

RESEARCH AND PRACTICE OF HEALTH PROMOTION

STRATEGIES TO REDUCE HEALTH INEQUALITIES

**Creating an internet platform
to improve networking**

VOLUME 13



Federal Centre for Health Education

BZgA

The Federal Centre for Health Education (BZgA) is an authority in the sphere of responsibility of the Federal Ministry of Health and Social Security and is based in Cologne. In the field of health promotion, it handles both information and communication tasks (education function), as well as quality assurance tasks (clearing and coordination function).

The information and communication tasks include the provision of information and education in subject areas with particular priority as regards health. In cooperation with partners, the BZgA implements campaigns in various fields, such as AIDS prevention, drug prevention, sex education and family planning. The target group-specific work of the BZgA currently focuses on promoting the health of children and young people. The key tasks of the BZgA in quality assurance include the formulation of basic scientific principles, the development of guidelines, and the elaboration of market overviews of media and measures in selected fields.

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VOLUME 13

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Creating an Internet platform to improve networking

Frank Lehmann, Monika Meyer-Nürnberg, Thomas Altgeld, Sven Brandes,
Claudia Brendler, Christiane Bunge, Irina Fröse, Raimund Geene, Uta Grey,
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Foreword

It has also been proven in Germany that socially disadvantaged people have a reduced life expectancy and increased rate of illness. For example, a study (Reil-Held, A., 2000) shows that men with a low income have a life expectancy, which is ten years lower than that of men who have high incomes. For women the difference is five years. This is attributed to a combination of factors: greater strains on health (e.g. living conditions), fewer means to deal with problems (e.g. poor individual health concepts), unhealthy behaviour and differences in healthcare for socially disadvantaged groups.

In his article Mielck explains which groups among the population are especially affected and how this can be proven. Altgeld and Leykamm describe the players involved in health promotion for socially disadvantaged groups and the structures for this, focusing particularly on the regions. Geene traces the history of the nationwide platform which evolved as a place for main players in the field to exchange information and experiences: the annual "Poverty and Health" congress in Berlin. The article by Pott and Lehmann looks at developing an effective intervention concept on health promotion for socially disadvantaged groups, taking children and young people as an example.

The BZgA is aware that health promotion for socially disadvantaged people is an extremely complex field of work. For this reason this area has been included as an ongoing element of its cross-sector work. Having set up and further developed a "lively database" which provided access to approx. 2,600 projects and measures for health promotion which socially disadvantaged people with reference to the status of October 2003 (described in the article by Kilian et al.), it should now be much easier for those active in the field to exchange practical experiences and network with others.

The Internet address for this communication platform, which was set up on behalf of the BZgA by Gesundheit Berlin e.V. [Association for Health Promotion Berlin] is: www.datenbank-gesundheitsprojekte.de. I should like to take this opportunity to invite you to use this valuable tool as much as possible to help strengthen health promotion for socially disadvantaged people.

Cologne, October 2003

Dr. Elisabeth Pott
Director of the Federal Centre
for Health Education

Outline of the project

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| Project title: | Strategies to reduce health inequalities – Creating an Internet platform to improve networking |
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| Aims: | <ul style="list-style-type: none">• Description of the fundamental issues involved in the key topic of “Strategies to reduce health inequalities”• Nationwide and regional structures for health promotion for socially disadvantaged groups• Intervention strategies• Creation of a nationwide reliable overview of projects and measures to reduce health inequalities (final report of the initial survey) |
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| Initial survey: | <p>Survey period: from September 2002 to the end of January 2003</p> <p>Survey tool: cover questionnaire, project documentation sheet (return rate for 10,067 questionnaires sent out 38.3 percent, of which 1,309 completed questionnaires with dedicated services)</p> <p>Project carried out by: BZgA in collaboration with Gesundheit Berlin e.V. [Association for Health Promotion Berlin] and the Berlin Centre for Public Health, BZPH, Landesgesundheitsamt Baden-Württemberg [State public health office of Baden-Württemberg] LGA, Landesvereinigung für Gesundheitsförderung LVG Niedersachsen [Lower Saxony Regional Association for Health Promotion]</p> |
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| Authors: | Thomas Altgeld, Sven Brandes, Claudia Brendler, Christiane Bunge, Irina Fröse, Raimund Geene, Uta Grey, Daphne Hahn, Holger Kilian, Frank Lehmann, Barbara Leykamm, Andreas Mielck, Tanja Philippi, Elisabeth Pott, Antje Richter |
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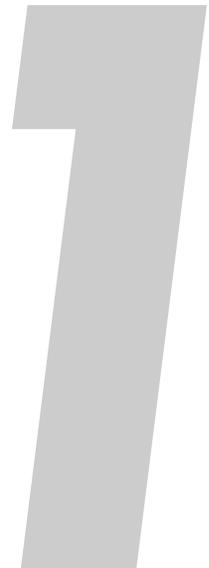
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ANDREAS MIELCK

**PROJECTS FOR GREATER
EQUALITY IN HEALTH:
FOR WHICH POPULATION
GROUPS IS THE NEED
PARTICULARLY GREAT?**



The following article presents the basic findings that are available on the topic of “social and health inequalities in Germany” and what need for action can be derived from these. The main issue here is for which population groups is the need for health promotion measures particularly great. At the centre of this discussion is the term “social inequality”. In order to avoid possible misunderstandings, this term will first be more precisely defined.

1.1 Criteria for describing social inequality

In our everyday understanding, the term “social inequality” is usually understood to mean differences in terms of education, occupational status, and income. To be more precise, these are criteria of “vertical” social inequality. By adding the word “vertical” it should be clear that these criteria make it possible to divide the population into upper and lower groups. With the aid of data on education, occupation, and income, a person’s “social status” can be determined; the term “status” in itself implies classification into a hierarchy. The hierarchical nature of vertical social inequality is linguistically clearest in the term “social class”.

It is largely agreed that vertical social inequality can be easily determined with the aid of the three criteria named above (education, occupational status, income). Particular importance here is attributed to income, since income-related poverty is often regarded as the key indicator for vertical social inequality.

The population, however, can also be divided into groups using criteria such as age, gender and nationality, and there may be social inequality between these groups too. The boundaries between these groups cut across those boundaries of vertical social inequality; consequently in sociology one refers to “horizontal” social inequality. Horizontal social inequality can be described using a number of criteria. Alongside age, gender and nationality, criteria such as family status, number of children and size of dwelling, for example, may also be included. A generally accepted list of criteria for determining horizontal social inequality is not currently available and it is likely that it is not possible to compile it. The four criteria of age, gender, family status and nationality, however, are of central significance.

Current sociological discussion generally emphasises that there are no longer “social classes” in Germany that can be clearly distinguished, and that the diverse “life circumstances” can no longer be easily placed in a simple hierarchy on the basis of criteria such as education, occupational status and income. In many studies in social epidemiology (i.e. studies concerned with the social distribution of illnesses), however, it has been shown again and again that people from lower status groups have significantly more health problems than people from the higher status groups. Criteria for vertical social inequality are very helpful for describing the variations in morbidity and mortality. If it

is wished to describe as precisely as possible the particular burden placed on specific population groups, it is, however, important to combine the vertical criteria (education, occupational status, income) with the horizontal criteria (age, gender, family status, nationality). To be more specific: in Germany, around 11% of the population live below the poverty line (Becker/Hauser 2002). This population group is very large and, correspondingly, it is not homogeneous. It is therefore important to search for subgroups within this population group where the strains are particularly great. In order to plan intervention measures directed at specific target groups it needs to be known, for example, in what age group and for which nationality poverty is greatest.

The two key questions are:

1. For which population groups is the strain on health particularly great?
2. How can health in these population groups be improved?

This article is focused primarily on the first question. The second question is the main point of the other articles in this publication.

To answer the first question one might in a first step identify the population groups in which social disadvantage is particularly great; then in a second step one might examine the level of health in these population groups. This is rarely done, however. In many population groups the social and health problems are so obvious that scientific evidence for the need to conduct interventions is no longer required. Although this pragmatic approach is often very useful, the disadvantage is that some population groups for whom there is a high need for intervention may be overlooked.

As yet there is no systematic description of population groups in which the social and health strains are particularly great. It is therefore not possible (and probably not even necessary) to give precise scientific reasons why in which population groups this is the case and in which population groups it is not. The range of population groups listed below, therefore, is based more on plausibility than on scientific studies. The people that are focused on here are primarily those who have a low level of education, a low professional status and/or a low income.

1.2 Population groups with a particularly great need for intervention

A list of those population groups exposed to particularly great social and health strains should contain the following groups:

- people with a very low income (e.g. those receiving social benefits),
- people with a very low occupational status (e.g. unskilled workers),
- people with a very low level of school education (e.g. people who have no primary education),
- people who live in areas with great social problems,

- long-term unemployed people,
- single parents,
- adults and children in those families where there are many children,
- migrants with a poor knowledge of the German language,
- asylum seekers,
- illegal immigrants,
- prostitutes,
- convicts,
- homeless people.

The “Poverty and Health” conference, which has been held annually in Berlin since 1995, has established itself as the largest event nationwide in this area (Geene et al. 2002; cf. the article “Nine Years of Congresses, Poverty and Health” in the present publication), and at this conference too, the focus is on the above-mentioned population groups. At the European level, the report of the project “The Health of Disadvantaged Groups in Europe” was submitted in the year 2000. And here too, these population groups emerged as being particularly disadvantaged socially and as regards health (Streich 2000). The population groups include both men and women and all age groups. The groups are usually defined by using the social criteria of adults, but children who live with these adults are also exposed to these strains.

Even if there is no need for intervention for every individual person who belongs to the above-listed population groups, and even if belonging to one of these groups does not automatically mean that a particularly great strain exists from a social and health point of view, it can be assumed that these strains are generally significantly higher than in other population groups.

It should also be kept in mind that the groups frequently overlap. It is often the case, for example, that a long-term unemployed person must live on a very low income, has only a very low level of school education and also lives in an area with social problems. These overlaps make it clear that the need for interventions is particularly great when different strains are combined.

1.3 Social inequality and health

The current discussion on health policy increasingly raises the question of whether and why persons with low socio-economic status have particularly poor health and what can be done to combat this. The catchphrase of “health inequalities” has been established as a key word in this discussion.

In looking for a reduction in this health inequality, the question first arises as to how the goal can be defined. Are all humans to be equally healthy and live for the same amount of time? This proposition would be neither an achievable nor a desirable aim. Based on

the arguments of the WHO Regional Office for Europe, the aim can be defined as follows (Mielck 2000): “Everyone should have a fair chance to fully utilise his or her health potential, i.e. all avoidable obstacles to achieving this potential should be removed”. This goal can be rephrased using the term “equal health opportunities”. Even if it can rarely be fully achieved, realistic achievable proposals are sought which can help achieve this goal as far as possible. Particularly at a time when socio-economic differences in the population are visibly becoming larger, it is very important to develop and implement such proposals for achieving “equal health opportunities”.

In recent years, not only are reports of poverty becoming more frequent in Germany, but also publications on the health disadvantages of the lowest status groups. In an overwhelming number of studies it has been shown again and again that people with low socio-economic status (i.e. low education, low occupational status and/or low income) usually have a particularly poor level of health: they suffer more from diseases and they die earlier than people with a higher socio-economic status (e.g. Grobe/Schwartz 2003, Heinzel-Gutenbrunner 1999, Helfferich et al. 2003, Helmert 2003, Jungbauer-Gans 2002, Klocke 2001, Mielck 2000). This health inequality has been reported so often that its existence can no longer be in doubt.

Two studies illustrate the extent of this health inequality: in an analysis of data from the “socio-economic panel”, Reil-Held (2000) has calculated the life expectancy for people from different income groups. The data allow possible an analysis of the mortality rate of 2,675 men and 3,136 women for the period between 1984 and 1997. If the men from the lower income group (at most 25% of the average income) are compared with the men from the upper income group (75% or more of the average income) then one sees a difference in life expectancy of approximately ten years. The corresponding difference for women is about five years. When they analysed data from one AOK [local health insurance fund], Geyer and Peter (1999) were able to look at data on 80,172 men and 32,166 women for the period between 1987 and 1996. They put the data on professional status into four groups; the lowest group primarily includes unskilled and skilled workers, and the upper group primarily includes those who have a university degree. If the age distribution is statistically controlled, the mortality rate is approximately four times higher in the lower professional group than in the upper one, this being the case both for men and for women.

Studies on morbidity provide impressive confirmation that persons with low education, low occupational status, and/or low income generally have significantly more diseases than those persons in the other population groups. Almost all indicators of health indicate that prevalence (frequency of illness) is higher in the lower status group than in the upper status groups, and this is the case both for adults and children. As is the case with mortality, in regard to morbidity there is usually a “gradient” of health inequality, i.e. morbidity gradually increases with decreasing socio-economic status. The morbidity in the lower status group is often two to three times higher than in the higher status group.

The studies that are available from Germany also report that the lower status groups are exposed to particularly high health risks. Discrimination at the social level, which in some cases is quite glaring, leads in some groups to further stresses (e.g. in the case of asylum seekers, illegal immigrants, prostitutes, convicts and homeless people). One can, therefore, safely assume that in the population groups mentioned above health is generally particularly bad (even if this has not yet been empirically shown for all groups).

1.4 Approaches to explanation and intervention

When explaining health inequalities, a distinction is usually made between the two following basic hypotheses:

1. Socio-economic status affects health (in simple terms, “poverty makes you ill”).
2. Health affects socio-economic status (in simple terms, “ill health makes you poor”).

Most discussions emphasise that the first hypothesis is more important in Germany than the second. Accordingly, a number of possible explanations have been offered as to the influence of socio-economic status on health. For many of these factors it has already been repeatedly reported that they can make a contribution to explaining health inequality. The following approaches are of primary importance:

- *Working conditions*: employed people in the lower status group are particularly affected by physical and psychological strains at work (e.g. physically demanding work, noise, monotony, lack of opportunity to participate in decision-making); e.g. Noll/Habich 1990, Bosma et al. 1998.
- *Living conditions*: the discussion about the unequal social distribution of environmental strains such as noise and air pollution has begun in Germany too under the key word “environmental justice”. The empirical results are quite clear: the lower status groups are exposed to particularly high environmental pollution (e.g. Mielck/Heinrich 2002).
- *Healthcare*: as yet there are only few results on this topic. They show, for example, that the lower status groups are particularly dissatisfied with outpatient care, that low status persons with diabetes have particularly low attendance rates at diabetes training courses and that low-status people have considerably more missing teeth than those with a high status (e.g. Mielck et al. 2001, Steinmeyer 2001).
- *Prevention*: the lower status groups make less use of most check-ups and early detection examinations than the higher groups (e.g. Delekat/Kis 2001, Kirschner et al. 1995).
- *Health behaviour*: the largest number of results is available on smoking, overweight, high blood pressure and lack of physical activity. These key cardiovascular risk factors are particularly prevalent in the lower status groups. Various studies on nutrition also leave no doubt that nutrition in the low-status groups is generally less healthy than in the high-status groups (e.g. Helmert et al. 1997, Mielck 2000).

What does this mean when it comes to developing intervention strategies? At a very general level, it is possible to distinguish the following two approaches for reducing health inequalities:

1. reducing social inequality,
2. improving the health of people with low status.

The first approach would, as it were, tackle the root of the problem. Its disadvantage is, however, that it requires fundamental structural changes which could only (if at all) be achieved in the long term. Attempts to achieve a reduction in health inequalities in the short- and medium-term will probably be more successful if they focus primarily on the second approach. If this is adopted, one could identify the following goals for low-status persons:

- reduce their exposure to environmental conditions that pose a risk to health,
- enhance the environmental conditions that are beneficial to their health,
- improve their preventive and curative healthcare,
- improve their health behaviour,
- improve their social protection (e.g. financial situation) in the event of illness.

In order to achieve these aims, there must be close cooperation between those involved in the theoretical and practical aspects. Those involved in the practical implementation should inform the researchers about the most important problem areas, and the researchers should use their scientific analysis to produce practical recommendations for the reduction of health inequality. Those on the practical side should then attempt, in the next step, to implement these recommendations and to define new problem areas. At the moment this kind of integration of research and practical implementation – in the sense of an “optimisation cycle” – is barely present. Establishing a process of this kind is also hindered by the fact that in Germany there is no official programme for reducing health inequalities. This alone makes it clear that the key players in the area of health policy are not (yet) paying great attention to the problem of health inequalities.

Current discussions in health policy frequently emphasise the importance of health behaviour and of individual responsibility. Improving health behaviour in the lower status groups would unquestionably result in a considerable reduction in health inequalities. Health behaviour can, however, scarcely be influenced by appeals to take responsibility for one’s own health, particularly when members of lower status groups are being urged by members of higher status groups. Also, health behaviour is frequently not based merely on freely made decisions, but strongly influenced by living conditions. If these complex causes of health behaviour are not considered, there is a great danger that victim will be blamed.

The crucial role played by living conditions also means that strategies for health promotion and prevention must be tailored to each target group. Measures directed at all groups of the population would be more likely to increase, not decrease, health inequalities since campaigns of this type often primarily reach the upper status groups. The more heavily a measure is focused on members of the lower status groups, the more likely it is to contribute to a reduction in health inequalities. Consequently it is particularly

important to carry out the health promotion measures also, and above all, in those places where socially disadvantaged people live, work or spend their leisure time.

1.5 Health promotion for socially disadvantaged people

Until recently it was hardly possible to obtain an overview of health promotion activities that were primarily directed at socially disadvantaged people. In Germany attempts to compile such a review have been rare until now (cf. *Table 3* in the article by Thomas Altgeld and Barbara Leykamm). The extent to which such a review can provide us with information can be illustrated by the following four examples:

1. One review comes from Baden-Württemberg (Social Ministry 1996). Following a conference on “Social Inequality as a Challenge for Health Promotion”, the Social Ministry of Baden-Württemberg carried out a survey in 1996. The final report, “Health Promotion with Socially Disadvantaged People”, lists and gives a brief description of 115 projects.
2. Another review comes from Lower Saxony (Hofrichter/Deneke 2000). In the context of the Regional Conference on Poverty in Lower Saxony, a “Poverty and Health” working group has been in existence there since 1996, organised by the Landesvereinigung für Gesundheit Niedersachsen e.V [Association for Health in Lower Saxony]. This working group gave rise to the idea of “developing a Project Reader for Lower Saxony where practical projects and other initiatives ... can be presented that deal with and are aimed at socially disadvantaged people” (ibid. p. 5). 74 health promotion projects are briefly described in this publication.
3. A third review was developed by the Institute for Medical Sociology at the Heinrich Heine University in Düsseldorf. The project’s focus was nationwide research aimed at locating and describing projects concerned with health promotion among socially disadvantaged people. The final report was submitted at the end of May 2001, but the range of the review was rather small: “Of the 83 questionnaires submitted, 42 projects were reported which involved practical intervention measures in the area of health promotion for socially disadvantaged people. Of these projects 29 were interventions of a fixed duration, whilst 13 are of a permanent nature.” (Siegrist/Joksimovic 2001, p. 21). Most importantly, five exemplary projects were described which addressed the following issues: unemployment and health, AIDS prevention among prostitutes, health promotion in a socially deprived district, health promotion for young people in vocational training, and affordable food.
4. A fourth review is based on a project that was financed by the EU and carried out jointly with partners from the UK and Sweden. It tried to find health promotion activities which can be shown to achieve a reduction in health inequalities among children. The search was restricted to published studies from Western European countries. A total of approximately 40 studies were found, but none of these were from Germany (Mielck et al. 2002).

The fact that these four activities are relatively recent illustrates that there have been attempts in Germany only in the last few years to systematically obtain information about health promotion for socially disadvantaged people. It is, however, also becoming very clear that up to now there has hardly been a system which made it possible to learn from the experience gained in past projects. We know far too little about where which projects were carried out and how successful they have been.

Even more important is the Internet platform that is being presented in this book (see p. 72 ff). It makes it possible, for the first time, to produce a comprehensive overview, constantly updated, of the initiatives aimed at health promotion for socially disadvantaged people and to make this information available to all relevant people and organisations free of charge. The planning and development of health promotion measures could therefore be considerably improved via this Internet platform.

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THOMAS ALTGELD AND
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**HEALTH PROMOTION
FOR SOCIALLY DISADVAN-
TAGED PEOPLE MUST BE
SET UP ACROSS ALL
SECTORS: NETWORKING
ACTIVITIES AT FEDERAL STATE
LEVEL BETWEEN THE HEALTH-
CARE SYSTEM, SOCIAL
SECTOR AND YOUTH
WELFARE SERVICE**



2.1 Introduction

Equal health opportunities is a relatively new topic for the German healthcare system. If it is addressed at all, it at most constitutes a marginal issue in the current debate on health reforms. It is only as part of the implementation of Article 20 of the Social Security Code V, which was revised in 1999 by the statutory health insurance funds, that approaches to and successes in the creation of equal health opportunities through prevention and health promotion measures are being discussed in greater depth (cf. e.g. the Federal Association of the AOK 2001).

Where international health policy is concerned, however, equal health opportunities have been a priority area since the mid-1980s (cf. WHO 1993 and 1998). This became particularly clear in the ministers' declaration on health promotion at the WHO conference in Mexico in 2000 which stated the following in its final report: "Bridging the equality gap is one of the greatest challenges of our times. Promoting health is one effective strategy for reducing these inequalities. To achieve health for all it is essential to focus efforts on improving conditions for the underprivileged and marginalized groups in both developing and developed countries. Health promotion has a major contribution to make in bridging the equality gap and in addressing the main determinants of health." (WHO 2000, p. 1)

Public acknowledgement of poverty in Germany, which, after all, is one of the richest industrialised nations in the world, has been subject to delay at a national level by way of official figures. It was not until March 2001 that the German Federal Government published its first Poverty and Wealth Report which officially makes clear the social contrasts that are part of daily reality in Germany. In particular, the report addresses areas of insufficient care or service provision in different areas of life. The consequences of poverty in terms of health are among the weaker sections of the publication, which is otherwise written in a very sophisticated, pioneering way. The report was chaired by the then Federal Minister for Labour and Social Affairs (cf. Federal Ministry for Labour and Social Affairs 2001).

