither Nor	31	15.3	17	17.0	14	13.7	25	15.0	6	17.6
Bad	11	5.4	4	4.0	7	6.9	8	4.8	3	8.8
Very bad	0	0	0	0	0	0	0	0	0	0
Total	202	100	100	100	102	100	167	100	34	100
I expect my health in the next three years to be …										
Improved	54	26.9	40	40.0	14	13.9	44	26.5	10	29.4
Staus Quo	121	60.2	58	58.0	63	62.4	101	60.8	19	55.9
Worsen	26	12.9	2	2.0	24	23.8	21	12.7	5	14.7
Total	201[a]	100	100	100	101[d]	100	166[e]	100	34	100

The difference between the consumers' knowledge about food and their food handling in reality can be attributed to optimistic bias effect also known as risk-related optimism (Regan et al., 1995; Joffe 1999; Clarke et al. 2000; Miles / Scaife 2003; Wilcock et al. 2004). This means that people have a blind faith in themselves and believe they run a smaller risk than others of being harmed by health problems (Weinstein 1984).

3. Health, vulnerability, and the need for information

As more people become older and average longevity increases, the elderly is considered to be a vulnerable group in the society, unless their needs and resources are looked into. The objective of the qualitative study based on nine individuals all living on their own (72 and 93 years) was to get an understanding regarding their need for information related to food and health, as well as to find out what meanings they ascribe to the term *health* (Lundmark 2007). None of the informants thought that they needed information in any field, even though their knowledge of

food safety was limited and their knowledge of food brands was poor. In a discussion regarding computers and an assessment of the Internet, it was reported that the technology goes too fast and that it is difficult to keep up with these developments.

"You feel left out. There is a lot of talk using different terms, and it's taken for granted that you know all the acronyms. And I don't think people in general really understand how difficult it is for old people / ... / often you might have some relative who can show you, but if you don't have any relatives…" (Gerd 89 years).

A qualitative study based on eight subjects aged 31 to 70 years all living alone with and without children, two of whom had a non-Swedish background, showed that the word *health* was defined differently by older and younger people (Pettersson / Eklöf 2008). The older people found that the meaning for the word *health* was "to be healthy" and "to be able to cope on your own," while the younger people found the word meant "a balanced diet", "exercise", "avoiding stress" and "factors increasing their well-being". The results also indicated a need for clear and consistent information about health.

"(...) The large amount of information is not good (...) I am not specially trained and may not know much about nutrition and health. I can find it difficult as a layman to know what all of those alarms are ... which you should take seriously and which should you ignore?" (Lisa, 31 years).

Who is vulnerable? In the same study it was shown that you cannot take a whole societal group and say that it is vulnerable (Pettersson / Eklöf 2008). The authors emphasize that there are individuals with varying abilities within the same category. This knowledge must be taken into account when developing health interventions targeting selected social groups, at least in Sweden.

"I read a lot, listen to the radio, read a lot of magazines and so on (...) I combine it with my own thoughts (...). you have to listen to your own body to feel good ... if I eat, for example, this particular food at night before I go to sleep and get a stomach ache, I have to wonder what it is that gives me a stomach ache (...) and to avoid this" (Mariam, 44 years).

A consensus among the responders from the main health authorities in Sweden showed that the responsibility for an individual's health lies with the individual, but society must give everyone the opportunity to base their choices on knowledge (Garpe 2008).

"Responsibility can never lie with anyone other than the individual himself, I think, but like the rest of society we must create conditions to be able to make sensible decisions" (Respondent, Count councils).

"It's both. In the end it is the individual who makes choices, but it is also the responsibility of society, which has an obligation and an interest in ensuring that people feel good, but I really think that if you, as an individual, have knowledge, all the knowledge you need to make a decision and the conditions provided by environments supporting you, then you have shared the responsibility"(Respondent, Swedish National Institute of Public Health).

"I think that ultimately it is individuals who are responsible, for we can never force a person to do anything; it is a free choice. However, I think it is the government's job to ensure that choices are possible, thus ensuring that you have access to good food and good bike paths. The government has an obligation to ensure that it is possible, and we will provide advice and information so that they can make their choices. But in the end, it is the consumer's choice" (Respondent, National Food Administration).

"Individuals have the responsibility for their own choices regarding lifestyle, but society must step up and convey knowledge to the individual, so individuals make their choices based on knowledge"(Respondent, Community).

The media play an important role as a public source of nutrition and health information. However, the communication is not always evidence-based but often based on news value and controversial statements, which reflects the primary goal to attract and entertain the reader (Cooper et al. 2011). Thus, the main Swedish health authorities still play a very important role when it comes to evidence-based health information. On a local level, however, updated health information should be available, as exemplified in the present study.

4. A simplified computerized health information model

Based on the reported low consumption of fruit and vegetables, defiences in food handling, and in addition, to requests for clear and consistent information about health, a simplified computerized intervention study focusing on the concept of "5 a day" and food safety was developed and performed (Nydahl et al 2011). The objective of the intervention was to evaluate to what extent this health information model can be implemented in city district settings e.g. healthcare centers, schools, retirement organizations, grocery stores, or through various networks. In total, 92 people living or working in the selected city district participated. The effect of the intervention was determined by means of questionnaires (multiple-choice) that were carried out prior to, immediately following, and three weeks after the intervention.

The intervention consisted of two information sessions at the same meeting, where two educational programs were exhibited: *"5 a day"* and *"Food safety*". In addition, two brief discussions regarding the themes of each program were performed (Nydahl et al. 2011). The home economics and computer classrooms at the secondary school in the city district were chosen as the principal venues. The pupils of the school got involved in the project and offered assistance when the older participants felt uncomfortable operating the computers. The rest of the intervention meetings took place in the cafeterias at the school, in the local library, and some were also held outdoors in an allotment-garden district using battery-powered laptop computers. A statistically significant increase in knowledge of the meaning of *"5 a day"* among the 92 participants was identified for the period between the questionnaire taken before and immediately after the intervention, as well as between the questionnaire taken before and the one three weeks afterwards (Nydahl et al. 2011). No statistically significant correlation was found between the consumption of fruit and vegetables several times per day and knowledge of the "5 a day" concept.

Regarding the handling of raw ground meat that might contain the pathogen *E.coli* bacterium VTEC, the majority stated, both before and three weeks later, that they refrained from tasting raw minced meat.

No statistically significant difference was found between those who tasted raw ground meat before the intervention and following the intervention indicating no change in behavior after the intervention.

Managing simplified health information materials by means of computers is flexible and cost-efficient. The materials could easily and inexpensively be distributed to other municipalities. But even though there was an increase in people's knowledge of the concept of "5 a day" as well as for food-safety-related issues, no behavioral change could be recorded. Among the elderly, one explanation for this would be information barriers (Miles / Scaife 2003). In the present studies, a large proportion of the elderly grew up in the countryside. They have first-hand experience with slaughter and preservation techniques. Typically, they consider themselves fully capable of handling foodstuffs. Such skills may not always apply to food items of today. For example, new bacterial pathogens have appeared in raw ground meat. The attitude that one already knows everything necessary may hamper one's receptiveness to relevant new health information. Regarding results from the present intervention, i.e., no significant behavioral changes, one interesting approach would be to apply the Health Action Process Approach (HAPA) demonstrated by Schwarzer (2008; 2010). In a further similar intervention this model should be applied in the recruitment process to target people who really are in need of knowledge enhancement and behavioral change regarding these health issues. In this multi-stage model self-efficacy is an important factor for translating intentions into behavior (Richert *et al.*, 2010).

4.1 No need for information – an information barrier

Reaching out with health messages or risk-associated information can be problematic in cases where the target group consider themselves fully and satisfactorily educated (Tierpstra et al. 2005). According to Michie and Prestwich (2010) theory-based interventions can aid understanding of why interventions are effective or ineffective.

Optimistic bias may be a barrier to risk communication when individuals ignore risk information because they think it is meant for others who are more vulnerable. This means that they are not acting to prevent a given hazard (Miles / Scaife 2003). In one of the qualitative studies performed on eight elderly individuals (77 to 95 years), it was shown that the elderly

informants taking part in the intervention (Nydahl et al. 2011) did not consider themselves to be targeted by the information as they already knew everything (Pettersson 2009).

"Yes the information was absolutely correct, I can attest ... but it was not directed to us elderly, but to young people" (Edith 93 years).

Many respondents felt they had a good knowledge of how food should be handled. Humans tend to overestimate their own skills, which leads to risky behavior resulting from a lack of knowledge that could prevent them from being affected by a hazard. We underestimate the risks of things that are perceived to be under control (Joffe 1999). Therefore we think we have a good knowledge and tend to underestimate the risks.

4.2 Health Literacy

Health literacy is a concept that involves an individual's ability to find, read, and understand health information (Zoellner et al. 2009). Understanding health information is a key element needed to give a person an opportunity to adopt healthy habits (Soedberg Miller et al. 2010). Zoellner et al. (2009) found that people with lower health literacy were more uncertain in searching for food-related information and more often saw obstacles to assimilating the information than those who felt that they had adequate health literacy.

For the recipient to absorb health information, it is required that he/she has good faith in the person communicating the message. In a recent study the quality of the evidence for dietary advice given in UK national newspapers was studied (Cooper et al. (2011). The authors concluded that misreporting of dietary advice was widespread and may contribute to public misconceptions about food and health.

5. Designing health information for the public

For health communication to reach people and be effective, it should be tailored to its target group (Ashfield et al. 2006; Miles and Scaife 2003). Richert et al. (2010) examined how confidence in their own ability, or self-efficacy, can affect people's ability to change their diet. The authors

conclude that a person's self-confidence plays a major role when they convert their intentions into action, for example to increase their intake of fruits and vegetables. People with low self-confidence must be encouraged to believe in their abilities before they can take in information and embrace healthy habits (Richert et al. 2010). In order to get people to participate in health promoting interventions, the experiences garnered from the present study suggest that educational programs should take place in environments where consumers tend to gather of their own accord – for instance in local networks and venues for group activities.

In summary, the selected district is characterized by a higher proportion of elderly and individuals with foreign backgrounds compared to Sweden in general. There are health factors that enable a healthy life in the selected city district and the participants experienced their health as good, and very importantly, the majority also expected that their health would remain so over the next three years (Table 2). This suggests that the participants live in a society that benefits their health. A prevalent problem is that the principal recipients of health information are those who are already advantaged. Thus efforts must be made to reach out to disadvantaged groups e.g. the elderly and low-income groups. We suggest that further research in this area should focus on methods to reach out to disadvantaged social groups to contribute to a more equitable distribution of good health.

Additional knowledge about health promotes the realization of a healthy life. The improvement in knowledge demonstrates that the simplified educational programs may be useful in increasing people's awareness of proper food hygiene and the importance of "5 a day". Computerized programs can easily and inexpensively be administrated. A possible strategy would be to invite different target groups and to include computerized programs as an approach in line with the already established course material *Food classes for the elderly,* which has been initiated by Uppsala University and performed in cooperation with Uppsala Municipality (Nydahl 2006). In order to achieve substantive behavioral change we suggest that the recruitment process should target participants based on their actual need for improved knowledge and behavior changes related to health.

References

Anonymous (2007): Verotoxinbildande *E.coli*. – VTEC-bakteriers smittvägar, förekomst samt risker för folkhälsan. Rapport från Livsmedelsverket, Statens Jordbruksverk, Statens veterinärmedicinska anstalt, Smittskyddsinstitutet, Socialstyrelsen och Naturvårdsverket.

Ashfield-Watt, P. (2006): Fruit and vegetables, 5 a day: are we getting the message across. *Asia Pacific Journal of Clinical Nutrition*, Vol. 15, Nr. 2, pp. 245-252.

Clarke, V./Lovegrove, H./Williams, A./Machperson, M. (2000): Unrealistic Optimism and the health Belief Model, *Journal of Behavioral Medicine*, Vol. 23, No. 4, pp. 367-376.

Cooper, B./Goldacre, B./Sanders, T. (2011): The quality of the evidence for dietary advice given in UK national newspapers, Public understanding of Science. DOI: 10.1177/0963662511401782. Available online 11 April 2011.

Enroth, M. (2007): Elderly people in the area of Eriksberg – a study of health, vulnerability and the need for information. Master thesis, Department of Food, Nutrition and Dietetics, Uppsala University.

Garpe, J. (2008): The publicly funded information and communication about healthy diets, Master thesis, Department of Food, Nutrition and Dietetics, Uppsala University.

Goulet, V./Hedberg, C./Le Monnier, A./de Walk, H. (2008): Increasing Incidence of Listeriosis in France and other European Countries. *Emerging Infectious Diseases*, Vol. 14, Nr. 5, pp. 734-740.

Joffe H. (1999): Risk and "the other*",* The Pitt Building, Trumpington Street, Cambridge UK. pp. 56-60.

Lindqvist, R./Y. Andersson/J. Lindbäck/M. Wegscheider/Y. Eriksson/L. Tideström/A. Lagerqvist-Widh/K.-O. Hedlund/S. Löfdahl/L. Svensson/A. Norinder. (2001): A one year study of foodborne illnesses in the municipality of Uppsala, Sweden. *Emerging Infecing. Disease,* Vol. 7S, pp. 588–S592.

Lundmark, L. (2007): Cold storage of risky foods – habits and need for information. Master thesis, Department of Food, Nutrition and Dietetics, Uppsala University.

Marklinder, M.I./Lindblad, M./Eriksson, M.L./Finnson, M.A./Lindqvist, R. (2004): Home storage temperatur and consumer handling of refrigerated in Foods in Sweden. *Journal of Food Production*, Vol. 67, No.11, pp. 2570-77.

Michie, S. / Prestwich, A. (2010): Are interventions theory-based? Development of a theory coding scheme., Health psychology, Vol. 29, No. 1, pp. 1-8.

Miles, S./Scaife, V. (2003): Optimistic bias and food, *Nutrition Research Reviews*, Vol. 16, pp. 3-19.

NFA (2003) Livsmedelsverket. Dietary habits and nutrient intake in Sweden 1997-98. The second national food consumption survey; 2003.

NNR (2004) Nordic Nutrition Recommendations. Integrating nutrition and physical activity. Copenhagen: Nordic Council of Ministries; 2004.

Nydahl, M. (2006): Food Classes for the Elderly. In Swedish. Department of Food, Nutrition and Dietetics. Uppsala University, Sweden.

Nydahl, M./Jacobsson, F./Enroth, M./Marklinder, I**.** (2011): A simplified health information model increased the level of knowledge regarding "5 a day" and food safety in a city district. Accepted for publication in British Food Journal, 2011.

Pettersson, M./Eklöf, A. (2008): Perceived health and need of information – a qualitative study performed in the urban area Eriksberg, Uppsala. Bachelor thesis*,* Department of Food, Nutrition and Dietetics, Uppsala University.

Pettersson, M. (2009): It does not affects me- a qualitative study about elderly´s way of obtaining information about food handling. Master thesis, Department of Food, Nutrition and Dietetics, Uppsala University.

Regan, P.C./Snyder, M./Kassin, S.M. (1995): Unrealistic Optimism: "Self Enhancement or Person Positivity?" *Personality and Social Psychology Bulletin*, 21; 1073-1082.

Richert, J./Reuter. T./Wiedemann, A./Lippke, S./Ziegelmann, J./Schwarzer. R. (2010): Differential effects of planning and self-efficacy on fruit and vegetable consumption. *Appetite*, Vol. 54, pp. 611-614.

Schwarzer, R. (2008): Modeling Health behavior Change. How to predict and modify the adoption and maintenance of health behaviors, *Applied psychology*: An international review Vol 57, No 1, pp. 1-29.

Schwarzer, R. (2010): Differential effects of planning and self-efficacy on fruit and vegetable consumption. *Appetite*, 54, 611-614.

SNR (2005): Swedish Nutrition Recommendations. National Food Administration, Sweden.

Soederberg Miller, L./Gibson, T./Applegate, E. (2010): Predictors of nutrition information comprehension in adulthood, *Patient Education and Counseling*, Vol. 80, pp.107-112.

Tierpstra, M./Steenbekkers, L./Maertelaere., N./Nijhuis, S. (2005): Food storage and disposal: consumer practices and knowledge. *British Food Journal,* Vol. 107, pp. 526-533.

Vintila, M./Marklinder, I./Nydahl, M./Istrat, D./Kuglis, A. (2009): Health Awareness and behaviour of the elderly: between needs and reality. A comparative study. *Romanian Journal of Applied Psychology*, **2**, 81-87 (1454-8062).

Weinstein, N. (1984): Why it won´t happen to me: Perceptions of Risk Factors and susceptibility . *Health Psychology*, Vol 3, No 5, pp. 431-457.

Wilcock, A./Pun, M./Khanona, J./Aung, M. (2004): Consumer attitudes, knowledge and behaviour: a reviw of food safety issues. *Trends in food science & technology,* Vol. 15, pp. 56-66.

Zoellner, J./Connell, C./Bounds, W./Crook, L./Yadrick, K.(2009): Nutrition Literacy Status and Preferred Nutrition Communication Channels Among Adults in the lower Mississippi Delta. *Preventing Chronic Disease.* Vol. 6. Nr 4, pp. 1-11.

Creating a local network and implementing public health activities in Romania

Mona Vintila

Introduction

In many European countries there is a serious attempt to educate people about eating behaviour, methods of planning a diet and disease prevention, which is reflected in the health level of the population and in social programs. However, in many of the less developed European countries, such as Romania, the consumer health education domain stands in need of a variety of approaches which will have more powerful and longer-term effects on society. Despite the fact that we now have a better knowledge than ever before of what healthy behaviour and a healthy lifestyle mean, this knowledge – promoted as an official message – fails to reach most of the population. Romania is well known for its plentiful but unhealthy eating patterns, for its sedentary lifestyle and for the lack of preventive health behaviour. Unhealthy eating habits are maintained for many years and we can observe those patterns. To substantiate these statements we may point to the high number of deaths caused by cardiovascular diseases, to which unhealthy eating behaviour make a major contribution.

A report - *Empowerment of the European Patient, Options and Implications* - published in Brussels in March 2009 places Romania in thirtieth place in Europe in terms of health information (Health Consumer Powerhouse, 2009). The report considers that Romania provides its citizens with very poor information and knowledge about health, even poorer than other East European countries. The topics evaluated were patients' rights, health information, technologies in the health system and financial motivation. The conclusion was that Romania needs to invest more in its health system and in health education.

At national level, 87% of people aged between 15-60 years declare themselves to be interested in receiving health information. This infor-

mation is found by 38% of them on the Internet (specialist sites) and by 31% on TV and in magazines and newspapers. Only 4% seek health information from specialist sources (general practitioners or specialist magazines) (Health Consumer Powerhouse, 2009). Women aged between 45 and 60 years, with a high educational level and top jobs, are the category most interested in obtaining health information. Their resources are: specialist magazines, special columns in newspapers and their physician. Unfortunately, most of those interested in health information prefer to look for it 1-4 times a month on TV shows and specialist Internet sites.

The most extensive national campaign concerned with health education is carried out through the Romanian TV channels. There are a number of TV spots designed to highlight and raise awareness of various issues about health: "Excessive consumption of salt, sugar and fat is a serious threat to health".

Community profile

The Romanian research team selected Dumbrăviţa as the community to be assessed for their information on and their level of education regarding health as well as to implement the intervention program. Dumbrăviţa is a community in Timiş, a western county of Romania. It was founded in 1892 by Hungarian settlers from Szentes, its original name being Hungarian: *Ujszentes* (New Szentes). It is located near Timişoara, on the northern side. As result of the city's development, many people from Timişoara have built homes in Dumbrăviţa, which is tending to become a suburb of Timişoara. This development has divided Dumbrăviţa into two different areas: the old part of the community, which functions as a village, and the residential part, where the standard of living is higher than average. This new area has raised the socio-economic level of Dumbrăviţa.

Dumbrăviţa has an area of 18.99 km^2 of which 112 497 m^2 is residential. It also has a lake and a forest. Dumbravita has 2915 inhabitants and 1417 households, giving a density of 153.5 inhabitants / km^2. The average size of households in Dumbravita is 2.06 persons. There is a school, 1 kindergarten, there are several churches and a relatively large forest –

648 ha. 27 teachers work in Dumbravita and 2 doctors. A little more than half of the population is represented by the female gender – 52.63%.

The local community studied has significant ethnic and religious diversity. About 54% of Dumbrăviţa's inhabitants are Romanians, 36.15% Hungarians and 1.16% Germans etc. The main religion is Orthodoxy (47.13%), but Catholics (20.51%) and Protestants (17.28%) also make up an important part of the community. There are also 3.91% Pentecostals and 0.85% Greco-Catholics. Although relatively few of the present inhabitants were born in Dumbrăviţa, its culture and customs have not been noticeably impacted by the fact that people have moved there from places nearby. Regarding households, most of Dumbrăviţa's inhabitants live in houses (over 50% of them of more than 100 m^2) and just a few in small apartment blocks. More than 90% are owner-occupiers; it is the mentality in our country that a person should own his house/flat rather than rent it, so this figure is standard across all environments, not specific to this area or for rural communities. The highest ratio between the number of persons living in a house and its number of rooms is 2 to 1.

In the analysis of the Romanian population, the target group identified as being disadvantaged was that of the elderly. Dumbrăviţa has about 400 inhabitants aged over 65. The elderly are indeed among the disadvantaged in Romania. Their difficulties are many: economic, social, and cultural (including in their access to information). Their nutrition is also problematic, partly because of low economic resources, and partly because of increased resistance to change and a greater tendency to maintain traditional eating habits which are enjoyable but not always healthy. Often their ideas of health, transmitted to the younger generations, contain expressions such as "to be healthy means having round, red cheeks". Whereas in the past the consumption of fats represented an effective method of dealing with physical effort, present conditions have turned this eating behaviour into a toxic one. Low physical effort, sedentary lifestyle, even the lack of activity and social involvement - which so clearly characterize our elderly people - have a negative effect on their state of health, more pronounced than would be expected simply on the basis of their chronological age. Lack of social involvement, due either to exclusion or to economic limitations, decreases their access to good information about health. Slipping into familiar unhealthy eating habits may represent a form of resistance in the inter-generational conflict, a

way of keeping alive a world able to withstand a modern society that does not suit them. Low life expectancy, decreasing self-esteem, the feeling of being useless, the lack of encouraging social contacts and a lack of will to live (for many of Romania's elderly, retirement is equivalent to social death, since the necessary means that permit an active life are missing) have a major effect on their health.

Last, but not least, emigration leaves many old people in Romania on their own. Many of them lack the emotional support of the younger generation, or are burdened with responsibility for grandchildren whose parents are working abroad. Unfortunately there are only a few institutions devoted to maintaining the quality of life of elderly people. Consequently, this population group needs a much more caring approach from society, as well as needing to find appropriate means to solve their specific problems.

The most valued parts of the house are the garden, the yard and especially the kitchen, which is considered the centre or the "soul" of the house; this is the place where the whole family gathers. In most of the houses there are 2 or 3 generations living together, which is a common pattern in Romanian culture. From the economic point of view, it is important to note that the rate of unemployment is very low (0.37%). Most of the inhabitants moved to Dumbrăviţa when they were young because of the large number of jobs that can be found in the area. The statistical data show 135 employers in Dumbrăviţa.

The educational system is good, with well-equipped schools and well-motivated teaching staff. Dumbrăviţa has one school with primary and secondary levels with 162 students and one kindergarten where 112 children are taught either in Romanian or in Hungarian.

An important part of the community is the church. In Dumbrăviţa there are three churches that represent the three main religions in the region. Healthcare provision in Dumbrăviţa does not meet the inhabitants' needs. There is only one clinic where two doctors work shifts, covering only a few hours per day. In addition, there is one dentist. There are no clubs or voluntary services in Dumbrăviţa.

Results of the survey

The quantitative research was carried out on a sample of 200 people, 90 elderly (60-85 years) and 110 between 18 and 60 years as shown in figure 1. In the whole sample there were 112 females and 87 males, 96 were pensioners.

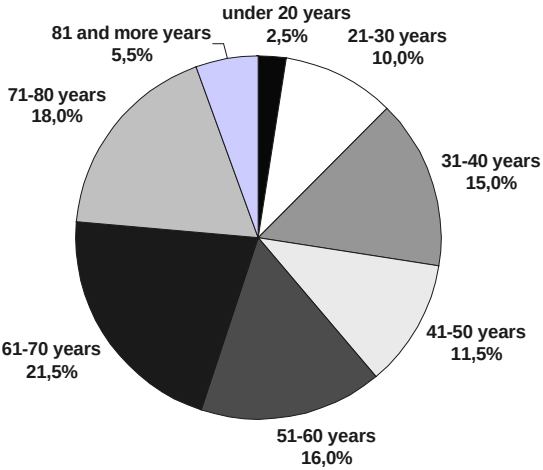

Figure 1 Age groups in the sample n=200

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

Health patterns

The quantitative results show many similarities between the whole sample and the elderly. These similarities permit the assumption that the elderly have not adapted their health behaviour to their age. Furthermore, changes from one generation to another are rare and are influenced by mentalities and traditions.

More than 50 percent of our research group think that they are well informed about healthy behaviour as regards physical activity, nutrition, mental wellbeing and social wellbeing. But, when asked, almost 80% of them do not know the meaning of "5 a day" and about 20% think that they can safely keep minced meat in a fridge for up to seven days. About 95.5% of the participants consider that in order to be healthy it is important to wash one's hands after using the toilet and to keep the fridge at the right temperature.

The low interest in communication networks in the community is also shown by the fact that people look for health information from internal sources (family, relatives, TV and the doctor) more than from external ones (neighbours, friends, courses, associations and clubs, local administration) see figure 2. About 66.5% of the whole group and 74.4% of the elderly receive health information from the doctor and 63% of people from both groups from TV, but 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% of the sample, refer to their doctor if they have a problem regarding their health, about 40% turn to their family for help and only 1 to 2% attend a meeting or a lecture.

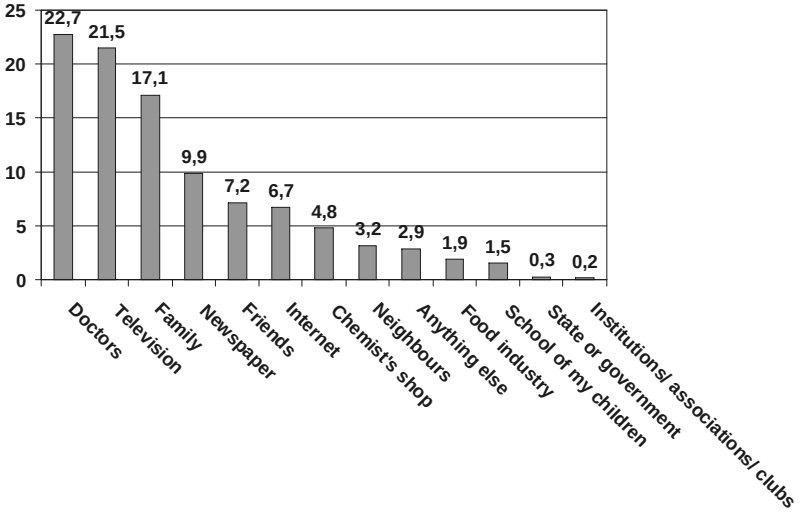

*Figure 2:*Sources of health information in %, multiple answers possible, n=200

The results regarding the sources of health information can be explained in terms of the structure of the households in this area. In Dumbrăviţa, most of the households contain members of two or three generations and the maximum ratio between the number of people living in a house and its number of rooms is 2:1. The extended family is therefore naturally the main network of support and information. Wider social networks are underdeveloped and there are no clubs or associations where people can interact and share their problems. Thus they are not used to seeking help from outside their households.

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 would have to spend more money if they wanted to eat more healthily.

At a local level, in Dumbrăviţa, there are no other existing projects or health related programs. Despite the poor availability of information regarding health, more than 50 % of our sample group considers that they are well informed about what a healthy lifestyle means. People ob-

tain health information from the doctor, from TV, from the pharmacy (Figure 2). The inhabitants of Dumbrăviţa take in health information without being selective. They tend to trust unconventional "quack" remedies (acacia seeds for diabetes, hot pepper for gall bladder problems, etc.) and their neighbours' suggestions rather than the advice of specialists.

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

People in Dumbrăviţa think that three aspects of their locality are very important, but this top three is different in the two groups analysed. In the whole sample, the public green space is important for 86%, health services for 85.5% and church for 81%. In the elderly group, 43% consider the church as a very important aspect of their locality, 41% identify health services and 39% consider the public green space to be important. On the other hand the areas considered "not at all important" are social and sports clubs.

Nutrition aspects

The elderly seem to have the same eating habits as the rest of the population. More than 50% of both groups studied eat bread several times a day, while rice and cakes are consumed by 40% several times per week. Potatoes are consumed several times a week by 50% of the whole sample. They seldom or never eat/use whole grain bread, cereals, oil, butter, organic products, minerals, vitamin supplements or wine (Fig. 3). About 20% seldom or never eat cheese or drink milk.

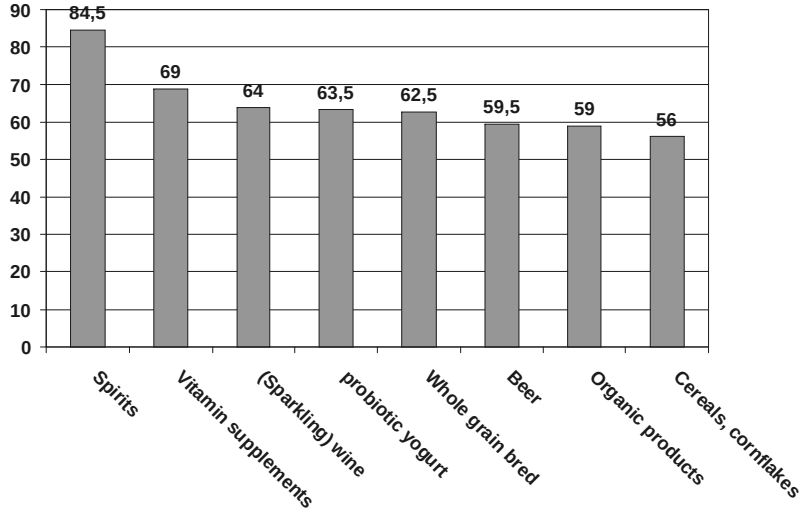

Figure 3: Products seldom or never consumed in %, n=200

Seasonal aspects may have influenced the findings with regard to fruit and vegetable consumption. The subjects said they were eating fruit and vegetables almost daily, but this can be related to the fact that the research was carried out during the summer when they had fruit and vegetables in their gardens. We suppose that if the research had taken place during the winter the results would have been very different. They also affirm that they do not eat sweet foods very often, but they habitually eat cake as often as several times per week. It is traditional to bake cakes at home in this area; the older women are well known for being good cooks and baking cakes is customary.

The qualitative research analysed 20 households where families with 2 or 3 generations live. The parts of their houses that are most appreciated by the owners are the garden or the kitchen, which is considered "the centre" or "the soul" of the house. 25% of the interviewed subjects are retired and their main complaint regarding their status is that their income, which is very low, is by no means sufficient to provide a decent life.

Their daily program is mostly routine; they do not engage in activities with other family members, especially those from other generations, and community engagement is also poor. Lack of involvement in community activities is omnipresent in our society. Engagement in such activities has no history in Romania; we had no experiences in this area during the communist regime, so it is only now that the younger generation is experimenting with these kinds of activities.

There are no specific patterns for the eating of meals. Most people eat two or three meals a day, with snacks between them that are irregular and more likely taken on impulse than a "real snack". Even people who claim to be on a diet do not follow specialist guidelines; they simply give up some sorts of food they think are not good for them. These bad habits regarding nutrition are backed up by ideas that are considered axioms: "You can't fight your appetite!" and "It's not the meal which makes you fat, but the nibbling in between!". Coffee and cigarettes are consumed on a daily basis by most of the interviewed subjects. Shopping is an important aspect of life where health is concerned. The people questioned generally shop in response to their felt needs, without a shopping list, but there are also kinds of food that they do not buy as they produce them at home such as vegetables and meat.

Health behaviour

Health is acknowledged to be a very important aspect in the life of 67% of the people questioned (Figure 4), although only 27.5% of the whole sample and 16.5% of the elderly evaluate their health as 'good'. At the same time, people's mentality is that health is very much related to everyone's destiny; there are people who are sick and others who are healthy. Furthermore, health is related to youth, and therefore someone cannot expect to be healthy after the age of 50. An interesting idea about health is that the 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.

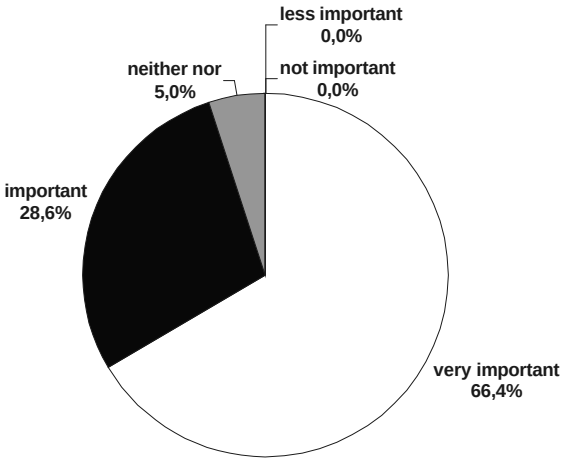

Figure 4: Importance of health

For most of the interviewed people, "to be sick" means to need to go to the doctor or to keep to one's bed. A healthy person, by contrast, is someone able to work who does not have to take pills. For most respondents, taking care of their health means avoiding anything that makes them sick (especially bad food), but also keeping in shape by working and being careful about hygiene.

When evaluating their health, most respondents gave themselves 8 points out of a maximum of 10, where 10 signified "perfect health"; the score was not always related to the number of medical conditions they reported. Surprisingly, some of the questioned subjects, who had been diagnosed as suffering from specific conditions, evaluated their health status at a higher level. This shows that they are not really aware of what good health means. As an example, high blood pressure is such a common condition in Romania that nobody mentioned it as a health problem. The people questioned did not know the difference between high and low blood pressure and were not consistent in taking the prescribed medication (they either do not take it at all or discontinue the course from various motives). Their reasons for not following the treatment are that they think it is very expensive or that they are not even convinced they are sick, because different doctors give different diagnoses or

treatments to the same patient. This is also a typically Romanian behaviour – to visit several doctors if you are ill, to ask for several opinions, so as to check if the doctor is right, as patients seldom receive the same opinion regarding diagnosis and especially treatment. Consequently they become suspicious and in the end do not take the correct medication or continue for the indicated period of time. They ask for help from the family doctor just "at the last moment" and then only seeking a referral, since they have more trust in specialist doctors. Despite the fact that the elderly do not trust themselves as 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.

The research provides important information about health behaviour in Dumbrăviţa. Some notable patterns emerge from analysis of the responses given. Results show that despite the fact that people are pleased with the development of their village, their level of social commitment is poor. Their general impression of their community is very positive; they appreciate that the school, kindergarten, parks, local council offices and churches have been renovated and they feel safe living in Dumbrăviţa. Although respondents generally have a very good impression of the area they live in, only 18% of those questioned considered it important to take shared decisions in the community. This is both symptomatic of, and contributory to, poor levels of civic communication. Despite the significant development of this rural area, social and communication networks have remained underdeveloped. This seems to be a throwback to the days of the communist regime, when the existence of different groups and organisations was not acceptable, so people are not used to joining groups with common interests. This phenomenon is now evolving with young adults and teenagers being more eager to join NGOs or to take part in community related activities.

The interest and involvement of the local administration in community health are very low. Furthermore, community cohesion is limited and people do not think that the administration ought to be doing something to improve community health. A very low percentage of people are involved in clubs or organisations and practically no one attempts to get health information or help from the local administration. The general level of interest in health education is low and even when the opportunity is presented, people prefer passive involvement. The people are not prepared to work together in order to improve the situation.

The social network in the community is underdeveloped. Social contacts in the neighbourhood are limited to the extended family and very close friends so that social cohesion is low, and even lower in the new residential part. Less than 50% of the people in Dumbrăviţa think that it is important to make shared decisions in the community.

Mobilisation for community health projects

In the practical part of the project we focused on mobilising the inhabitants for the development and initiation of local Health Information projects by:

- designing specific intervention methods, considered to be helpful for the community of Dumbrăviţa;
- stimulating the participation of different local institutions and firms to actively take part in the intervention program (as sponsors and partners);
- obtaining the support of the local mayor and the local administrative council for our activities; they provided the space for the meetings and expressed their willingness to support the development of a local network for promoting healthy lifestyles in the community;
- obtaining the support of the local churches and the interest of the local medical network;
- getting support from the local schools, in order to disseminate our intentions and information about the project and the meetings; the teachers also supported us in the organization of special meetings to improve knowledge of healthy eating behaviour in children;
- using circular letters to announce the program of meetings to all the inhabitants.

Between January and May 2009, these methods of community intervention were implemented because it was realised that the direct involvement of the local inhabitants would improve the success of the intervention as a whole.

In order to create a complex communication network, we involved people from various levels of the local administration. We developed an intervention program which aims to create social networks that will improve health behaviour through communication. The intervention pro-

gram consisted of five meetings with community members. Our purpose was to offer information about healthy eating behaviour and to stimulate the interest and participation of all members of the community in developing a local communication network to ensure the success of the intervention.

In the intervention program we also built on a fact that we had previously established, namely that in Romania, two or three generations live in most homes and the maximum ratio between the number of people living in a house and its number of rooms is 2:1. Therefore the extended family is the main network of support and information and there are few social networks in the community. So, we worked on three generations. In Romania, social networks are underdeveloped and there are no clubs or associations where people can interact and share their problems. Thus they are not used to seeking help from outside their households. The children come more into contact with the "outside world" through school and other activities. They could be the main bearers of the message of a healthy lifestyle to their families. In some households, the children are raised by their grandparents, who are in charge of cooking for their grandchildren. For this reason we also paid attention to children and the elderly in our intervention program and devised specific activities for them.

The first meeting:

- The presentation of the project: the purpose of our action and our short and long term intentions in the community
- The presentation of the results of the first phases of the quantitative and qualitative studies regarding the resources of households, the barriers and the need for information
- General information on healthy food: advice and rules for a healthy diet, presentation of the healthiest kinds of 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 serious illnesses caused by an unhealthy diet: diabetes mellitus, coronary heart disease and hypertension, ulcers, colitis
- Practical activities: measurement of arterial pressure and body mass index, with practical advice aimed at ameliorating any problems identified

The third meeting:

- A healthy diet is usually more expensive. So, we tried to demonstrate "How we can eat more healthily for the same money" and to present options for healthy eating

The fourth meeting:

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

The fifth meeting:

- The final analysis of our intervention program
- Discussion of 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.

Results of the intervention

The results of the intervention program were assessed through a re-evaluation questionnaire: Almost 50% of the participants considered that the intervention program had influenced their health behaviour significantly. The program was successful and had a great impact on the community. As a result of the intervention program some teachers from the local school introduced a number of topics on health behaviour and nutrition into their teaching program. In addition, the kindergarten menu was modified to take account of the information given during the program. The success of this intervention program underlines its importance and also suggests how relevant such programs are for Romanian communities. The social and communication networks developed during the intervention give it high medium- and long-term sustainability in promoting and developing health behaviour.

References

Directia regionala de statistica timis, www.timis.insse.ro.

Health Consumer Powerhouse AB (2009) The Empowerment of the European Patient 2009 – options and implications. http://www.healthpower house.com/files/ EPEI-2009/european-patient-empowerment-2009-re port. pdf.

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

RAF: Public health promotion in a former company housing estate in Latvia

Aija Eglite

1. The local community "RAF"

Jelgava is the fourth largest city in Latvia. It is located in the southern part of Zemgale plain, 40 km from the capital city of Riga. The total territory is 60.3 km² and 66 thousand inhabitants are living there. There are several urban districts within the towns, which are named after companies located there. "RAF" is the name of an inner city of Jelgava, named after the Riga Autobus Factory. It was built for the manufacturing plant's employees. Initially mainly RAF employees were living in the local community. RAF was completely liquidated in 1998, and its former employees had to find a job elsewhere. RAF microdistrict has became a residential area for employees working in Riga..

RAF microdistrict in Jelgava is located around 3 km to northeast away from the centre of Jelgava. 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 case study on health information perception. As of 1 January 2008, 4520 residents lived in the microdistrict's territory and the average size of households (2008) in RAF is 2.89 persons. A residential block in RAF microdistrict consists of five-story and nine-story dwelling houses which were built in the 1970s.

Table 1: Description of RAF, Jelgava, Latvia in 2008

Indicators	RAF	Jelgava	Latvia (Country)
Inhabitants (thousands)	4.520	65.804	2276.282
Area (km²)	0.3	60,3	64.589
Density (inhabitants/km²)	15066	1096	35.2
Employed (%)	no data	no data	70.3
Unemployed (%)	no data	3.9	4.9

The houses were built when Latvia was part of the USSR in order to create apartments for the future. Within the last few years, special measures were undertaken in order to improve the quality of the apartments (e.g. heat insulation of buildings). These measures will help to attract more inhabitants to the area from the centre, where apartments are of equal quality but more expensive. The ability 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.

The RAF housing estate is equipped with a varied social infrastructure (the Jelgava Secondary School No 6, a Russian secondary school with 647 pupils, a kindergarten, three children playgrounds), a large number of commercial facilities (four food stores, a bakery, a market place, a flower shop, a hardware store, three shopping malls and a fast food restaurant) and public and private services (library, halls with gambling slot machines,, dry cleaner's and laundromat, shoe repair shop, petrol and gas stations, car repair shop etc.) At first glance a diverse health-infrastructure is located in RAF (two pharmacies, one dentist and general medical practice office).

The ecological structure of the community is characterized by a well-organised public transportation system between RAF and the city centre. For 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. On the other side of Loka Magistrale, a forest is located, it lies near the ex-RAF plant and RAF multi-unit apartment complexes. Through the forest the "Old Road", previously the connection between Jelgava and the capitol Riga, functions as a popular hiking route. Near the forest, there are guarded car parking garages, a gravestone store and a cemetery.

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. This will be the largest reconstructed industrial park in the Baltics.

2. The Residents of RAF: Results of the Survey

There are 21 multi-apartment houses in the territory chosen for the Chance-project, in which 1562 households reside. The average size of households is 2.89 persons, 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 a focus group in the summer and autumn of the same year.

There were 255 (169 women, 85 men, one respondent did not indicate his/her gender) respondents in the quantitative survey; 44 of them were aged 61 and over. Young people (aged 21 up to 30 years) and individuals of preretirement age (between 51 and 60 years old) mostly live in two-person households, residents in their thirties and fourties mostly live in three or four person households.

In Jelgava pensioners mostly live alone (43%) or in couples with a partner or a child (38%), while the rest of them live in multi-person households. Seven of ten of our interview partners were home owners and only seven percent were subtenants. The size of apartments is mostly less than 80 m^2. If a household consists at least three persons, there is a greater possibility that the apartment size is less than 60 m^2 rather than larger. The size of apartments belonging to almost half of the respondents is less than 60 m^2, one third of the respondents own apartments within a size range of 61 to 80 m^2. As to the language used for conversation at home, 121 respondents said they talk Latvian, 132 – Russian, but three used both languages, however, the native language of 129 respondents was Latvian, 117 – Russian and most respondents (211, 83%) were born in Latvia.

2.1 The "Typical Resident of RAF": The Daily Life

The "typical resident of RAF" means a kind of average resident to show daily life in the chosen urban area and to get a first feeling for adequate measures of health education and health information on the community level. So the typical resident of RAF is well informed about healthy lifestyles measured by items like 'physical exercises' and 'diets', he/she is partially informed about the 'feeling of social and mental comfort'.

The main source of information is the television; it is watched on average one to two hours a day. He/she believes that only sometimes is it easy to use information on a healthy lifestyle in everyday life. If he/she has a problem, usually he/she solves it him/herself. Problems with food and health are solved in the family, on serious occasions a doctor is visited. On acute occasions, the typical resident goes straight to a hospital.

The average RAF-Resident lives together with a partner in his/her own apartment, smaller than 60 m^2. However, he/she does not consider his apartment is small. At home, he feels well and safe where it is possible to rest in peace and quiet. He/she likes the apartment which was furnished by him/her. In most cases, the neighbours are known and sometimes he/she "has the best neighbours ever could be".

He/she spends more than three hours a day outdoors and is engaged in physical exercise for up to three hours a week. He/she feels safe in his neighbourhood and likes to stay here. He/she believes that he lives in a health-friendly environment with unpolluted air and he/she is not bothered by traffic noises. The most valued aspect of RAF mentioned by the residents is the green zone and the varied infrastructure nearby. The shopping centres, sports ground, sports hall and the marketplace are also important places in the locality.