At the level of the Länder (Federal states) and individual local authorities, however, Poverty and Wealth Reports were published considerably earlier. There were also investigations into the consequences of poverty in terms of health in individual groups of the population prior to 2001 (e.g. regional capital Munich 1990; Parliament of Lower Saxony 1998; Bavarian State Ministry for Labour and Social Affairs, Family, Women and Health 1998; Parliament of Schleswig-Holstein 1999). The fact that the identification of instances of poverty as a theme took place at regional level as early as the 1990s and was linked to other areas of life (e.g. health, education) is a direct effect of the Federal state competencies in many areas, for example as bodies that provide social benefits to several locations within a region or legislators of public health service laws. In the following, therefore, the level of the Federal states will be initially identified as a key interface for

the creation of equality in health. Next is a review of key competencies, activities and structures at the level of the Federal state, after which factors will be named which improve the functioning of cross-sector health promotion work.

2.2 Competencies of the Federal states

Projects in the field of health promotion and prevention aimed at socially disadvantaged groups cannot be organised solely in the context of healthcare and health promotion, but they rather play a key role within the social sector, in child and youth welfare or urban development as a sub-aim of certain measures.

Segmentation resulting from German social legislation in the one hand and the fragmentation of responsibilities between federal government, Federal states and communities in a federal system on the other make it difficult to obtain a precise overview of the health promotion and illness prevention schemes available for socially disadvantaged people. Legal provisions that enable or govern preventive or health-promoting measures can be found in nearly all sections of the social laws (cf. Seewald/Leube 2002).

Over and above social legislation, other legal regulations at national level, for example, maternity protection and occupational safety laws, may develop a preventive effect. At regional level, it is primarily the laws for the public health service in that area and school and environment laws which play a key role, particularly in the health of children and young people.

The complexity of German legislation related to preventive measures has often been criticised in political discussions since the end of the 1990s and has led, among other things, to the founding of the “German Forum for Prevention and Health Promotion” in 2002.

Areas which fall under the responsibility of the Federal states as legislators or regulatory authorities and which might have important preventive effects and health-promoting effects in particular also for socially disadvantaged people are listed in *Table 1* on page 22.

The Federal state competencies also mean that there are differences in the legal regulations. In some Federal states, for example, there have, until now, not been any youth welfare plans, or, with regard to the public health service, the old regulations of the Law on the Standardisation of the Public Health Service are still in force. Nevertheless, the level of the Federal state has proved to be a key stimulus for discussions on equal health opportunities in Germany. This may, in particular, be attributed to the following activities:

- political resolutions at the level of the Health Ministers’ Conference of the Federal states;
- creation of social and health reporting systems which enable social data and health data to be linked;

| Competencies relating to legal regulations at Federal state level |
|---|
| <ul style="list-style-type: none"> • Public health service (14 “new” health service laws in the Federal states, two regulations in accordance with the 1934 Law on the Standardisation of the Public Health Service in Lower Saxony and Hesse) |
| <ul style="list-style-type: none"> • School legislation in the Federal states (16 different regulations) |
| <ul style="list-style-type: none"> • Law on benefits and protective measures for mentally ill people of the Federal states (PsychKG) |
| <ul style="list-style-type: none"> • Legislation on higher education of the Federal states |
| <ul style="list-style-type: none"> • Plans relating to hospital requirements |
| <ul style="list-style-type: none"> • Plans relating to youth welfare in accordance with Social Security Code VIII of the Federal states |
| <ul style="list-style-type: none"> • Environment law of the Federal states |
| <ul style="list-style-type: none"> • Agreements on group prophylaxis of the Federal states (in accordance with Section 21 of the Social Security Code V) |

Table 1: Competencies pertaining to legal regulations at the level of the Federal states

- creation and/or promotion of structures which provide services and create networks between the social work, health, youth welfare and education sectors;
- creation of inventories of projects that create equal health opportunities.

All the areas referred to are shown in the following in the form of a summary and/or with the aid of examples.

2.3 Resolutions adopted by the Health Ministers’ Conferences of the Federal states

The Health Ministers’ Conference of the Federal states has addressed the area of “equal health opportunities” several times, primarily in relation to children and young people. The most important resolutions are described briefly below.

In 1997, the 70th Health Ministers’ Conference of the Federal states [Gesundheitsministerkonferenz; GMK] passed a unanimous resolution on the “Effects of social disadvantage on children’s health”. In this resolution it is emphasised “that social disadvantage constitutes a health risk” (Health Ministers’ Conference 1997, p. 1). In addition, the range of healthcare services provided is examined closely in relation to its benefits for socially disadvantaged groups: “An appropriate range of services is available, but its usability and effectiveness must be examined from the perspective of socially disadvantaged groups ... Close proximity to social and health assistance together with improved cooperation between service providers is required in order to recognise problems where they exist, deal with them effectively and facilitate the use of these services ... By linking services together, access barriers can be broken down.” (ibid. p. 3)

This resolution also involves extensive differentiation of different socially disadvantaged groups of children whose health situation is to be improved. This list represents the first time that an attempt has been made to carry out systematic differentiation of sub-target groups for the child/youth sector and makes it clear that very varied situations with regard to poverty and health are encountered among children and young people. This differentiation of precisely defined sub-target groups can be utilised for the development of health promotion and prevention activities. It also shows that other institutions from the social and youth welfare sector are already involved in support and must therefore be included in any programme planning that may take place. The following sub-target groups are differentiated:

- children of single parents
- adolescents whose mothers are single parents
- families with many children whose living conditions are strained
- children of foreign citizens who are not integrated into society (e.g. migrants, asylum seekers and civil war refugees)
- children of unemployed parents
- children of parents with an addiction problem
- children with disabilities
- children from disadvantaged residential areas
- special needs pupils and pupils attending a “Hauptschule” (less academic secondary school)
- young people who are unemployed (e.g. young people without an apprenticeship placement, young adults who have not completed any professional training or are unemployed)
- young people with no fixed home (ibid. p. 2 ff)

In 2000 the 73rd Health Ministers’ Conference adopted the “Quality Standards for the Reduction of Repercussions on Children’s Health” (cf. Stender 2000a). The conference is based on the resolution of the 70th Health Ministers’ Conference and defines three key elements for reducing the effects of social disadvantage on children’s health:

1. Quality standards which were significant in reducing social disadvantage in all stages of childhood and youth. Among other things, it is stated that there should be regional cooperation between key players from the health and social care system and that institutions and people, particularly from outside the health sector, should be involved to provide information relevant to health.
2. Agreement on suggested improvements from the time before birth to the end of infancy. Among other things, targeted cooperation between gynaecologists, paediatricians, paediatric nurses at counselling centres for mothers, midwives (wherever they work, including in the home), hospitals and information centres are proposed with the aim of achieving the more purposeful employment of midwives.
3. Quality aims for care of and health promotion among children aged 1 to 6 years, paying particular attention to daycare centres for children. Among other things, there

are demands for the integration of health and health promotion into the daily lives of children in daycare centres, and also for early support (cf. Stender 2000a, p. 2 ff).

In its session in 2002, the 75th Health Ministers' Conference unanimously decided on the proposal: "Health of children and young people: prevention, early detection and early intervention must be strengthened". This includes the proposal that "A focus of future measures and activities must be increasingly in the areas of health promotion, preventive measures, early detection and early intervention" and above all be directed at the target group of socially disadvantaged children and young people.

Discussion on health targets at national level is expressly welcomed and supported in this proposal, namely the working groups on the topics "Health Targets for the Under-20 Age Group" and "Quit Smoking". In addition, the Health Ministers' Conference is in favour of better coordination and networking of all services, above all those provided by youth welfare, schools, health services and family education close to where people live.

The resolution makes a plea for health reporting to be developed further. "More consideration should be given to class and gender-specific aspects. Moreover, it is important to find better ways of bringing together social and health data." Other points in the resolution are concerned with increasing the number of young non-smokers, improving protection by immunisation, increasing the number of people who make use of early detection tests and developing recommendations for early detection and early intervention.

2.4 Creation of social and health reporting systems which allow social data and health data to be linked

In order to be able to develop effective measures for socially disadvantaged groups, improvement in the available data was required. This development was, at the level of the Federal states, of a double-tracked nature. In some Federal states, as part of reporting on social affairs and poverty, health as a living condition was also picked out as a theme and integrated into the reporting (for example the Parliament of Lower Saxony 1998; Bavarian State Ministry for Labour and Social Affairs, Family, Women and Health 1998; Parliament of Schleswig-Holstein 1999). In parallel to this, social indicators were increasingly adopted in health reporting (e.g. the Hamburg Authority for Labour, Health and Social Affairs 1995 and 2001; Ministry for Women, Young People, Families and Health for the Region of North Rhine-Westphalia 2000). The revision of the set of indicators for the regions for health reporting makes it possible to link social and health data. The most important cross-sector health and poverty reports at the level of the regions are listed in *Table 2*.

| Year of publication | Title | Published by |
|---------------------|--|--|
| 1995 | <i>Health of children and young people in Hamburg</i> | Freie und Hansestadt Hamburg [Free and Hanseatic City of Hamburg], Authority for Labour, Health and Social Affairs |
| 1998 | <i>Report by the government on the the social situation in Bavaria</i> | Bavarian State Ministry for Labour and Social Affairs, Family, Women and Health |
| 1998 | <i>Regional report on the development of poverty and wealth</i> | Parliament of Lower Saxony |
| 1999 | <i>Regional poverty report, Schleswig-Holstein</i> | Parliament of Schleswig-Holstein |
| 2000 | <i>Health of migrants in North Rhine-Westphalia; health of men and women in North Rhine-Westphalia</i> | Ministry for Women, Young People, Families and Health for the Federal state of North Rhine-Westphalia |
| 2001 | <i>Social situation and health of young people in Federal state of Brandenburg 2001</i> | Ministry for Labour, Social Affairs, Health and Women |
| 2001 | <i>City diagnosis 2</i> | Freie und Hansestadt Hamburg [Free and Hanseatic City of Hamburg], Authority for Labour, Health and Social Affairs |
| 2002 | <i>Report on the health of children and young people</i> | Lower Saxony Ministry for Women, Labour and Social Affairs |
| 2002 | <i>Children's nutrition in Baden-Württemberg</i> | Baden-Württemberg Ministry for Nutrition and Rural Areas and Social Ministry |

Table 2: The most important cross-sector health and poverty reports at the level of the region (1995–2002)

2.5 Creation and development/promotion of structures which provide services and create networks between social work, healthcare systems, youth welfare and education sectors

The formation of structures at Federal state level to reduce unequal health opportunities resulting from the social situation is diverse in nature. Common to all developments is a wish for greater interlinking with other social subsystems. Until now the health system (like other social subsystems) has been a rather closed system without significant links to or cooperation with the labour employment sector, social affairs, education or youth welfare sectors. This is also a significant handicap in the current discussion on effective

implementation of Article 20 of the SGB V [Social Security Code]. In the legal text itself it is only in the area of occupational health promotion that there is an obligation to refer to the Social Security Code VII and collaborate with accident prevention and insurance associations. There were no references at all to other main players at the level of the local authorities or of the regions since, when drawing up the legal text, the Federal Council and its competencies were to be factored out. This is proving however to be a crucial error in the law (cf. Altgeld 2000), which has a major negative impact on the implementation of Article 20 with regard to the commitment to create equality in health opportunities. In the draft law, the public health service was named as a partner for health promotion activities but this passage was deleted without being replaced since it had to be approved by the Federal Council.

It would also have been conceivable to formulate a regulation similar to that formulated for Article 21 of the Social Security Code V. This stipulates that the health insurance funds must, “in collaboration with dentists and the institutions responsible for dental care in the regions, without prejudice to the tasks of others, jointly and in a standardised way, promote measures for detecting and preventing dental diseases among those insured with them who have not yet reached the age of 12, and contribute to the costs of implementation” (Paragraph 1). For implementation, general agreements should be concluded at regional level (Paragraph 2). In the event that such an agreement is not reached by the deadline of 30 June 1993, “the content, financing, documentation not relating to the insured and control are determined by a legal decree by the Federal state government, taking into account the standardised national general recommendations by the central associations of the health insurance schemes” (Paragraph 3). This setting of a deadline, combined with the “threat” of a legal decree by the relevant regional governments, has resulted in general agreements being concluded in all Federal states of Germany which have substantially improved group prophylaxis. As this obligatory agreement at regional level has been chosen, it has also been possible to take account of region-specific conditions (e.g. the relevant ÖGD [public health service] laws and institutions at regional level). A regulation along the same lines has not been followed up any further in the new version of Article 20 of the Social Security Code V (cf. also Lower Saxony Regional Association for Health 1999).

Various routes have been chosen in the individual Federal states to try to improve networking between the different sectors. In particular, three areas of activity can be recognised at this level:

- establishing focuses of work aimed at achieving equal health opportunities in regional health offices,
- establishing focuses of work aimed at achieving equal health opportunities in the relevant regional health associations,
- equal health opportunities as a topic of health conferences or within the formulation of health targets at regional level.

Individual Federal states such as North Rhine-Westphalia, Brandenburg, Lower Saxony and Mecklenburg-Western Pomerania have simultaneously developed activities in two or three of the named areas. In the following, the individual areas will be presented using individual examples so as to illustrate clearly the different approaches.

Establishing focuses of work in regional health offices aimed at achieving equal health opportunities

In some cases, establishing focuses of work in regional health offices aimed at achieving equal health opportunities is closely linked to activities connected with region-specific health reporting (cf. Chapter 2.4). In Baden-Württemberg, furthermore, for the first time in a regional health office, they have begun to develop additional activities. In 1995, the Social Ministry of Baden-Württemberg organised a symposium entitled “Social Inequality as a Challenge to Health Promotion”. A review of initiatives, projects and ongoing services aimed at health promotion for socially disadvantaged people was published in 1996 (cf. Chapter 2.6). In the following years, regional events on the subject were held which provided information on steps that might be taken in this area. In 1998 a planning group was set up which consisted of specialists from the public health service and other sectors. The aim of the planning group was to develop a planning manual under the heading of “Healthy Children – Equal Opportunities for All” (Baden-Württemberg Regional Health Office, NRW [North Rhine-Westphalia] regional institute for the public health service 2003) and to hold a conference on the subject. In addition, it was intended that equal health opportunities for children be a permanent topic in the regional working groups for health.

The “Manual for the Public Health Service to Promote Participation in Health Issues” published in 2003 in collaboration with the NRW regional institute for the public health service is designed to contribute towards creating a bridge, otherwise a rare occurrence, between academia and practical work. It provides basic principles for the area of “social and health inequality in Germany”, defines children and young people as an important target group, gives an overview of systems of help for these target groups and the limits of their effectiveness and outlines approaches for changing local practices. This is achieved both by providing a theoretical foundation and by using projects, checklists and literature references. The chapter on the systems of help, for example, names the seven “most important barriers to health promotion for socially disadvantaged people”:

- “lack of information,
- lack of time and insufficient mobility,
- language barriers,
- services offered that do not take specific living conditions into account,
- the image of the authorities,
- cognitive barriers: attitudes, values and priorities,
- finances” (ibid. p. 60 ff).

The list of information deficits on both sides is of particular interest:

“socially disadvantaged groups have little knowledge of:

- behaviour with regard to health risks and dealing with health problems,
- health promotion in general and implementation of recommendations in everyday life,
- provision of standard healthcare and relevant contact persons,
- needs of children and young people and particular opportunities for health promotion,
- their rights.

Those involved in health promotion often have too little knowledge of:

- the links between poverty and health,
- needs, problems, circumstances and requirements of the target group,
- the extent of potential poverty in that geographical area,
- possible cooperation partners,
- existing support services for the target group” (ibid. p. 60).

Subsequently, assistance is provided in overcoming hurdles by using an information flow checklist. The booklet on practical implementation emphasises the unique role of the public health service and gives valuable working tips both to those who have little or no experience in the area and to those with many years’ practical experience.

Over and above this manual, in 2003 practical tips relating to networking and planning in health promotion, training of multipliers, nutrition, physical activity and relaxation were developed at the Baden-Württemberg Regional Health Office in collaboration with the public health service project group. There already exists a draft project for public health services in the area of obesity prevention for practical implementation locally, under the title “Leicht durch(s) Leben” [Lightly through life]. (Baden-Württemberg Regional Health Office 2002). Activities of a similar nature, even if in some cases these have different focuses, have been developed in the regional health offices of Brandenburg and Lower Saxony and in the regional institute for the public health service in North Rhine-Westphalia.

Establishing focuses of work in the Federal and regional associations for health [Bundes- und Landesvereinigungen für Gesundheit] aimed at achieving equal health opportunities

At regional level, there exist tried and tested models in most of the regions for networking and coordinating health promotion activities. Regional associations for health/health promotion took on this role in 12 of the 16 Federal states and have proved to be effective forms of organisation in this context. The individual institutions have been developed over differing lengths of time and have different focuses that are specific to the region. All the regional associations are designed as member associations, i.e. institu-

tions and individuals from the health, social and education sectors organise themselves within the association. The members range from statutory health insurance funds, medical/pharmacists' associations, professional associations, employer/ employee organisations, self-help groups, local authorities and adult education centres to individuals from political or academic spheres. The actual networking is arranged in various levels. The following are networked:

- the formal and informal sector,
- scientific knowledge and practical implementation,
- health promotion approaches and preventive concepts,
- different specialisms,
- sponsors and service providers,
- different “settings” (e.g. school, local authority and companies),
- health promotion and quality management strategies.

These networking activities are in turn achieved by means of different access methods and services. The standard services offered by most regional associations include:

- conferences, further education opportunities and seminars,
- working groups on specific topics,
- project planning and consultancy,
- design and implementation of independent model projects,
- evaluation and documentation assistance which has practical relevance,
- media, documentation and assistance,
- exhibitions,
- creation of an information pool,
- publishing of newsletters for health promotion purposes,
- databases.

The main areas of activity in the regional associations for health vary depending on structural conditions in the region. Traditionally, the following are heavily represented: “health promotion in schools and nursery schools”, “municipal health promotion”, “combating health inequalities”, and “occupational health promotion”. Equal health opportunities as a separate focus play a key role primarily in the regional associations in Berlin, Hamburg, Mecklenburg-Western Pomerania, Lower Saxony, Saxony-Anhalt and Thuringia. It has a fixed position in all regional associations as a requirement of work in health promotion settings across all areas. This publication will also outline the steps that might be taken in this area, using an example from Lower Saxony below.

In establishing the “social situation and health” focus of work in 1995 in the Lower Saxony Regional Association for Health, the aim in particular was to provide the multipliers from the health and youth welfare sectors a greater awareness of the health risks of socially disadvantaged people. Moreover, a platform was to be created which made it possible to develop comprehensive strategies for action. For this purpose, a region-wide working group on “Poverty and Health” was initiated as part of the Lower Saxony regio-

nal conference on poverty which was started in 1995 with involvement of the central associations of the Freie Wohlfahrtsverbände [independent charitable associations], the DGB [Federation of German Trade Unions] region of Lower Saxony-Bremen and of groups and initiatives. This connection to the regional conference on poverty enabled the desired exchange between the different sectors to be achieved more effectively.

The working group has been continuously active since 1995. A key focus is the training of multipliers via conception or encouragement of different specialist conferences. In the past, a region-wide survey of health-related projects from the social and youth welfare sectors was prepared and then carried out by the Lower Saxony Regional Association for Health. In the first year, the working group analysed a variety of municipal health and social reports and discussed these with the relevant municipal offices. This discussion gave rise to recommendations on networking social and health reporting which were intended to make it easier to interlink the two reporting systems at the levels of local authority and region where local resources are scarce and which aim to improve the available data (cf. Lower Saxony Regional Association for Health 1997). The recommendations included the following:

- “Networking social and health reporting at an early stage is necessary. Since various departments are generally responsible for this at municipal level, there is not usually a unified approach. Consequently it tends to be the rule rather than the exception that there is fully independent, separately performed data collection and reporting ... Attempts must therefore be made to interlink the two areas better. This dovetailing begins a mutual exchange of information about intentions, contacts between relevant employees and may lead to the joint planning of measures.
- In view of the shortage of public money, general surveys of a smaller nature may be the model for municipal health and social reports; hypothesis-derived, more pragmatic forms of reporting are probably easier to produce in these conditions. These should cover as small an area as possible, for example, at the level of a town district. In this way, requirements for assistance at a municipal level can be identified and it may even be possible to develop health targets at a municipal level ...
- Quality assurance in school admission health checks is necessary. Up to now there have been only few quality assurance measures taken in this area. They must be introduced, however, at regional and national level to make the data more reliable and to ensure comparability.
- Better transparency of the available data at municipal level must be aimed at. Most of the data collected are accessible neither for the purposes of municipal policy nor for the public, since either no analysis is performed or it is made available only to a small group. Regular publication of the data available for those involved in policy-making and for practical municipal healthcare and social work can improve the effectiveness of specialist discussions and the planning of measures.
- Institutionalised collaboration between youth welfare planning, the public health service and social planning – for example in the form of working groups that span different departments – is necessary. This allows the data available to be analysed and

may be the stimulus for the production of small reports. In addition, it enables assistance planning and the use of resources to be improved.” (cf. *ibid.* p. 1 f)

In 2002 a practical guide to assist social projects when applying for resources was drawn up in accordance with Article 20 of the Social Security Code V (cf. Lower Saxony Regional Association for Health 2003) and its implementation in the social sector in Lower Saxony was studied. In addition, various project consultations were carried out, for example on medical care in a newly established care home for the homeless and for the creation of municipal networks on poverty and health. At the moment, the working group consists of 29 members from the research and education sectors and also from the social, youth welfare and health sectors.