The typical resident of RAF goes shopping on weekdays and cooks for him/herself own. He/she does not need help with household work. When shopping, sometimes he reads information about ingredients and the nutritional value of food. He drinks water, tea, or coffee several times a day. At least once a day he/she eats a hot meal. Every day he/she consumes wheat bread and vegetables as well as vegetable oil, but he/she does not know anything about the meaning of the campaign "5 a day". Every day he/she eats fresh fruits, meat, milk, curds, butter, and sweets. Several times a week he/she eats potatoes, rice or pasta, cheese, sausages, yogurt (in Latvia yogurt is considered 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, and lean fish. So the typical resident of RAF really cares about his/her health. He believes that his health status is quite good and nothing will change the next years.

2.2 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 a state of social and mental comfort. The main source of health information is television, followed by friends, the press, the family, the internet, the doctor, and neighbours.

Though the elderly are not the majority in our survey they are a vulnerable social group in the community in the sense of health equality and resources to live a healthy life. Therefore their perception of health information and their daily lifestyle behaviour will be taken as an example:

People in Latvia understand that the terms 'healthy lifestyle' and 'life quality' are closely interrelated, yet studies reveal that the Latvian elderly consider their health an instrument for providing the quality of life rather than a part of their life quality. In this connection, the Latvian Sustainable Development Strategy (2030) includes the need for promoting a healthy lifestyle and improving the health care system, as well as reducing social inequality, so that an increase in well-being would ensure satisfaction with life among all societal groups – especially for the elderly and rural residents whose life was rated poor by around 70% of the elderly surveyed.

About one half of the elderly believe that they are well informed about a healthy lifestyle (physical exercise, healthy food and social and psychological feeling of comfort). Concerning information on healthy food, six of ten elderly feel 'well informed', while 16 percent feel quite uninformed. At the same time the greatest part of the elderly believe that keeping a healthy lifestyle 'is boring'.

The elderly try to cope with their household work themselves. Almost two thirds of them believe that they need no help in their household work, but one in four needs help in cleaning up the apartment. Nearly nine of ten still cook food at home themselves and three out of four still go shopping themselves (and scrutinise the daily shopping to read the information on product packages carefully).

The elderly in the Jelgava community 'feel well' in their homes, three out of four of them are the owners of their apartments and therefore their attitude towards living in their neighbourhood is the same you find in several studies about contentedness of dwelling all over Europe. Due to their living in the high-rise estate the elderly get most information about healthy lifestyles from TV, followed by a doctor and friends. Because most of the elderly live alone, the family is not one of the main sources of information.

Their solitary life is also the reason why most of them try to cope with problems themselves. If they encounter severe health problems they call family members or visit the doctor. Depending on their health condition, the largest part of the elderly spends more than three hours outdoor. Almost a third of them claim to have abandoned physical exercises. This could be explained by the lifestyle issues, the type of housing and national traditions in Latvia concerning sport activities in the public.

Yet in Latvia the elderly have rarely assessed their health condition as very good. Half of them believe their health will not change over the next three years. However, the other half of the Latvian elderly are more pessimistic. The elderly are not very interested in active sports, but when we ask them, what they would do in the role of the 'Mayor of RAF', they dreamed about constructing recreational and sports grounds and a green zone, restoring a health trail in the forest, repairing sidewalks, installing benches, making flowerbeds and organising various activities for the elderly, for instance, gymnastics exercises, tea evenings and dancing. In conclusion these fantastic but not utopian ideas show clearly that the right method of participation could bring out a lot of needs that should be addressed in community based projects, developed with the help of the (elderly) residents.

2.3 Resources, barriers and social networks

The family is the most valued aspect of life. Environmental protection is also important for the residents of RAF, followed by their careers, income and healthy food. Physical activity as well as participation in decision making are also important.

NGOs do not exist in the local community. There was an English club 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, business people and local government representatives were invited to a focus group interview, but there was no local NGO to invite. The intervention activity was developed on the basis of ideas from the empirical studies.

The Ministry of Regional Development and Local Government aims to coordinate the elaboration of development strategy which aims 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 for providing accessibile health care as well as encouraging people to follow a healthy lifestyle.

3. Local Interventions: Activating the Neighbourhood

3.1 Participation of the inhabitants

In spring 2008 results of the surveys conducted in the local community 'RAF' were conducted. Based on the results and suggestions given by respondents, we have developed a special educational and information program for people living in this community.

The two local schools were involved in a health competition called "*Be Healthy at Home*". Sixty students in teams developed a formula for a healthy lifestyle. They were asked to accomplish the following tasks:

a) study the literature about healthy lifestyle (not more than ten written pages)
b) explore the habits of your own family and neighbours and its relationshipp to a healthy lifestyle (attachment to the first task)
c) on the bases of the first and second tasks: create a group formula for healthy lifestyle and
d) prepare a creative presentation of the "formula" and submit to a semi final and, if successful, the final rounds of the competition.

A second activity was a focus group interview in which different social groups living in the local community of RAF such as business people, teachers and students participated. It was done in order to get a deeper understanding of the needs and structure of the institutional side of the local society.

3.2 Local activities an measures

The main activity, in which around 3000 inhabitants were involved, was the "*Marathon of Health*". The event was open for any interested person. 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, youth, middle generation and retired people) the following program was developed:

- Morning exercises for seniors;
- Students' presentations of "Formulas" for a healthy lifestyle;
- The marathon of health for families with ten different tasks in the forest led by the association of athletics;
- A market of healthy farm products;
- Diagnostics of health - free of charge: teeth, sugar level in blood, heart, CO level in breath of smokers;
- Information about reproductive health;
- First aid "school";
- Consultations with a sports doctor;
- Automobile ergonomics and auto sport.
- At the same time as the activities outside, a set of lectures given by professionals was offered:
- Ecology of consciousness;
- Foll's Diagnostics – diagnosis of health condition using acupuncture points of the human body;
- How to become healthy without using medicines;
- Life without tobacco;
- Apiculture products for improvement of health.

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

As mentioned the RAF housing estate have some health facilities for local people but only one practical doctor. The local inhabitants are more or less reliant on their own resources or they have to go to the city centre and use the facilities there. Furthermore there is a swimming pool in RAF but it is not advertised effectively. Since it is located on the site of the local school, it is mostly used by families that have children in school. There is also a modern sports hall in the other school in the community, but it is mainly used for educational purposes. Moreover there is a local health centre where health information can be received. Unfortunately, information does not spread out of the centre. Health promotion in RAF community needs to be developed and activated by the involvement of all possible stakeholders.

3.3 The Meaning of Participation

Non-governmental organizations are ready to continue to engage in health promotion-related projects. These kinds of events are well attended and the organizations are interested in presenting themselves.

Also access to finance from a variety of funds could encourage involvement of more nongovernmental organizations in implementation of similar projects. During the event, a number of invited organizations did not show up because they did not plan such an additional trip in their budget or they did not have finance for the stalls and leaflets.

Business people are willing to support health-related activities only if there is a wide target audience and an advertising opportunity is provided: The business sector was not prepared to deal with sponsorship, but wanted to know the possible tangible benefit to them from supporting the event.

Citizens willingly attend the activities which are related to health promotion, especially choosing free health assessments. The activities attended most of all were the measurement of the level of blood glucose; testing heart health in a special heart consulting-room and testing health of teeth, which ordinarily is a paid service in health centres.

The local government has an interest to organize health promotion-related activities in their territory. All necessary permissions and docu-

ments were successfully approved. The executives of the local government took part not only in the opening ceremony of the project event, but also in the closing ceremony, they regard it as a good idea that they were able to speak with inhabitants not only in the centre of the city, but also in a housing estate, because the problems of the community from the housing estate are different from the community from the centre of city, and sometimes different between housing estates.

There are not enough organizations and institutions which operate in the RAF community to organize an informative event about health promotion for inhabitants within this RAF housing estate. It is necessary for city level organizations to be involved. There were 32 organizations, institutions and farms involved in this project event but only one is located at RAF housing estate; the local school. All the other participating organisations are located in the city centre of Jelgava or even from Riga, or other cities in Latvia.

Mass media have an important role in promotion of events and the dissemination of information, especially for groups of inhabitants with special needs and restricted skills. Inhabitants, especially socially weak groups, still trust printed media, for instance, the local press. Considering the circumstances under which the project event took place; straight before elections for the local government, the printed media were reserved by political parties, which decreased the accessibility of information on the project. Because of that it was necessary to work more with own resources – flyers in the post boxes and placards in the nearest shops and health centres.

In a period when the dependence of the population on the market increases and medical services are very expensive and less accessible, this kind of could be especially popular. Health services are relatively poorly accessible in Latvia, and that is why there is a great demand for such kind of events. During the implementation of the project event (within 4 hours) there were used 1000 reagents for measuring the level of sugar in blood as well as 2000 reagents for testing CO in the exhalation of the smokers.

Involving the young generation from schools in investigation (observation and interpretation) of the health habits allows us to look at the healthy lifestyle from a different point of view; a healthy lifestyle is not

only nutrition, physical activities, a feeling of comfort both socially and psychologically, but also planning the time and money (all resourses), Youngsters from basic and secondary schools demonstrated their point of view of a healthy lifestyle by working out a special formula.

Pedagogically different methods such as group work, discussions, critical thinking, responsible solutions and individual work were used. During the project event the school students demonstrated their skill of presentation and communication skills in their group work.

3.4 Success assessment of the project implementation activities

The assessment was performed as follows: 1) to assess activity, 455 participants in the implementation activity were surveyed by means of a quantitative survey. 180 of the participants were residents of RAF. Further analysis is related to the assessment of the microdistrict's residents. 2) qualitative assessment of the performance and activity of other stakeholders was carried out.

Sixty percent of the respondents had secondary education, 28 percent had a higher education and 12 percent left school with primary education. More than one in four respondents was pensioner, every third was a full-time employee, a quarter lived in a single-person household.

Aspects of health were important for nine out of ten of the respondents. When asked about the influence of the project, four out of ten respondents living in the RAF community admitted that their eating habits had changed. Forty four percent of them decided to eat healthy food, less than one out of ten participants in the health project was interested in components of food now and one in ten preferred to purchase food products from local producers or in the marketplace. Others preferred to consume more dairy products but less meat and a fifth, however, wanted cheaper goods. We asked, what were the reasons for a change of shopping and eating habits. Nearly one third gave "health" as a reason for change, a change in life outlook was named by 20 percent, while change in the financial situation was referred to by half of the respondents. Now more than one in two of the interviewed residents of RAF believes to eat healthy food every day.

Asked about their sporting activities one in ten reported a daily run and 18 percent were running once a week. One out of ten respondents rides a bicycle every day and 18 percent cycle once a week. Nearly 20% does gymnastics every day, while almost a quarter does it once a week. Due to the restricted access to the local (school) sports hall, just three percent attend it daily and one fifth once a week. A very small group of 2 percent of the respondents attend a fitness centre every day and 12 percent utilize this kind of sporting activity once a month.

After our intervention nearly eight out of ten respondents believed that they were able to influence their own health and that much depends on their own efforts. Opinions of the residents concerning whether or not aggressive advertising promotes the consumption of vitamins were split in half. 'Taking care of health' to the residents of RAF means:

- refraining from addictions (98%);
- promoting a healthy lifestyle (95%);
- maintaining one's own body in a good shape (93%);
- avoiding illnesses (93%).

As regards a question on how people take care of their health, the most frequent answers were observing hygiene, not smoking, consuming vitamins, having enough sleep and eating healthy food. Finally the implementation activity made people reflect on their health situation, its role in human life and will make people pay more attention to it.

4. Summary and Conclusions

Latvia's national health plan has existed since 2006, and focuses on prevention strategies. Health is defined as a human basic right. In the future, health education is to be a main focus. There are many institutions involved in the health information system in Latvia.

In Jelgava, the inner district RAF (Riga Automobile Factory) is an enclosed living area, which was originally built in the 1970s with multilevel constructions for employees of the automobile factory in Riga. The community consists of a well-established infrastructure with regard to schools, a kindergarten and shopping facilities, and is bordered by a forest. The largest disadvantage is the fact that no local nongovernmen-

tal organisations exist in the microdistrict. The largest problem in Latvia is how to make individuals active, so that they rise above their subsistence problems and advocate and implement the most important, common ideas with enthusiasm.

The people in the community start to think about their health and become aware of its importance only 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 is associated by them with a comfortable place of residence having a large green zone and forests, but not with joint festivities with their neighbours.

The activities organised within the project were received with enthusiasm from the residents. They took part in interviews (qualitative, quantitative) with pleasure and a focus group interview with experts on health matters because they were really interested in it. They expressed their opinions about what has to be improved or introduced in the microdistrict in order to live a healthier life.

A more reserved attitude towards the healthy lifestyle project was observed from the representatives of various institutions and organisations in the microdistrict. It took a long time to convince them to participate in the project, to share their available rooms, and to disseminate information about the activities. Sometimes they regarded the project participants as an obstacle or barrier in their working day. The schoolchildren, active pensioners, and families were very enthusiastic about the project. Those who already have professional or semi-professional knowledge in health matters had the largest interest in the health lectures.

The population prefers to attend activities related to health promotion, especially free of charge assessments. Public organisations are ready to get engaged in health promotion projects in the future as well. Businessmen are ready to support health promotion activities only if a target audience is numerous and they can advertise their products. The mass media played a significant role in popularising the activity and disseminating information, especially for population groups with limited abilities.

References

Belovs M. (2009): Jelgavas veselības maratons – pirmais, bet ne pēdējais! Available at: http://www.laukutikls.lv/vietejas_iniciativas/laba_prakse/262-jelgavas_veselibas_ maratons_pirmais_bet_ne_pedejais.

Eglīte A./Vintila M./Grīnfelde A./Kantiķe I. (2009): Healty Lifestyle in the Elderly's View in Romania and Latvia// Economic Science For Rural Development. Proceedings of the International Scientific Conference. Primary and Secondary Production Consumption. Nr. 19, Jelgava 2009. 97 – 103 p. [online]] Available at: http://ef.llu.lv/files/ p2/Economic_ Science_ for_Rural_ Development_19-2009. pdf (13.05.2009).

Gaidamoviča R. (2009): Aizvadīts pirmais veselības marathons Jelgavā. Available at: http://www. jelgavasvestnesis. lv/page/1 ?id=121 &news _id=4583.

Jelgava (2008): Publiskais pārskats Jelgava, 90. lpp. Available at: http://www. jelgava. lv/index.php?id=17331 (19.07.2011).

Notiks veselības "marathons". (2009): Available at: http://www.zz.lv /news/ article. html?xml_id=14426 (25.04.2009).

Pirmoreiz – veselības «maratons» Jelgavā (2009):. Available at: http:// www.zz.lv / news/article.html?xml_id=14385 (16.04.2009).
Veselības «maratonā» iecienītas cukura un CO pārbaudes. Available at: http://www.zz.lv/portals/veseliba /raksts.html? xml_id=14576 (25.04.2009).

Veselības maratons Jelgavā 25.04.2009. Available at: .http://www.jzk.lv /galerija2/ index1.php?id_gallery=77 (19.07.2011).

Veselības ministrija (2008). Definīcijas (Definitions). In Latvian, Available at: http://www.vm.gov.lv/index.php?top=117&id=120 (20.08.2008).

Veselības ministrija. (2007): Informatīvais ziņojums par Sabiedrības veselības stratēģijas Rīcības programmas ieviešanu 2005.-2006.gadā. (Informational Report on the Public Health Strategy Action Program 2005-2006) Riga, 29.01.2007. In Latvian, Available at: polsis.mk.gov.lv/LoadAtt/ file40244.doc (17.07.2011).

Health factor "neighbourhood": A participatory project with inaccessible socially disadvantaged groups in Vienna

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1. Introduction

The EU-project "Community Health Management to Enhance Behaviour – Chance" uses a community-based approach. Beyond educational advertising and mentoring campaigns, this approach focuses on social space and the processes of networking within the local community. The needs of the inhabitants living in the community on the one hand, and the environment, the social and spatial structure influencing people's daily lives on the other hand are very important for health perception and behaviour. Our basic assumption is that local resources, (social) networks, and neighbourhoods should have a very high priority for community health management.

The Vienna project was originally implemented in the 11th district (Simmering) in the area called "Schneiderviertel" (tailor's quarter). The target groups were single parents, Turkish migrants and elderly people. In the first step we evaluated the general health-constitution and the knowledge on health issues of the target groups via quantitative methods (questionnaire). Using qualitative methods (analysis of social space, systematic observation, interviews and analysis of social networks) structural, personal, civil-societal, spatial and material resources were investigated. This approach shows that the neighbourly relations as well as the social and institutional networks are not limited within administrative borders. Using our first results we enlarged our research area where the intervention "Healthy Simmering" – with the participation of local stakeholders – was launched and established in three steps.

The following text outlines the specific initial conditions, the analytical approach, and the development of the intervention. Our presentation focused mainly on Turkish migrants, who were, with single parents and

elderly people, a target group of the Chance project.

2. Description of the research area

The "Schneiderviertel" is located in the Viennese labour district Simmering. The urban renewal office (called Gebietsbetreuung - GB 11) is active in the research area and implements neighbourhood management. Its main goals are the development of strategies for the participation and empowerment of the inhabitants and the implementation of general urban planning strategies in Simmering.

About 4,012 people live in the project area of 20 km². There is a total of 1,765 households with 1,600 employed and 331 unemployed people. Compared to the average in Vienna, the percentage of employees in the Chance-area is medial, the percentage of unemployed people is above the average. Compared to the percentage within the whole Viennese population, more migrants and less elderly are living in the "Schneiderviertel".

Migrants, unemployed people, single-parents and the elderly are among the socially disadvantaged groups. General health information does not reach them in a satisfying way, while their health behaviour and status is worse than that of other groups.

Figure 1: left: "Gründerzeit" houses at Schneidergasse, right: sports area at Hyblerpark, *source:* W. Hertzsch/ ISRA

The densely crowded Chance-area is located in the urban renewal area

which has middle to high need for urban regeneration. The structure of the buildings is determined by the fact that the houses were built as multi-level houses (four to six storeys) at the beginning of the 19th century, the so called "Gründerzeit". Furthermore, there are three social housing buildings. It is mostly a residential area that has only a very basic infrastructure for daily food supplies. The streets and pavements are significantly wider than in the city centre, therefore the individual has more room to move. Yet, even though there is ample public space it is rather unattractive because it is mainly characterized by parked cars.

In the area of social housing buildings there are generous semi-public green spaces – the inner courtyards – which are sparsely frequented. The only public green space – the "Hyblerpark" – is located in the south of the quarter. The "Hyblerpark" has a very high recreational quality. It is divided into two areas: an area to stay and rest and an area for sports. Both areas are used mainly by migrants and elderly people. The sports area is also used by children and pupils in their leisure time and by schools and the kindergarten in the neighbourhood. In general, there is a low conflict rate between the users. The only problem concerns dog owners and young persons in the evening.

Bordering on the intervention area in the south-west, the Simmeringer Hauptstrasse is one of the main roads in Simmering with heavy transit traffic. Apart from its importance as a traffic junction, the infrastructure of the Simmeringer Hauptstrasse supplies the inhabitants of the "Schneiderviertel" with daily food, retailers and restaurants, and guarantees their basic provisions.

3. Results of the analysis of social-space

As mentioned before, the Chance-project used a community-based approach. In the context of health promotion it is sometimes also called a setting approach. It is very complex and requires a lot of work. Therefore, it is a rather demanding way to develop health promotion interventions. The setting approach focuses on the living environment of the target groups and clarifies how the targeted population already participates or how they could be motivated to engage in the respective fields. From this perspective, health promotion and the social, material

and socioeconomic living conditions of the target groups are interdependent. This means that the living conditions of the target groups influence individual health promotion, yet it also indicates that they can potentially be configured in a way for a positive effect on health (Bauer / Bittlingmeyer 2006: 781-818).

To identify, understand, and make use of the mutually dependent requirements it is necessary to include the neighbourhood or community in the generation of health information. According to Alisch (2009) it is essential to empower inhabitants and important actors engaged in the respective fields to analyze and articulate their needs and problems. At the same time it is crucial to view the respective inhabitants or target groups not only in terms of needs and problems, but also to acknowledge and make use of their resources and potentials.

Based on this approach we chose various interdisciplinary methods and adopted a mixture of quantitative and qualitative methods of social-empirical sciences. These methods are in the tradition of action research and normally used in social space analysis (further information about social space analysis see Gestring /Janssen 2002: 147-160; Riege / Schubert 2002 and Kessl et al. 2005: 147-160) as a part of social work and urban planning. On the one hand, this methodological mix was important for analyzing the social life in the research area. On the other hand, we had to arrange the methods in a way that enabled us to reach local people, social institutions, important actors and disseminators in order to integrate them into the process-related development of the project. This was necessary since we sought to get to know and understand the research area from various perspectives. Furthermore, representatives of the municipal administration were integrated into the process of analysis.

The following questions constituted the starting point and basis of our analysis:

– Who are the people living in the research area? What are their different health conditions and how do they define health? Which health resources are available in the daily life of the community (social capital)?

- What are their living environments? What are the social spaces of the different social groups? Who are the disadvantaged social groups in the community and in which ways are they disadvantaged?
- What impact does the quarter as a social-space have on the health of the inhabitants? How do the various social groups use the public space?
- Are there areas well-known to cause problems or make people feel insecure?

In summer 2008 the survey in Simmering started. To get in contact with the inhabitants and to learn about their lives and living environments as well as about their needs and problems twenty qualitative interviews and 254[1] quantitative interviews with questionnaires[2] were carried out. In addition, we analyzed the economic, ecologic and social structure of the area. To find the aims and regulations for the spatial development in this particular urban area, historical and current documents about the development of this area were studied and structured and random city walks were organized with the research team. Parts of the investigation area were systematically observed to learn more about the patterns of use: about the movements and activities in the public space, about the routes people take and the contacts they make, and where they stay, communicate, and linger. It was interesting and necessary to know which areas are important for the target groups, in which way they use and adopt the public space, what they like about it and/or what causes them problems.

Local experts and stakeholders were interviewed, networks with strong and weak ties and "important" persons ("local heroines and heroes") were identified to answer central questions in our field work: who are the actors and disseminators in the area, what kind of local social and cultural institutions are important for the target groups, and which role do (or can) they play in community health management? At the end of

1 177 (69.7%) of them were born in Austria and 72 (28.3%) were migrants. The description of the whole sample is in the appendix.

2 The questionnaires were distributed by female students of Nutritional Sciences. We interviewed the inhabitants at home and the students filled in the questionnaire. Individual interviews were conducted at the "Hyblerpark". The qualitative interviews were carried out by male students of urban planning, recorded with a dictaphone and transcribed. The interviews took place in the flat of the interviewed person. Individual interviews were conducted at the "Hyblerpark".

2008 / beginning of 2009 these results were presented to local institutions and organizations in two round-table discussions. The findings of the interviews and round-table discussions were essential for the development of future co-operation and for establishing the intervention "Healthy Simmering" in the summer of 2009. In the following the focus is on the results of the investigation and intervention with Turkish migrants.

For successful health management *personal contact* at local level has a very high priority in particular for migrants: The interviews, meetings and collaborations with the Turkish migrants showed that relationships and friends (social surroundings) are very important for exchanging and gathering of health information. Besides, physicians and pharmacies are relevant resources for health information. Most of the interviewees understand the doctors' advice and can implement health information into daily life.

Small and informal networks are also essential to reach the inhabitants at the level of the urban quarter. These systems include neighbourhood based and stakeholder based networks with a low degree of organization. These "secondary networks" are very important especially for Turkish women and can be used for the dissemination of health information.

For migrants the access to the health care system in general, and to health information in particular, is more difficult than for native residents [Schenk et al. 2008: 18.el-18e2; Wimmer-Puchinger et al.. 2006: 884-892; Keller / Baune / 2005: 22-29; Razum et al. 2004: 2882-2889]. This is a result of lacking intercultural competencies, translators or native speakers, besides deficient adequate health offers or prejudices. On the other hand, migrants are more commonly illiterate, lacking language skills, and have deficient knowledge of the health care system. Compared to the native residents migrants have different points of view concerning health and disease and they more often mistrust public institutions [Schenk 2007: 87-96; Walter et al. 2007: 349-53; Akbal 1998: 115-120].

To summarize: the migrants interviewed acquire health information in their social and spatial (regional) environments and rarely from large-scale campaigns, because the latter are more often confusing for them. To acquire and understand health information they need familiar and personal surroundings they trust.

Through our analysis of social networks and also in relation to the aforementioned facts we observed that *collaboration with local disseminators* is necessary to reach the target groups, especially the Turkish migrants. Furthermore, our field experiences demonstrate that integration of native speakers is necessary to get in contact with them. The participating Turkish migrants predominantly live and operate within their migrant community. They don't have any experiences beyond these imaginary borders and only a few are in contact with Austrian inhabitants. For the organization of their daily life it is not necessary to speak German. Our analysis also demonstrated that the Turkish women have a low education level and the majority were illiterate. Nevertheless, in most of the cases they organize the family businesses and childcare.

Due to this, their interactions were spatially limited to their living surroundings. Many of the Turkish women have never left the district or the urban quarter. Consequently, it is very difficult to reach this social group with general health information and offers of assistance.

For implementing the intervention the mosque at Grillgasse played a critical role: to reach out to the Turkish women and understand their living environment the mosque served as contact institution, opinion leader, and disseminator. By personal contact with the female opinion leader of the mosque, who organizes all women specific courses in the community, many of them could be reached.

To summarize, perception of health information happens mainly in familiar resp. neighbourhood networks. Furthermore, the spatial living environments of female Turkish migrants are delineated by the district or neighbourhood. Thus, *spatial proximity is very important*. Female migrants are particularly dependent on their immediate surroundings. They find everything for the organization of daily life (shopping, running errands, escorting children and adolescents, visiting the mosque) on-site. Initially they use offers of help from their ethnic community or economy. Furthermore, the results of our systematic observations

indicate that female Turkish migrants in particular use public spaces. Due to their cramped housing conditions they need to make ample use of public open and green spaces.

As mentioned before the Turkish women live and act exclusively in their native tongue. Because of their low level German language skills, the mosque provides help with translations, especially with administrative support. In addition, children assist their mothers in German and in the organization of the family's daily life. All in all, this means that the organization of daily work and family life happens within a rather limited space and is carried out on a small scale. Our results confirm that female Turkish migrants are strongly identified, and satisfied, with their housing situation and with their life in the district or neighbourhood.

The quantitative questionnaire observed that the majority assessed their quarter and their living situation positively, e.g. 83.1% consider their homes as comfortable and 57.1% feel safe in their quarter. Compared to Austrians, migrants more frequently noted to feel safe in their neighbourhood / quarter, to have the best neighbours they can imagine, and to live in healthy surroundings, although they live more crowded. On average migrants lived together with 4 others, while Austrians shared their homes with 2 family members. This finding reflects the Austrian situation: the average Austrian has 45m² of living space while a migrant has only 31m² on disposal (Marik-Lebeck et al. 2009: 33).

In addition, community work is more important for migrants compared to Austrians. Migrants participate more often in events within the quarter and they are more frequently members of clubs / organizations in their neighbourhood than Austrians. These results – according to the description above –indicate that migrants have a stronger relation to their quarter than Austrians. Their higher participation in events and clubs, if organized on the level of the city quarter or neighbourhood indicates the acceptance, importance and dependence on spatial proximity. Of course, participation mainly concerns events organized within their community and not beyond at a multi-cultural level, but that also means that they have strong networks within the community.

To summarize: if the community concentrates on neighbourhood then health promotion strategies must also focus on it. Local actors, social

meeting points, important places and institutions need to be integrated into health promotion services.

The social sciences as well as the natural sciences approach demonstrated that Turkish migrants belong to a disadvantaged group in this urban district, especially in terms of social and economic resources and in their daily mobility. Moreover, studies have shown that migrants are difficult to reach through traditional ways of health information - which maybe one of the causes leading to unfavourable health behaviours.

The analysis of questionnaires detected that independently from socio-economic factors the majority estimate their health as good (59.1%) and very important (64.6%). Furthermore, 62.6% think that their health will be the same in three years. Only a minority consider their health to be bad (5.5%) or very bad (0.8%), not at all important (0.8%) and think that their health will worsen (3.1%). Migrants have a more positive view of their future health than Austrians. This outcome is opposite to the results of the interviews conducted because Turkish women tend, among other issues, towards higher body weight - a source of much discontent. Furthermore, the survey shows that due to insufficient options in mobility, female migrants are less active than the local Viennese population.

In general, the Austrian health survey 2006/07 showed more migrants to have bad or very bad actual health [Statistik Austria, 2008]. Moreover, non communicable diseases like obesity [Lahrmann et al. 2000: 620-631; Wändel et al. 2003: 435-439], cardiovascular diseases [Marik-Lebeck et al. 2009: 35; Uitewaal et al. 2004: 1068-1076; Porsch-Oezceruemez et al. 1999: 185-198; Khattar et al. 2000: 267-271] or diabetes mellitus [Wändel et al. 2003: 435-439; Uitewaal et al. 2004: 1068-1076; Hoppichler / Lechleitner 2001: 271-274; Brussard et al. 2001: 659-664] are more common within the migrant than within the native community. Because of the younger age of the participating migrants, it can be hypothesized that the stronger social support in families with a migration background has a protective effect [Hermann / Mielck 2001: 741 - 747].

With the background of these multiple disadvantages, it is essential to design *milieu and target specific proposals*. Within the interventions undertaken, there was an active response to this need.

4. Intervention "Healthy Simmering"

The project was designed and implemented to improve self-reliance and independency within the target group by increasing transparency concerning resources and the possibilities of healthy daily life activities and knowledge of healthy behaviour. Based on existing skills the project intervention "Healthy Simmering" was established.

Neighbourhoods and their existing interests, as well as networks as communities of space and communities of interests were integrated to start collective learning processes and to guarantee empowerment. The Simmerings' inhabitants were actively included in the process of problem definition, solution finding, and in the development of an adequate intervention. Furthermore, local stakeholders were included in the development and implementation of "Healthy Simmering". These approaches assure sustainability.

Based on the outcomes of site inspections, qualitative and quantitative surveys, interviews, and round table discussions the three-staged intervention (nutrition lectures, cooking classes and physical activities) "Healthy Simmering" was developed and started in May 2009. According to the project's criteria the intervention focused on single-parents, elderly and migrants. Due to the big Turkish community in Simmering and the high number of Turkish migrants without satisfactory German language skills, special courses in their mother tongue were offered.

The Chance-project in general and the intervention "Healthy Simmering" were presented to the residents at Neighbourhood festivals and the Simmeringer Street Festival. The Austrian Chance-team got in contact with the target groups via the urban renewal office, a trusted institution. We used two round table discussions to get in contact with local stakeholders.

According to the analysis of results (see above) the project team got actively in contact with the focus groups by existing networks like religious communities, especially the mosque at Grillgasse and the catholic and evangelic denominations, or local clubs for the elderly. These are very important meeting points for the target groups because

they can meet their friends, they can interact and take up some offers of assistance. Besides, local stakeholders like the pharmacy, kindergartens, and various organizations like the Fund for Social Affairs in Vienna, the adult education centre, and the urban renewal office participated in the interventions' planning, promotion and implementation. Furthermore, information concerning the intervention was given to the residents at the local festivals and by direct contact at the public green space, the Hyblerpark. Besides personal contact, information was distributed via leaflets in German and Turkish, by the internet (target group specific and governmental homepages) and via a hotline and email-contact.

The Turkish-speaking offering was enlarged and adapted after consultation with the Turkish women of the local mosque. According to the group's needs lectures on healthy nutrition concerning adequate nutrition for children, cooking courses using modified Turkish recipes and special sport courses were organized. All information materials and courses were translated by a native speaker into their mother tongue. During most of the courses free child care was offered.

After the intervention the evaluation was carried out through interviews with the Turkish women. The results of pre- and post-analysis and of the interventions' experiences can be summarized in following four points:

1. Personal contact

To get in contact with the targeted residents specific strategies at the Hyblerpark, local events, social clubs, and, for migrants, the local mosque at Grillgasse were chosen. While the project was generally presented at local events, a direct and trustworthy relationship was built with the Turkish women through the female speaker of the mosque at Grillgasse. She introduced the Chance-team after they had regular meetings at the mosque. Due to this it was possible to reach the women and to motivate them by using her as a role model. As a result of her high position within the group her opinion was very important and her support of great benefit for the womens' participation in the project. Because of the high percentage of illiterates direct contact with the Turkish target group was the only way to integrate them in the project. Communication with the Turkish target group happened mainly through the active integration of the female speaker.

2. Collaboration with local stakeholders

The intervention "Healthy Simmering" was designed and implemented in co-operation with the target group stakeholders. For Turkish migrants collaborations with the mosque at Grillgasse, the adult education center and the Fund for Social Affairs in Vienna were of major importance. Through this cooperation lectures on healthy nutrition were offered at the mosque, a cooking course in the adult education center and sports courses were held in the mosque and the adult education center. Furthermore, the low-threshold health promotion project "ge(h)sund – bewegte Apotheke" was introduced and continued by the Viennese Health Promotion. This project is organized by the local pharmacy and offers Nordic walking courses for a nominal sum (1 Euro).

3. Importance of the quarter

The qualitative and quantitative surveys showed that Simmering with its spatial resources is the center of daily life, especially for the Turkish women. Therefore, the mosque, the "Hyblerpark", and the Danube Island were included in the intervention approach as important parts of the quarter. All local actors of the health care system like the pharmacy, the oculist, the adult education centre, the Fund for Social Affairs in Vienna, the Viennese Health Promotion, and the kindergarten were enrolled.
For the Turkish cooking classes, traditional foods were bought in the local ethnic supermarket.

4. Target-group specific offers

Depending on the needs and regional resources milieu-specific events were developed. These offers were incorporated in the daily routines of the Turkish women. Based on this personal contact the Turkish intervention was adopted according to the needs mentioned. Following the clear wish for adequate sports facilities the offer of physical activities was enlarged. Because of a lack of space in the mosque, sports events were organized in the adult education center. In these windowless rooms it was possible to train in a relaxed way because the women felt secure. Furthermore, the adult education center was used as a safe place for cooking. Without men it was possible to undo the head cloth and move up sleeves during the cooking classes. According to requests traditional Turkish recipes were cooked. These recipes were adapted by the

Department of Nutritional sciences. Because of religious norms only halal-meat was used. Due to the high rate of illiterates it was necessary to adapt nutrition information and to use a more practical approach. Traditional food, pictograms or food-quizes came into operation to communicate nutrition knowledge.

5. What happens now?

Resulting from the co-operation with local stakeholders and the evaluation of the needs within the quarter, two other health promotion projects were implemented in Simmering by the Department of Nutritional Sciences. These projects profit from the experiences made during the Chance-project and focus on kindergarten children and the elderly.

References

Akbal, S. (1998): Migrant/innen in Österreich und Europa – ihre mangelnde Integration im Gesundheitswesen und Perspektiven. In: David M, Borde T, Kentenich H. (Hrsg.): Migration und Gesundheit: Zustandsbeschreibung und Zukunftsmodelle. Mabuse-Verlage, Frankfurt am Main. Pp. 115-120.

Alisch, M. (ed.) (2009): Lesen Sie die Packungsbeilage …?! Sozialraumorganisation und Gesundheitsinformation.. Opladen/Farmington Hills: Barbara Budrich Verlag.

Bauer, U./Bittlingmeyer, U.H. (2006): Zielgruppenspezifische Gesundheitsförderung. In: Hurrelmann, K.; Laaser, U/Razum, O. (eds.): Handbuch Gesundheitswissenschaften. Weinheim. Juventa Verlag. 781-818.

Brussard, J./Van Erp-Baart, M./Brants, H. et al. (2001): Nutrition and health among migrants in the Netherlands. Public Health Nutrition 4: pp. 659-664

Gestring, N./Janssen, A. (2002): Sozialraumanalysen aus stadtsoziologischer Sicht. In: Riege, M./Schubert, H. (eds.) (2002): pp. 147-160.

Hermann, N./Mielck, A. (2001) Der Gesundheitszustand von deutschen und ausländischen Kindern: Warum ist Mehmet gesünder als Maximilian? Gesundheitswesen 63(12): 741 – 747.

Hoppichler, F./Lechleitner, M. (2001): Counseling programs and the outcome of gestational diabetes in Austrian and Mediterranean Turkish women, Patient Education and Counseling 45: pp. 271-274.

Keller A./Baune B. (2005): Impact of social factors on health status and help seeking behaviour among mitgrants and Germans. J Publ Health 13: pp. 22-29.

Kessl. F./Reutlinger, C./Maurer, S./Frey, O. (eds.) (2005): Handbuch Sozialraum. VS Verlag für Sozialwissenschaften. Wiesbaden.

Khattar, R./Swales, J./Senior, R. et al.(2000): Racial variation in cardiovascular morbidity and mortality in essential hypertension. Heart 83: pp. 267-271. http://heart.bmj. com/content/83/3/267.full.pdf (access: 22.4.2010)

Lahrmann, P./Lissner, L./Gullberg, B. et al (2000): Differences in body fat and central adiposity between Swedes and European immigrants: The Malmö Diet and Cancer Study, Obesity Research, Volume 8, Issue 9: pp. 620-631.

Marik-Lebeck, S./ Wisbauer A, Kytir J (2009): Migration & Integration. zahlen. daten. fakten 2009. Herausgeber: Bundesministerium für Inneres, Österreichischer Integrationsfonds, Statistik Austria, rötzer druck, Wien. Pp 33,35. .http://www.integrationsfonds.at/fileadmin/Integrationsfond/5_wis sen/5.1.1_zahlen_und_fakten_2009/migration_integration.pdf (acess: 21.4.2010) wohnen und kardiovaskular dis.

Porsch-Oezceruemez, M./Bilgin, Y./Wollny, Y.M. et al. (1999): Prevalence of risk factors of coronary heart disease in Turks living in Germany: The Giessen Study. Atherosclerosis 144: pp. 185-198.

Razum, O./Geiger, I./Zeeb, H./Ronellenfitsch, U. (2004): Gesundheitsversorgung von Migranten. Deutsches Ärzteblatt 101 (43): pp. 2882-2889.

Riege, M./Schubert, H.(eds.) (2002): Sozialraumanalyse. Grundlagen – Methoden – Praxis. Opladen: Leske + Budrich.

Schenk, L. (2007): Migration und Gesundheit – Entwicklung eines Erklärungs- und Analysemodells für epidemiologische Studien. Int J Public Health 52: pp. 87-96

Schenk L./Ellert U./Neuhauser H. (2008): Migration und gesundheitliche Ungleichheit. Publ Health Forum 16 (59): pp. 18.el-18e2.

STATISTIK AUSTRIA (2008): Subjektiver Gesundheitszustand http://www.statistik.at/web_de/statistiken/gesundheit/gesundheitszustand/subjektiver_gesundheitszustand/index.html (access: 9.5.2011).

Uitewaal, P./Manna, D./Bruijnzeels, M. et al. (2004): Prevalence of type 2 diabetes mellitus, other cardiovascular risk factors and cardiovascular disease in Turkish and Moroccan immigrants in North West Europe: a systematic review. Preventive Medicine 39: pp. 1068-1076.

Wändel. P./Hjörleifsdottir-Steiner, K./Johannsson, S. (2003): Diabetes mellitus in Turkish immigrants in Sweden. Diabetes & Metabolism 29: pp 435-439.

Walter, U./Salman, R./Krauth, C./Machleidt, W. (2007): Migranten gezielt erreichen: Zugangswege zur Optimierung der Inanspruchnahme präventiver Maßnahmen. Psychiat Prax 34: pp. 349-53.
Wimmer-Puchinger B./Wolf H./Engleder A. (2006): Migrantinnen im Gesundheitssystem. Inanspruchnahme, Zugangsbarrieren und Strategien zur Gesundheitsförderung. Bundesgesundheitsbl. – Gesundheitsforschung – Gesundheitsschutz 49: pp. 884-892

Appendix

Table 1: Detailed information on the study subjects.

	Austrians	migrants
sex		
female	61.0% (n=108)	66.7% (n=48)
male	39.0% (n=69)	33.3% (n=24)
age-groups		
under 20 years	7.3% (n=13)	8.3% (n=6)
21 – 30 years	23.2% (n=41)	27.8% (n=20)
31 – 40 years	24.3% (n=43)	34.7% (n=25)
41 – 50 years	22.0% (n=39)	16.7% (n=12)
51 – 60 years	10.2% (n=18)	9.7% (n=7)
61 – 70 years	9.0% (n=16)	1.4% (n=1)
71 – 80 years	2.3% (n=4)	1.4% (n=10
81 and more years	1.7% (n=3)	0.0% (n=0)
education level		
secondary school max.	18.6% (n=33)	23.2% (n=59)
secondary school min.	81.4% (n=144)	76.0% (n=193)
job situation		
studying	4.0% (n=7)	5.5% (n=14)
working part time	15.8% (n=28)	14.2% (n=36)
working full time	44.6% (n=79)	40.2% (n=102)
unemployed	8.5% (n=15)	10.6% (n=27)
housewife	6.8% (n=12)	11.4% (n=29)
pensioner	18.1% (n=32)	15.0% (n=38)
others	2.4% (n=6)	2.4% (n=6)

Turning a "community of space" into a "community of interests" – local health networks in Germany

Monika Alisch and Barbara Freytag-Leyer

The German Chance project's case study in the medium-sized town Fulda was based on several years preliminary work concerning community-related health information interventions. This preliminary work particularly consisted of the development of the local network integrating local actors of a district at the border of the city centre. For this local network, initiated by the University of Applied Sciences Fulda, so-called community forums, where the community's issues as well as the institutions' opportunities and problems were discussed, had taken place just before the Chance project started. Furthermore, a first empirical study concerning household resources (Freytag-Leyer 2007; Freytag-Leyer/ Hampshire 2009) and a first public health study (Metz 2006) were implemented.

In Germany, there have been considerable area-based policies since the 1990s. It is their intention that available resources are pooled, especially in disadvantaged urban areas, so that different policy fields such as social policy, health promotion, employment promotion, education work, and housing policy are integrated and applied to a positive and sustainable development of the respective areas (social urban development). For neighbourhoods not characterised by multiple problems (poverty, environmental problems, poor housing), such an social space-related approach has only gradually been used.

These experiences, with area-based local policies and a health policy operating with the setting approach in different national and regional programmes, facilitated the start of community-based health information for the German local Chance project.

This article's first section shortly depicts the principles of the German policy of a social urban development and the health promotion policy. Both policies are not systematically connected in the 16 German states

so that there are only individual cases of succeeding community-related health promotion approaches. This also influences the development of local health information and education projects because established structures of cooperation are missing.

The next section presents the local community Fulda-Southend, then focuses on the network analysis then details the process of the local project development with a special focus on the specifics of the social space. The degree of information on different social groups is presented as well as their responsiveness to community-related health information by means of a qualitative and quantitative survey within the Chance project.

1. Community-based policies and measures in Germany

Since the 1970s, western European cities have attempted to overcome the socio-spatial consequences of the economic and social structural crisis by applying special urban policies. As a reaction to the analysis of the social city's crisis ("Krise der sozialen Stadt") (Hanesch 1997) and the crisis of Germany's welfare state, several action approaches have been discussed. In the 1990s, the social political solutions have been directed to reduce expenses in municipal action areas. On the one hand, it has been attempted to directly provide employment to single welfare recipients by ambitious pilot projects. On the other hand, thinning out social services and the privatisation of services seemed to be the only way to rescue the status of the communities as "social" (in the sense of the German welfare state).

The concept of the social urban development has directly tackled the social spatial consequences of social-spatial processes since the mid-1990s (and it therefore follows policies of other European countries such as Great Britain, France, and the Netherlands).

Starting point are the inequalities within the society, which have grown in parallel and as direct consequences of economic restructuring. These processes are marked by socio-economic polarisation, socio-demographic inequality, and a multi-cultural differentiation especially in cities (see Alisch / Dangschat 1998).

The area based policy of the social urban development involved *area-related* aims (upgrading, improving life situation) and *structure-related* aims. These aims should result in a fundamental change of the municipal administration: the cooperation of different departments, the methods of decision-making, and the participation of non-governmental organisations and the ability of citizens to indicate structure-related aims within the policy field.