Overall, the Lower Saxony Regional Association for Health has, in collaboration with the working group on “Poverty and Health” and other institutions, organised more than 20 specialist conferences on the issue of “equal health opportunities”. Below are just a few examples of the issues handled at the conferences:

- Poverty and ill health: interactions between ill health/good health and the social situation of women (1996);
- Unemployment and health (1997);
- You don’t see the ones in the dark – poverty and the risk to children’s health (1998);
- People on the streets: psychiatry, help for the homeless and the people with addictions (1998);
- Living on the streets. On the health and social situation of women and men, girls and boys whose lives are centred on the streets (1999);
- Addiction and poverty (1999);
- A virtual stranger. What does an intercultural approach mean for work with children and young people from different cultures? (2000);
- Soup kitchens in the land of milk and honey? Nutrition and poverty (2000);
- Does no one notice anything? Poverty in the everyday lives of children in daycare centres and schools (2001);
- Poverty and violence!?! (2001);
- The social situation and the education of children ... and the consequences for their health (2002);
- “Children and money” practical workshop (2002);
- Chronically ill, chronically poor? (2003).

Most of the specialist conferences have been documented (one example being Altgeld/Hofrichter 2000) and consequently the materials produced can also be made available to a wider circle of multipliers. In addition, equal opportunities have been chosen as a focal theme with different emphases in terms of content for different editions of the newsletter on health promotion, “impulse”, which the Regional Association publishes every quarter with a circulation of 5,000. In this way it is also possible to reach multipliers from the health, social, education and youth welfare sectors.

In Berlin in 2003, Gesundheit Berlin e.V. [Association for Health Promotion Berlin] organised what is now the ninth national congress on “Poverty and Health”. It takes place annually and regularly has around 800 participants. The congresses are also documented in detail and constitute a comprehensive collection of materials and projects for health promotion among socially disadvantaged people (cf. for example Geene/Gold/Hans 2001 and 2002 and the specialist article by Raimund Geene in this publication).

The work in the regional associations is characterised by its focus on further education and training of multipliers, the collection and target group-oriented preparation of information, charring and founding working groups that span different bodies, and drawing up of guides on practical implementation and the initiation of model projects. In all the regional associations where a special focus has been placed on equal health opportunities, a number of relevant activities have been developed over the last ten years. Moreover, there has been a pooling of resources and improved networking of different social subsectors. In the area of medical care for homeless people, for example, new forms of collaboration between the health and social sectors have been introduced.

For example, the Lower Saxony Medical Association has launched an appeal for the voluntary involvement of doctors in organisations providing assistance to homeless people along with a mobile healthcare service which seeks out homeless people. In addition, it has been possible to ensure that the mobile service is staffed by doctors and makes available medical consultations in institutions that provide assistance to the homeless. Furthermore, the Lower Saxony Medical Association has, via an associated institution, carried out an evaluation of the first care home for the homeless in Hanover and organised outpatient medical care for the sick person’s home. Cooperation between different bodies from various sectors can only function, however, if it is associated with an expected benefit for the different partners, of whatever nature this may be, and if this can be realised.

Intermediate structures and professional facilitators with key qualifications that are present in the regional associations make it easier to create structures of a neutral nature that span different organisations.

Equal health opportunities as a topic of health conferences or within the formulation of health targets at Federal state level

Equal health opportunities play a key role within the work of individual regional health conferences and in the discussions on health targets that are instigated by an increasing number of Federal states. To give examples of this emphasis, the work of the regional health conference of North Rhine-Westphalia, along with the new health target processes from Brandenburg and Mecklenburg-Western Pomerania will be presented briefly here.

In 1991 in North Rhine-Westphalia, a regional health conference was founded as an analogous structure to the regional associations with the aim of achieving better dovetailing of the public health system. The regional health conference can be understood as a stimulus for a new culture of joint action in the health system in North Rhine-Westphalia (cf. Weihrauch 2003). In 1995, a comparable structure was tested out at local level in 28 local authorities of the region with the project “Local coordination of health and social care”. The law on the North Rhine-Westphalia public health service (ÖGDG) enshrines both the regional health conference and the municipal health conferences in law.

Resolutions and declarations from the most recent regional health conferences have been prepared in working groups and decided on at the general conference. In the area of equality in health, the following resolutions have been the most important in determining the direction:

- “Strengthening the position of citizens and patients in the public health system of North Rhine-Westphalia”,
- “Health for children and young people in North Rhine-Westphalia”,
- “Social situation and health”.

In the resolution from the 10th regional health conference in 2001 on the issue of “Social situation and health”, recommendations and background information were provided on three areas:

- gender-specific aspects of health and illness,
- class-specific inequalities of health (particularly in the case of children, young people and homeless people),
- the health of immigrants (cf. Ministry for Women, Young People, Families and Health in the Federal State of North Rhine-Westphalia 2001).

In eight Federal states health target processes have been started at regional level:

- Hamburg,
- North Rhine-Westphalia,
- Berlin,
- Saxony-Anhalt,
- Schleswig-Holstein,
- Lower Saxony,
- Brandenburg,
- Mecklenburg-Western Pomerania.

In Bavaria, a similar project has been launched under the name of “bayernaktiv” [active Bavaria], which aims to improve the health situation in Bavaria. It was not, however, conceived explicitly as a project dealing with health targets but rather as an umbrella campaign for various activities in the areas of healthcare, prevention, research and health promotion.

The health target processes and their implementation are at different stages of development. Hamburg and North Rhine-Westphalia started this at the beginning of the 1990s, the other Federal states much later. In some target processes, particularly in the newer activities centred on the formulation of targets in Lower Saxony, Brandenburg and Mecklenburg-Western Pomerania, a key role is played by equal health opportunities.

In 2003 in Brandenburg a target-related discussion started concerning the health of children and young people. As with Hamburg and Lower Saxony, the target discussion process was to focus exclusively on children and young people. A process of health target development was set in motion by the Ministry for Labour, Social Affairs, Health and Women in the context of a specialist conference. “Together with all those involved in healthcare and support, particular deficits will be identified on the basis of valid data, suggestions for solutions will be produced and tools for achieving those targets about which consensus can be reached will be developed.” (Ministry for Labour, Social Affairs, Health and Women in the Federal State of Brandenburg 2003, p. 1)

Even in the context of the opening conference, social situation was taken as a core topic across all target issues: “The social compensation aspect should be given particular consideration with all topics that are under discussion.” (ibid. p. 2). The target areas decided upon range from immunisations and accident prevention to health promotion/addiction prevention in the settings of daycare centres for children and schools (cf. ibid. p. 4). The process of target definition in Brandenburg is due to be completed in 2003.

In Mecklenburg-Western Pomerania, May 2003 saw the adoption at a child health conference of a catalogue of aims entitled “Grow up healthy and with equal opportunities in Mecklenburg-Western Pomerania”. “In the process, the health target of “Grow up healthy: nutrition, physical activity and combating stress” that was formulated in the *gesundheitsziele.de* nationwide campaign should be taken up and implemented in a way that is region-specific.” (Social Ministry of Mecklenburg-Western Pomerania 2003, p. 1) This makes Mecklenburg-Western Pomerania the first Federal state to push at federal level such a region-specific adaptation of the model health targets that were developed as part of *gesundheitsziele.de* (cf. Altgeld 2003). “The four health targets developed for Mecklenburg-Western Pomerania for this purpose in the areas of physical activity, nutrition and combating stress should be a top priority for daycare centres for children, schools, family and free time. The needs of socially disadvantaged children should be given particular consideration.” (ibid.)

Over and above the implementation of the four target areas, another six health targets have been developed which are designed to improve “preventive healthcare and healthcare provision” (cf. ibid. p. 2). The concept consists of the following ten targets:

- development of opportunities for physical activity, to reduce lack of activity,
- promotion of healthy eating behaviour to reduce malnutrition,
- strengthening ability to deal with stress,

- improvement of overall conditions in relation to health promotion and addiction prevention in the environments of children and young people,
- preventive check-ups among children and young people,
- oral health among children and young people,
- immunisation,
- treatment and support of chronically (allergy-related) ill children,
- psychiatric healthcare for children and young people,
- health of infants and reduction of the number of premature births.

For all ten target areas, in preparation for the child health conference, precise targets were formulated in working groups and partial targets/areas of action, the people at whom the measures are targeted, proposed measures and potential partners for the implementation were decided upon. In a follow-up conference in 2005, an initial interim balance sheet will be drawn up. “The social ministry is being asked, in close collaboration with the regional association for health promotion and other partners necessary for this purpose, to chair and coordinate the entire health target process in the future. The child health conference refers to the fact that this process must be established on a long-term basis and should therefore be designed in a way that is flexible and open for the other participants.” (cf. *ibid.* p. 2)

Common to all three processes is a close dovetailing of the health sector with the social and youth welfare sector. Both the collaboration within the regional health conference and the child health conferences as part of the discussions on targets have been designed in a way that crosses sectors.

2.6 Compilation of reviews of projects that produce equal health opportunities

Most of the actual practical projects aimed at reducing health inequality are in the social sector. Here suitable access routes exist to the target group of socially disadvantaged people. There are, however, also opportunities and needs for action in the health sector which as yet have not been exploited. In five Federal states, reviews of health-related services in other support schemes have been produced which are aimed in particular at socially disadvantaged people. *Table 3* on page 36 gives an insight into the structure of the studies and their results.

With the exception of the first review from Baden-Württemberg, all the surveys relate to regions. In Hamburg and Berlin, data have been collected only from the child and youth sector, and the other surveys also establish a clear focus of services in this sector (cf. Lower Saxony Regional Association for Health, 1999; Social Ministry of Baden-Württemberg 1996). Evidently, little has changed in the structure of services provided, since even the initial report from Baden-Württemberg states that: “With regard to the target groups, we

| | BADEN-WÜRTTEMBERG | LOWER SAXONY | BERLIN | HAMBURG | THURINGIA |
|--|--|---|---|---|--|
| Period of the data collection | 1995/1996 | 1998/2000 | 2001/2002 | 2002 | 2002/2003 |
| Scope of the survey | Baden-Württ. and, in some aspects, nationwide | Lower Saxony | Berlin | Hamburg | Thuringia |
| Projects recorded in total | 115 | 74 | 544 | 428 services from 102 institutions | 123 services from 112 organisations |
| From the following areas in the social and youth sector | Children/young people; girls/women; single parents; families; people receiving social security benefits; unemployed people; homeless people/street children; immigrants; prison inmates/convicts; AIDS/HIV patients; addicts; disabled people; old people; residents of particular districts | Unemployed people; families; women/girls; community; inmates; children/young people; ill/disabled people; people from an immigrant background; multipliers; homeless people | Health promotion services in the child and youth welfare sector | Institutions for public youth work | Health-related services for socially disadvantaged people in education, social and health fields |
| Nature of survey | Nationwide review of model services | Region-specific survey linked to a qualitative analysis of two model regions | Region-specific survey | Region-specific survey of the youth sector | Region-specific survey and qualitative follow-up survey of 25 projects |
| Financed by | Regional resources | Regional resources; Federal Ministry for Research and Education | Regional resources | Student project at the Hochschule für Angew. Wissenschaften [University of Applied Sciences], published by the Hamburg Working Group for Health Promotion | AOK Thüringen |
| Year and type of publication | 1996 as a project reader | 1999 as a project reader | Not yet published | 2003 as an overview of institutions in the regions with examples of health-related services | 2003 as a project reader |

Table 3: Surveys of health-related services in Baden-Württemberg, Lower Saxony, Berlin, Hamburg and Thuringia

notice that there are scarcely any projects involving young males, furthermore, there are very few projects involving homeless people/street children, recipients of social benefits and old people. The small proportion of projects specific to districts underlines the need for greater consideration to be given to community orientation.” (Social Ministry of Baden-Württemberg, 1996, p. 6)

In Lower Saxony a qualitative analysis of two model regions was carried out between 1999 and 2001 to supplement a nationwide survey. The study results show that suitable access routes exist to the target group of socially disadvantaged people, but not actually in the health sector itself. The study very clearly shows that there are “forgotten” target groups in the areas of prevention and health promotion – groups where there exists a need for action to be taken but only few or no services. These target groups are as follows:

- socially disadvantaged men in general,
- young males,
- migrants, particularly males,
- unemployed people, particularly those whose family were migrants,
- old people (cf. Waller et al. 2001, p. 65).

The analysis carried out in Thuringia 2003 also arrived at similar results: “It was also established that the majority of providers make use of traditional health education methods. The services are very strongly knowledge-oriented. The reported services are for the large part individual types of assistance i.e. a relation to settings and/or social environment can only be ascertained for a few services. The services identified are primarily found in conurbations which usually have a very good infrastructure in parts, high purchasing power, a high level of education and a low unemployment quota.” (cf. Agethur 2003, p. 2). In Lower Saxony too, half of all the services were found in the Federal state capital Hanover, although only 7% of the Lower Saxony population live there (cf. Deneke et al. 2001, p. 48).

The conclusion reached in the investigation carried out in Hamburg is also interesting: “In the area of public youth work, specifically those target groups are reached who are hardly addressed at all by “conventional” health promotion. Whilst the focus of the services is in the area of physical activity and sport, additional services are viewed as particularly necessary in the area of nutrition. It is evident that here – in addition to the need for health promotion – that there are gaps in healthcare which cannot be met by youth institutions owing to the current staffing and material resources available to them.” (Institut für Gesundheitswissenschaften e.V. 2003 [Institute for Health Sciences], p. 53). The Hamburg investigation also comes to the conclusion that socially disadvantaged young males are reached very effectively through public youth work (ibid. p. 5).

In 2001 in Lower Saxony, the implementation of Article 20 of the Social Security Code V in the social and youth welfare sector was also investigated. The statutory health insurance schemes have as yet not demonstrated any significant initiatives for fundamental

reorganisation of their activities for primary prevention among socially disadvantaged target groups. This may be understandable in view of the increasing pressure of competition within the area of statutory health insurance and the financial situation; however, it remains unclear why the social sector has not yet demanded greater involvement on the part of the health insurance schemes.

Most of the institutions surveyed (58%) do not even know that the statutory health insurance schemes can give financial support to projects for health promotion as outlined in Section 20 of the Social Security Code V. Nevertheless, 40% of those surveyed know about the legal initiative (cf. Richter/Altgeld 2002, p. 125 f). Most of the institutions and persons questioned receive no support and as yet have only received insufficient information about the newly created opportunities for primary prevention. As the investigation shows, however, there is no shortage of ideas for projects and ongoing interest. Yet the obstacles encountered when submitting applications are too great, and far more information and education work is needed than has so far been carried out (ibid.).

Above all, an information policy across sectors would appear to be urgently needed, so that one does not repeat in practice the example set at the level of the specific ministerial departments that has so far been too narrow – namely the completely unconnected development of two sectors which are fundamentally closely linked. On the basis of the results of the investigation, a project manual has been developed which is designed to make it easier for projects from the social and youth welfare sector to apply for resources from statutory health insurance schemes (Lower Saxony Regional Association for Health 2003).

All the studies presented have shown that health promotion can profit from experience gained in other sectors and that, conversely, suggestions from the health promotion sector can inspire work in other areas. The results from Baden-Württemberg and Lower Saxony played a key role in the discussion about the activities of statutory health insurance schemes in the area of primary prevention. Harmonisation between statutory health insurance schemes and social work organisations is slow to take place and is unfortunately sometimes overwhelmed by demands and expectations on both sides without any concrete directions for action being found. Regional associations for health, working groups that span different organisations or regional health conferences could form bridging organisations in this case which could lay the foundation for closer dovetailing of health promotion and primary prevention activities across sectors.

2.7 Conclusion

Greater cooperation between the health and social sector was requested back in 1998 by Mühlum et al. in the policy paper on “Social Work and Health” (Mühlum et al. 1998). In the concluding recommendations they summarise it as follows: “The relationship between social work and health work should be realigned in practice, teaching and theory.

In particular, the connection between health and living conditions should be given greater consideration. Social and health professions must, accordingly, be repositioned” (ibid. p. 120). This repositioning has not been carried out by either of the two parties.

A clearer positioning of the health, social and youth welfare sector in relation to community activities – combined with concrete cooperation projects – would be desirable. At regional level, there are some examples which show that this cooperation works. This cooperation will be made easier if political will at the top level of the relevant Federal state ministries sets a focus on the area of equal health opportunities as a key aim. In view of the heterogeneity of structures at regional level, various structures could promote closer dovetailing between the sectors, in particular regional associations for health or regional health conferences: i.e. structures which by their very nature work across the various bodies and are able to moderate and to lead, in order to facilitate cooperation on the part of the different players.

This increasing formation of structures and promotion at national level which should drive forward prevention and health promotion activities, in particular for socially disadvantaged people, is reliant on partners in the federal system for the purposes of implementation. Examples of these structures at national level are:

- the new version of Article 20 of the Social Security Code V,
- the Federal Government’s Soziale Stadt [Socially Integrative City] programme and its accompanying programme Entwicklung und Chancen [Development and Opportunities],
- the national discussion process for drawing up health targets “gesundheitsziele.de” with equal opportunities as a theme running through the formulation of objectives,
- the founding of the Deutsches Forum Prävention und Gesundheitsförderung [German Forum for Prevention and Health Promotion] at the Federal Ministry for Health and Social Security,
- the ongoing survey of projects and measures for health promotion among socially disadvantaged people in the Federal Republic of Germany carried out by the Federal Centre for Health Education and Gesundheit Berlin e.V. [Association for Health Promotion Berlin] (cf. p. 65 ff).

The processes at national, regional and local level may produce substantial synergy, particularly if equal health opportunities are anchored as a political aim at all levels. This development is relatively new for Germany. The implementation of Article 20 of the Social Security Code V and the development of quality standards for projects and measures for health promotion among socially disadvantaged people are the first concrete opportunities for implementation of improved cooperation. Health promotion among socially disadvantaged people is a task for the community and one in which all players must be incorporated and which can only be successful by means of a stronger intersectoral approach. The intersectoral nature begins with a mutual exchange of information and may result in joint project planning and implementation as is already shown by the experiences in some Federal states.

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RAIMUND GEENE

**NINE YEARS OF
"POVERTY AND
HEALTH" CONGRESSES**



The setting is Berlin, autumn 1995. Gerhard Trabert, a committed doctor from Mainz, and Jenny de la Torre were making preparations at her surgery specialising in medicine for homeless people at the Berlin East railway station for the annual flood of homeless people which begins every year with the onset of the winter weather. Ellis Huber, President of the Berlin Medical Association, was keen to follow tradition and Rudolf Virchow's legacy. He wanted to widen the scope of medical practice to include health problems related to social status. A group of students on the new "Public Health" course at the Technical University of Berlin were preparing to compare theoretical knowledge about social epidemiology developed in their academic ivory tower with the real experiences of those affected and practitioners in the field. Together they developed the concept of a national "Poverty and Health" congress in Berlin. The conference was organised by the recently founded registered association of health promotion, Gesundheit Berlin e.V. [Association for Health Promotion Berlin] and the Medical Association subsidiary MUT.

In terms of subject matter the congress was restricted to the health problems of migrants, homeless people and single mothers. Initially, still largely excluding the public, with no response from academic circles, politicians or associations, over 200 people affected by social deprivation together with their professional helpers gathered to discuss the conditions needed for health in their given circumstances and strategies for promoting health.

In spite of the small number of people attending, the exchange of experiences encouraged the local practitioners and gave them hope and new strength to continue the often difficult work they do in the area. A follow-up congress was arranged and took place a year later. Yet this second congress was accompanied by an even greater sense of their "stewing in their own juice" and a feeling that they were not in fact reaching the target audience for improving the health situation of poor people. Consequently, the third congress in December 1997 widened its net to include representatives of the trade unions and politicians from the Berlin government's department of social welfare and health. In particular, the newly formed planning and management centres of the Berlin health offices became involved in the area of forums on unemployment and health to widen the scope of the congress.

3.1 Poverty and health in specific living conditions

The definition of poverty, however, still remained controversial. Can it be assumed that social benefits prevent poverty? Or is poverty in Germany rising despite unemployment benefit and income support? The federal government took a firm stance on this in 1998: the first Poverty and Wealth Report in the Federal Republic of Germany, agreed on as part of the coalition agreement in 1998, acknowledged the existence of poverty and investigated its effects on health. Andrea Fischer, the Federal Minister for Health, is involved as part of the "Poverty and Health" congress, in which she has taken part every year of her three years in office and is developing concrete measures. Alongside the Poverty and

Wealth Report mentioned above, an important measure is the reintroduction of health promotion as a service provided by health insurance funds, whereby it is specified that the health promotion activities should focus on reducing inequality in terms of equal health opportunities caused by social circumstances [Social Security Code V, Article 20 (1)]. Furthermore, a permanent working group should be set up to address the issue of “Poverty and Health”, led by the ministry. Concerted efforts need to be made by everyone involved in healthcare to initiate and bring together measures to improve the health situation of people living in difficult circumstances. The Federal Government is also involved in the European network “Tackling Inequalities in Health” via the Federal Centre for Health Education.