The essential principles of this policy related to the geographic area and to the local community are:

1. *Community of space*: The cooperation of administrative departments and local networks is implemented via a common place of action. All projects and strategies arise from personal, spatial, financial, and institutional resources available in the community or district.
2. *Participation*: Intermediate partners act together with the addressees. The activation of strengths and potentials is oriented to the people's everyday life. Professional action is closely connected with the potentials, abilities, and activities available for the inhabitants.
3. *Related to resources:* A wide turning away from dealing with deficits: It considers the strengths and explores resources of individual and structural problem-solving.
4. *Cooperation*: Organisations and institutions of the local and urban level work closely together. All relevant actors cooperate in problem-solving and the implementation of specific projects.
5. *Integrated approach*: A search for crystallisation points for activities, where preferably all citizens could participate. Actions related to certain target groups or issues always occur in the context of other actions.
6. *Involving all departments*: All administrative departments cooperate concerning the community or its visible problems. Intermediate organisations link departments and responsibilities (see Alisch 2010a;b).

This kind of policy has been implemented in more than 500 disadvantaged urban districts in German cities since 1998. Currently, public funding is dramatically reduced by the conservative-liberal Federal Government.

2. Public Health and the setting "community'

Recommendations of health promotion include the advice to apply strategies of empowerment and to refer to health (not disease). The so-called setting approach of health promotion is defined by the Federal Centre for Health Education (BZgA) (2007) and refers to 'setting' as spaces, where people practice their everyday life activities and / or live their social relationships. People are no longer perceived as objects of professional health care, but as acting and designing subjects (Gerber / v. Stünzner (1999: 52) who take responsibility for their own health by co-creating the circumstances.

The scientific and professional discussion in this context sees a connection between health promotion and social urban development (see Boos-Krüger / Pallmeier 2009): 206-216). Suggestions for health promotion on the community level count on the increased attention to the connection of social inequality (poverty) and health (Bär et al. 2004) as well as on the pooling of local power in the district even with limited financial resources.

Even here, the connection between community work and health promotion refers to disadvantaged urban areas and their socially and health-related disadvantaged citizens. The starting point is also the idea that the poor especially rely on the community's resources and on that health promotion reaches them where they deal with their everyday life.

Medical-anthropological studies therefore emphasise the non-professional, private sector of health care as relevant (Heindl 2007: 36) and show that health and its maintenance (salutogenesis) as well as coping with disease is predominantly dealt with in everyday life and not in professional care systems (ibid.). That is why the perspective is directed to the promotion of a salutogenetic environment within the society, which considers social inequality (poor = ill).

Boos-Krüger/ Pallmeier (2009: 200) argued that in the German political landscape in both domains, the social urban development and health promotion, problems are characterised by complexity related to globalisation, structural change, and demographic development which indicates that integrated and very similar approaches are needed for coping

with these challenges. The medical sociologist Alf Trojan (e.g. Trojan et al. 2001: 69) summarised these connections and then criticised the great discrepancy between comprehensive programmatic requests and the state of implementation.

This is the reason why it is still up-to-date to initiate and support community-related strategies of health information and education as a part of health promotion. On the one hand, strategies of health information should not focus on cities' single areas of crisis which would promote a restricted understanding of the social space as a territory or one of planning. On the other hand, social community-related acting comprises much more than the health political support of disadvantaged groups of inhabitants.

On this basis, Boos-Krüger / Pallmeier (2009) suggest so-called strategic partnerships. It means that *practice-related professional* partnerships (operative) on the level of *communities and districts* should be prepared or reinforced by *specialised political alliances* (strategic) on the political-administrative level of the city and the state. Such strategic partnerships need to stabilise the interdisciplinary cooperation in the practice field by even integrative control structures across departments. This is the only way to enable practitioners, who are expected to work interdisciplinarily, to have resources and legitimisation for working to such patterns (ibid. 208). In this respect, it is necessary to particularly pay attention to the initiation of local health networks and their establishment on the side of local authorities.

3. Living in Fulda-Southend: An urban area on the edge of the town

3.1 Social space analysis "Fulda-Southend"

Fulda which is the ninth largest city of Hesse and its corresponding river are the regional centre of Eastern Hesse. It is the county town of the rural district of Fulda and one of seven special status cities in Hesse. Due to its convenient connection via high speed ICE train and regular local trains, Fulda profits from its closeness to the economically strong region Rhine-Main. Concerning its own economy, Fulda offers a range

of textile, automotive and metal processing industries. But, in the course of globalisation, these industries have had to cut a high number of jobs due to production relocation especially to eastern Europe.

In Fulda, there live 64,500 inhabitants, spread over the city's core with its twelve statistical districts, and further 24 districts around it. One very delimited district of Fulda is called Southend („Südend") with about 4,700 inhabitants (population density 15.9/ha) and Kohlhaus with about 1,200 inhabitants (population density 8.5/ha) [1].

Southend and Kohlhaus are both characterised by a strong blending of residency and industry, and are considerably burdened by traffic. They are located between a developing main road and a mainline of the Federal Railway. The investigation area is cut into different districts by the railway line. The area shows a mixture of buildings with, predominantly, apartment buildings with three or four floors. There is a high proportion of houses owned by three housing associations.

In relation to the entire city, Southend has a higher proportion of migrants, this being 18.6% compared to 10.2%.[2] The age structure slightly deviates from the entire city. It is noticeable that the proportion of children and adolescences is lower in Southend than in the city of Fulda.

The social space analysis showed that the urban district Southend is cut into five smaller neighbourhoods, which form own 'communities of place' due to their structures of urban development and inhabitants. The districts Southend and Kohlhaus only have the primary school as a common centre with a joined youth club and the club house of a Turkish sports club right next to it. Altogether, there are four kindergartens, as well as three Catholic churches, one Protestant church, and one Free Church in the districts.

1 It has to be noted that this is based on data on nationality. There could even be a migration background with a German nationality.

2 City of Fulda (2008): Data 2007 (in original: Daten 2007). Statistical office Fulda.

3.2 Results of the quantitative and qualitative research

The quantitative research included 186 participants (64.5% female, 35.5% male), who were accessed by means of Random Walk integrating all streets (see Raithel 2006: 57) and via randomly selected local groups such as parents' evenings in the school or parents from the kindergarten.

Different age groups were represented as follows: 29% under 30 years, 45% with the age 31-61, 29% over 61 years. A migration background was found in 42% of the respondents. They represented 23 home countries with the emphasis on Turkey (38%), Kazakhstan (17%), and Poland (9%). The proportion of participants living in family households with one or more children was at 37%, 9.5% were single parents, 21.3% were singles, 26% lived with a partner.

Health is highly valued. It is 'very important' for more than half of the respondents, for further 40% it is at 'least important'. Every tenth respondent evaluated their health as 'very good', six of ten as 'good'. Two thirds expect a stable health status in the next three years, 30% hope for an improvement. The physician is the most important source of health information, followed far behind by the pharmacist. He/she is also the most important source (87%, multiple answers possible) in cases of problems with health, nutrition, or physical activity, followed by the family (44%), friends (29%), and the internet (27%).

Just over eight of the ten interviewees said they are physically active daily, and almost two third do not smoke as a means to stay healthy. But, more than a quarter of respondents also said they had never done sports (27%), each one tenth admitted doing sports only one hour per week. Only about a quarter responded that they were able to get 'all information concerning health', 35% 'sometimes', and further 38% 'never'. So, the physician plays an important role as a source of health information (see above), but there is only one doctor's practice at the edge of the Southend community.

As to the most important facilities in the area, the responses pointed to supermarkets (89%), green areas (88%), kindergarten (75%), and school (68%). The citizens' claims concerning an improvement of health were strongly influenced by the districts' constricted situation due to the main road and the railway line, as well as the level of industrial buildings.

They demanded less noise and traffic, more green space, an improved public transport system, cycle tracks, having pharmacies and physicians in both districts, more free sports availability, as well as fields for playing, soccer and sports for children and adolescence of different age groups. Concerning communication and intercultural exchanges, they wanted a meeting point or café. Generally, the respondents feel fine at home (94%), 90% 'like their apartment or house', and 84% stated that 'their home is secure'.

In order to discover the different needs of the social groups in Southend, we concentrated the qualitative interview study on three inhabitant groups, which are more dependent on the resources available in the local community in relation to general citizens: the elderly, families with young children, and migrants, especially older migrants and mothers with young children.

"Health is most important" is a statement predominantly given by older citizens, who report the efforts made to maintain their health. Numerous strategies are used, and advice and information are usually considered (see Lemme 2009: 145).

The data also referred to a feeling of powerlessness in a number of contexts, and also the impression of "not understanding the world anymore". These interferences and challenges lead to behaviour changes and modifications in the participants' everyday life. For example, they are less physical active which reduces further their participation opportunities because many walk only short distances or stay at home for most of the day.

The neighbourhood is generally, with a few exceptions, experienced as 'good' by the elderly. Here the specific support or help of neighbours seems to be less important, rather is a 'peaceful and polite community'.

Health held a central place in family households. Information on physical activity and nutrition were particularly absorbed concerning the development of the own children, and the own community is evaluated related to opportunities for a healthy everyday life.

"It ranks first, yes, but I think, when we were younger, we didn't think so much about it. Well, if you have children yourself, I think, you will be more concerned about it" (see Hubertus 2009: 109)

Caring for their children and the men's shift work both determine the structures of everyday family living. Still, women carry the main burden of caring for their family, even if they additionally have a part-time work or aid people in their family environment. Meals were prepared by the family members themselves and they aimed to eat together. Thereby, they attached great importance to fresh ingredients. All homes provided bowls with fresh fruit as snacks. Children were given sandwiches for their break at school.

Physical activity was perceived as important. Single men and women, and many children did sports in a club. Some parents stopped their sports activities due to their heavy burden by family work and employment. For families, going for a walk was the main kind of sports (see Hubertus 2009: 109).

Trust plays a key role in the case of health issues. Informed people from the family environment and a physician who could be trusted, generally the general practitioner, therefore performed the key roles in accessing the health system. A respondent indicated thus :

"So, in terms of health, then I just talk to my mother usually, or even to my sister." (in original: „Also wenn es um Gesundheit geht, dann red ich schon mit meiner Mutter hauptsächlich oder mit der Schwester.")

Family-related and neighbourhood-associated support systems had a central meaning for a well-functioning organisation of everyday life and for handling the topic health. These provided the basis from which each family developed its specific strategy to handle emerging and on going issues (Hubertus 2009: 111).

Among the interviewed families, there were also those with a migration background, mostly Turkish or from the former Soviet states. Here, social networks play a stronger role in disease prevention and medical care than for Germans. The close connection to the family and to compatriots who are friends might help migrants to better cope with stressful situations or disease.

Their health information happened rather by chance. Regular information sources, i.e. oriented to prevention and the basic everyday life, seemed not to exist. The interviewed migrants stated that they would only search for information 'if they were just interested'. This also made clear that, here, a subjective health concept in the meaning of 'absence of disease' was used, and health information was searched for in the context of disease symptoms. The main source was the printed word for all respondents, they referred to the local press, or trusted their family members (see Ackermann / Alisch 2009: 144).

Among the 'Aussiedler' (native German emigrants from the former soviet states), an informal network of health counselling had been developed. It used the knowledge and skills of former physicians, who were not allowed to practice in Germany, either to receive information on disease treatment or to ask them for an explanation of other physicians' diagnosis which were not understood because of language barriers (see Alisch et al. 2010; and on the homepage: www. amiqus.de).

3.3 Measures and interventions

The qualitative and quantitative study was not only used to develop tailor-made projects of health information and education, which were also adjusted to the resources and opportunities of the different citizen groups. Even more, the data sets should improve the knowledge about the addressees of the different institutions located at Southend, so that measures were developed out of the network of local actors including the citizens' participation. So, the results of both surveys had been able to be transferred into the community forums and to be discussed. That way, the 'Health Days' were organised together with a high publicity value, and new cooperation between actors of the health system and the districts were established.

The starting point was a Health Day with the slogan "Fit in spring" at the local primary school by the end of February 2008. Different network partners presented their offers concerning physical activity, nutrition, and recreation. Several short and needs-related activities originated from this, for example an intercultural cooking event for Turkish and German women, as well as an event concerning healthy breakfast in a Protestant kindergarten for children and accompanied by information for parents

(both offered by the German Housewife Association ("Deutscher Hausfrauenbund e.V."); presentations for the elderly and for local actors about choosing outpatient care services (by the Consumer Advice Centre of Hesse), and counselling offered by the city of Fulda for parents dealing with education problems as well as by the seniors office directed to the elderly were also offered. Also, the Consumer Advice Centre of Hesse has implemented a nutrition project at the kindergarten St. Sturmius over one year called 'Joschi can – don't miss good food' (in original: Joschi hat´s drauf. Nicht vergessen. Gutes essen"). The frog ‚Joschi' was the symbol for the intercultural project. The aim was to teach educators, parents, and children about how to achieve balanced nutritional intake. Even the topic of special food for children was discussed.

The summer festival "All about health" as an easily accessible event turned out to be a "door-opener" for different target groups in June 2009. A variety of offers concerning activating, information, and education on physical activity, nutrition, and recreation were presented, e.g. the activities of the different sports clubs „SG Frischauf", „SV Kohlhaus"„SV Blau-Gelb", and the Turkish sports club addressing children and adults, as well as dance groups for the elderly of the Catholic and Protestant church. It also led to the offer of a swimming course for migrant women in cooperation with the Helene-Weber-House – a Catholic Family Education Centre – at the Mediana Residential Home.

In 2010, the community festival "All about health" was repeated, this time in connection with the school festival of the local primary school "Sturmius School". From 2011 onwards, there have been various minor community festivals in cooperation with single institutions, such as the Luther Church ("Lutherkirche") in the year 2011.

4. Local networking for a "Healthy Neighbourhood"

The theory-related and concept-related background of the approach outlined here refers to the origins of community work developed by Saul Alinsky in the 1940s and called "Community Organizing" (see Alinsky 1972). 'Organizing' explicitly refers to the process of organising common activities on the basis of common interests. While Alinsky's "Community Organizing" was targeted to politicisation disadvantaged

urban citizens (empowerment), the organisation of common interests here refers to the different local actors, who each have individual and institutional interests concerning their professional target groups or their responsibility as an institution (kindergarten, school, church, sports club, citizens association, local principal, trade association). Finally and with reference to the comprehensive understanding of health by the WHO, it could be shown that health is a common and connecting interest.

Even if a network of local actors is already established such as the 'healthy community Southend', the interests stay diverse which makes it necessary to implement continuous processes of coordination as shown by the following network analysis (also see Endres / Scarbata 2009: 155 ff.).

4.1 Network analysis

A qualitative network analysis was applied to activate local actors to cooperate in terms of "health information on a local community level". By implementing problem-oriented interviews with local community actors, relevant or influential further actors were became apparent.

The total number of included actors was allocated to three action levels concerning their role in and their affiliation to the districts Southend and Kohlhaus:

- local existence in the communities of Southend and Kohlhaus (e.g. retailer, restaurant, caretaker and property manager, physician, director of the kindergarten),
- committed local citizens,
- local community administration of Fulda responsible for the districts Southend and Kohlhaus.

The analysis detected strong and weak "knots" inside the network (functional and private ones), implicit cooperation, and conflicts (see Schubert et al. 2001; Keupp 1987).

It also determined the overall amount of relevant actors as well as the intensity and kind of their relationships (structural level). These are differentiated between a) formal pre-structured relationships on a *functional* level, which result from administrative positions and institutionalised

communication channels, and b) hidden, transversely running and voluntarily followed *informal* communication channels (v. Kardoff 1989: 35) among the locally active or relevant actors.

Referring to Ziegler's (1984: 435) definition of a net, the network analysis has to determine which kinds of exchange processes are present in the system, i.e. which:

- resources are exchanged,
- information is transferred,
- influence and authority are applied (stakeholder),
- support is engaged,
- coalitions are established,
- activities are coordinated.

Even if a relationship is very close, it does not allow a complete evaluation because even long-lasting conflicts, mutual ignorance or disinformation represent a close relationship in the net. Consequently, the analysis has to examine the quality of the relationships, their stability, as well as their potential for progress. In that special case, the network analysis focuses on the health promotional potential of the local actors and on empowering them to reflect on this.

Methodologically, the project is based on activating survey instruments, which are traditionally applied in the integrative community work. Referring to Richers and Habermann (2005), 'activating' means the examination of experiences and background, motivations, and interests. The aim is to initiate a process in which the participators reflect on their individual and common interests to effectively organise and implement them (ibid). Following Hinte and Karas (2002), a network analysis of local actors is a problem-specific activation, targeted on shared options of improved community-related health education and information.

4.2 The professional view on the community

Generally, the interviewed representatives of the included institutions in the analysis agree with the statement that Fulda's district Southend tends to have a negative image, represented by quotations like "Southend is not a good start for participating in life" and "the social circumstances here are a bit difficult". But, the district Southend (which does not exist

as an independent district), where very diverse people live from poor ones receiving specific financial state aid (so-called "Hartz IV" recipients) up to better off citizens, is also described as "socially stable and well blended".

A special area of Southend called 'Kongo', where larger numbers of migrants live, and which was announced as a focal point and a reason for the mentioned negative image to the project team, did not appear in the interviews (see Endres / Scarbata 2009: 164ff.). The tenor is that the stigma of being a problematic focal point is not reflected in reality, it is rather the bad image of Southend, which manifest in the perceptions other may have of the area.

4.3 Co-operation: Reality and expectations

After the interpretation of the interviews, it became clear that the institutions rarely, if at all, cooperate with each other, even if they are situated spatially close, e.g. Sturmius-School, the AWO child care 'Southend Charly' and the Turkish sports club. Cooperation and exchange among these institutions are scarce or not at all present. Despite that, the analysis reveals previously unused potential synergies, e.g. between the school's desire for more afternoon care offers – especially sports – and the Turkish sports club, who would like to provide more sports, if the financial means were available to rent the sports field, or if they were allowed to use it for free. This case shows many connecting points for future cooperation.

In fact, each institution is engaged for itself and has various offers for its specific target group. But, they do not get in touch with each other beyond their institutional borders, even though the mentioned requests could be realised through synergistic effects.

4.4 The profits of networking

The expectations on the network predominantly concern the development of a moderated meeting space, where the establishment of cooperation is made possible, especially in the field of child care because an adequate offer in the district – within a walking distance - is missing so far.

The interview partners mentioned numerous possible roles that their institution could play in a network, reaching from "co-thinker", over "project supplier", "financial supporter" to "help seeker", whereby it has to be kept in mind that these roles can not be deduced from the institutions' capacities and are therefore no stable roles. Main goals should be the improvement of the "inhabitants' quality of life" with special care to "getting all on board". Citizens as well as politics and the economy sector should be activated. Accessibility of children and adolescence could be facilitated with the help of 'native people' as role models or of key persons.

5. Future of the interventions: What happens now?

The community forum Southend/Kohlhaus has become a sustainable network. While it was organised by the University of Applied Sciences Fulda during the project time, the leadership passed on to the Bureau of Youth and Family Affairs of Fulda. The meetings take place at the school, the sport clubs, churches and the kindergarten alternating. The bureau published a booklet with the support of the AWO and all other stakeholders which contains all offers for health, sport and culture in Southend/Kohlhaus esp. for children, families and elderly.

The topics and activities result on the basis of participation from the needs and requests of single groups. Students of the Department of Nutritional, Food and Consumer Sciences and the Department of Social Sciences can be involved by project works. In the meantime, an afternoon programme for school children at the Workers' Welfare Association (Arbeiterwohlfahrt, AWO) and a girls' project in cooperation with the AWO and the sport club „SG Frischauf" were developed with the help of social work students.

The swimming courses for Turkish women in the Mediana are continued at the Helene-Weber-House and the kindergartens are still going on. The kindergarten "St. Sturmius" implemented a fitness project in 2010/11, and the kindergarten of the "Lutherkirche" started a three-years family project with various topics in autumn 2011, assisted by social work students. The topic of healthy nutrition is integrated by students of the Department of Nutritional, Food and Consumer Sciences.

Furthermore, both kindergartens were involved in a first survey of educators concerning nutrition as part of the new Leonardo project NUTGECS – A nutrition guide for active early childhood stakeholder (www.nutgecs.eu) and where the integration of different cultures is valued highly.

Currently, the community forum plans a common network of voluntary visitor services of the Catholic and Protestant churches and the development of respective education programmes due to the demographic development in both districts. Two of the largest housing associations want to participate. They have commissioned restoration work at different houses in the district which supported the satisfaction with housing.

The establishment of a citizen office and the involvement of local companies have not been possible yet. In that case, some more development is needed although, to be sustainable, this should originate inside the stakeholders themselves. Concerning health promotion and company catering, we can be referred to an empirical survey in 2008 (Sabsabi 2008): 31 SME were interviewed regarding health promotion and catering in their companies. They had predominantly measures for job safety, scarcely for health promotion and prevention. Catering was offered very seldom. At this time, it was only paid little attention to this topic because of the economically poor situation (see also Kesting 2009).

References

Ackermann, T./Alisch, M. (2009): Alltagsbewältigung und -organisation von Menschen mit Migrationshintergrund. In: Alisch, M. (ed.): pp. 139-144.

Alinsky, S. (1972): Anleitung zum Mächtigsein. Ausgewählte Schriften (Deutsche Übersetzung von Reveille for Radicals). Göttingen: Lamuv Verlag.

Alisch, M./Dangschat, J.S. (1998): Armut und soziale Integration. Strategienb sozialer Stadtentwicklung und lokaler Nachhaltigkeit. Opladen: Leske+Budrich.

Alisch, M. (ed.) (2009): Lesen Sie die Packungsbeilage?! – Sozialraumorganisation und Gesundheitsinformation. Beiträge zur Sozialraumforschung, Band 3. Opladen / Farmington Hills: Barbara Budrich Verlag.

Alisch, M. (2010a): Instrumente und Methoden sozialraumbezogener Gesundheitsförderung. In: EREV – Schriftenreihe, Themenhelft „Gesundheit in der Kinder- und Jugendhilfe". Hannover.

Alisch, M. (2010b): Sozialraummodelle im arbeitsmarktpolitischen Kontext – Ein unvollständiger Überblick über die sozialwissenschaftlichen Diskussion(en) zum Sozialraumbegriff. In: Bundesamt für Bauwesen und Raumordnung (Hrsg.): Bildung, Arbeit und Sozialraumorientierung. Informationen zur Raumentwicklung, Heft 2/3.2010. S. 103-110.

Alisch, M./Dölker, F./Fröba, S. (2010): AMIQUS – Ältere Migrantinnen und Migranten im Quartier Initiierung und Stützung von Netzwerken der Selbstorganisation in Fulda, München und Wiesbaden. In: BAGSO Nachrichten – Das Magazin der Bundesarbeitsgemeinschaft der Senioren-Organisationen. Heft 1/2010. S. 9.

Bär, G. et.al. (2004): Der Stadtteil als Ort von Gesundheitsförderung – Erfahrungen und Befunde aus stadtteil-bezogenen Projekten, in: Rosenbrock, R./Bellwinkel, M/Schröer, A. (eds.): Primärprävention im Kontext sozialer Ungleichheit. Wissenschaftliche Gutachten zum BKK-Programm 'Mehr Gesundheit für alle'. Bremerhaven: Wirtschaftsverlag NW.

Boos-Krüger, A./Pallmeier, H. (2009): Gesundheitsförderung in der Sozialen Stadt. In: Alisch, M. (ed.): pp. 197-221.

Bundeszentrale für gesundheitliche Aufklärung (BZgA) (2007): Kriterien guter Praxis in der Gesundheitsförderung bei sozial Benachteiligten. Ansatz – Beispiele – weiterführende Informationen. http://www.bzga.de/.

Endres, S./Scarbata, J. (2009): Local Governance für eine gesundheitsfördernde stadtteilpolitik. In: Alisch, M. (ed.): pp. 155-176.

Freytag-Leyer, B. (2007): Empirical testing of household analyses to collect information on situations in life in "Cabbage-House" – district of Fulda – Germany. In: Academy of Agricultural and Forestry Sciences of Latvia, Latvia University of Agriculture Economic Science for Rural Development. Proceedings of the International Scientific Conference, pp. 219-224.

Freytag-Leyer, B./Hampshire, J. (2009): Der Stadtteil als CHANCE: Gesundheitsfördernde Information und Bildung vor der Haustür. In: Alisch, M. (ed.): pp. 79-99.

Gerber, U./von Stünzner, W. (1999): Entstehung, Entwicklung und Aufgaben der Gesundheitswissenschaften, in: Hurrelmann, K. (ed.): Gesundheitswissenschaften. Berlin, Heidelberg, New York: Springer. pp 9-64.

Hanesch, W. (1997): Überlebt die Soziale Stadt? Konzeption, Krise und Perspektive kommunaler Sozialstaatlichkeit. Opladen.

Heindl, I. (2007): Ernährung, Gesundheit und soziale Ungleichheit. In: Aus Politik und Zeitgeschichte. Heft 42/207. pp 32-38.

Hinte, W./Karas, F. (2002): Aktionsforschung in der Gemeinwesenarbeit. Url: www.stadtteilarbeit.de. Abruf: 3.3.08.

Hubertus, W. (2009): „Wenn alle gesund sind in der Familie, fühl ich mich auch wohl." Gesundes Leben und Raumaneignung von Familien im Stadtteil. In: Alisch, M. (ed.): pp. 101-118.

Kardoff, E.v. (1989): Zwischen Netzwerk und Lebenswelt - Soziale Unterstützung im Wandel. Wissenschaftliche Analysen und praktische Strategien. München.

Kesting, U. (2009): Corporate Citizenship: Unternehmen als Partner (in) der Stadtteilentwicklung. In: Alisch, M. (ed.). pp. 177-196.

Keupp, H. 1987: Soziale Netzwerke. Eine Metapher des gesellschaftlichen Umbruchs? In: Keupp, H. / Röhrle, B. (Hrsg): Soziale Netzwerke. Frankfurt /Main, New York. Campus.

Lemme, R. (2009): Älter werden im Quartier: Raumaneignung als Gesundheitsressource. In: Alisch, M. (ed.): pp. 119-138.

Metz, M. (2006): Quartiermanagement als Public Health-Intervention — das Konzept einer stadtteilbezogenen, gesundheitsförderlichen Maßnahme für Kinder und Jugendliche zur Bewegungsförderung in Alltag und Freizeit. Mastertheses. Hochschule Fulda (unpublished).

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

Richers, H. / Habermann T. (2005): Aktivierende Befragung. Url: www.stadtteil arbeit.de/ methodenkonzepte. Abruf: 3.8.11.

Sabsabi, K. (2008): Betriebliche Gesundheitsförderung und Betriebsverpflegung verbunden mit einer empirischen Untersuchung im Industriegebiet Fulda – Kohlhaus und – Südend.

Schubert, H. (2005): Das Management von Akteursnetzwerken im Sozialraum. In: Bauer, P./Otto, U. (Hrsg.): Mit Netzwerken professionell zusammenarbeiten. Band II: Institutionelle Netzwerke in Steuerungs- und Kooperationsperspektive. Tübingen: DVGT- Verlag. S. 73-103.

Schubert, H./Fürst, D./Rudolph, A./Spieckermann, H. (2001): Regionale Akteursnetze. Analysen zur Bedeutung der Vernetzung am Beispiel der Region Hannover. Opladen. Leske+Budrich.

Trojan, A./Stumm, B./Süß, W. (2001): Gesundheitsförderung als Gesamtpolitik: Leitbild und Programmatik nachhaltiger Gesundheit und Entwicklung. In: Alisch, M. (ed..): Sozial, Gesund, Nachhaltig. Vom Leitbild zu verträglichen Entscheidungen in der Stadt des 21. Jahrhunderts. Leske + Budrich: Opladen. pp. 47-70.

Ziegler, R. (1984): Norm, Selektion und Rolle. Eine strukturale Rekonstruktion soziologischer Begriffe. Kölner Zeitschrift für Soziologie und Sozialpsychologie. 3. S. 433-463.

IV Conclusions: Community Health Management to Enhance Behaviour

Results and comparison of the quantitative data

Barbara Freytag-Leyer and Christoph Klotter

1. Introduction

The quantitative survey was implemented in the first phase of the Chance project alongside a qualitative survey. The quantitative element was not intended to measure changes, but to analyse the status quo of the citizens' self-assessment of their health information sources, their self-assessed health status and health behaviour, their subjectively experienced neighbourhood relationship, and the resources in the households and within the community. The generated data was also intended to be compared to other data sources.

Initially, it was planned to use a short questionnaire, but during a participative process including all international project partners a comprehensive questionnaire written in English was developed and pretested, comprising open and closed questions, some with the option of multiple answers, and prioritising the topics:

- health and attitudes to life;
- living in the community;
- forms of household and household management;
- nutrition and hygiene behaviour as well as knowledge; and
- socio-demography.

The questionnaire was translated into the various languages of the collaborating partners (German, Latvian, Romanian, Swedish). The main questions were the same in each country-specific questionnaire, but some questions deviated, especially in the English version.

The overall evaluation comprised 1,271 completed questionnaires. The actual participation was higher than that but several questionnaires could not be included due to formal errors.

The distribution to each country in absolute values is as follows:

Austria 254,
Germany 184,
Latvia 255,
Romania 200,
Sweden 212,
United Kingdom 166 interviews.

The statistical analysis was carried out by means of SPSS software (SPSS Inc., Chicago, IL) versions 15.0 and 19.0. The British data could not be considered completely because its ethics committee necessitated changes in the wording of some questions.

Some further target group-specific evaluations in single countries or comparisons of single questions among all countries are indicated in the references (also see www.community-health.eu).

2. What Did the Socio-Demographic Data Tell Us?

More women than men took part in the survey in all participating countries. In Romania, the proportion was lowest with 56.3%, and in the United Kingdom highest with 69.5% (see table 1). Similar to many other surveys, it was demonstrated here that women were more interested in health and had a greater willingness to participate. In Romania, as a younger EU-country, surveys were less common, especially in areas outside the city.

Table 1: Proportion of men / women in % participating in each country, n=1,271

	Austria	Germany	Latvia	Romania	Sweden	United Kingdom
Men	36.6	35.5	33.5	43.7	35.1	30.5
Women	63.4	64.5	66.5	56.3	64.9	69.5

According to the communities' structures and the different ways of study implementation, there was a very heterogeneous age distribution of respondents comparing all countries. In Austria, the 20 to 60 years old age group dominated with 82.2 %, while older people >60 years were represented by 10.3 %, and those younger than 20 years by 7.5 %. Even in Latvia, the proportion of people being 20 to 60 years old was highest with 70.3 %, but also the oldest age group aged >60 years had a share of 17.2 % in contrast to 12.5 % of the younger than 20 years group. This percentage value was also represented by the under-20-years olds in Germany, but here, the oldest age group participated with a share of 26.1 % and the middle age group (20 to 60 years old) of 61.4 % (see table 2).

In the United Kingdom (UK) and in Romania (RO), the greatest groups were the 20 to 60 years olds with 59.1 % (UK) and 52.5 % (RO), but even the older people above 60 years old were highly represented in Romania (45.0 %) and the UK (39.1 %), with the highest value in Sweden (52.8 %).

Table 2: Age distribution of participants to three age groups (under 20 years, 20 to 60 years, and above 60 years old) in % (and in absolute values), n=1,271

	Under 20 years	20 to 60 years	Above 60 years
Austria	7.5 (19)	82.2 (209)	10.3 (26)
Germany	12.5 (23)	61.4 (113)	26.1 (48)
Latvia	12.5 (32)	70.3 (179)	17.2 (44)
Romania	2.5 (5)	52.5 (105)	45.0 (90)
Sweden	0.0 (0)	47.1 (100)	52.8 (112)
United Kingdom	1.8 (3)	59.1 (98)	39.1 (65)

One study's aim was to address disadvantaged groups such as the elderly, families, and citizens with a migration background. The United Kingdom especially reached this aim by addressing so-called Carers, while Romania and Sweden predominantly reached the elderly. Citizens with a migration background were dominant in Austria and Germany (see table 5). Besides, the qualitative interviews of the Chance project included these disadvantaged groups similarly in each country.

The participating countries showed great differences concerning the school-leaving qualifications. Romania had a strikingly high amount of 50.5% of participants who left school without qualification just like the United Kingdom with an amount of 32.5%. The dominating qualifications were in Germany the certificate of secondary school (41.1%), in Austria and Latvia the certificate of secondary modern school, and in Sweden the high school graduation (54.5%) (see table 3).

Table 3: School-leaving qualification values (none, certificate of secondary school or secondary modern school, high school graduation) of participants in each country in %, n=1,166

	none	certificate of secondary school	certificate of secondary modern school	high school graduation
Austria	4.9	19.3	50.2	25.5
Germany	4.3	41.1	28.1	26.5
Latvia	4.0	14.3	52.4	29.4
Romania	50.5	27.3	22.2	0.0
Sweden	0.0	27.0	18.5	54.5
UK	32.5	32.5	14.3	20.8

3. Types of Household and Household Management

The sizes of households differed in the participating countries and communities. One-person-households were mostly represented in Sweden with 48.6% where also two-person-households were dominant with altogether 79.7%, followed by the United Kingdom with 58.3% and Austria with 52.2%. All other countries showed amounts under 50.0%. Households with 5 and more members were especially represented in Romania (21.1%), Germany (14.6%), Austria (11.1%), and Latvia (10.6%) (see table 4).

Table 4: Number of household members (from 1 up to 6 and more persons per household) in each country in %, n=1,265

	1	2	3	4	5	6 and more
Austria	23.7	28.5	15.4	21.3	7.1	4.0
Germany	19.5	26.5	20.0	19.5	9.7	4.9
Latvia	16.2	26.9	24.9	21.3	5.9	4.7
Romania	9.0	30.7	23.6	15.6	14.6	6.5
Sweden	48.6	31.1	11.8	6.1	2.4	0.0
United Kingdom	23.9	34.4	20.2	15.3	4.3	1.8

On the average of all countries, about 24.0% lived alone, 24.7% with a partner, and 38.5% had children in their household of which 10.3% were single parents and 28.2% parents.

Several questions referred to a migration background, e.g. whether mother or father were born in the respective country, whether the respective first language was also the native language, how good their language skills were, and whether the participating person was born in the country of the Chance project. On this latter point, especially Austria showed a high value (28.9 %) as well as Germany (23.5 %) (see table 5).

Table 5: Migration background represented by the answer (no, yes) "I live in [the country] since my birth." (in % for each country, n=1,250)

	Austria	Germany	Latvia	Romania	Sweden	United Kingdom
no	28.9	23.5	14.9	1.0	14.2	8.2
yes	71.1	76.5	85.1	99.0	85.8	91.8

Support in the household keeping was necessary for half of respondents. Multiple answers were possible (n=804), and results showed that support was most needed in cleaning (60.4%), followed by shopping (37.8%), cooking (31.3%), administration (27.4%), child care (20.4%), and care (15.9%).

Common sense existed in all forms of households, regardless of whether households with one or more persons answered the question. The family was very important or important, almost everybody (98.0%) agreed with that statement. The same was stated only by six of ten (59.3%) for the carer.

4. Living in the Community

There were clear differences visible between the living conditions in the various local communities. In the city of Vienna, living in rented homes dominated with 86.8 % (only 9.2% property ownership), while Germany (42.4%), Sweden (44.5%), and the United Kingdom (46.3%) showed similar percentages of property ownership. Sub-tenancy relationships were remarkably present in Germany with ten percent - with relatively many students in the area -, in the United Kingdom with 6.1% and in Latvia with 5.2%. Property ownership was especially prominent in Romania with 91.4%, and with 71.3% in Latvia (see table 6). Here, it became visible that homes had been sold to private persons in the post-communist era by the state.

Table 6: Living conditions (property ownership, rented homes, or sub-tenancy) in each country in %, n=1,257

	Property ownership	Rented homes	Sub-tenancy
Austria, Vienna, sartorial quarter	9.2	86.8	4.0
Germany, Fulda, Southend / Kohlhaus	42.4	46.7	10.9
Latvia, Jelgava, RAF	71.3	23.5	5.2
Romania, Timisoara, Dumbravita	91.4	6.6	2.0
Sweden, Uppsala, Eriksberg	44.5	55.5	0.0
United Kingdom, Liverpool, South Central	46.3	47.6	6.1

Apartments and houses are small in Latvia: Half of the respondents live in as small flat with less than 60 sqm, one third lives in 61 up to 80 sqm) (independent of theownership status), while in Romania, 57.3% had more than 100sqm and one quarter between 81-100 sqm (see table 7).

Table 7: Sizes of houses/flats in each country in %, n=1,212

	Up to 60 sqm	61-80 sqm	81-100 sqm	More than 100 sqm
Austria, Vienna, sartorial quarter	52.5	33.3	11.8	2.0
Germany, Fulda, southend and Kohlhaus	15.7	22.7	20.0	41.6
Latvia ,Jelgava, RAF	51.8	34.9	7.5	3.5
Romania, Timisoara, Dumbravita	3.0	16.1	23.6	57.3
Sweden,, Uppsala, Eriksberg	48.1	24.5	13.2	13.2
United Kingdom, Liverpool, South Central[1]	Bed-site 1.2	One bed 7.2	Two beds 27.1	Three or more beds 64.5

In Romania, these larger living areas are occupied by households with a larger number of people. Smaller houses are dominant in Timisoara.

On the average of all countries, 87.7% felt comfortable at home, 81.3% liked their home, 79.7% felt safe, 74.6% experienced their home as restful, 77.5% knew anybody in their neighbourhood (but only 38.0 % experienced it as the 'best neighbourhood'), 66.2 % did not feel restricted in their home, 60.8 % felt safe in their neighbourhood, only 51.3 % evaluate their surrounding as healthy, only 49.0 % did not feel affected by traffic noise, only 42.8 % believed that they had clean air in their area. These data may be interpreted in this way: "My home is my castle". At home, everything was largely good and 85 % felt good at home, but 13.2 % felt insecure in their community, the neighbourhoods were valued suboptimal, or predominantly, the surrounding was experienced as health-threatening. But, even 58.5 % did not want to live in another district, 21.3 % wanted a change. So it fits that only 40.9 % of the participants attended events in the community. The connectedness with the community or identification with it would probably lead to an increase in attendances of local events (only 17.9 % are local clubmembers)..

1 In the United Kingdom, the implemented questionnaire showed a little variation, so the data varies accordingly in this table.

The question which facilities and areas were most important for the citizens in their community was answered by 82.9 % with public green, 72.8 % stated grocery (58.7 % shopping mall), 65.8 % a health service, 62.5 % school, 59.9 % nursery school, 49.3 % a welfare service, 44.0 % a sports hall / sports field, 43.5 % church, 39.9 % sports club, 34.7 % social clubs, and 30.9 % education service. As public green was most important for 82.9 %, then this could have been a hint that these areas are missing. Finally, almost half of the respondents complained about an unhealthy environment. It was also noticeable, that a church seemed to be more important than a sports hall, a result, which might have been impossible a century ago. But, the church in Romania was with 81.4 % and in Germany with 55.6 % very important which is obviously above the average of 43.5 %. This fact even confirmed the vital role of church that it played in both communities. And, this fact was also represented in the qualitative interviews.

An open question concerning aspects which could enhance health in the community brought forth almost 800 suggestions that differed enormously depending on the community and the life situation. For example, less traffic and noise as well as more public green were in focus in the two districts in Fulda / Germany due to their confined situation.

5. Health and Attitudes to Life

The results showed altogether an optimistic attitude to health – currently and for the future – even if there were some country-specific deviations.

For 62.4 % of respondents, health is 'very important' and for 33.1 % 'important'. The subjective evaluation of own health was answered unlike the question of relevance: on average, 17.1 % experienced their health as 'very good', 50.9 % as 'good', only 7.7 % as 'bad'. The Swedish had with 27.8 % a good position concerning their health evaluation, just like the Austrians with 22.1 %, while the Latvians (10.3 %) and the Germans (11.5 %) were positioned far below the average. Concerning the evaluation of health as 'bad', the British were in front with 13.7 % together with the Latvians with 11.1 % which was above the average rate of 7.7 %.

It was optimistically believed by 26.5 % that their health status would improve in the next three years, 59.7 % expected a stable health status, and 13.7 % a worsening. Even here, country-related specifics were noticeable. A decrease in health was expected most by British participants, and with a little lower percentage by the Latvians and Romanians, while the Austrian were most optimistic alike the German respondents with a little distance.

"It is easy to implement health information in my daily life". For 53.5 % of respondents, this statement was 'very true' or 'true', only 20.0 % judged it as 'less true' or 'not at all true'. Facing, for example, the well-known fact that weight loss and its maintenance are very difficult (Klotter 2007), the respondents seemed to be overall very optimistic or present themselves in a positive light.

Answering the statement: "If I am in trouble I can usually think of a solution." created a similar picture. The statement was confirmed by 60.5 %, only 3.0 % negated it. From a salutogenetic perspective, the majority seemed to have a high sense of coherence (Antonowsky 1988 and 1997).

Where did the respondents get their health information from? Doctors were the most common (multiple answers possible) information source (without Latvia), and 61.8 % referred to them. They are followed by television (46.0 %), newspapers (38.0 %), the family (35.6 %), and friends (29.9 %). The internet and the chemist's shop were at the same level with 26.5 % each. The food industry reached at least 9.9 %, while institutions / organisations with 4.8 %, and the state / government with 2.8 % were far behind. Thus, it was shown that state efforts for health information or those from NGO's did not reach their addressees.

But, there were some country-specific differences. The doctors were named in Germany (79.6 %) and in Austria (70.5 %) most common, while the food industry was stated most common in the United Kingdom with 20.6 %, followed by the local authority (12.1 %), institutions / organisations (10.9 %), and the state / government with at least 7.9 %. The highest values got the television with 56.4 % in the United Kingdom, while the physician was only named by 45.5 %. In Sweden, newspapers played the most important role (52.0 %), followed by doctors (43.6 %), while in Romania, doctors (66.5 %) were prior to television

(63.0 %). In Latvia, the data analysis only determined the most important source. Here, television was most important with 26.3 % and followed by friends, newspapers, the family, and the internet with 13.3 % each. Here, doctors came on a posterior place with 12.2 %. The reason for this was that people had to pay for each visit to the doctor except for children less than 18 years old and disabled people. So, many people went to see a doctor only at the very last moment[2].

Even to the question "If I have a problem regarding my health, nutrition or physical activity", it was referred to the doctor (with multiple answers) as the most important advisor in 83.5 % cases, followed by the family (47.9 %), friends (33.7 %), and the internet (29.3 %). In all countries, this same order was visible, except for Austria and Romania where the internet was in front of friends.

"I understand my doctor's advice", this is a statement confirmed by 79.7 %, and only 19.3 % said that it was sometimes valid[3]. For 40.8 %, it was possible to always receive information in the community, for 43.3 % sometimes, and for 15.9 % never. Thereby, especially the low values in Germany (27.0 % always, 34.9 % sometimes, 38.2 % never) mirrored the poor medical service supply in the participating districts. In contrast, Sweden had an almost optimal health care supply in the community (3.8 % never). Whether information on health was confusing, was denied by 45.4 %, for 48.0 % it was sometimes true, and 6.6 % totally agreed.

The subjective perspective regarding the relevance of the people's own health did not lead to that all those who evaluated their health as important acted accordingly and cared for their health[4]. None or only a few did sports 29.3 %. At least, 45.8 % stated that they would do more than three hours sports per week, of which 26.4 % did more than 5 hours sports per week. Outdoor sport was the favourite with 41.3 %, a fitness studio with 13.0 %, and the sports club with 6.7 %.

2 For further comparisons see Eglite et al. 2009; Freytag-Leyer/Hampshire (2009); Freytag-Leyer et al. 2009; 2010).

3 In this part the results refer only to Austria, Germany and Sweden.

4 From here on, we refer to the results of all six country surveys.

A daily television consumption of 1 to 4 hours was reported by 66.4 % of the respondents. The statement "Living healthy is boring." was agreed to or totally agreed to by 17.3 %, while 63.0 % disagreed it, or confirmed it less.

6. Knowledge Concerning Nutrition and Hygiene

Several questions referred to the frequency of single food consumption (several times daily or almost daily, several times per week or about once a week, several times per month, seldom / never). The questionnaire also included questions concerning shopping, cooking, and hygiene behaviour, as well as the familiarity with the "5-a-day" campaign which was chosen because it had been implemented European- and worldwide.