The congress is supporting and strengthening this development in a harmony of politics, associations and social movement, the like of which is rarely seen. From these beginnings a regular annual forum has been developed which takes place during the first weekend in December. Here experiences are shared, weighing up progress and set-backs against one another, and structures are formed bringing together the issues which make up the discussion on health promotion in social situations. The congress, which takes place under the auspices of the Federal Health Minister, Ulla Schmidt, and the Mayor of Berlin, Klaus Wowereit, is attended by many committed local individuals who are active in the field, such as the academics Rolf Rosenbrock, Adelheid Kuhlmeier, Gerd Glaeske, Gisela Fischer and Karl Lauterbach (German Council for Health System) and Ulrike Maschewsky-Schneider (Berlin Public Health Centre), representatives from the medical profession such as the Presidents of the Berlin Medical Association Ellis Huber and Günther Jonitz and many more, as well as many other politicians, of whom the Social Minister for Brandenburg, the late Regine Hildebrandt, is deserving of particular mention.

The input of these people has helped to establish these congresses – which now involve around one thousand participants – as the largest public health events in Germany. With the support of numerous partners such as Caritas, das Deutsche Institut für Urbanistik [German Institute of Urban Affairs], the AOK [Allgemeine Ortskrankenkasse; the biggest health insurance] Federal Association and in particular Elisabeth Pott, the Director of the Federal Centre for Health Education, the staff of the Gesundheit Berlin (Health Berlin) have been able to bring together a great variety of local and federal perspectives, the views and needs of associations, political groups and self-help groups under one roof.

3.2 Branding health and social inequality a scandal

The congress is making every effort to brand health and social inequality a scandal and to bring this to public attention by means of their slogans which change on an annual basis. Hence the subject in 2000 was “Poverty makes illness”. In the subheading, the question is raised: “How is it possible to reach poor people with preventive and curative healthcare?”

International experiences are also important to this as the WHO Director, Ilona Kickbusch, who has been in the role for many years, pointed out at the 2000 congress in her introductory speech. She related findings into the relationship between social inequality and health to the situation in Germany and shared her own results. In addition to the discussions about people living in disadvantaged circumstances, there is an ongoing health policy debate on prevention, health targets, patient rights, urban development, care by mobile doctors, dental prophylaxis and disease management programmes. Central to the discussion are key findings such as those from the former chairman of the German Council for Concerted Action Friedrich-Wilhelm Schwartz to the effect that the life expectancy of poor people is up to 7 years shorter than that of richer people and that the risk of poor people becoming severely ill, dying, having an accident or being affected by violence is at least twice as high in almost every situation in life.

On the occasion of the sixth year of the congress, Health Berlin and the Federal Ministry for Health published a joint Internet project, in which individual health projects were presented as models for helping people living in difficult living conditions. Every month the site promoted by Federal Minister Ulla Schmidt presented concrete projects for helping disadvantaged people. Issues addressed were the health situation of children and young people, families and women, the homeless and the unemployed and people suffering from AIDS and addictions. Editorial articles and reports from the “Poverty and Health” congress complemented the temporary Internet project which ran until 2002. The partnership project which is now being developed as part of a new Internet platform (cf. below) is documented at www.armut-und-gesundheit.de.

3.3 Participation and empowerment in health promotion

As a concept for strengthening the health potential of poor people and those living on the fringes of society we refer to the approach taken by the World Health Organisation (WHO), which uses “settings” as a basis for formulating health targets in social and organisational structures in accordance with specific living conditions. The concept is based on the assumption that people spend the greatest part of their time in professional, regional and social spheres. The setting approach to health promotion aims to establish the health potential in each of the spheres and to develop this with the help of as many participants as possible. As a result of the active participation of the people themselves, their understanding of the issues relating to health questions and their ability to deal with them locally should be used (participation) and strengthened (empowerment).

It has been proved again and again that the participation of those involved – not only patients but others around them who are affected – can be the key to developing healthy living spheres and lifestyles. Settings which have been studied for a long time are the “Healthy cities”, “Health promoting schools”, “Health promotion in the workplace” and “Health-promoting hospitals” networks.

3.4 Interdepartmental approaches and measures relating to social situations

Continuing the network idea, the seventh congress – “Poverty and Health 2001” – took “Health aims for combating poverty: networks for people in difficult circumstances” as its main theme. Networks are the way in which to advertise health promotion geared to social situations as well as being the target of health promotion. Networks are a means for people to make themselves heard and to overcome health problems. Social structures are networks. Creating networks is one of the main health aims to ensure the quality of healthcare processes and structures. The reduction of social hardship and inequality in terms of health opportunities available to someone based on their social circumstances is one of the main goals which current health policy aims to achieve as already stated in the above legislation on health promotion.

In order to develop and promote measures based on social circumstances, implement them as models and as forms of regular healthcare, there is a need for interdepartmental approaches and for a broad spectrum of those people affected, supporters from the political sphere, academia, health insurance schemes, government and social movement as well as from professional helpers, who are aware of their responsibilities, to unite. As an example of this, alongside Elisabeth Pott, the Secretary of State, Ulrike Mascher (Federal Ministry for Labour and Social Affairs) and the Secretary of State, Achim Großmann (Ministry for Transport, Building and Housing) opened the 2001 congress, bringing together health policy approaches and social and employment market policy issues from other departments. The exchange of experiences carried out as part of the Bund-Länder-Programm [Governmental Federal States Alliance Programme] “Socially Integrative City” has now become a permanent part of the “Poverty and Health” congresses, and the German Institute of Urban Affairs (Difu) has since become a member of the fixed circle of organisers.

3.5 The congress goes online: database on projects and measures

The eighth congress in December 2002 focused on “Locations for health promotion: strengthening the health potential of people living in difficult circumstances”. In addition to the many discussions held in the 45 forums, the establishment of the project www.datenbank-gesundheitsprojekte.de is of particular importance. As an additional measure to the “Socially Integrative City” programme, the Federal Centre for Health Education commissioned the Association of Health Promotion Berlin to carry out a survey of the projects and measures aimed at promoting the health of socially disadvantaged groups in the Federal Republic of Germany. The services they discovered were collated in a “lively database” which could be searched via the Internet and which would provide all interested parties with a basis for exchanging information and experiences and a pool

of information for creating networks as well as a means of distributing up-to-date information quickly.

The database now provides for the first time a reliable overview of the variety of health promoting measures and projects aimed either in part or predominantly at people living in difficult or demanding circumstances. Supported by an advisory committee of experts from scientific and practical areas, it will be possible to work out criteria for creating successful measures and strategies (by means of benchmarking). The survey thereby provides an important basis for developing and making more professional the field of activity surrounding health promotion focused on social situations.

Now that the questionnaires which were received by post have been included in the database, since August 2003 it has been possible to obtain an up-to-date and sophisticated overview of the health promotion services available for socially disadvantaged groups at www.datenbank-gesundheitsprojekte.de (cf. also final report for phase one of the project: "Survey of projects and measures for promoting the health promotion of socially disadvantaged groups in the Federal Republic of Germany" in this specialist booklet). It is possible to download survey questionnaires from the above Internet address for new entries and information can be submitted about services, projects and measures directly via an online questionnaire. With editorial management of the ongoing discussion about health promotion, the site provides a widely used forum for communication – the congress is going online as a live Internet platform with a database which is updated on a continual basis and therefore equally live to provide the world of health promotion with a place where it is possible to gain a clear overview of services and which is readily accessible not only to those actively involved in the field but to anyone with an interest in the subject matter.

The congress theme in 2002 "Locations of health promotion: strengthening the health potential of people in difficult circumstances" also made reference to the need for being able to locate facilities, networks and projects aimed at promoting the health of poor people in the Federal Republic of Germany. The following questions were raised in connection with this: Where do poor people live? What kinds of living conditions are they exposed to which are detrimental to their health? How is it possible to reduce their problems and increase their resources for overcoming their problems at the same time?

Not only do poor people have a special need for support when it comes to health: the discrepancy between their health situation and their health potential is high. It is even more important to identify and publicise the places where support can be obtained, be it real places, i.e. concrete projects, or virtual places such as the database mentioned above, which record and catalogue these services.

In this quest the important strategy of health networks and the creation of networks once again comes to the fore. Only in places where health as a concept is recognised and com-

municated is it possible to introduce concrete measures to promote the health of individuals and social groups. Networks serve to provide target group-specific support for people living in difficult circumstances and to offer people a way of finding social groups on their own initiative. In networks, people are in a situation to recognise their own health potential and improve it. Ultimately they aim to “empower” people in one sense or another and enable them to discover a healthy path for themselves by way of individuals and social groups. This takes place, for example, in self-help groups, health and social centres, in courses and counselling centres for young mothers, often bringing up children on their own, as well as in services for elderly people who have become isolated and impoverished. Networks which promote health also include recreational centres for school children and young people for whom the subject of health is often not a priority, the importance of which, however, cannot be emphasised enough if they are to lead a healthy life. The aim of this is to bring the issue of health to the attention of each of the peer groups. At the same time networks are a method of policy creation which serves to strengthen cross-sector work. Initiatives in various political areas (town planning and social policy) convincingly prove the necessity for such interdepartmental approaches to which too little attention has been paid up to now in the health system.

Continuing this topic, the theme for the ninth congress in 2003 was “Strategies for Health Promotion”. If the places where health promotion activities for socially disadvantaged groups have been established, the question arises as to how work should be carried out at these places and whether the activities they offer are successful in terms of bringing about a “health gain”. This provides a useful definition of the network concept in that it is essentially about the exchange of practical experiences, results and quality benchmarks in the sphere of health promotion work.

This takes up a discussion which has been ongoing for many years and which, in particular, criticises the unsatisfactory academic approach taken so far to compiling and processing current knowledge of practical work and data on health promotion and deriving methods from it. Problem areas which form part of the discussion are, for example, the criteria on which evidence is based, quality assurance, and the evaluation of measures for health promotion.

This debate will progress in a meaningful way, focused on results, if the various approaches to action and evaluation can first be formulated, presented and compared. In doing this, a district project, for example, will provide equally important information in terms of learning and teaching material as an academic study from a group of experts. This prevents the congress becoming an exclusive meeting of experts. Of far greater importance is that the various participants come together to take part in a responsible dialogue and exchange ideas about the best strategies in a constructive manner. An important yardstick for measuring the success of this could be the answer to the question as to the extent to which these strategies can be seen as part of a tradition of health promotion as laid down in the Ottawa Charter drafted by the WHO in 1986. More speci-

ficably, it must be established whether the strategies presented satisfy the principles of the representation of interests, participation, enabling, empowerment, new direction and sustainability. What types of areas of activity, structures and experiences can we bring together? How do we justify and substantiate the benefits to be gained from our health promotion and prevention? How do we measure quality and effectiveness? What kinds of integration, partnerships and objectives exist?

The confident handling of these questions at the “Poverty and Health” congresses is an illustration of the way in which the health promoters organise themselves in respect of practical quality management. The database and Internet platform provide a systematic requirement for this purpose and develop this process over and above the single annual event.

ELISABETH POTT AND
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**INTERVENTION MEASURES
OF HEALTH PROMOTION
FOR CHILDREN AND
YOUNG PEOPLE FROM
SOCIALY DISADVANTAGED
GROUPS***



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4.1 Starting situation

There are around 13 million children between the ages of 0 and 14 and 5.5 million young people between the ages of 15 and 20 living in Germany. The question as to which of these and how many are socially disadvantaged cannot, however, be answered quite as simply. Various assessment criteria are used to establish this:

- low income,
- insufficient provision in various spheres such as work/profession, education and housing,
- subjective or environment-related estimation of poverty
- social/emotional problems.

A readily accessible statistic is the number of people receiving social security benefits, although this is flawed because the estimated number of undetected cases is very high and also only takes account of the economic aspect initially: the percentage of children and young people whose parents receive social security benefits is 7% or 910,000 for children between the ages of 0 and 14 and 4.3% or 236,000 for young people between the ages of 15 and 20. Other living conditions to be found which often go hand in hand with social disadvantage are, among others, single parent families (9.7 million married couples bring up their children together; 3 million men and women are single parents), families with a large number of children (93,000 families bring up five or more children, 11,000 of which are single parent families) and migrants (in Germany around 2 million children and young people are not German citizens) (Robert Koch Institute in association with the German Federal Statistical Office 2001).

Even if the data available in Germany provide a less than accurate picture of the situation than in other European countries – for example, the statistics relating to causes of death in the United Kingdom contain details about social status which we do not have in Germany – the correlation between social disadvantage and poorer health is now undisputed even in Germany.

The current state of knowledge about the connection between social inequality and health is the result of various studies (for a summary, cf. Mielck 2000): higher than average figures for socially disadvantaged groups have been established in the case of perinatal mortality (Collatz/Hecker 1983), infant mortality (Schwarz 1966), illness rates and illnesses in school children (Glaser-Möller et al. 1992; Klocke/Hurrelmann 1995; Ministry for Labour, Social Affairs, Health and Women of the Federal state of Brandenburg 2001), dental health (Micheelis/Bauch 1991 and 1993) and accident-related hospital admissions (Geyer/Peter 1998). By contrast, allergies are more common among the upper social groups (Heinrich/Mielck et al. 1998), though this concerns milder forms of illness. More members of the lower social groups suffer from severe asthma (Mielck et al. 1996). Behaviour which is detrimental to health is especially common in children and young people from socially disadvantaged groups (see *Figure 1*).

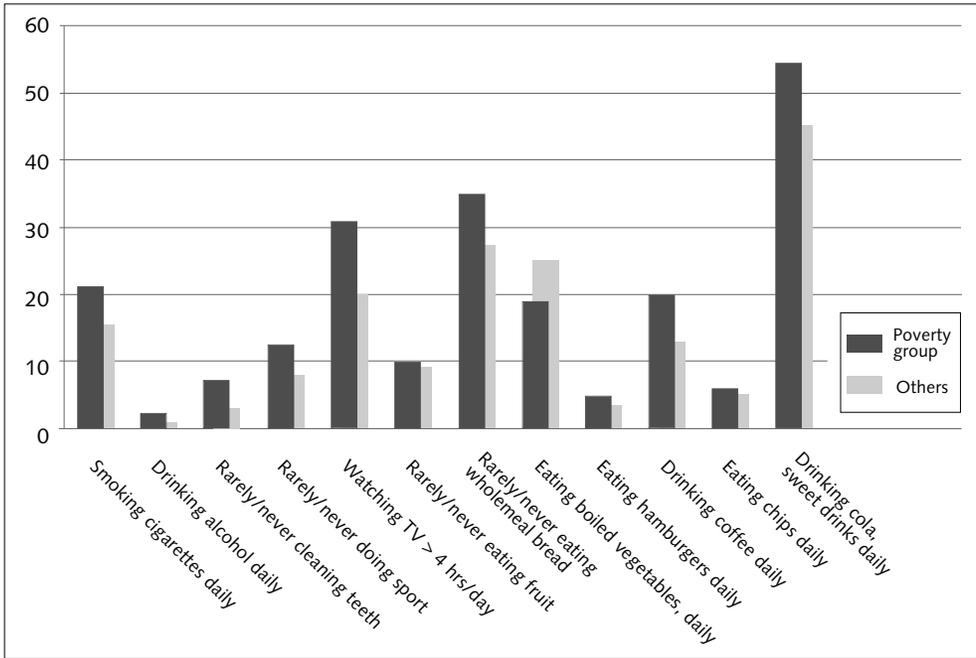


Fig 1: Health behaviour of children and young people according to social situation (age group 12–16 year olds; in whole percentages). Source: University of Bielefeld, 2001.

There are now very consistent findings on smoking from the representative drug affinity studies carried out by the Federal Centre for Health Education (cf. *Figure 2* on page 54) and the study performed by Setter et al. on 20,462 vocational training college pupils (Setter/Peter et al. 1998). In this study for students following a course at the lowest level of education the risk of smoking was 5.2 times higher than at the highest level of education for males interviewed between the ages of 14 and 30 and 4.5 times higher for females interviewed between the ages of 14 and 30.

There are other findings concerning psychological and physical development disorders and age inadequate developments in children. It is known largely from surveys carried out by the public health service, in particular during school admission health checks, that there is a higher rate of basic motor coordination disorders and of speech disorders in socially disadvantaged children, and the need for early intervention with these children is greater (Federal Centre for Health Education 1998; Ministry for Labour, Social Affairs, Health and Women for Brandenburg 1999). Early detection examinations and vaccinations are made use of less frequently by children from socially disadvantaged families in terms of completing full courses of treatment and having them at the appropriate time (for regional results, cf. Schubert 1996; Siegrist 2002, for example).



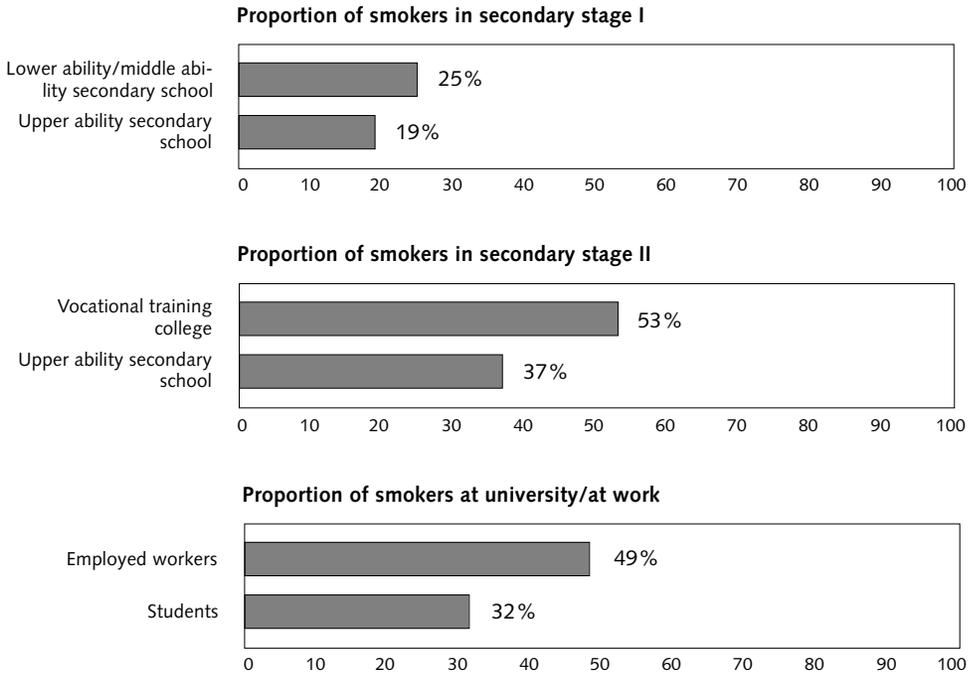


Fig 2: Proportion according to current education/employment status. 12–25 years in the Federal Republic of Germany in 2001 (n = 3,000). Source: Federal Centre for Health Education 2001a.

Despite the need for other surveys (cf. also the article on the Children and Young People Survey carried out by Prof. Kurth in the focus series of the Federal Health Paper, RKI; Health of Children and Young People, Part 1, volume 45, no. 11, November 2002) there are truly consistent findings for Germany which show that socially disadvantaged children and young people are more frequently impaired in their physical and psychological development and more often develop behavioural patterns which are detrimental to health. This negatively affects quality of life, incidence of illnesses and life expectancy. Even if it is necessary to promote the health of all children and young people, stronger measures surpassing all previous efforts must be taken to develop suitable methods and strategies to reach socially disadvantaged children and young people in particular.

4.2 Requirements for developing intervention concepts

In order to develop practical intervention strategies, three requirements must be met:

1. Knowledge and understanding of how social influences can affect the development and progress of illnesses and which ones these are.

2. Results of scientific studies on the effectiveness and quality of intervention measures and evaluation of experiences in the implementation of preventive strategies.
3. Supportive political strategies which ensure that intervention measures are implemented over as wide an area as possible and are continuous. For this to happen there needs to be effective and efficient interaction between academics, people working in the practical sphere and politics at national and international level (transfer).

Explanatory approaches

A summary of the methods currently under discussion to explain why socially disadvantaged groups tend to have poorer health, as stated above (Mielck 2000), may be adapted to apply to the health of children and young people as follows (see *Figure 3*).

The following summarises the relationship between social inequality and strains on health, between social disadvantage, inadequate empowerment strategies and opportunities to relax. It shows how social disadvantage affects people's use of healthcare services and attitudes to health. Ultimately it becomes clear that the resultant increased morbidity in socially disadvantaged groups has repercussions on their social situation. This means that illnesses suffered by socially disadvantaged people increase their social inequality and social exclusion (Siegrist 2002).