The statement "When I buy food I take a look on the list of ingredients and nutrition information." was answered by 41.5 % with 'always' and 'often'. Only 13,4 % stated that they would never do that. It could be assumed that a social desirability influenced these responses. This could possibly be similarly valid for the context of food consumption where 15.3 % stated that they consumed 'several times daily' or 'almost daily' organic products, 23.2 % mineral and vitamin supplements, only 15.4 % soft drinks, and 54.0 % tea. Most popular was coffee consumption: 63.8 % drank it 'several times daily' or 'almost daily'. It fitted together that only 4.5 % drank wine and sparkling wine 'several times daily' or 'almost daily', but 55.9 % 'seldom / never'. Only 7.3 % consumed beer 'several times daily' or 'almost daily'.

Water and mineral water were consumed by 80.2 % 'several times daily' or 'almost daily', whereby Romania (96.0 %), Sweden (92.9 %), Germany (90.0 %), and Austria (85.3 %) were over the average, while Latvia (77.4 %) and the United Kingdom (26.3 %) were below it.

The meaning of the campaign "5-a-day"was known by 35.2 % of respondents, 23.0 % gave a wrong answer, and 41.5 % made explicit that they did not know. So, almost two thirds of respondents did not know the meaning of the "5-a-day" campaign, which was an amazingly high quota of unknowingness facing an issue so intensely present in the media.

The knowledge about the campaign "5-a-day"was best in the United Kingdom (32.5 %), followed by Austria (21.2 %). The Latvian (7.2 %) and Romanian participants (7.9 %) knew the right answer most seldom. It was also surprising that the Swedish (16.3 %) and German (14.9 %) participants were relatively uninformed. In the United Kingdom, the"5-a-day" campaign was very present, for example in supermarkets, products are labelled accordingly. This was a very good example how to arrange a campaign effectively concerning publicity and sustainability which was urgently necessary, because the average consumption of fruit and vegetables in the United Kingdom was under the average of other countries, as shown in the following.

On the average of all participating countries, 66.1 % ate vegetables and 67.8 % ate fresh fruit 'several times daily' or 'almost daily'. It was noticeable that Austria had a lower value at vegetable consumption with 54.9 %, as well as Germany (56.6 %) and the United Kingdom (59.7 %), while Romania and Sweden were far above with 82.9 % each. Regarding fresh fruit consumption, the according average was at 67.8 %, whereby Sweden (83.4 %) and Romania (79.0 %) were again above it; the United Kingdom (56.2 %) and Latvia (57.4 %) were far below.

Strikingly, another question concerning the average consumption of fruit and vegetables was answered by 77.4 % in the average of all participating countries with 'almost daily' added with the explanation to stay healthy, only 5.5 % denied it, 17.4 % stated 'neither nor'. This fact exceptionally mirrored a social desirability.

The daily consumption of ready prepared meals was almost in all countries except Latvia below 8 %. In this case, only Romania stepped out of the line with a consumption of these products 'several times weekly' by 30.2 %, compared to the average of 16.9 % of all countries (in Latvia the question was misunderstand as ready prepared meals at home).

In the field of knowledge on hygiene, the questionnaire asked for how long raw minced meat could be stored in the fridge. The answer '0 days' was given by 19.9 %, '1 day' by 36.6 %, '2 days' by 19.2 %, '3 days' by 7.0 %, '4 days' by 2.3 %, '5 days' by 3.0 %, and 11.9 % stated that they would not know. The answers' desirability again became apparent at the reactions to the statement "To be healthy I keep the fridge at right temperature." This statement was confirmed by 75.6 %, it was denied by

7.2 %, and 17.2 % were undecided. "Don't let raw meat touch other foods" was confirmed by 76.2 %, 7.2 % disagreed, and 16.6 % were undecided

7. Summary and Conclusion

The results present country- and city-specific commonalities and differences. Interpreting these presented results requires considering the country- and city-specific background such as the rural or urban character of some participating communities or the socio-demography of participants.
The position of the WHO is that social factors like education determine health status and health behaviour. This position could be confirmed by the Chance data. Swedish people with the highest education level feel good and secure in their home, people from Latvia feel worse and less secure. Swedish people eat a lot fruit and vegetables. Sweden thinks that it has a good health status, Latvia less. In Latvia, people do not think that they are able to realise health information in daily life. Similarly, they do not expect to find solutions for their problems. Thus, it becomes obvious that social factors determine health status and health behaviour.

Furthermore, it is considered that the family generally was a special resource. It was evaluated as important by 98.0 % of respondents independently of their current life situation. Participants were mostly satisfied with their housing, but concerning the environment in the communities there were some wishes to change or improve it regarding health aspects.

People generally had optimistic attitudes to their health. Doctors played an important role as an information source for health (except in Latvia). Mass media such as television and newspapers were next. Family and friends were positioned previous to the internet. Doctors stood at first in health problems, but followed by family and friends. Own opportunities to maintain health especially regarding physical activity and recreation were used too little. In this case, some community-related offers could cause positive modifications. The nutrition and hygiene behaviour pictured some partly unhealthy habits, but included country-specific differences. But, there was a backlog demand in these basic hygiene-related

behaviour rules. Here, the five rules of the WHO should be implemented more intensive (WHO 2001).

Concerning alcohol consumption, amazingly 58.5 % stated that they consumed beer 'seldom / never'. So, it is not surprising that only 2.2 % consumed spirits 'several times daily' or 'almost daily'. But, facing an average quota of alcoholics of 5 % (5 % of men, 1 % of women in Europe (see Anderson and Baumberg 2006: 5)), it is astonishing that the participants in the Chance project seemed to drink so little alcohol.

Intending an improvement of the nutrition and hygiene behaviour on the European level, the targeted usage of media such as television, newspapers, and the internet with short und easy to understand messages such as "5-a-day" and "Five keys for safer food" make sense. It would also be a contribution to a unification of health messages on the European level.

The country- and city-specific commonalities and differences could well be integrated in local practice-oriented actions. Such actions should be oriented to the needs of the respective target groups and be developed by integrating their participation. In this way, disadvantaged groups could be better reached. Thereby, a sustainable and community-related form of lifelong learning should be emphasised. For example, a DVD with the topic of hygiene in the kitchen was developed in the United Kingdom which especially addressed Carers. Or in Austria, special courses for people with a migration background were offered in mosques. Elaborate surveys such as in the Chance project can not always be implemented. The guidelines for a Community Health Management, which were developed due to our multifaceted experiences, are an aid. They should be used for community-related project work with and for the different actors.

References

Anderson, P./Baumberg, B. (2006): Alkohol in Europa. Eine Public Health Studie. Institute for Alcohol Studies UK. http://ec.europa.eu/health-eu/doc/alcoholineu_sum_de_en.pdf.

Antonowsky, A. (1988): Unraveling the mystery of health: how people manage stress and stay well. Jossey-Bass. San Francisco.

Antonowsky, A. (1997): Salutogenese: zur Entmystifizierung der Gesundheit. Dgvt-Verlag. Tübingen.

Eglīte, E./Vintila, M./Grīnfelde, M./Kantiķe, I. (2009): Healthy lifestyle in the elderly's view in Romania and Latvia. In: Economic Science for Rural Development, No 19, p. 97-102.

Freytag-Leyer, B./Hampshire, J. (2009): Der Stadtteil als CHANCE: Gesundheitsfördernde Information und Bildung vor der Haustür. In: Alisch, M. (ed.): Lesen Sie die Packungsbeilage …?! Sozialraumorganisation und Gesundheitsinformation. Opladen/Farmington Hills: Barbara Budrich Verlag. pp. 79-99.

Freytag-Leyer, B./Zimmerer, S./Klotter, C./Hampshire, J./Straka, D. (2009): Perception of health information in the community Fulda-Südend and Kohlhaus. In: Economic Science for Rural Development, pp. 91-96.

Freytag-Leyer, B./Schlecht, I./Hampshire/J./Hackett, A./Lybert, P./ Meadows, M./Richards, J./Stevenson, L. (2010): Access to Food and Health Information among Elderly People Living in Germany and the United Kingdom. In: Economic Science for Rural Development Nr. 23, pp. 135-141.

Klotter, C. (2007): Einführung in die Ernährungspsychologie. München: Ernst Reinhardt Verlag.

WHO World Health Organization) (2001): Five keys for safer food. Poster. WHO World Health Organization/ Geneva. http://www.who.int/ foodsafety /publications /consumer /5keys (5.8.2011

How to initiate a community based health information system

Monika Alisch and Barbara Freytag-Leyer

1. Introduction: Guidelines for tailored health information strategies

The most difficult task in a transnational and especially in an interdisciplinary project such as "Chance" is the search for a common denominator. Such a common denominator should facilitate health promoting behaviour on the community level anywhere, independent of any circumstances such as Europe-wide differences in health care systems and the different strategies of health information. The common basis should also be independent of differences in the respective cultures of cooperation between institutions, from traditions of decision-making including participation of citizens, as well as from the respective spatial circumstances of any district. At the same time we need "tailored" strategies and projects that deal with the specific circumstances we find in a community.

Certainly, one could simply give up at this point and transfer the responsibility for adequate health promotion to the individual European countries and their local authorities. But, we assumed that the different prerequisites would be especially helpful to uncover parallels in health promoting behaviour which are largely independent of these briefly explained national and cultural differences. In particular with regard to an integrated view of health, we can build on the basic comparability of a person's health and their individual behaviour patterns even at a transnational level.

The case studies revealed differences which promote intercultural learning processes, especially in the fields of participation, cooperation and concrete action in projects.

On these premises, the project "Chance" has developed an international guideline, which helps institutions aiming at health promotion to easily establish community and social space related supportive structures to improve health behaviour. While there has been a network "gesundheitliche-Chancengleichheit" in Germany since 2003, which has meanwhile published a six part folder "Get active for health - Aid for prevention and health promotion in a community" (in original: „Aktiv werden für Gesundheit – Arbeitshilfen für Prävention und Gesundheitsförderung im Quartier") (see www.gesundheitliche-chancen gleichheit.de /gesundheitsförderung.de), a Europe-wide guideline for the generation of a community based health promotion project is missing[1].

In the following, these guidelines are subdivided into four main fields: the first three guidelines refer to the relevance of social space and community. This is because in the health science professions, these categories have so far only been received as relevant for health promotion with reference to the setting approach. The second main field directly refers to the target of community based health information. This field focuses on questions concerning participation, as well as on being enabled and empowered. All guidelines in this field are adjusted not only to define single especially endangered social groups as target groups, but also possibly to fully understand the diversity among the inhabitants of a local community and to adequately reach them. Then, the perspective changes to networking and resources, whereby resources and the requirements for interaction between institutions are the focus. Finally, guidelines are presented which refer to the nature of projects. Special requirements will be defined for the implementation of health information projects , which refer to their visibility in the community, the tangibility of information beyond the written word, and their sustainability.

In the sense of a conclusion, that usually closes such studies, the single guidelines include according methods to allow the consideration of a

1 Funded by the Federal Ministry of Health (in original: Bundesministerium für Gesundheit) and the Federal Centre for Health Education (in original: Bundesministerium für Gesundheit und der Bundeszentrale für gesundheitliche Aufklärung (BZgA), this folder presents numerous examples, ideas, and concepts, which promote health in communities. The tools are a contribution to "IN FORM – Germany's initiative for healthy nutrition and more sports" (in original: „IN FORM - Deutschlands Initiative für gesunde Ernährung und mehr Bewegung"). It aims to establish partnerships and to strengthen the engagement for healthy living (ibid.).

guideline's recommendation. They also contain some project examples from the six enrolled local communities.

2. The meaning of space and community

The setting approach is the supreme discipline among a wide variety of health promotion interventions. Settings can be defined as "a place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and well-being" (Nutbeam, according to Paton et al. 2005).

Hence, the setting approach aims to target concrete people in concrete circumstances, in which they think, talk and act, e. g. in their living environment, in the community, at the workplace, in day care institutions, in education, senior and recreation centres such as clubs. The setting approach in health promotion is oriented to the living environment. It is questionable whether in such settings people only interact to induce health and well-being, stated by Nutbeam (2004).

The setting approach is the core strategy in health promotion and clarifies the participation of the targeted population. Social and material living circumstances are regarded as interrelating requirements, which always affect formulating aspects associated with health. At the same time, they are configurable and can alter the association with health (Bauer / Bittlingmeyer 2006: 807) The operational level of the living environment, the neighbourhood or community, is crucial in health promotion, including strategies of health information to identify, understand and use the interrelating requirements. It is essential to support available structures and/or to promote the establishment, which enables the integration of the population needs and their problems throughout all phases of the concrete development of the project. In addition, all relevant actors who are engaged in their respective fields need support to empower them to import their resources and create the potential to link them comprehensively to departments and target groups (see Alisch 2009: 21). This includes not only health promoting activities narrowed to exercise or good nutrition, but also the improvement of neighbourhood bonding, the establishment or support of clubs and social structures in general.

a) Health information has to be specified according to the situation/condition, structures and resources of a local community

A local community often does not define itself in the same way that the administration delimits urban districts. The spatial lived-in world (sociological category *Lebenswelt*) is often more small-scaled according to the possibilities of mobility as well as the material resources of households. The spatial delimitation and definition of such a local community as the center of interventions may follow categories such as:

- spatial boundaries and barriers;
- spatial hierarchies, functional land use;
- detailed housing structure, traffic lines and
- symbols of identification and special marks.

The local community level with its social networks, voluntary services, and educational institutions, and its socio-cultural and socio-economic characteristics is an appropriate resource for health behavior. The neighborhood and community as the spatial centre of everyday life make the needs of individuals more visible and neighborhood support is generally more present. Less mobile households can be reached with beneficial health information and educational offers, because they are particularly dependent on the circumstances and resources of the district (compare Kronauer/Vogel 2001: 45). With this physical boundary the social-spatial general conditions are reconstructed to give structure every day to the realms of experience (Riege / Schubert 2005: 255).

The planning of interventions should begin with the careful analysis of the selected local community. The potential and resources of an urban area cannot only be described with statistical data – even if these are present on a small scale at all. The infrastructural stock of the local urban neighborhood must also be known. This includes: the social, cultural and commercial facilities and services with their offers for different target groups; informal connection nets; clubs; employment and training centers.

The delimitation should consider the lived-in world perspective of the inhabitants. To define the local community, both "outsiders" and "insiders" views should be taken. So that the delimitation could be expert based (outsiders) or empirically determined by interviews with local institutions and inhabitants (insiders), if enough time can be arranged

and financial resources are available a survey could perhaps be organized (e. g. a "snap poll" in the social institutions). In order to mark out the spatial frame for appropriate health information the subjective district pictures of its inhabitants (The "Image" of the urban area, Lynch 2000) are collected in any case.

The structural stocktaking shows the potential and resources within the social space dimensions of an urban area and can be submitted to a strength/ weakness analysis. This is required in order to quickly find suitable partners and cooperation for interventions and also to initiate health promotion projects with low additional resource costs.

For example: the German urban district, called "Südend" is not just a statistical district defined by the administration but an area of four or five mature neighborhoods with their own history, social-networks and recreation patterns. The delimitation follows in the first instance the natural and built boundaries (railway track in the East, road in the West). The smaller local neighborhoods are defined by the mobility of the inhabitants and the ownership of the buildings (housing associations). Another example is the "Schneiderviertel" in Vienna: With the sartorial quarter in Simmering, the 11th Viennese municipal district, it is a 19th century quarter (the so called period of foundation) with 4 to 6-storey buildings as well as three community buildings. It is mostly a residential area with little infrastructure. In the area of the community buildings there are semi-public and few busy parks and other green places. In the south of the quarter lies the only publicly accessible green space (Hyblerpark) with recovery and sports zones. In Jelgava, Latvia the chosen local community "RAF" (Riga Automobile Factory) is an enclosed living area, which was originally built in the 1970s with multilevel constructions for employees of the automobile factory in Riga. The community consists of a well established infrastructure with regard to schools, kindergarten and shopping facilities and is bordered by a forest, but these resources have to be mobilized for a health strategy.

b) *Project development in social space: Local interventions should be developed with all available structural, financial, personal, and civic resources of the local community.*

A scientific consensus about the social relevance of space is that it is more than a "Container" (Lefebvre 1991; Löw 2001). Moreover space

means the constitutions of objects, people, rules, and symbols, etc. in between this space and therefore space is the result ('product' Lefebvre 1991) of the interrelationship of all these dimensions. Constitution in this context means social order as well as spatial constitutions and the perception of space (which is different for every individual as well as for every social group). Social space, which community health management emanates from, describes the arrangement and relationship of individuals on the one hand and social good at places on the other hand.

Community Health Management aims to influence the lived-in world especially the health behavior of the inhabitants, to start educational projects which are oriented to needs and to promote and assist healthy spatial structures. The neighborhood as a built environment affects health in a different way. Based on the integrated health definition of the WHO, the living environment sets the standards for social, physical and psychological health. Here the barriers and obstacles to a healthy life need to be recognized which appear to include e.g. the location near a very busy street or industry, accessible or missing green areas, missing areas for informal meetings and a lack of medical care.

For developing community projects of health education and health information the structural, ecological, economic and social circumstances are resources. Ground floor residences may be available as structural resources as in communal rooms and/or unexploited and seldom used open spaces between residential buildings. Other spatial resources can be mobilized on the basis of the coordinated cooperation of local stakeholders: They could synchronize the occupancy of rooms and other facilities.

Methodologically the social, ecologic, economic and urban structure has to be described. This analysis needs an instrument which has to be sensitive according to the different cultural backgrounds and able to consider the specific circumstances of the local community in question. The methods to analyze these structures in this way follow ethnographic standards: for example systematic observations (on movements or daytime activities of specific target groups in the local field site and public space; routes, roads or path connections). Spontaneous interviews at several locations were also used; interviews with local experts; network analysis (see the chapter of Monika Alisch and Barbara Freytag-Leyer about the German case study in this book).

A network-analysis can be used to receive information about local stakeholders, organizations, and well known local authorities and their relationships. The analysis can figure out resources for activity. The leading questions are:

- Which resources in community-daily-life are available ('social capital' see Putnam 2000)?
- Which are the local social places used by the various social groups? (accessability)
- How is public space used by the inhabitants (and others)?
- Can we identify special places, which a) cause conflict between social groups, b) are commonly known and/or c) make people feel insecure?

These methods have to be arranged in a way that reach people as a part of an increasing process in "their" neighborhood. In the tradition of action research (Lewin 1975) these methods should help to understand social life in this special community. All these methods are normally used in social space analysis as a part of social work (Community work); urban planning and social planning.

c) Use the similarity of the place of residence as a resource for common interests (community of space and community of interests).

In our context "community" means an "ensemble of relations, organizations and institutions with whose help the people can articulate their needs" (Szynka, 2006). In this physical community only the common characteristic of living in the same area or place of residence expresses itself at first. For a community based health information campaign it is helpful to know such neighbourhood interests. The idea is to awaken the common interests in a healthy life environment and the own healthy everyday life encompassing various target groups impartial with regard to age, gender or ethnicity. The specific action aims at satisfying basic needs (salary and health). This is the requirement for the "community of interest" as named in traditional community organizing (Alinsky 1972).

Projects covering the district on health information are based on the existing "natural networks" of each individual (Schubert 2005) as social resources. An initial inquiry with Eastern European and Turkish migrants in German towns has shown that the primary networks of family,

relatives and friends play an essential role in obtaining health information (Alisch / May 2011; Alisch et al. 2010; www.amiqus.de). Educational projects should start here and aim at an exploration of the passing on of information and transfer of knowledge. Also to be recognized in local communities are "secondary networks" these informal, small networks (neighborhood networks, groups with common interests but with little organization) can serve as a contact partner for reaching out to the inhabitants of a district. Such networks are a matter of supporting and of strengthening (self-organization and self-help).

Strongly organized 'secondary' or 'private' networks (Schubert 2005) like clubs and formal organizations are the exception rather than the rule in the European countries of our research. In cases where there are such local clubs or initiatives, they are an important partner in order to:

- understand the lived-in world of the inhabitants,
- reach difficult to contact groups and
- provide spatial and civic resources.

The health projects that pay attention to these local social networks could use multipliers to form opinion on health matters.

To explore the natural networks of the inhabitants requires direct methods of addressing whether: the method of "activating inquiry" is reliable in community work. The inhabitants of a local community are surveyed not only about their opinions or facts about their social position, but also additionally they are stimulated to participate in concrete local projects, in neighborhood working groups on specific problems.

To attract inhabitants for the process of forging a local, community network of health activities, we started with guided interviews touching on aspects of lifestyle, empowerment and residential environment as categories of daily life. The Romanian chance-research team tried to extend the local social network by facilitating interactions between the inhabitants. On every day of the intervention, inhabitants from Dumbravita had the possibility to interact, to exchange opinions and to find out more about each other. For example, on one of the days during the intervention program, they put the participants in small groups of five and they had to communicate with each other and do some activities concerning healthy eating.

3. The target groups of community bases health information

a) All inhabitants are the target group for community based health information. Identify who are the disadvantaged social groups in the specific community.

If health information is more than basic information on health questions, most often it is designed and formulated for specific groups at risk, diseases or therapy. In health promotion as a preventive instrument, target groups do not consider themselves as a target group (e. g. information with regard to overweight, smoking and exercising). Therefore, community based health information and education is targeted at all inhabitants in an area. They are the target group for offerings and is keen to respect and reach the inhabitants in its diversity. In addition it is important to identify the most vulnerable groups respective to the social and environmental context. The disadvantage could apply to cultural, social or economical resources or mobility. Norms of tolerance (e.g. with regard to ethnic minorities, religion, elderly people, families with many children) are different with regard to each regional culture, the political and judicial frame, and are important for the diversity of disadvantaged target groups. Hence, the diversity of target groups occurs on the basis of the environmental frame and in comparison to other urban areas.

If small scale data of the socio-demographic and social structure of the differentiated area are available, they should be evaluated with regard to the dissemination to age groups, gender, country of origin, occupancy, education level, occupation and type of household. If such data are not available, key people (pastor, school principal, director of the kindergarten, owner of shops, head of clubs, housing societies) in the area are adequate sources for information to identify most relevant groups.

As is obvious both from common sense, as well as from statistical evidence, the elderly are truly a disadvantaged category in Romania and in Sweden, Latvia and Germany. Their difficulties are many: economic, social, cultural and include information inaccessibility. Low life-expectancy, decreasing self-esteem, the feeling of being useless, the lack of encouraging social contacts, the lack of the will to live greatly affect their health status, as we could see in several case studies.

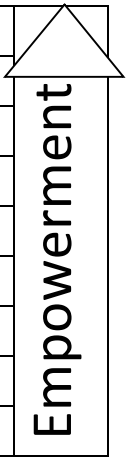
In Germany and Austria immigrants are a specific target group for health information: In Vienna courses are offered by the Fund for Social Affairs. The local mosque 'Grillgasse', the pharmacy and the local kindergarten cooperate. All courses offer the support of a native interpreter and child care (lectures on healthy nutrition held in the mosque, cookery courses using modified Turkish recipes e.g. reduction of fat, different ways of preparation) at the VHS Simmering and sport courses at the mosque. In Germany special swimming courses for Turkish women have been initiated.

b) Participation in practice: Designing local health information projects around the needs and resources of the target groups and their networks.

This guideline assumes the acceptance that the development and stabilization of neighborly or community based support systems, as well as the self-organization of the inhabitants' interests with a view to social sharing and social participation, is a central key for the improvement of the quality of life and health. This corresponds to the specification of the WHO in the Ottawa Charter of 1986. To realize and get to know the needs and resources of the inhabitants and of the different social groups for a healthy life in the local community, a strong and direct sharing of the inhabitants in the process (participation) is needed of a) the problem definition, b) solution finding and c) project development in the social space.

This process must be initiated professionally and be supported by an established organization. The participation model in health promotion according to Wright et al. (2007: 4f) assumes from the requirements of the Ottawa charter that self determination of the citizens should be at the core of health promotion. Participative processes of health promotion can be estimated according to the degree of the active participation of the inhabitants. The efforts concerning participation can thereby be improved gradually. Participation is a process of development (Wright et al. 2007: 4). It is befitting that the first preliminary stages of participation must be realized before direct participation in the decision-making process is feasible.

Table 1: Nine steps of participation

Level 9	Independent Organization far beyond the participation	
Level 8	Decision power	
Level 7	Partial decision competence participation	
Level 6	Co-determination	
Level 5	Inclusion	
Level 4	Hearing pre-stage of the participation	
Level 3	Information	
Level 2	Educate and treat non-participation	
Level 1	Instrumentalisation	

Origin: Wright / Block / von Unger (2007: 5).

The basic information about preventive behavior should be collected directly through instruments of participative social research. This way the inhabitants' perceptions of what is a local problem can be registered. This also applies to collecting observations of previous typical health information (step 4). In the 5th step of participation, persons from the target group (focus group) are to be included in the process of the project development and decision making. Steps 6 to 8 of the 'real participation' will only be realizable when, at the municipal level, a structure is found for questions of health promotion covering both the district and health information. On the basis of activating inquiries, workshops can be initiated in which project ideas are developed together – according to the articulated needs e.g. in the design of future workshops (May / Alisch 2011). Even the preliminary stages of participation are to be planned carefully and must be adapted to the structures of the district and its population.

c) Enable especially vulnerable inhabitants to improve their independence and autonomy through increasing their practical knowledge (in everyday life).

Participation in the development of culturally appropriate interventions can foster a sense of empowerment, authority and self-worth by acknowledging the skills and knowledge that already exist within that group. Interventions therefore, need to reflect the social, cultural and psychological processes that are relevant to this group. A traditional top-down approach is not necessarily appropriate to improving independence and autonomy. Encouraging new skills in the context of existing knowledge develops a sense of self-efficacy and is a positive contributor to overall health and well-being.

The idea is to encourage them to become active independently, to stand up for their own interests and to help in solving of problems in the community (e.g. the activating inquiry by Lüttringhaus / Richers 2003). Attention should be paid to:

a. Activation as a collective learning process: experience shows: "it pays to become active, I can provoke something through my activities together with others, I am not only a victim of a situation but am (co-) creator".
b. Activating surveys need open questions.
c. Activating inquiries are not short term actions, but the beginning of a long-term process. In this process crucial experiences are always necessary; the important individual talks with other participants in the district. (see ibid)

Such an activating inquiry could be one method to get in contact with individuals in the community and make them part of a longer process of community health management. But this kind of activating method needs activities to be identified which they could acquire an interest in. The case studies show some examples:

In Liverpool a certain group of people was addressed with the Chance project. This enabled carers to be instrumental in identifying an area of need and providing training incorporates freedom of choice and encourages lifestyle and behavior change and potential quality of life. Carers were initially invited to participate in a food hygiene course in which they could share their own knowledge and practices with others. This

provided an opportunity to learn along-side others who exist within the same or similar circumstances and who consequently understand the shared problems and limitations that bind them. In addition to understanding their own power relations and influences, carers were encouraged to utilize their skills in the most effective way, thus promoting autonomy and further empowerment.

To enable elderly to improve their independence and increase their practical knowledge the Swedish researchers suggest the following interventions e. g. regularly performed "Food classes for the elderly". In these health-promoting activities two major issues have to be emphasized e.g. the "5 a Day"-concept and food safety. These issues could be easily implemented by using CD-programs regarding food and health.

Food hygiene knowledge claims of carers of older people do not necessarily reflect what happens in practice. Many carers in the Liverpool study struggle with the demands of caring and tend to rely on culturally acquired knowledge and skills that have been passed down through generations. Furthermore, limitations and restrictions on time, finances and emotional and psychological resources lead to a significant number of carers adopting strategies that enable them to prioritize the tasks that they feel are most important and result in providing food for others that is affordable and easy or quick to prepare. Fatigue or tiredness associated with caring may also result in the carer not adhering to food storage and handling recommendations.

4. Networking and institutional resources

a) Get knowledge to the organizational, financial, spatial, personal resources of local stakeholders and use it for "tailored" local health Information projects.

Local institutions, which have to be involved in health promotion, are generally well known. This includes general practitioners, health care services, health insurance, hospitals, health authorities, centres for mothers etc such as church health institutions. Furthermore, with regard to the life cycle concept, kindergarten, schools and adult education centers incorporate an educational mandate for health. Certainly, each institution has different goals and target groups and introduces different methods

and media for health education and health information. The contextualization in a community is often grown from coincidentally originated aspects, rarely concerted and planned by respective institutions. This "health map" in a community should carefully be examined. This includes:

- What task does the respective institution in a community have?
- Is it a matter of general health information or education offerings? and for which target group are they offered?
- Is there an existing network and to what extent? or can it be established? and
- Are the health information and educational needs of the inhabitants covered?

At first it is necessary to examine available institutions, their objectives and available offerings and the willingness to provide new offers based on the needs of the inhabitants in a community. This includes the acquisition of personnel resources and business hours at which health information is possible to propose. Furthermore it has to be established whether the locality is easy to access and free from barriers. Furthermore, the arrangement of rooms needs to be considered and whether the information and education offered is adequate. Cooperation and agreement between institutions avoid competing offerings and can result in differentiated target group oriented offers.

b) Time: The process oriented, participative set up of a Community Health Management requires enough time.

To set up a "Community Health Management", it is necessary to go beyond just short term organization of separate projects. This is a collective learning process which is a matter of organization.

While single projects depend exactly on limiting the target group and on finding suitable ways of addressing the project systematically (multipliers), the intention of Community Health Management always refers to long term processes which are enabled to cover separate project ideas and existing resources relative to each other. Behind every project idea there are people or institutions with specialized competencies, knowledge and experience and spatial-material resources. This applies to making it transparent to all local institutions and to bringing in the creative

process to project development. These collective learning processes refer not only to the organized inhabitants of the local community who should find out together the possibilities for a healthy life in their district, but also to the professional participants who are learning in the district and the city. They need to be able to recognize common aims, to adjust their interests in each other and to open up resources.

Therefore the perspective of having their own areas of responsibility is to be changed, so that case oriented, real-estate oriented and space oriented forms of support can become compatible. Furthermore, it could be shown that the setting up of social and professional networks requires time. Success for the purposes of improved health behavior as well as improved constitutional structures can, according to the general conditions (social structure, infrastructure), be expected only after several years.

The organization of each project requires a careful plan which considers the following aspects:

- the inhabitants and the local stakeholders were involved in the definition of locally relevant problems;
- the inquiry into the needs of different target groups requires time and personnel resources;
- the health-promoting measures are developed as a learning cycle: needs analysis on site, aim definition, resource analysis, project development, monitoring;
- enough time was given in presenting the process to the local institutions/organizations to get to know each other and to exchange and recognize common interests and to mobilize resources; and
- particularly, the contact and trust to set up disadvantaged inhabitants' groups requires time.

So, on the initiative of the Fulda University of Applied Sciences, networking with local organizations in Southend and Kohlhaus started two years before the European Chance-project set up. This period was very important to start local networking. This network still exists but defines itself as a 'Community-Conference' with a broadened agenda. In 2009 the administration of the network activities shifted to the authorities of the city of Fulda.

5. The "nature of projects"

This last field of guidelines relevant for the success of Community Health Management refers to the general circumstances of concrete projects of health information, that should not as always be prepared as written information (flyer, brochures, websites), but as a learnable tool. A reference to the social spatial approach is reflected in the visibility of projects in space.

a) Health projects should involve all senses: Information about health, nutrition and physical activity should be "tangible".

Most of the information about healthy lifestyles overwhelms individual consumers. Guidebooks and booklets provide extensive explanation and act as a deterrent with their complexity and depth. Furthermore, the diets offered are expensive or take a lot of time and effort to be implemented throughout everyday life. Bans act as a deterrent instead of providing practical pathways.

Migrants are often regarded insufficiently when information is provided. Most people are not aware of the fact that health must be regarded every day. There are a lot of small aspects which can be introduced with small effort: The day could start with a healthy breakfast, with exercise to travel to the workplace and during work a sequence of: exercise, relaxation, healthy snacks can improve structures. After work, well-being can be influenced by a healthy and tasty meal. The meal preparation at home should not take too much time or effort and should meet the needs of all members in a household. Children and adolescents should be involved in the meal preparation. Consequently, the time and effort, which is traditionally carried by the "housewife", can be distributed to all members of the household. Or during the week every member of a household might be responsible for all work on one day. Thus, adolescents can prepare and offer their preferred meals. The collective meal should be scheduled by all members of a household. Physical activity and relaxation should be scheduled in at the end of the day.

So health projects – regardless of information or education offerings – must call to people where they stand and live. The simpler, more practicable and suitable for daily use the offers are, the more likely is their

implementation. Furthermore, it is important that information about health and nutrition are not isolated, but take a holistic approach as their basis. In addition, the more senses are addressed, the better is the effectiveness. The more independent activity and self-determination exists, the more acceptance can be expected. Thereby seasonal aspects have to be considered as well as environmental aspects such as the infrastructure for physical activity and shopping facilities and the special needs of groups.

Local or regional food supply should be integrated and exercise and recreation offers should be designed to be attractive. New offers should be able to be tested without barriers and without the purchase of items. In order to ascertain what offer suits a person and can be enjoyed, it is important that exercise and physical activity offerings can be tried out beforehand. For elderly people simple daily offers with which they feel safe, such as walking, should be started. For those people who are strongly involved in caring, unburdening offers should be implemented. Thereby, it has to be considered that the nursing person is still provided so that the carer can relax and take some recreation. In several European countries there exist different examples. The assistance can take place at home, in the neighborhood or in institutions outside of the home.

b) Visibility: The Process of installing Community-Health-Management should be carried out by an engaged person who is available at a central place in the community.

To make long term community health management visible the resources should be focused in a central, accepted location and one person should give it a personal "face". Essential resources for successful community based health education and health information are:

a. *persons* in the local community who are already known to be dedicated and know the district with its structures and resources and
b. *places,* represented by rooms or buildings which are centrally located and are accessible for everybody without social barriers.

Such community health activities should not only be run by one single organization, but also should be one of many institutions that give support on site. It is important that from the perspective of the inhabitants a central person is connected with the efforts towards a "healthy neigh-

borhood" and a healthier life in the local urban community. It is the task when setting up a local network to identify a personal authority who is well known in the community and can organize Community Health Management and coordinate all health-related measures and projects and represent them publically.

This has been learned from the strategies of urban management in disadvantaged urban areas around Western Europe since the 1980s. This kind of urban management is the key point in organizing the distribution of information, the coordination of projects, the inclusion of all inhabitants and the protection of the sustainability of these processes. Another task of the local network and its management is the combined search for suitable rooms to give "Community Health Management" a home and make it visible for the inhabitants. Therefore rooms are needed that make a spontaneous consultation possible, as well as for the display of information about local events, specific health information of local health organizations or for a noncommittal talk with neighbors.

The community centre of the German district 'Südend' is defined by the elementary school, a social youth club in the school's basement and the club house of the Turkish sports club over the way. This infrastructure – particularly the school building – is well known in the neighborhood and attainable barrier free. The different rooms have already been used for meetings of the local network. Meanwhile, the urban senior citizens consultancy as well as the educational guidance hold regular consulting hours and discussion hours in these facilities.

6. The future: evaluation and sustainability

a) Employing and learning from on-going, overall and mixed method evaluations

Evaluations should take place in every phase of a project or an intervention in order to keep close to the needs and expectations of the inhabitants and the local stakeholders. Evaluation also has the function to motivate for the purposes of a "dialogue control" (Guba / Lincoln 1989). This dialogue control can help the local network to make consensual decisions, to keep the right orientation of the initiated projects.

Because of the manageable local networks it is possible and meaningful to plan a regular evaluation of the process of the local network which is organized in dialogue formats (forum sessions, round tables, etc). In the Chance project we understand evaluation as a part of community work. It is not an objective measuring instrument. Therefore, the aim should be, to enable the stakeholder to evaluate on the basis of simple learnable methods. Michael Quinn Patton, a prominent representative of qualitative evaluation of research, supports such an "Evaluation oriented usage", which orients itself towards "primarily intended users" (2000: 429). Therefore, we suggest for a meaningful evaluation surveys which are directly accessible to the users (inhabitants and local participants).

Here, the instruments used should not be too difficult or be too extensive in order to make the evaluation a current issue and with a view to the improvement of the health information available. The evaluation of oriented community projects of health information and health education must be integrated into the everyday business of the executing organizations. So called "snap polls" with a simple, short form covering the respective project can serve as self-assurance on the quality of the project and its execution. Short, easy understandable forms which are used, e.g. at events can be evaluated with excel. For migrants who do not have a command of the language (or only have a little knowledge) a translation can take place or one can work with pictures and drawings.

At big events simple methods are also best – coupled with the gift of a healthy treat, e.g. fruit. A written evaluation for older people should particularly use larger writing for better legibility. With computer experienced target groups an evaluation can take place by computer. With networks, a common discussion about successes and difficulties with documentation on e.g. flipcharts can be presented. They provide a visible, fast view and can be assigned or realigned if necessary in different ways.

b) *Ensuring the projects build capacity in the community in terms of participation of professional (stakeholders) and civic actors (inhabitants, volunteers) and resources so that activities can continue.*

Long term Community Health Management is made more visible by focusing resources in a centrally accepted location. Promoting effective food hygiene practices amongst carers of older people facilitates greater

engagement and collaboration of those carers with other services that exist within the partner organization. Indeed, working with an established organization can:

a) facilitate access to a target group (especially if dealing with vulnerable people);
b) provide an infrastructure for efficiency, thereby adding value;
c) maintain a level of interest post-interventions (influencing the influencers) promoting sustainability; and
d) afford extra credibility to initiatives.

The partner organization in Liverpool is a well-known social enterprise, selected because of its continuing engagement with carers of older people providing a well established network of service-users. The organization has personnel with appropriate experience, motivation and enthusiasm to engage and communicate effectively with the target group. Incentives were used to attract participants at every stage and evaluation was built into the interventions at every opportunity to ensure that future interventions were likely to be effective and appropriate. Active involvement of carers in the identification of health related needs, and subsequent design, implementation and evaluation of culturally appropriate interventions engendered a sense of value in the contributions that were made. Issues of gender, age, ethnic diversity and inequality were addressed at the outset by inclusion of members from all groups within the given geographical location. Additionally, independence and autonomy, together with self-esteem and motivation of the target group were also considered and interventions were conducted in locations convenient to the group, at times that were manageable. Due to the lifestyle restrictions that are inevitably experienced by carers it was also considered appropriate to offer assistance with transport. This project utilized innovative strategies to encourage stricter adherence to food hygiene routines, encouraging behavioral change through an understanding of interactions within an environment, rather than being merely instructive. However, it is acknowledged that circumstances in England and Liverpool are very different to those in partner countries and would necessarily affect both the methods used and the outcomes achieved.

The described guidelines are accessible for all stakeholders in a shortened form (in English, German, Latvian, Romanian, Swedish) on the Chance website (www.community-health.eu). The Chance project was a

very good possibility to introduce the guidelines in all participating countries and allowed the translation in the several languages and the publication in printform additionally.

References

Alinsky, S. (1972): Anleitung zum Mächtigsein. Ausgewählte Schriften (Deutsche Übersetzung von Reveille for Radicals). Göttingen: Lamuv Verlag

Alisch. M. (ed.) (2009): Lesen Sie die Packungsbeilage …?! Sozialraumorganisation und Gesundheitsinformation. Opladen/Farmington Hills: Barbara Budrich Verlag.

Alisch, M./Dölker, F./Fröba, S.(2010): AMIQUS – Ältere Migrantinnen und Migranten im Quartier Initiierung und Stützung von Netzwerken der Selbstorganisation in Fulda, München und Wiesbaden. In: BAGSO Nachrichten – Das Magazin der Bundesarbeitsgemeinschaft der Senioren-Organisationen. Heft 1/2010. p. 9.

Alisch, M./May, M.(2011): Lokale Netzwerk- und Raumressourcen älterer Migrantinnen und Migranten in unterschiedlichen Stadtstrukturen. In: Soeffner, H.-G. u.a. (eds.): Transnationale Vergesellschaftungen. Verhandlungen des Jubiläumskongresses der Deutschen Gesellschaft für Soziologie in Frankfurt 2010. Wiesbaden: VS Verlag.

Bauer, U./Bittlingmeyer, U. H. (2006): Zielgruppenspezifische Gesundheitsförderung. In: Hurrelmann, K. / Laaser, U. / Razum, O. (Hrsg.): Handbuch Gesundheitswissenschaften. Weinheim: Juventa Verlag. 781–818.

Feichtinger, E. (1995): Armut und Ernährung im Wohlstand: Topographie eines Problems. In: Barlösius, E. et al. (Hrsg.): Ernährung in der Armut – gesundheitliche, soziale und kulturelle Folgen in der Bundesrepublik Deutschland. 295. (AG Public Health).

Guba, E.G./Lincoln, Y.S. (1989): Fourth Generation Evaluation. Newbury Park.

Kronauer, M./Vogel, B. (2002): Erfahrung und Bewältigung von sozialer Ausgrenzung in der Großstadt: Was sind Quartierseffekte, was Lageeffekte? In: Häußermann, H. / Kronauer, M. / Siebel, W.: An den Rändern der Städte. Armut und Ausgrenzung. Frankfurt a. M.

Lewin, K. (1975): Tat-Forschung und Minoritätenprobleme. In: ders. (Hrsg.): Die Lösung sozialer Konflikte. Bad Nauheim, S. 278-304.

Lefèbvre, H. (1991): The production of space. Oxford.

Löw, M. (2001): Raumsoziologie. Frankfurt a.M.: Suhrkamp.

Lüttringhaus, M./Richers, H. (2003): Handbuch Aktivierende Befragung. Konzepte, Erfahrungen, Tipps für die Praxis. Arbeitshilfen für Selbsthilfe- und Bürgerinitiativen Nr. 29. Verlag Stiftung MITARBEIT. Bonn.

Lynch, K. (2000): Das Bild der Stadt. Bauwelt Fundamente Bd. 16. Vieweg Friedrich und Sohn Verlag.
Nutbeam, D. (2004): Getting Evidence into Policy and Practice to Adress Health Inequalities. Health Promotion International, 19, 2, 137–140.
May, M./Alisch, M. (2011): Methodologische und forschungsmethodische Überlegungen zur Rekonstruktion integrationsbezogener Orientierungsmuster. In: Alisch/May (Hrsg.): Integrationspotenziale in kleinen Städten – Rekonstruktion der Interessensorientierungen von Zuwanderern Band 6... Opladen/Farmington Hills: Barbara Budrich Verlag. pp. 29-41.
Paton, K./Sengupta, S./Hassan, L. (2005): Settings, Systems and Organsiation Development: the Healthy Living and Working Model. Health Promotion International, 20, 1. pp 81–89.
Patton, M.Q. (2000): Utilization-Focused Evaluation. In: Stufflebeam, Daniel L./Madaus, George F./Kellaghan, T. (eds.): Evaluation models. Viewpoints on Educational and Human Services Evaluation. Boston/Dordrecht/London. pp 425-438.
Riege, M./Schubert, H. (2005): Konzeptionelle Perspektiven. In: Kessl, F: / Reutlinger, C. / Maurer, S. / Frey, O. (eds.): Handbuch Sozialraum. Wiesbaden: VS Verlag. 247–259.
Putnam, Robert D. (2000): Bowling Alone. The Collapse and Revival of American Community. New York: Simon & Schuster.
Schubert, H. (2005): Architektur und Erfahrungen mit Netzwerken in E&C-/ Soziale-Stadt-Gebieten-Aufbau, Management und Wirkungen. In: Bundesministerium für Familie, Senioren, Frauen und Jugend: Lokale Bündnisse für Stadtteile mit besonderem Entwicklungsbedarf – Arbeitsformen, Methoden und Standards: 17–24
Szynka, P. (2006): Theoretische und empirische Grundlagen des Community Organizing bei S. D. Alinsky (1909–1972). Akademie für Arbeit und Politik der Universität Bremen.
Wright, M./Block, M./Unger, H. von (2007): Stufen der Partizipation in der Gesundheitsförderung. Ein Modell zur Beurteilung von Beteiligung. In: Info-Dienst für Gesundheitsförderung. 7. Jahrgang, Nr. 3/2007. pp. 4–5.

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This book discusses the results of an international project about new ways of organising health information. The project Chance – Community Health Management to Enhance Behaviour – based on the preliminary assumption that a local community's structure determines the perception of health information and health promotion in a specific way. Therefore the relevance of space in dailylife was the starting point for an interdisciplinary research in six European countries with very different frames of health systems.

As it is obvious that knowledge of a healthy lifestyle is one essential factor for its implementation, the multiple offers of health information and education have their justification. But, the most effective offers are those that relate to a local community's specific needs. This book shows different ways to install tailored local projects. The main important keywords are participation, local networks and social cohesion. The idea of a "Community Health Management" outlined in the last chapter, is to change the perspective of health work.
The project was funded in the EU Lifelong Learning Programme Grundtvig over two years. Here are presented the main results for stakeholders, students and researchers.

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