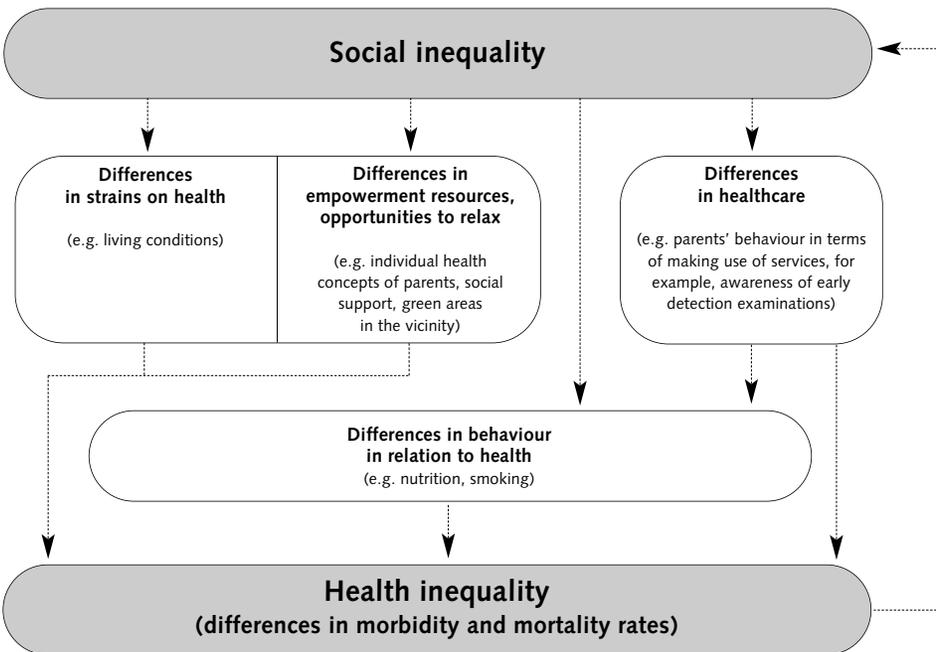


Fig. 3: Health inequality of children and young people, adapted representation based on the comments of Mielck (Mielck 2000)

In view of the problem of a lack of resources and empowerment strategies together with the higher number of strains on the health of socially disadvantaged people there is a considerable need to develop the range of psychosocial methods of coping, as well as the resources already mentioned, such as social support and basic environmental conditions. There is evidence to suggest that a precarious view of oneself and one's feeling of self-worth can lead to addictive substance abuse (cf. recapitulating Siegrist 1995). This is confirmed by the results of successful smoking prevention schemes for young people, which mainly focus on increasing a child's range of social skills, learning confidence in one's abilities and experiencing positive out-of-school success (Jessor 1984; Gohlke/Gohlke-Bärwolf et al. 1989). In addition to this, different concepts of health and different ways of dealing with different areas of daily life for members of the different social groups are also significant factors.

Helfferich (Helfferich 2002) has summarised the requirements of a concept for promoting health in nursery schools which also seems suitable for children from families with difficult social backgrounds in that it considers the spheres in which they operate, the concept of self and empowerment structures:

- Educators and multipliers in the field of health promotion must, for example, be trained in such a way that they can also talk to parents who have the attitude to health of "body = machine". This is very demanding in practice. It requires a high level of specialist knowledge and excellent social skills and should therefore be considered as part of the training and further training of educators.
- For nursery schools in areas of particular social deprivation or with a high proportion of children from socially disadvantaged families, integrating these nursery schools into a local networked structure which encompasses all health-related areas of life is especially important for making a health promotion concept a reality. Nursery schools are an important part of a social network where personal interaction is facilitated and there is an opportunity to learn about social issues. For example, at nursery schools it is possible to draw attention to early detection examinations for children or to motivate parents to include their children in vaccination programmes by working closely with paediatricians, public health departments and statutory health insurance schemes. In cooperation with family counselling centres, educational counselling centres and parental self-help services, nursery schools can contribute to developing the right approach to dealing with children with behavioural problems. By means of health promotion programmes in nurseries which include leisure time and health sport services appropriate to the children's ages, it is possible to improve health promotion opportunities for children.

The following approaches to intervention with socially disadvantaged children and young people arise from the diagram of the links between social disadvantage and poor health opportunities (see *Figure 3* on page 55):

- support when there is stress, e.g. family counselling for psychosocial conflicts;

- strengthening personal resources, e.g. development of social skills at nursery school and school;
- more information on and motivation for making proper use of early detection programmes and early intervention services;
- greater use of prevention measures and measures to promote health where children are behaving in ways which are damaging to their health;
- breaking down barriers which prevent access to people affected by social disadvantage, in particular linguistic barriers;
- integration of factors which determine health in different political spheres such as upbringing, education, economics, finance, housing, etc.

Scientific studies and practical experiences

If we take evidence as a benchmark for measures of health promotion for socially disadvantaged children in Germany, we are still a long way from showing that the measures have proved to be effective. In Germany, for example, there have been no randomised controlled intervention studies so far in this field. Similarly there is a lack of comprehensive methods for evaluating the effectiveness of measures. Related academic research in this area has room for improvement. There is a consequent need, therefore, to make up the obvious research deficit. This must not, however, cause further delay in taking action. There are a number of project approaches (cf. also Deneke/Hofrichter 2001; Social Ministry of Baden-Württemberg in association with the Baden-Württemberg Regional Health Office in 1996; Association for Health Promotion Berlin 2002; Federal Centre for Health Education 2001d), which provide a good basis for a feasible and professionally sound strategy of intervention. Until there is firmer evidence available for Germany, it is necessary to refer to the project approaches which already exist in Germany. Selected measures for intervention must then be assisted, guided and evaluated particularly intensively by science.

In Western Europe there is now a whole range of studies which have investigated intervention measures for socially disadvantaged children and young people with regard to their effect. These were summarised in 2002 by Mielck, Graham and Bremberg (Mielck et al. 2002). The evaluation supplies a wide range of information about successful measures in the fields of nutrition, dental health, general illnesses and diseases, accidents, mental health, smoking, impaired vision and general child development, vaccinations and sudden infant death. These results must be incorporated into the working knowledge of people actively involved in the field at a national level. Currently, a communication platform is being developed by the Federal Centre for Health Education (cf. article by Kilian et al. in this specialist booklet) in order to make the international results more readily accessible to people in Germany. In addition to this, existing projects which are suitable for transfer and aim to promote the health of socially disadvantaged children and young people in Germany should be identified and presented.

The list below details the practical steps to be taken which were identified from a first evaluation of the results of the studies mentioned and experiences from projects:

1. The preventive measures must be carried out intensively with the appropriate resources (funds, personnel, expertise) on a long-term basis and in an interdisciplinary way.
2. They must include direct one-to-one discussions with individuals or small groups in their everyday environment.
3. They should start with a survey of the existing specific need for intervention and in doing this take social group and culture-specific values and communication methods into consideration.
4. The information in the media must be formulated in simple language that is easy to understand.
5. They should include members of the target group at the planning and execution stages.
6. They should make information, services, official bodies and material support easier to access through networks.

In addition, it must be noted that insufficient attention has been paid to the following target groups in national projects in the past: young males, migrants (in particular male immigrants) and people who are unemployed (in particular those from an immigrant background). The special role of the public health service is clear in many German projects. The public health service is able to expose the need for action on a regional level using small scale health reporting, promote cooperation projects and improve access to target groups through networks and low threshold counselling services (for more detailed information, cf. Brand/Schmacke 1998).

4.3 International and national activities and programme developments

The Black Report, produced by an expert commission for the government of the United Kingdom at the beginning of the 1980s (Townsend et al. 1990), provided the initial stimulus for public discussion about health inequalities in Western Europe. Subsequently, equivalent research and government programmes were started in several European countries. In Germany, the topic of “promoting equal health opportunities for socially disadvantaged groups” has been discussed with greater intensity since the mid-1990s, supported considerably by the newly created discipline of public health. This to some extent involves a wide-ranging discussion on poverty, which became especially evident as a result of the National Poverty Conference in 1993 and the Poverty and Wealth Report by the Federal Government in 2001. As investigations show that socially-related health inequalities are increasing instead of decreasing, a growing awareness of the topic is evident.

Now there are numerous activities organised by the state (at federal, regional and local authority level) as well as non-state activities. The following will identify a selection of

current activities without claiming to be complete. There is also development at a European level, in particular the new campaign programme of the European Union in the area of public health from 2003 to 2008 (Art. 2, para. 3 b). Also the European network (ENHPA) has worked out recommendations for prevention and health promotion in socially disadvantaged groups (BZgA 2002) as part of a project funded by the EU Commission. The WHO programmes must also be mentioned: Health for All in the 21st Century, targets 1 and 2 (World Health Organisation 1999) and other implementation recommendations (Whitehead 1991; Dahlgren/Whitehead 1993; Kunst/Mackenbach 1996).

Federal level activities

The Federal Government decided on the national action plan for combating poverty and social exclusion from 2001 to 2003 in May 2001. Suggestions as to possible links with the area of health promotion as proposed by the Federal Centre for Health Education are given in brackets:

- promotion of access to resources (e.g. by making pregnant mothers aware of antenatal examinations and raising the profile of early detection examinations for children),
- working out extensive measures for areas which are confronted with the problems of social marginalisation (e.g. through networking between nursery schools, schools, sport clubs and paediatricians in areas with social problems),
- promotion of cooperation and division of work between the participating centres, development of tailor-made services and improvement of the effectiveness and accurate channelling of help; this can be realised by making current research results available, through measures for improving the training for multipliers from the healthcare areas, health promotion, personal and social education, social work and by means of interdisciplinary networking, for example.

In 2000 the “Poverty and Health” working group was set up at the Federal Health Ministry. Recommendation papers are available for the topics of “Healthcare for the Homeless” and “Migration and Health”. Currently, a recommendation paper is being drafted by a working group sub-committee “Children and Young People Living in Disadvantaged Districts”.

As a further measure for reducing disadvantages in terms of health, the Federal Government has developed the “National Health Targets” programme. One of the key criteria used in developing each individual target was the need to reduce health inequalities. Particularly within the seventh committee, “Targets for childhood and young adulthood: nutrition, physical activity and coping with stress for children and young people”, the focus of strategy development is on improving the health opportunities for socially disadvantaged children.

An additional basis for recognising existing health problems and assessing social trends is provided by the Federal Government's health reports. These have already facilitated assessments specific to social situation as part of the DHP study (German study on preventing cardiovascular disease) and in the Federal Health Survey in 1998. This also applies to the intended nationwide children and young people survey.

Using this as a foundation, the Federal Centre for Health Education considered the issue of health promotion in socially disadvantaged children and young people in their annual programme for 2002:

1. Development of documentation for improving the basis on which to act by setting up a "lively database". All multipliers who work with socially disadvantaged people and all political decision-makers should be given the opportunity to pass on practical know-how and theoretical insights about successes and failures. The database has now been launched on the Internet and can be accessed at www.datenbank-gesundheitsprojekte.de (cf. also article by Kilian et al. in this booklet).
2. Further development of ideas for intervention strategies with the aim of promoting the health opportunities of socially disadvantaged children and young people. This will be achieved by including the approach whereby the social issues of an area are considered via the Federal Government's "Soziale Stadt" [Socially Integrative City] programme. The BZgA is responsible for incorporating the topic on health.¹
3. Implementation of tried-and-tested projects designed by the Federal Centre for Health Education in areas with social problems and rural areas which are particularly under-developed.

Although there are a number of tried-and-tested and evaluated projects for promoting the health of children and young people, it is only recently that an increasing number of studies have been carried out specifically in areas with social problems. The results, however, with regard to structures, process and outcomes are not yet available. It is an important step to develop new ways of accessing the relevant target groups and improving access to groups experiencing particular strain.

Particularly projects which are based on the following principles are relevant for implementation in areas with social problems:

- promoting life skills,
- making health a reality,
- promoting integrated concepts (e.g. physical activity, nutrition, combating stress),
- using new types of media,
- working in partnerships,
- involving target groups.

1 Up to now two specialist forums have taken place: on 4/5 June 2002 in Düsseldorf ("Health of Children and Young People in Areas with Social Problems") and on 30 June/1 July 2003 in Berlin ("Networking – Power – Health. Partnerships between Youth Welfare Services and the Health Service in Areas with Social Problems").

The following four examples demonstrate these principles:

Example 1: Apfelklops & Co. – A rock and music festival relating to nutrition and physical activities for those aged 5 and over

With songs about enjoyment and physical well-being, about being fat and thin, about eating rituals and having fun whilst exercising, the BZgA presented a combination of ideas about exercise, nutrition and combating stress in the style of a revue. Children's songs are ideally suited to communicating messages to promote health in an emotionally appealing and entertaining way. The BZgA worked closely with partners such as youth and health departments as well as schools and nursery schools as a network. The children's concerts were enriched with workshops for parents and multipliers as well as supplementary material e.g. a song and manuscript book for singing or playing the songs at home or at school afterwards.

Example 2: "Make Children Strong"

With its "Make Children Strong" programme the BZgA addressed all adults who are responsible for looking after children and young people. The aim of the campaign was to improve the self-confidence and sense of self-worth of young people as well as their ability to resolve conflict and their communication skills. The basic concept of promoting life skills primarily focused on everyday situations encountered by children and young people (Federal Centre for Health Education 2001b).

The programme is implemented in particular in association with sport clubs and associations. Sport clubs offer favourable conditions for influencing children in this regard. Key multipliers are the trainers and the people supervising the children and young people. The BZgA offers these people training in this concept and also looks at ways for reorientating how the club works with young people. The evaluation of the training course, for example, showed that there was a high percentage of people willing to implement these new concepts into the work the club does, after taking part in the training course (Federal Centre for Health Education 2003).

Example 3: CD-ROM LoveLine/www.loveline.de

With the "LoveLine" CD-ROM, the BZgA developed a multimedia project relating to sex education. Based on scientific studies, the CD-ROM provides extensive information about love, relationships, sexuality and contraception. LoveLine helps people to reflect on and examine their attitudes towards themselves, their own bodies, the opposite sex, sexual identity, the behaviour of others, and rules and values. Finally, the CD offers an opportunity to test methods of communication and gives tips for making self-confident decisions about love and relationships. The project uses an experience-oriented multimedia approach to provide the user with realistic experiences through four different levels: the body, an interactive game, an information database, and Internet access (www.loveline.de). The system, which allows the user to act according to his or her own needs and research his or her own topics, should make it possible to strengthen the user's ability to deal with positive experiences as well as conflict situations by means of play. The evalu-

ation showed that this concept appealed in particular to boys between the ages of 12 and 15, who are usually significantly harder to reach when it comes to sex education than girls. There was also a very high level of comprehension and acceptance, particularly among pupils attending the lower ability secondary schools (Schroll 2001).

Example 4: The spread of HIV and the risk of AIDS – pictograms for working with immigrants

The Federal Centre for Health Education has had positive experiences in terms of addressing specific target groups of socially disadvantaged people, particularly immigrants, by using pictograms on the subject of AIDS prevention (Federal Centre for Health Education 2001c). These pictograms show the most significant routes of infection and the relevant methods of protection. The pictures are supplemented by a minimum number of words and have been produced in 19 languages. As counselling services need to be combined with the media resources to address these target groups, these BZgA resources are used by the counselling centres.

Regional and local level

The 25th Health Ministers' Conference on 20/21 June 2002 made a renewed plea to focus future measures and activities for early detection and early intervention for children in the target group of socially disadvantaged people. It is not only up to those involved in the health service to improve the health of children and young people, but the responsibility of all sectors. In several Federal states relevant concepts and resolutions are already in place, for example the resolution made by the tenth North Rhine-Westphalian Regional Health Conference "Social Situation and Health" (Ministry for Women, Young People, Families and Health for the Region of North Rhine-Westphalia 2001). The same applies to a number of local authorities whose activities are implemented to a considerable extent by the public health service, e.g. "Poverty and Health" working group in Düsseldorf (Schneitler/Pöllen et al. 1997) and the Munich Declaration of 2001 based on the resolution of the Health Ministers' Conference in 2000, the Cologne Resolution of "Healthy Cities" in 1999 and the Munich Health Conference (Advisory Health Board of the regional capital of Munich in 2001) (for further details of activities at regional level, cf. article by Thomas Altgeld and Barbara Leykamm in this book).

Social insurance sector

Among the social insurance companies the statutory health insurance schemes have a particular duty to contribute. The Social Security Code V (Article 20) states that statutory health insurance schemes are obliged to provide services aimed at prevention which "improve the general health status and in particular contribute to reducing socially related inequality with regard to health opportunities".

Non-state sector

Federal and regional associations for health [Bundes- und Landesvereinigungen für Gesundheit], in particular, provide an important stimulus for “promoting the health opportunities of socially disadvantaged groups” and coordinate activities in the non-state sector, for example, via the “Poverty and Health” working group of the Lower Saxony Regional Association for Health. The “Poverty and Health” congress, which has been held annually in Berlin since 1995 and which involved approximately 900 participants the last time around, represents a nationwide platform for all multipliers and scientists to directly exchange ideas and experiences. (For further details of activities taking place at regional level, cf. the article by Raimund Geene in this book.)

Conclusion

In conclusion it must be noted that experience with the issue of “reducing health inequalities” is growing mainly at an international level, but also increasingly on a national level. Particularly with regard to the situation in Germany, however, there is still no scientific evidence at high level of the effectiveness of intervention. There is no documentation and analysis of the available activities. There is no systematic transfer of available results. The following tasks thus present themselves:

- improvement of academic foundations e.g. for the development of methods, access strategies and the carrying out of studies to accompany intervention measures,
- transfer, e.g. by consolidating the existing recommendations and successful methods of approach to create guidelines for “Promoting the health of socially disadvantaged groups” and the distribution of these among those active in the field of social work and healthcare,
- coordinated strategies for implementing health targets especially in areas with social problems and for socially disadvantaged groups.

The aim of improving the health opportunities of socially disadvantaged children and young people can only be achieved with sustainable effect through a combined strategy: it is essential to create differentiated and targeted preventive strategies for clearly identified health problems. In addition, non-specific health promotion must be strengthened by improving life skills and conditions, which is in first line the task of policy-makers in different sectors of general politics.

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**CONCLUDING REPORT
FOR PROJECT PHASE 1:
"SURVEY OF PROJECTS
AND MEASURES OF
HEALTH PROMOTION WITH
SOCIALY DISADVANTAGED
GROUPS IN THE FEDERAL
REPUBLIC OF GERMANY"**



5.1 Introduction/description of the problem

The continuous development of science and technology over the course of the 20th century has brought about improvements in living conditions. Despite a growing life expectancy, however, the extent of the imbalance between the social strata in terms of mortality and morbidity has increased. There has been found to be a clear correlation between social circumstances and health status, whereby poverty represents the clearest of all risk factors for illness of almost any kind and for accidents, encounters with violence, social isolation and other factors which place a strain on health. Poor people do not have the same options (resources) available to them to deal with problems and promote their health. It is estimated that the difference in life expectancy between members of the lowest and the highest social group quintile is approximately seven years and that the risk of a member of the lowest quintile of the population contracting an illness is twice as high for almost every situation in life.

Research debates two factors responsible for the link between poverty and health. The questions under discussion are: “Does poverty make you ill?” and “Does ill health make you poor? (cf. article by Andreas Mielck in this publication). In both cases intervention is necessary. After all, prevention is better than “treatment”. Not only does this need to be carried out at an early stage but also at the right time. Part of designing any comprehensive service to promote health, particularly for socially disadvantaged people, involves recording existing measures and turning practical experience which has been collected thus far as well as existing knowledge into something useful.

The objective and subjective living conditions of social groups and individuals play a crucial role in the approach to making changes. Any systematic recording of existing services would have to distinguish between the different stages of life (e.g. childhood, adolescence, adulthood and the various degrees of old age) and living circumstances (among others, those of women, homosexuals, migrants, unemployed people, homeless people) and show the specific disadvantages. There are specific health problems and different ways of promoting existing internal and external resources. Some health promotion and medical care programmes already reflect this diversity – overall, however, still too few. In order to reach those target groups which the services aimed at promoting health find difficult to access, such as socially disadvantaged groups in particular, it is necessary to work with the people affected in the circumstances in which they live and at the relevant places (known as settings).

The law governing health promotion provided by the statutory health insurance schemes according to Article 20 (1) of the Social Security Code V takes account of the need for measures which focus on specific target groups as well as on quality. The text of the law states that the main priority should be in relating the measure to social settings: “Primary prevention services should improve general health status and, in particular, contribute to reducing socially related inequality in terms of health opportunities”.

As there has been only insufficient and inadequate information available on services which meet these criteria so far, in August 2002 the Federal Centre for Health Education (BZgA) commissioned the regional working group for health promotion in Berlin, Gesundheit Berlin e.V. [Association for Health Promotion Berlin], to create a nationwide, reliable overview of projects and measures to promote the health of socially disadvantaged groups as part of the “specialist databases/market analyses” field of work. To support the project, the BZgA set up a working group known as “Health Promotion for Socially Disadvantaged Groups” as an official advisory body comprising national and international scientists, people working in practical fields, representatives of governmental and non-governmental organisations and representatives from the areas of health promotion and social work.

As the finished product, a “lively” searchable database was made available on the Internet in the summer of 2003. In addition to providing addresses for the services included in it, it also contains information about the content of the services and tips on implementing them. The database increases the transparency of the complex field of health promotion for socially disadvantaged groups for everyone for whom this information is relevant. The provision of addresses and further information about the services promotes and supports communication and networking between the service providers. By presenting “model” services in later stages of the project it will be possible to provide service providers with new ideas and suggestions for implementing their own measures.

The period from September to the end of January 2003 was set aside for carrying out the nationwide survey and setting up the “lively database”. In order to ensure that the project benefited from both academic and practical expertise, the Berliner Zentrum Public Health [Berlin Centre for Public Health] BZPH; the Landesgesundheitsamt Baden-Württemberg [Baden-Württemberg Regional Health Office] LGA and the Landesvereinigung für Gesundheitsförderung Niedersachsen [Lower Saxony Regional Association for Health Promotion] LVG, were involved as cooperation partners to help carry out the survey.

The following sections describe the activities carried out in the period from September 2002 to January 2003 during the first project phase of the “Survey of projects and measures for promoting the health of socially disadvantaged groups in the Federal Republic of Germany”:

Section 5.2 deals with the steps involved in preparing and carrying out the survey. As the main focus of the first phase of the project was on creating a nationwide database and there had been little experience with comparable surveys so far, this section looks in detail at the organisational and logistical work involved.¹

¹ While the first phase of the project was being carried out, the BZgA was provided with up-to-date information on the progress of the work through three interim reports on 25.11.02, 19.12.02 and 15.01.03.

Section 5.3 gives an overview of services surveyed based on an evaluation of the answers to closed questions given in the questionnaire. Many questions which arose from the first examination of the data must remain unanswered at this stage and require subsequent evaluation according to topic.

Section 5.4 outlines the further outlook following on from the results of the first phase of the project. In particular, this section looks at the concept of setting up a nationwide network of regional hubs as proposed in December 2002 by the Association of Health Promotion Berlin and the Baden-Württemberg Regional Health Office.

5.2 Preparing and carrying out the survey

The main focus of the first phase of the “Survey of projects and measures for promoting the health of socially disadvantaged groups in the Federal Republic of Germany” project was on creating a nationwide database on services to promote the health of socially disadvantaged groups. These services include, for example, counselling services, leisure facilities and special services within the community for people living in difficult and stressful social circumstances – for example, services and projects for people with a very low income, unemployed people, and single parents living in areas with social problems. Taking this as a focus, the steps carried out as part of the survey need to be looked at in detail. In particular, these were:

- testing the survey tool,
- compiling an address directory,
- setting up a survey website,
- carrying out the actual survey (sending out and recording the replies),
- entering and processing the collected data.

Questionnaire development and pre-test

At the beginning of the project the BZgA, as the commissioning body, provided a survey tool developed by the advisory working group.

The survey tool was subjected to a pre-test in September 2002. The aim of this was to test the feasibility of the questionnaire with regard to:

- the average length of time required by respondents to answer the questionnaire,
- the comprehensibility of the questions and predefined answers,
- the completeness of the questions and predefined answers,
- the design of the survey tool.

The survey tool developed by the BZgA – an outline questionnaire for participants to provide information about themselves and a project documentation sheet – was sent out together with an evaluation sheet and a covering letter on 12 September 2002 to

40 government agencies, institutions and associations. The covering letter gave a brief description of the planned survey and requested help in carrying out the pre-test by returning the completed questionnaires and the evaluation sheet by 20 September 2002.

The majority of the addresses for the organisations ($n = 37$) were provided by the BZgA. The organisations had been exhibitors at the conference “Health of Children and Young People in Areas with Social Problems”, which had been held at the beginning of June 2002 in Düsseldorf by the BZgA together with the management centre for “Development and Opportunities for Young People in Areas with Social Problems (E & C)” programme. A further three addresses were provided by the Baden-Württemberg Regional Health Office.

As only a few replies had been received by the return date of 20 September 2002 specified in the covering letter, the participating institutions – as far as they could be contacted – were requested by telephone to take part in the pre-test. 24 questionnaires were included in the evaluation of the pre-test; the return rate from 40 questionnaires was therefore 60%.

In order to gain a clearer overview of the replies, the answers were compiled in overview and grouped according to the relevant questions in the outline questionnaire, project documentation sheet and evaluation sheet. This method of structuring the information provided a systematic and quick overview of the individual replies. The results of the pre-test were discussed with experts (among others, from the Berlin Centre for Public Health, the Lower Saxony Regional Association for Health Promotion and the Baden-Württemberg Regional Health Office), documented in detail and presented to the BZgA by the end of September. In mid-October the survey tool was then modified on the basis of the pre-test and other feedback provided by the advisory working group and the cooperation partners and finally agreed with the BZgA. The main changes related to the:

- extending or modifying some predefined answers,
- giving the setting approach a stronger weighting by adding question 1.2,
- modifying predefined answers and moving question 9 (sources of funding) to the end of the questionnaire,
- revising the layout of the questionnaire (printing on coloured paper; creation of a cover sheet in A3 format in order to be able to insert the project sheets in A4).

Once the final revisions had been made the questionnaire was printed at the end of October.

Compiling the address directory

Whilst the survey tool was being developed, a nationwide address directory was also created; the aim of this was to create as extensive a list of potential providers of measures to promote the health of socially disadvantaged groups as possible. In doing so, two parallel strategies were pursued:

1. As part of the process of a systematic search a list of service providers was compiled which included the organisations, associations, institutions and authorities with a potential connection to the field of “Health promotion for socially disadvantaged groups” (cf. *Table 1* on pages 73/74). Attempts were made to record the participants in areas which were as small as possible in order to ensure the greatest possible proximity to the actual services. As far as these could be accessed, information was taken from existing databases. Where collections of data of this kind did not exist and could not be provided upon request, reference was made to the Internet services provided by the relevant participating institutes.
2. At the same time as the systematic search was being carried out, existing, thematically related databases were merged in order to include in the survey main players in the survey, which had not been recorded during the course of the “systematic” search.

The website www.datenbank-gesundheitsprojekte.de

At the same time as compiling the addresses and carrying out the pre-test, the website for the survey was built. This was ready to access at www.datenbank-gesundheitsprojekte.de (database-healthprojects) at the same time as the questionnaires were being sent out, and it is still available now.

The website explains the aims of the survey and offers anyone interested the opportunity to either download the questionnaires in PDF format onto their own hard disk, view them on screen and print them out. As a central function the website provides an online questionnaire. This allows users to enter their details directly into the central database without having to first fill in a paper questionnaire.

The survey website was very well received as shown by access figures for the homepage² during the survey period in November and December 2002 and the number of questionnaires which were filled in by service providers online (cf. Appendix: *Table 1* and “Questionnaires sent out and returns” section).

Returned questionnaires

The number of questionnaires returned as at 31 December 2002 out of a total of 10,067 which had been sent out was 38.3% ($n = 3,852$). Included in this number are:

- 1,309 completed outline questionnaires received by post or fax or completed online with categorised services and
- 2,543 replies by post, fax, e-mail or telephone stating that the participant does not offer any measures to promote the health of socially disadvantaged groups.

2 The access figures for the online questionnaire page were generally several times this number.

| Participating institutions | Description |
|--|--|
| AIDS help centres | Regional level |
| Alzheimer society | Regional and local |
| Arbeiter Samariter Bund (ASB) [Workers Samaritan Union] | District level |
| Arbeiterwohlfahrt (AWO) [Worker's Welfare Association] | District level |
| Initiatives for unemployed people | Local, where available |
| Labour ministries | Regional level |
| Medical associations | Regional level |
| Blaues Kreuz in der Evangelischen Kirche e.V. [Blue Cross in the Evangelical Church] | Federal association and regional associations, two local associations |
| Blaues Kreuz in Deutschland e.V. [Blue Cross in Germany] | Federal association, individual services |
| Bundesvereinigung für Gesundheit [Federal Association for Health] | Federal association and members |
| Nationwide "Arbeitskreis Migration und öffentliche Gesundheit" [Committee for Immigration and Public Health] | Members |
| Caritas Association | District level (or dioceses) |
| Christlicher Verein junger Menschen (CVJM) [Christian Union of Young People] | Regional level |
| Deutscher Paritätischer Wohlfahrtsverband (DPW) [German Equal Welfare Association] | District level |
| Deutsches Rotes Kreuz (DRK) [German Red Cross] | District level |
| Diakonisches Werk [social welfare organi- sation of the protestant church] | Regional/diocese level, members recorded according to availability |
| Technical colleges specialising in social work | Complete, nationwide |
| Freundeskreis Suchtkrankenhilfe e.V. [Substance abuse support group] | Regional associations, some local associations |
| Gesunde Städte Netzwerk [Healthy Cities Network] | Member local authorities |
| Health offices | District level |
| Health ministries | Regional level |
| Trade unions/DGB [German Trade Union Confederation] | Regional districts |
| Trade union unemployment associations, coordination centre | Regional level, including Arbeitslosenver- band Deutschlands e.V. [Registered German Unemployment Association] |
| Guttempler [self-help association] | Federal association, regional associations |
| Youth offices | Regional and local level |

| | |
|---|---|
| Health insurance schemes (AOK, BEK, BKK, DAK, IKK, TK) | Regional branches |
| Kreuzbund e.V. [Catholic self-help and assistance society for addicts and their families] | Regional level, where available |
| Regional sporting associations | Regional level |
| Regional anti-addiction centres | Regional level |
| Regional association for disabled people | Regional level |
| Network of companies working to promote health | Members (distributed by LVG Lower Saxony) |
| Network of hospitals working to promote health | Members |
| “Netzwerk Hauswirtschaft” [Domestic Economy Network] (BMFSFJ Project) | Addresses from LVG Lower Saxony |
| OPUS – network to promote health in schools | Member schools (research carried out by LVG Lower Saxony) |
| Pro Familia [Association for family planning; sex education and sexual counselling] | Regional level and partly district level |
| Social ministries | Regional level |
| Sozialverband VdK [German association for the protection of social rights] | Regional associations |
| Addiction counselling centres | Where available |
| Regional accident insurance schemes | Regional level |
| Adult education centres (VHS) | Selection: regional capitals |
| Public solidarity association (VS) | District level |

Table 1: List of participating institutions which were included in the systematic search

The number of returns separated according to Federal states as at 31 December 2002 shows that there was only one region with a return rate below 30% (cf. *Table 2*). What is striking is the relatively high number of questionnaires returned from the five East German regions (excluding Berlin): three of these are among the six regions with a return rate of over 40%; only Brandenburg was below the national average with a return rate of just under 38%.

Feedback from participants

When the survey started, the Association of Health Promotion Berlin set up a hotline at the beginning of November 2002 which was available during the core hours between 09:00 and 17:00 either by telephone or fax on one of the two numbers shown on the questionnaire. Alternatively, participants could send an email to info@datenbank-gesundheitsprojekte.de.

| Federal state | Questionnaires sent out (total: 10,067) | Returns from participants (total: 3,852) | Return rate in % (total: 38.3%) |
|-------------------------------|---|--|---------------------------------|
| Thuringia | 709 | 320 | 45.1 |
| Saarland | 136 | 58 | 42.6 |
| Bavaria | 894 | 379 | 42.4 |
| Mecklenburg-Western Pomerania | 262 | 110 | 42.0 |
| Saxony | 419 | 175 | 41.8 |
| Rhineland Palatinate | 434 | 177 | 40.8 |
| Schleswig-Holstein | 321 | 125 | 38.9 |
| Lower Saxony | 785 | 305 | 38.9 |
| Hesse | 656 | 252 | 38.4 |
| Saxony Anhalt | 303 | 116 | 38.3 |
| Brandenburg | 345 | 130 | 37.7 |
| North Rhine-Westphalia | 1,743 | 655 | 37.6 |
| Berlin | 1,549 | 540 | 34.9 |
| Hamburg | 222 | 76 | 34.2 |
| Baden-Württemberg | 1,141 | 390 | 34.2 |
| Bremen | 148 | 44 | 29.7 |

Table 2: Returns from the survey according to the Federal states (as at 31 December 2002)

There was keen interest in the database from the very beginning. Many potential participants requested detailed information about the target group and the subject of the survey. Some enquiries resulted from the terminology used in the title of the outline questionnaire or the project questionnaire. Public institutions in particular pointed out that their services should not be recorded as “projects” of a specific duration and wanted to know whether it was possible to include continuous services in the database. If it was ascertained from the conversation that they were involved in carrying out work relevant to the survey, they were asked to take part.

The “Comments on the questionnaire” field on the last page of the project questionnaire gives participants the opportunity to comment on the survey tool. Participants often made comments about their expectations of the overall “lively database” project and comments and suggestions about carrying out the survey in addition to remarks they made about the questionnaire.

Where the comments contained evaluations, these were largely positive. They particularly emphasised the expected practical benefits of having an extensive and readily available compilation of available services for promoting the health of socially disadvantaged groups:

I consider the questionnaire to be intelligently structured and hope to find new ideas and contact persons for future work [1572].³

I think the idea of combining projects in one general database, thereby giving interested parties the opportunity to search for services quickly, is really good. [294]

The questionnaire is described as “easily comprehensible” [25] and “well-structured” [1820] among other things. Individual service providers requested more detailed explanations for some of the questions and terms used, in particular, with regard to the specific content of the setting approach. This key concept of health promotion has obviously not yet been adopted in many services, mainly in the primary healthcare sector.

The uncertainty on the part of many service providers as to whether they and their services were part of the target group of the survey is also reflected in the comments on the questionnaire. It is part of the professional approach of many services that they address socially disadvantaged groups of the population without the service being aimed exclusively at these people. When these service providers contacted the survey office at the Association for Health Promotion Berlin with queries, they were asked to participate in the survey if the groups specified in the questionnaire were any of the key target groups addressed by the services. Their remaining uncertainty was evidenced in a series of comments, one of which refers to a service for promoting health in schools, for example:

... no idea whether this measure can be counted among projects and measures for promoting the health of socially disadvantaged groups, as all pupils are taking part in it at our school. [2127]

As a reason for not taking part in the survey, people often stated that they did not have enough time to fill in the questionnaire, “something which is taken up when carrying out practical work with children and young people” [688]. The following statement sums up the considerable strain which participation even in a very promising project would place on many service providers in addition to their regular work:

Intelligent approach to obtaining relevant data. However, extensive and time-consuming. [442]

In some cases people took part in the questionnaire online in order to save time and effort.

Questionnaires always mean work :-) but doing them online is less work for us. [158]

In particular, towards the end of the survey period in mid-December 2002, the willingness of many service providers to describe their services conflicted with increased workloads (“reports, accounts and new applications” [2138]) in terms of work which needed to be completed by the end of the year:

³ As an indicator of the source, the numbers in square brackets identify the services.

It would have been better to have longer to complete the questionnaire. Projects often fail to provide enough time, especially at the end of the year when annual reports and usage lists have to be produced. The summer would be more suitable. [2030]

Some service providers said that they had filled in the questionnaire “when working at night” [2560] or “on the train” [2543] because of a lack of time.

Data processing

To compile the address directory for sending out the questionnaires, an Access 2000 database was developed into which the researched addresses were entered or existing data sets were imported. Later in the survey the database served as a place for recording who had returned their questionnaires.

The survey Internet database was programmed in database query language SQL (Structured Query Language). The online questionnaires and the administration area used by the survey office as a user interface were created in PHP. It is possible to enter information into the database via the “public” online questionnaire at www.datenbank-gesundheitsprojekte.de or via an input screen in the administration area.

5.3 Overview of the recorded projects

The following sections provide an overview of the details of 2,256 services. This includes all completed paper questionnaires which were received by 18 December 2002 at the survey office (end of the survey period plus an extra two days’ grace), as well as all questionnaires which had been submitted online by the service providers by 18 December 2003. At almost 40% of all positive returns the proportion of the questionnaires⁴ completed by the service providers online is relatively high and implies that the medium of the Internet as an information and communication channel is gaining increasing significance with providers of measures for promoting the health of socially disadvantaged groups also.

The following evaluation includes all “closed” questions requiring only a cross. The details in the free text fields (e.g. questions 1.1 and 2) will be evaluated in the second stage of the project. An evaluation in terms of content did not take place nor were the services filtered.

⁴ A clear classification of online and offline replies is difficult as there is some overlapping. Participants can, for example, – as happened in several cases – fill in the online questionnaire and also send a paper questionnaire to the survey office. It was also necessary in some cases to ask service providers to fully complete the incomplete questionnaires they had returned by post or handed in at the survey office.

Survey returns

The “lively database” project relies on the active participation of the organisations that provide services to promote the health of socially disadvantaged people. These were expressly invited to assist in expanding the overview in terms of available services by naming relevant projects and measures.

Agreeing to publication

The majority of participants consented to having their data published as part of a “lively” Internet database. The statement “We do not consent to the publication of the information we have provided” was ticked in only a few cases.

Regional distribution of the services

Table 3 gives an overview of the regional distribution of the services recorded in the survey; the information relates to the location of the service provider. Due to the high degree of variation in the number of inhabitants living in each region, the number of projects per 100,000 inhabitants is used as an indicator for the “density of services” in the region.

With 11.6 services for every 100,000 inhabitants, Berlin has by far the greatest “density” of services. This can partly be attributed to the fact that the Association for Health Pro-

| Federal state | Services (in total: 2,256) | Services per 100,000 inhabitants |
|----------------------------------|-------------------------------|----------------------------------|
| Berlin | 394 | 11.6 |
| Thuringia | 158 | 6.0 |
| Bremen | 31 | 5.8 |
| Mecklenburg-Western Pomerania | 107 | 5.5 |
| Hamburg | 63 | 3.9 |
| Schleswig-Holstein | 93 | 3.6 |
| Baden-Württemberg | 239 | 2.6 |
| Rhineland Palatinate | 94 | 2.5 |
| Brandenburg | 65 | 2.5 |
| Hesse | 133 | 2.4 |
| North Rhine-Westphalia | 395 | 2.3 |
| Saarland | 23 | 2.2 |
| Lower Saxony | 137 | 1.9 |
| Saxony | 88 | 1.8 |
| Bayern | 191 | 1.7 |
| Saxony-Anhalt | 45 | 1.5 |

Table 3: Services according to region

motion Berlin as the institution commissioned to carry out the survey has particularly good access to the field. A clear distinction between the Eastern and Western Federal states is not discernable: the East German regions are among the regions with a high “density of services” (Thuringia and Mecklenburg-Western Pomerania at positions 2 and 4) as well as those which fall into the middle category (Brandenburg in 9th position) and the states with the fewest number of services in the table (Saxony in 14th position and Saxony-Anhalt in 16th position).

During the further course of the project it will be necessary to ask whether the position of the regions in the table in terms of their “density” of services accurately reflects the situation in the regions or whether the problems in accessing the field has led to systematic distortion of the figures.

This is a suitable question for discussion during the course of the second project phase, preferably in the context of the regional “Poverty and Health” committee (cf. section “Continuation of the work and development of a nationwide network of regional focal points.”)

Implementation status of the services

In order to be able to use the data collected from the survey as part of the “lively database” to provide an up-to-date overview of the diversity of services to promote the health of socially disadvantaged groups and as a tool for building partnerships and encouraging networking between the service providers, it is important to have a high proportion of measures which are currently being carried out. At the same time, projects which have already been completed or are yet to be realised can provide important stimuli for new ideas as well as valuable experiences.

The majority (88.3%) of the services are currently at the implementation stage.⁵ The proportion of services which have been completed in the last three years or are still at the planning stage are approximately equal (6.2% and 5.4%).

Target groups for the services

Table 5 shows that more than two thirds of the services which form part of the survey were aimed at “adults” between the ages of 19 and 59. At the same time, the results show that there are broad areas of overlap between the age groups addressed. Over half of all services were designed to address two or three different age groups.

⁵ The question as to the implementation status of the services was not completed in a disproportionately high number of forms. This may be attributed to the poor position of the question above the details about the project. In order to obtain nevertheless a number of details which answered the question definitively, missing values were coded with “currently being carried out”, wherever “No end planned, service being carried out” was selected as an answer to question 5.1 (Duration of the project).

| Implementation status | Frequency | Percentage |
|---------------------------------------|--------------|--------------|
| Currently in progress | 1,802 | 88.3 |
| Completed within the last three years | 127 | 6.2 |
| At the planning stage | 111 | 5.4 |
| <i>Total</i> | <i>2,040</i> | <i>100.0</i> |
| <i>Missing</i> | <i>216</i> | |

Table 4: Implementation status of the services

Over half of the services (just under 60%) are aimed at the age groups of children and young people up to and including 18 years of age, and here too there is extensive overlapping in some cases with the older target groups. 442 services (19.6%) are aimed solely at children and young people (i.e. at the target group up to a maximum of 18 years of age with no overlapping of older groups).

The overview of the target groups addressed (cf. *Table 6*) shows a broad range with numerous cases of overlapping. This is also reflected in the fact that no single target group dominates clearly. What is noticeable is the frequent use of the free text option “Other”,

| Age groups | Number | References in % ⁶ | Cases in % ⁷ |
|---|--------|------------------------------|-------------------------|
| Babies (<1 year) | 216 | 3.2 | 10.1 |
| Infants and pre-school children (1–5 years) | 390 | 5.8 | 18.2 |
| School children (6–10 years) | 629 | 9.3 | 29.4 |
| School children (11–14 years) | 778 | 11.5 | 36.4 |
| Young people (15–18 years) | 981 | 14.5 | 45.9 |
| Young adults (19–29 years) | 1,468 | 21.7 | 68.7 |
| Adults (30–59 years) | 1,450 | 21.5 | 67.9 |
| Senior citizens (over 60 years) | 847 | 12.5 | 39.6 |

Table 5: Age groups (n = 2,137)

6 The “References in %” column contains the number of references as a percentage for an answer category for questions with the option to give multiple answers, relative to the total number of all references, so that the column total is always equal to 100%. The relative significance of an answer category is thereby recorded.

7 The “Cases in %” column contains the number of references as a percentage for every answer category, relative to the total number of all cases (here: evaluated services). Where multiple answers were possible the number in the column may be well over 100%.

| Target groups | Number | References in % | Cases in % |
|---|--------|-----------------|------------|
| Very low income | 658 | 8.7 | 33.1 |
| Unemployed | 553 | 7.3 | 27.8 |
| Single parents | 552 | 7.3 | 27.8 |
| People living in areas with social problems | 534 | 7.0 | 26.9 |
| Parents living in stressful situations | 505 | 6.7 | 25.4 |
| Very low level of school education | 490 | 6.5 | 24.7 |
| Migrants | 484 | 6.4 | 24.4 |
| Very low professional status | 474 | 6.2 | 23.9 |
| Resettlers | 441 | 5.8 | 22.2 |
| Families with a large number of children | 376 | 5.0 | 18.9 |
| Migrants with poor knowledge of German | 371 | 4.9 | 18.7 |
| Asylum seekers | 261 | 3.4 | 13.1 |
| Homeless people | 228 | 3.0 | 11.5 |
| Refugees | 168 | 2.2 | 8.5 |
| Prisoners | 168 | 2.2 | 8.5 |
| Illegal immigrants | 140 | 1.8 | 7.0 |
| Prostitutes | 117 | 1.5 | 5.9 |
| Other target groups | 1,071 | 14.1 | 53.9 |

Table 6: Target groups (n = 1,989)

indicating that the 18 predefined answer categories only rudimentary record the different forms of health promotion for socially disadvantaged groups in terms of their approach. A cursory look at the open answers for “Other” shows, however, that there are often overlaps to the closed predefined answer and “new” target groups were not always identified.

Gender-specific services

Question 6.2 focuses on gender-specific services. The predefined answers “Services for boys/men”, “Services for girls/women” and “No gender-specific services” were originally intended as alternative categories, i.e. it was assumed that the services would be either gender-specific (for boys/men or girls/women) or non-gender-specific. This cut-and-dried distinction, however, is not seen in practical intervention work aimed at promoting health (cf. *Table 7*). There are also service providers who offer both specific services for both genders and services which are aimed equally at boys and girls as they are at men and women.

| Specific services for | Number | References in % | Cases in % |
|-----------------------------|--------|-----------------|------------|
| Boys/men | 401 | 18.0 | 22.3 |
| Girls/women | 723 | 32.5 | 40.2 |
| No gender-specific services | 1,102 | 49.5 | 61.3 |

Table 7: Gender-specific services (n = 1,789)

With regard to the question of gender-specific services there was an above-average tendency to abstain from answering (20%). This may be an indication that the subject is either not considered relevant or that it is too difficult for the service providers to put their services into one of the predefined categories.

Access routes used by the services

In order to design services which are relevant to the target groups, it is crucial to choose appropriate access routes. In the field of health promotion for socially disadvantaged groups the setting approach⁸ is particularly suited to reaching those target groups which are difficult to access via courses to prevent specific types of behaviour.

In answer to question 1.2 as to whether the service uses a setting approach which is related to everyday life, over two thirds of the service providers answered positively (cf. *Table 8*). Just under a quarter of the participants said that they do not work in a setting-oriented way.

| | Frequency | Percentage |
|--------------------------|--------------|--------------|
| Setting approach | 1,326 | 68.8 |
| Partial setting approach | 132 | 6.9 |
| No setting approach | 469 | 24.3 |
| <i>Total</i> | <i>1,927</i> | <i>100.0</i> |
| <i>Missing</i> | <i>329</i> | |

Table 8: Does the service use the setting approach?

⁸ Setting intervention measures in the area of health promotion follow an integrated approach to preventing damaging behaviour and relationships. Within a social sphere (e.g. school, work, or neighbourhood) they are aimed at strengthening the skills and resources of the target groups and empowering them to recognise health-related problems by themselves and to deal with them. At the same time the setting itself becomes an object of the process of change, with the aim of creating a healthy living environment.

| Setting | Number | Proportion of all services in settings (in %) |
|-------------------|--------|---|
| Workplace | 252 | 22.5 |
| Neighbourhood | 698 | 62.4 |
| Recreational area | 305 | 27.3 |
| Nursery school | 192 | 17.2 |
| School | 439 | 39.2 |

Table 9: Services in settings (n = 1,119)

There is good reason to be sceptical about whether the information provided by the service providers themselves is actual proof of a clear dominance of the setting approach in the field of health promotion for socially disadvantaged groups. These doubts are consolidated by the fact that only 1,119 services (50% of the total) can be put in one or more of the defined setting categories which are workplace, neighbourhood, leisure time area, nursery school or school (cf. *Table 9*).

The high proportion of “self-designated” setting-related services can be seen as evidence that service providers are becoming increasingly aware of this approach and that it is beginning to represent a “model” approach for effective health promotion activities which are appropriate to the target group. The significance which is attached to the setting approach in the methods used by health insurance schemes in implementing Article 20 (1) of the Social Security Code V (cf. Arbeitsgemeinschaft der Spitzenverbände der Krankenkassen 2001 and 2002), in specialist publications (cf. Prevention 3/2002) and in political debate (cf. SVR [Expert Committee for Concerted Action in Health Insurance] 2001 and 2003) is also testimony to this.

Of the services surveyed (cf. *Table 10*) 698 are involved in the setting “home, neighbourhood, community”. Measures to combat the consequences of social “imbalance” in the district dominate: neglect, impoverishment, degeneration of an area to the point of

| Deplorable situation | Number | References in % | Cases in % |
|---|--------|-----------------|------------|
| Neglect, impoverishment, formation of ghettos | 510 | 48.6 | 73.1 |
| Damp, mould, unhygienic conditions | 141 | 13.4 | 20.2 |
| Accidents | 75 | 7.1 | 10.7 |
| Bad smells | 60 | 5.7 | 8.6 |
| Noise | 57 | 5.4 | 8.2 |
| Other improvement to living conditions | 206 | 19.6 | 29.5 |

Table 10: Improvement to conditions in the home, living environment, community (n = 698)

| Problem | Number | References in % | Cases in % |
|-------------------------------------|--------|-----------------|------------|
| Accidents | 66 | 17.1 | 26.2 |
| Narrow scope for decision-making | 55 | 14.2 | 21.8 |
| Noise | 36 | 9.3 | 14.3 |
| Unfavourable working hours | 31 | 8.0 | 12.3 |
| Dirt | 29 | 7.5 | 11.5 |
| Other improvements at the workplace | 169 | 43.8 | 67.1 |

Table 11: Improvement to conditions in the workplace (n = 252)

reaching ghetto status with all the associated strains on health should be avoided. Among the other approaches there are examples ranging from the creation of shared public (play) rooms and support services to specific measures for improving the neighbourhood (collecting used syringes and general clearing of waste), and the setting up of local initiatives (e.g. round table).

Of the services surveyed, 252 are involved in the “workplace” setting with just under half of them committed to ensuring a greater level of safety in the workplace (accident prevention) or extending employees scope for making decisions (cf. *Table 11*). By far the most entries fall into the category of “other” approaches to health promotion in a commercial setting. The issue of “bullying in the workplace” is mentioned frequently among the intervention measures named and is addressed by numerous measures to initiate and support processes for resolving conflicts among staff or between managers and employees. Other important topics are the creation of appropriate conditions for integrating disabled people in the work process and dealing with addictions (including the issue of “smoking at the workplace”).

The following sections – “School and day-care centre” setting and “Health promotion in the workplace” setting – focus more closely on the contents of the services in the settings “school and day-care centre” and “workplace” and have been written by the Lower Saxony Regional Association.

In particular, the evaluation draws on the open information provided for questions 1, 2, 3.5, 3.7 and 3.8. In order to guarantee the most up-to-date results only those services were included in the evaluation whose data were in the database at the beginning of January 2003.

“School and day-care centre” setting

Question 3.7/3.8 of the questionnaire asked which aims are pursued in the setting “school/kindergarten” with the measures described. Here the services are listed in order of rank for 26 target categories (cf. *Table 12*).

| Target categories | N school (Multiple answers possible) | N nursery school (Multiple answers possible) |
|---|---|---|
| Addiction prevention | 29 | 3 |
| “Healthy school” | 19 | – |
| Physical activity service | 21 | 7 |
| Social skills | 13 | – |
| Supervision service | 22 | 8 |
| Preventing violence | 11 | 2 |
| Nutrition service | 11 | 7 |
| Breakfast service | 10 | – |
| Social counselling | 10 | 2 |
| Sex education service | 9 | 2 |
| Cooperation between parents and day-care centres/schools | 9 | 5 |
| Cooperation between neighbourhood management/community development organisations and day-care centres/schools | 8 | 8 |
| Specialist training for multipliers | 8 | 8 |
| Prevention of HIV/AIDS | | |
| Prevention through peer education | 8 | 1 |
| Speech therapy | 4 | – |
| Careers service | 3 | 5 |
| Transition from day-care centre to school | 2 | – |
| School nurses | 2 | 2 |
| Prevention of eating disorders | 2 | – |
| School programme | 2 | – |
| School kiosk | 2 | – |
| Medical care in the school/ day-care centre | 2 | – |
| Parenting classes | 1 | 4 |
| Intercultural health promotion | 1 | 2 |
| Other | 6 | 6 |
| <i>Total</i> | <i>217</i> | <i>73</i> |

Table 12: Target categories for setting services in schools and day-care centre

Distribution of services in the “school / day-care centre” setting.

The total number of services which were evaluated for the “school” setting was 217, and for the “day-care centre” setting there were 73. It is noticeable that there is a significantly lower number of services for the school area in comparison with the day-care

centre area. It may be assumed that this situation cannot solely be attributed to the way in which the address directory was compiled, as it was not compulsory for the networks (e.g. Healthy Cities network) or even the (welfare) associations and municipal organisations to provide information on every service. It is more likely that this result provides an insight into the situation with regard to prevention.

Diverse preventive measures have always been aimed at schools, among other reasons in order to utilise the accessibility of entire year groups in an educational context. Model trials such as the OPUS network, the Schule 21 [School 21] network and other forums have ensured that in the education sector subject matter relating to health promotion is already incorporated on a regular basis in many schools. Similar measures do not seem to be in place for nursery schools yet, although there are various reasons in favour of improving efforts. The ease with which children can be reached during early childhood, the possibility of involving parents in prevention, the positive light in which day-care centres are seen by their users and their involvement in the community/social area provide suitable conditions for this.

Target categories in the "school" setting

With regard to measures carried out in schools, "classical" areas dominate in the fields of health and social affairs: addiction prevention, physical activity programmes or supervision services. There is a strikingly high number of services to prevent addiction with various foci and target groups. They often take the form of group work and project weeks. Counselling and support from drug advice teachers or intercultural addiction prevention are also to be found among the services, as is addiction prevention through peer education and education based on participation in an activity and subsequent reflection on it (experiential education).

A similarly diverse range is shown among the services relating to physical activity. They include dynamic sitting, exercise breaks and changing between exercise and relaxation units, as well as training for sports teachers. The heterogeneous range also includes therapeutic exercise services and sport and exercise through additional volleyball or table tennis games during break times and after school.

Among the support services there are school clubs or midday breaks designed by the pupils themselves to provide a welcoming atmosphere, as well as recreational services offering afternoon supervision or homework support.

Teaching children social skills and harmonious cooperation with others in a group is a priority in services that focus on learning social skills. Elements of health promotion are always incorporated in a creative way. Examples of ways in which this is put into practice are partnership arrangements between primary schools and neighbouring adventure playgrounds, through drama classes, preparation of breakfast for the class together or through first aid courses.

The “healthy school” category includes measures for health at school (e.g. by improving the school atmosphere), as well as other services which relate to the cooperation of everyone involved in the “school” setting. The category was always chosen where the general term of “health at school” was stated as an explicit aim of the preventative measures. The range of other target categories such as preventing violence, cooperation between parents and schools and sex education programmes is similarly wide-ranging. The latter includes the prevention of sexual abuse and gender-specific sex education for girls and boys.

Target categories in the “nursery school” setting

The situation with regard to day-care centres is quite different. Support services, specialist training for multipliers and the cooperation of neighbourhood management and community development schemes with nursery schools make up the majority of services. The usual range of support services provided by day-care centres are improved through efforts to make opening times coincide with modern working hours, even for part-time workers. Care for children of single working mothers and also individual care for children with disabilities can also be counted among the services in this area.

Great importance is attached to efforts to ensure multipliers have specialist training. Among the range of services offered are training courses for multipliers in preventing addiction and violence, psychosocial and intercultural knowledge and (German) language teaching. This area includes valuable intervention fields as teachers often make more exact observations – in terms of problems with a child’s development – but do not always pass on this information or, according to their own statements, are not taken seriously by parents or doctors owing to their inability to express or explain the issues properly. Improvements to the standard of training may help to alleviate this problem.

Some of the services are aimed at improving eating habits. Among them are campaign days or projects to reduce obesity. Breakfast or a supplementary breakfast for socially disadvantaged children consisting of fruit, dairy products and tea drinks is, for many day-care centres, part of the regular daily programme. This explains the relatively low number of services listed in this category and this explanation, incidentally, also applies in a similar manner to the significance of physical activity services.

It cannot be assumed that the services surveyed clearly reflect the true situation in day-care centres. Health and health promotion traditionally play an important role in this context and are a part of the everyday routine. Consequently, the measures are often taken for granted, meaning that some people involved in the field hardly perceive them as such (cf. hygiene, dental care, eating breakfast together, etc.). For this reason alone prevention measures should be developed for socially disadvantaged children in day-care centres in accordance with the setting approach. In many cases it would be possible to add them on to the tried-and-tested health culture in the institution, to include parents and to utilise thereby the available health potential.

The results of the second AWO-ISS study (Holz/Skoluda 2002) are further proof that these measures are especially necessary for children affected by poverty. It was again proven that the health status of poor children at pre-school as well as early primary school age is a relatively safe indicator of problematic living conditions.

The majority of poor children examined as part of the study were suffering from psychosomatic and/or chronic illnesses. If this result is considered in the light of the children's living conditions, these illnesses represent additional difficulties, not only in their current circumstances but also in terms of their future development and health opportunities. The support provided by the day-care centre in addition to that provided by the family, enriched with elements of integrated health promotion, can counteract this disadvantageous situation and thereby ensure more equal health and social opportunities.

“Health promotion in the workplace” setting

Point 3.5 of the questionnaire surveyed which aims are pursued in the area of health promotion in the workplace with the measures described. The 51 services listed in order of rank in *Table 13* can be included in the measures/projects for health promotion in the workplace. 15 services are listed under the target category “maternity”, which contains measures for implementing and adhering to maternity leave regulations as well as information about risks to reproductive health in the workplace. They are aimed at different target groups, among others, socially disadvantaged people and migrants. Some of the measures are also carried out for research purposes.

Diverse services aimed at improving or maintaining positive psychosocial states in employees are listed under the “psychosocial counselling” category. Institutions are included in this category whose services are explicitly aimed at companies or which take place in the workplace. As expected, there is wide diversity in this category: it ranges from

| Target categories | N |
|--|-----------|
| Maternity protection laws | 15 |
| Psychosocial counselling | 14 |
| Original tasks | 8 |
| Addiction prevention at the workplace | 5 |
| Physical activity service | 3 |
| Ergonomic design at the workplace | 3 |
| Leadership | 2 |
| School atmosphere / health of teachers | 1 |
| <i>Total</i> | <i>51</i> |

Table 13: Aim: Improvement of conditions in the workplace

| Area of activity | Number | References in % | Cases in % |
|-------------------------------|--------|-----------------|------------|
| Coping resources | 1,353 | 15.2 | 65.0 |
| Combating stress | 951 | 10.7 | 45.7 |
| Nutrition | 832 | 9.4 | 40.0 |
| Preventing alcohol abuse | 814 | 9.2 | 39.1 |
| Preventing violence | 729 | 8.2 | 35.0 |
| Use of medication | 699 | 7.9 | 33.6 |
| Preventing drug abuse | 658 | 7.4 | 31.6 |
| Sport and physical activities | 585 | 6.6 | 28.1 |
| Prevention of smoking | 527 | 5.9 | 25.3 |
| Sexual behaviour | 505 | 5.7 | 24.3 |
| AIDS prevention | 425 | 4.8 | 20.4 |
| Accident prevention | 191 | 2.1 | 9.2 |
| Other | 617 | 6.9 | 29.6 |

Table 14: Aim: improvement of individual health behaviour (n = 2,082)

general measures for social integration and integrating foreign employees and resettlers to information about employment law and activities for combating stress, psychological strains and bullying in the workplace.

In third position in the table there is a category called “original tasks”. Information about passive smoking and infectious diseases, counselling on rest and recuperation breaks, help for disabled employees in the workplace (barriers, technical resources etc.) are included in this category as well as information on how to deal with seizures of property (i.e. counselling for employers with regard to levels of seizures of property).

With regard to the remaining measures these are individual services concerning addiction prevention, promotion of physical activities, ergonomics in the workplace and similar measures in a business setting.

Aims and types of service

Table 14 gives an overview of the answers to question 3.1 with regard to the aims and areas of activity of the services to promote health, as far as they relate to the health behaviour of individuals. Two thirds of the service providers gave improving “coping resources” as an aim of their measures. A rather “non-specific” salutogenetic approach (cf. Antonovsky 1997) also emerges in the “combating stress” field, having the second highest number of references. Below is a description of clearly specified “preventative” areas of activity such as promoting healthy eating and the prevention of alcohol abuse or violence.

| Area | Number | References in % | Cases in % |
|--------------------------------------|--------|-----------------|------------|
| Improvement of social integration | 1,395 | 18.6 | 70.1 |
| Strengthening social support | 1,234 | 16.4 | 62.0 |
| Counselling in social matters | 979 | 13.0 | 49.2 |
| Dealing with aggression/violence | 655 | 8.7 | 32.9 |
| Assistance finding a job | 562 | 7.5 | 28.3 |
| Assistance finding a place to live | 517 | 6.9 | 26.0 |
| Protection of children/young people | 407 | 5.4 | 20.5 |
| Counselling on budgeting/debts | 392 | 5.2 | 19.7 |
| Assistance looking after children | 376 | 5.0 | 18.9 |
| Pregnancy/preparation for childbirth | 283 | 3.8 | 14.2 |
| Language training | 194 | 2.6 | 9.8 |
| Other intervention methods | 519 | 6.9 | 26.1 |

Table 15: Aim: to increase health and social resources (n = 1,989)

More than two thirds of the services give three or more areas of activity in which they are involved in improving the health behaviour of individuals. It may be assumed that the majority of service providers consider strengthening coping resources as a prerequisite for working on specific health-related aims, such as the prevention of violence or use of medication and that this is considered a central component of their services.

The significance of relatively non-specific resource-oriented approaches through which the target group should gain the means of coping with strains posing a risk to their health by themselves is also shown in the answers to question 3.2 relating to the approaches for improving the health and social resources (cf. *Table 15*). Approaches which aim to improve the social integration of the target groups and thereby make an important contribution to creating and strengthening the “feeling of coherence” as defined by Antonovsky (cf. Antonovsky 1997) receive the highest number of references by far.

| Care service | Number | References in % | Cases in % |
|--|--------|-----------------|------------|
| Participation in check-ups | 304 | 25.6 | 41.2 |
| Participation in early detection tests | 246 | 20.7 | 33.3 |
| Vaccinations | 208 | 17.5 | 28.2 |
| Other improvement in healthcare | 431 | 36,2 | 58.4 |

Table 16: Improvement in the extent to which healthcare is made use of (n = 738)

The area of strengthening health and social resources also shows a high degree of overlapping between several target areas. As *Table 15* has already shown, it may be assumed that increasing social integration and social support is used as a general label for services which are otherwise very problem-specific. 738 services aim to increase the number of people utilising healthcare services (cf. *Table 16*).

It is striking that there are a high number of “other” healthcare services. In this category there are frequent references to approaches aimed at reducing the target group’s fear of involvement with official organisations, e.g. by accompanying people to doctor’s appointments. Other important topics in this varied area of intervention are focused more on primary prevention such as sex education and the prevention of unwanted pregnancies as well as teaching people about transmitted diseases (in particular AIDS).

Types of services

Table 17 provides an overview of the types of service designed to achieve the above goals. When interpreting the figures it should be noted that approximately only one third of the services are an “exclusive” service, while the remaining measures include two or more types of services. Almost two thirds of all measures offer advice sessions, which are mentioned almost twice as often as the educational and training services which are the next most frequent.

Cooperation and networking

Cooperation and networking relationships are also of particular importance to the practical aspects of carrying out measures to promote health, as it is possible to pool resources and experiences in a targeted way through successful partnerships.

| Type of service | Number | References in % | Cases in % |
|--|--------|-----------------|------------|
| Counselling service | 1,358 | 23.5 | 62.2 |
| Education service/training programme | 758 | 13.1 | 34.7 |
| Leisure opportunities | 632 | 10.9 | 28.9 |
| Provision of materials | 403 | 7.0 | 18.4 |
| Campaign day | 400 | 6.9 | 18.3 |
| Conference/organised event (or series of events) | 382 | 6.6 | 17.5 |
| Work in community development | 351 | 6.1 | 16.1 |
| Supply service (e.g. lunch) | 288 | 5.0 | 13.2 |
| “Health day”/“health week” | 265 | 4.6 | 12.1 |
| Exhibition | 184 | 3.2 | 8.4 |
| Other type of service | 754 | 13.1 | 34.5 |

Table 17: Types of service (n = 2,185)

| Cooperation partner | Number | References in % | Cases in % |
|--|--------|-----------------|------------|
| Counselling centres | 1,345 | 10.2 | 63.2 |
| Health office | 965 | 7.3 | 45.3 |
| Local doctors | 881 | 6.7 | 41.4 |
| Social welfare authority | 873 | 6.6 | 41.0 |
| Youth welfare office | 867 | 6.6 | 40.7 |
| Charitable organisations | 807 | 6.1 | 37.9 |
| Schools | 793 | 6.0 | 37.2 |
| Self-help groups | 745 | 5.7 | 35.0 |
| Regional working parties | 698 | 5.3 | 32.8 |
| Hospitals | 641 | 4.9 | 30.1 |
| Health insurance schemes | 568 | 4.3 | 26.7 |
| Church communities/church-based organisations | 565 | 4.3 | 26.5 |
| Youth centres/youth clubs | 472 | 3.6 | 22.2 |
| Police | 452 | 3.4 | 21.2 |
| Nursery schools | 406 | 3.1 | 19.1 |
| Helping the neighbourhood district initiatives | 402 | 3.0 | 18.9 |
| Companies | 254 | 1.9 | 11.9 |
| Sport clubs | 245 | 1.9 | 11.5 |
| Remand centres | 239 | 1.8 | 11.2 |
| Medical associations | 190 | 1.4 | 8.9 |
| Health conference | 146 | 1.1 | 6.9 |
| Midwives | 118 | 0,9 | 5.5 |
| Other cooperation partners | 484 | 3.7 | 22.7 |
| No cooperation partners | 29 | 0.2 | 1.4 |

Table 18: Cooperation partners (n = 2,129)

Cooperation partners involved in health promotion

With regard to question 8 relating to partners or institutions which cooperate in work with the services, only 1.4% of service providers state that they work entirely without the help of partners (cf. *Table 18*). Approximately half of all services involved work with up to five cooperation partners.

In view of the large number of counselling services (cf. section “Aims and types of services”) it is not surprising that counselling centres represent almost two thirds of services, making these the most common cooperation partner mentioned by far. In creating services to promote health, health, social and youth welfare offices rank highly, making up over 40% of the services named. A cursory look at the open information provided for

question 2, which asks about the people involved in developing the service, often shows very complex cooperative partnerships and network relationships.

Multipliers and facilitators involved in health promotion

Involving multipliers or facilitators (Question 7) ensures that target groups are addressed and reached in an appropriate manner, which is an important condition for successful intervention measures to promote health. *Table 19* provides an overview of the multipliers and facilitators involved.

Almost one service in twenty service (4.5%) states that it does not work with multipliers or facilitators. The strong social relevance of the services is underlined by the fact that social workers are mentioned most often as a group of multipliers.

Documenting and evaluating the services

Documentation and evaluation of the services performed is becoming increasingly important as a method of assuring quality in the practical implementation of services to promote health, not least because this is a requirement of obtaining necessary project funds.

| Multipliers | Number | References in % | Cases in % |
|---|--------|-----------------|------------|
| Social workers/people involved in social education | 1,462 | 16.0 | 68.7 |
| Counsellors | 983 | 10.8 | 46.2 |
| Doctors | 935 | 10.2 | 44.0 |
| Teachers | 709 | 7.8 | 33.3 |
| Parents | 654 | 7.2 | 30.7 |
| Psychologists | 652 | 7.1 | 30.7 |
| Public for whom the subject is relevant | 640 | 7.0 | 30.1 |
| Educators involved in personal and social development | 547 | 6.0 | 25.7 |
| Course directors | 428 | 4.7 | 20.1 |
| Youth workers | 416 | 4.6 | 19.6 |
| Peers/contemporaries | 290 | 3.2 | 13.6 |
| Nurses/carers | 255 | 2.8 | 12.0 |
| Trainers | 254 | 2.8 | 11.9 |
| Facilitators (e.g. interpreters) | 229 | 2.5 | 10.8 |
| Midwives | 119 | 1.3 | 5.6 |
| Other multipliers/facilitators | 457 | 5.0 | 21.5 |
| No multipliers/facilitators | 95 | 1.0 | 4.5 |

Table 19: Multipliers/facilitators involved in the services (n = 2,127)

| | Frequency | Percentage | Cumulative percentage |
|---------------------------|--------------|--------------|-----------------------|
| No documentation | 442 | 22.5 | 22.5 |
| Documentation planned | 314 | 16.0 | 38.4 |
| Documentation in progress | 178 | 9.0 | 47.5 |
| Internal documentation | 928 | 47.2 | 94.6 |
| External documentation | 106 | 5.4 | 100.0 |
| <i>Total</i> | <i>1,968</i> | <i>100.0</i> | |
| <i>Missing</i> | <i>288</i> | | |

Table 20: Documentation of the services

Documenting the services

Over half of the service providers state that documentation on their work (e.g. in the form of an annual report) is available (Question 10, *Table 20*). The majority of service providers with documentation produce these reports themselves for internal documentation purposes. It is astonishing that there is a very high proportion of services (22.5%) for which no documentation is available and for which none is intended or is currently being created.

Evaluating the services

71.2% of the services do not produce any form of evaluation (Question 11, cf. *Table 21*). This is more than just documentation as it assesses the services in terms of whether they have achieved the aims previously set out. The reason that there is such a high proportion of services with no evaluation may be due to the financial costs involved, in particular with regard to evaluations carried out by external bodies.⁹

The boundaries between documentation and evaluation are fluent: an evaluation comprehensively documents the services performed. Similarly, documentation designed primarily as a quarterly report may include elements of an evaluation. One thing is clear, however, from cross-tabulation of both documentation and evaluation: services with no documentation are generally not evaluated, whilst the majority of services which have been evaluated by an external body have also been documented externally.

More detailed studies will need to investigate whether there is a connection between the use of both of these instruments for assuring quality and individual intervention fields/sources of funding.

⁹ An above average number of services (483 or 21.4%) do not provide any details of an evaluation, significantly more than is the case for the question about documentation. It may be assumed that there is no evaluation for the majority of these services.

| | Frequency | Percentage | Cumulated percentages |
|------------------------|--------------|--------------|-----------------------|
| No evaluation | 705 | 39.8 | 39.8 |
| Evaluation planned | 391 | 22.1 | 61.8 |
| Evaluation in progress | 166 | 9.4 | 71.2 |
| Internal evaluation | 391 | 22.1 | 93.2 |
| External evaluation | 120 | 6.8 | 100.0 |
| <i>Total</i> | <i>1,773</i> | <i>100.0</i> | |
| <i>Missing</i> | <i>483</i> | | |

Table 21: Evaluation of the services

Financing the services

The information gathered in question 9 regarding the services' sources of funding allow conclusions to be drawn about their "distribution", although they do not provide information about how much funding the services receive. It is therefore conceivable that funding source X is named by a large number of the services but that it only makes a small contribution to the total funds available. This is underlined by the fact that only a third of the services are funded exclusively by one source; the majority draw from a mixture of financial sources.

Three out of four services (77.8%) to promote the health of socially disadvantaged groups stated that they (also) receive public funding. This source of funding thereby receives the highest number of references by far (cf. *Table 22*). Donations (35.6%) and club subscription fees (20.9%) are also mentioned frequently. Every fifth service (also) uses volunteers (20.1%). In terms of the total number of services recorded, health insurance

| Source of funding | Number | References in % | Cases in % |
|---------------------------------|--------|-----------------|------------|
| Public resources | 1,657 | 33.5 | 77.8 |
| Donations | 758 | 15.3 | 35.6 |
| Club subscription fees | 446 | 9.0 | 20.9 |
| Volunteers | 428 | 8.7 | 20.1 |
| Contributions from participants | 371 | 7.5 | 17.4 |
| Money from sponsors | 288 | 5.8 | 13.5 |
| Health insurance schemes | 259 | 5.2 | 12.2 |
| Money from foundations | 170 | 3.4 | 8.0 |
| Other sources of funding | 567 | 11.5 | 26.6 |

Table 22: Sources of funding (n = 2,131)

| Source of funding | Number | References in % | Cases in % |
|--------------------------------|--------|-----------------|------------|
| Local authority resources | 1,019 | 39.1 | 62.5 |
| Regional resources | 970 | 37.3 | 59.5 |
| Job creation schemes | 225 | 8.6 | 13.8 |
| Federal government funds | 214 | 8.2 | 13.1 |
| Structural adaptation measures | 176 | 6.8 | 10.8 |

Table 23: Differentiation of the sources of funding “public funds” (n = 1,630)

schemes as sponsors for 12.2% of the services therefore have a rather low distribution. A few of the other sources of funding named are: church tax, lottery funds and other public benefactors (e.g. the Federal Insurance Institution for Employees) and it is also stated that the measures are financed by the service provider’s “own resources”.

The differentiated overview of public funds shows that health promotion (for socially disadvantaged groups) is primarily the responsibility of the Federal states and local authorities, which are named by approximately 60% of all services funded by public resources. By contrast, federal government resources (13.1%) make up a low percentage as do funds from job creation schemes (13.8%) and structural adaptation measures (10.8%).

The distribution of health insurance scheme funds shows a clear weighting in favour of services which comply with Article 20 of the Social Security Code V. A relatively clear distinction is made primarily between self-help projects in accordance with Article 20 (4) and primary prevention in accordance with Article 20 (1) in terms of funding. Measures to provide patient information in accordance with Article 65b of the Social Security Code V make up only a small percentage.

Of the 259 services which are (also) funded by health insurance schemes’ resources, three quarters (n = 190) refer to one of the three sources of funding listed in *Table 24*

| Source of funding | Number | References in % | Cases in % |
|------------------------|--------|-----------------|------------|
| Primary prevention | 87 | 43.1 | 45.8 |
| Promotion of self-help | 100 | 49.5 | 52.6 |
| Patient information | 15 | 7.4 | 7.9 |

Tab. 24: Differentiation of the sources of funding “health insurance company resources” (n = 190).

and specified in the Social Security Code V. It may therefore be assumed that the remaining quarter of the services receive funding from the health insurance schemes – e.g. as part of public work – as a subsidy to assist with events or publications.

Representation of instructive services

The aim of the survey was, on the one hand, to show the existing range of services and, on the other, the possibility of filtering out especially exemplary and innovative projects as part of subsequent work phases. During the course of the first project phase it was only possible to consider a few individual projects as examples. No systematic criteria were used to make the selection; instead they were selected on a more random basis during the data processing stage. Five of these projects will be briefly outlined in the following paragraphs. Each of the projects described shows a different characteristic. The selection does not reflect any preference over the other projects.

Project 1: Ongoing service in a comprehensive school

At a comprehensive school with an emphasis on sporting activities, a long-term project on the issue of “resistance to tobacco advertising” is being carried out by the health office in Frankfurt/Oder. Since February 2002 a monthly “project day” has been taking place for all pupils in the third year of secondary school. The work is being carried out in small groups and focuses on the pupil’s interests. The events are organised by employees from the health office, the youth welfare office, teachers and other professionals. The setting approach is considered important as the pupils learn most of their social skills within the school “environment”.

The aim is to have a smoke-free school, i.e. not only the pupils but also the teachers are encouraged not to smoke. Those teachers who do smoke are given information by a doctor and offered services to help them give up. Important multipliers, in addition to the course instructors, are teachers, parents and peers. The model project is being supported by local hospitals, health insurance schemes, welfare associations and regional committees. Plans are in place to provide continuous funding through Article 20 of the Social Security Code V and from donations.

Project 2: In-house interpreting service

In 1996 an interpreting service was started at Munich-Schwabing hospital, a hospital which provides acute care at the highest level, by the hospital management (in particular the head of nursing). The service can be used by all patients and their relatives as well as employees in the hospital.

Currently, 43 interpreters (mainly native speakers) are involved in a structured organisational concept. The hospital employees (mainly nursing staff) are able to interpret into 26 languages. The interpreters record their work and receive compensation through time off in lieu. Other colleagues perform any resultant overtime. Regular training sessions were set up. The aims of the interpreting service are to provide more effective and sus-

tainable care for migrants on the basis of improved understanding and reduction of culturally related misunderstandings. A side effect, in addition to the intended goal, was an improvement in the integration and appreciation of the foreign staff. The intercultural service has been extended, for example, to include prayer rooms for Muslims. The knowledge and experiences gained from the scheme were published in 1997. The publication *Muslimische Patienten. Ein Leitfaden zur interkulturellen Verständigung in Krankenhaus und Praxis* [Muslim patients. A handbook on intercultural understanding in hospitals and surgeries], published by Zuckschwerdt Verlag, Munich, is now in its second edition.

Project 3: Preparation for childbirth and parenthood for socially disadvantaged groups

In 1996 the Pro-Familia association for the region of Brandenburg carried out a survey of mothers who breastfeed their children. It showed that mothers who were better prepared for parenthood and the strains it involves tended to breastfeed their children for longer. Consequently, an antenatal course designed specifically for socially disadvantaged groups was set up.

Funding was assured in line with Article 20 of the Social Security Code V. Training was carried out by doctors, midwives and parents. Schools, the social welfare office, the health office, the youth welfare office and hospitals are also involved. As well as information about childbirth and the emotional stresses involved in parenting, the couples, single mothers and migrants were given information and tips on social, legal and financial issues on eight evenings. Many socially disadvantaged people, in particular, need support and detailed information about the possible support services available to them.

Project 4: A bicycle station as an employment project

The self-help group for unemployed people in Osnabrück has offered a varied service since 1984. An obvious basic activity is to provide advice to unemployed people and those threatened with unemployment. In addition, a number of other projects have flourished. The counselling services not only take the form of one-to-one interviews, there is now detailed information material available in the form of background information, flyers and on a website. In order to circulate information about the issue of “poverty and health”, a travelling exhibition has been produced on which detailed documentation is available. The main goal of the club is to improve people’s health by avoiding poverty.

At the railway station in Osnabrück there is a bicycle station which was set up some years ago by the unemployment help group. In the beginning this was a small project run by volunteer workers and job creation scheme centres. Through continual development and cooperation with the ADFC [General German Bicycle Club], the bicycle station is now a well-used service company with six permanent employees. The interesting thing about this project is its origin, since the idea for the project is not a new one but was adopted from North Rhine-Westphalia.

Project 5: Non-smoking project with a wide-ranging effect

In Bad Langensalza in Thuringia a scheme was started as part of a project carried out by the worker welfare association to prevent young people smoking which, it was hoped, would have an effect beyond a local level. At the “XXL” youth centre, a website was set up by young people under the guidance of a network administrator on the issue of “non-smoking”. This measure was created as part of a non-smoking campaign through “www.drugcom.de” with support from the regional film service in Thuringia. Whilst the project was being set up, several young people (smokers and non-smokers together) were asked about the subject of “non-smoking”. The resultant project which can be accessed at “www.raucher-pause.de.vu” now offers other young people the opportunity to find out in an appealing way about the consequences of smoking. The project is overseen by youth and social workers and funded by public money, among other sources (e.g. structural adaptation measures). Documentation is available in the form of a website.

5.4 Perspectives [Status: March 2003]

Extending and maintaining the Internet service

In order to give all interested parties the opportunity to use the pool of information on services to promote the health of socially disadvantaged people, a search function will be made available on the well-known Internet domain www.datenbank-gesundheitsprojekte.de once all information has been recorded and edited, including the questionnaires received after the mid-December 2002 deadline for the end of the survey. This will allow targeted searches for services according to the following criteria:

- Name of the service or service provider,
- Field of activity (predefined answers according to Question 3.1),
- Setting (business, community, nursery school, school),
- Type of service (predefined answers according to Question 4),
- Target groups (predefined answers according to Question 6.3),
- Age groups (predefined answers according to Question 6.1),
- Gender-specific services (input according to Question 6.2).

In addition to the search criteria relating to content, it is possible to limit the search results to a particular region according to

- Federal state,
- postcode,
- town.

Looking into the future, it is possible to continue developing the website, initially using the online questionnaire and the search function tailored largely to the results of the survey in the form of a comprehensive platform on “health promotion for socially disadvantaged groups”. Once a survey of requirements has been carried out, it will be possible to provide users with more detailed information (e.g. prepared results of the-

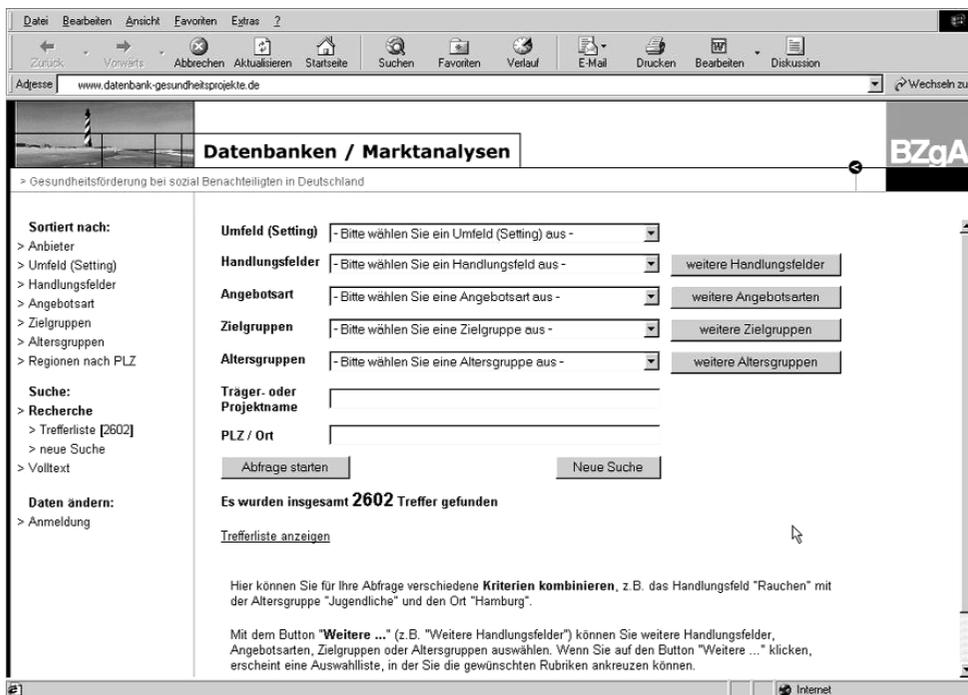


Fig. 1: Homepage of “www.datenbank-gesundheitsprojekte.de”

matically related studies), materials and services (dates, addresses, discussion fora) via this Internet platform.

Detailed proposals as to the content of the Internet portal were laid down in December 2002 in the joint concept for implementing a second project phase by the Association for Health Promotion Berlin and the Baden-Württemberg Regional Health Office.

Finding practical examples which are instructive and act as models

The list of services to promote the health of socially disadvantaged groups which was compiled during the first phase of the project offers an opportunity which has never existed before in terms of being able to identify which services are “useful” for motivating other service providers. In the section “Description of instructive services” five potential “model” services were presented as examples.

In order to provide a systematic foundation on which to base the selection of services with “good” practice out of all of the services recorded, plans are in place to derive criteria

from literature for filtering the services in a work step which will follow on from the first phase of the project (e.g. Federal Association for Health 2000, BZgA 2001) and put them into operation based on the categories in the questionnaire. These categories form the basis of an initial filter process.

The following criteria may be suitable for the first filter process:

- Target groups are (also) children and young people (Question 6.1).
- At least one target group in a “difficult social situation” (Question 6.3).
- Service to be continued in 2003 (Question 5.1).
- Service works in a setting (Questions 3.4 to 3.8).
- Guaranteed experience and sustainability: the service started before 2002 (Question 5.1).
- Network work/combining resources: at least two multipliers/cooperation partners are specified (Questions 7 and 8).
- The service is documented (Question 10).
- The service is evaluated (Question 11).

The screenshot shows a search results page from the website 'www.datenbank-gesundheitsprojekte.de'. The browser window title is 'http://artemis.bzga.de/ldb/ - Microsoft Internet Explorer'. The page content includes a navigation menu on the left with options like 'Sortiert nach:', 'Suche:', and 'Daten ändern:'. The main content area displays a table of search results with 14 entries. Each entry includes a number, a title, and the provider's name.

| Nr. | Titel | Anbieter |
|-----|---|--|
| 1 | Abenteuerlicher Bauspielfeldplatz Kolle 37 (Berlin) | Netzwerk Spiel Kultur Prenzlauer Berg e.V. |
| 2 | Abenteuerspielfeldplatz Sodener Str. 29 (Berlin) | Deutsche Schreiberjugend Berlin e.V., Abenteuerspielfeld |
| 3 | Aktionsbündnis Gesundheit im Knappenviertel / einem Stadtteil mit besonderem Erneuerungsbedarf (Oberhausen) | Stadt Oberhausen, Bereich Gesundheitswesen |
| 4 | Allgemeiner Sozialer Dienst ASD (Andernach) | Caritasverband für die Region Rhein-Mosel-Ahr e.V. Geschäftsstelle Andernach |
| 5 | Angebote zu gesunder Ernährung (Berlin) | pro agora e.V. Gesellschaft für nachhaltige Stadtkultur |
| 6 | Armut im Vorschulalter (Frankfurt am Main) | Institut für Sozialarbeit und Sozialpädagogik e.V. |
| 7 | Arzt-Patienten-Seminar 2003 (Bad Oeynhausen) | Verband Organtransplantierte Deutschlands e.V. |
| 8 | Aufbau von Sport- und Gesundheitszentren (Potsdam) | Landessportbund Brandenburg e.V. |
| 9 | Aufsuchende Gesundheitshilfen (Münster) | Stadt Münster Gesundheitsamt |
| 10 | Aussiedlerberatung (Würzburg) | Caritasverband Stadt und Landkreis Würzburg e.V. |
| 11 | BAG Kindersicherheit/Kindersicherheitstag (Bonn) | Bundesarbeitsgemeinschaft Kindersicherheit c/o Bundesvereinigung für Gesundheit e.V. |
| 12 | BASIK (Berlin) | Bezirksamt Steglitz-Zehlendorf von Berlin Gesundheitsamt |
| 13 | Beratung und Begleitung von HIV-betroffenen Familien (Hamburg) | Arbeitsgemeinschaft Kinder- und Jugendschutz Hamburg e.V. Projekt Kinder und AIDS |
| 14 | Beratung und Begleitung von Mädchen und Frauen mit aktuellen oder | Wirkwacker Würzburg e.V. |

Fig. 2: Results list from “www.datenbank-gesundheitsprojekte.de”. A search was carried out according to the following criteria “Environment”, “Nursery school” and “Age group 1–5”

The list of services identified after filtering will be submitted to the BZgA and the members of the advisory committee to serve as a basis for discussion with regard to further proceedings, in particular, surveying selected “good” service providers for project phase two. Should it be the case that the results of the first filtering with regard to the number and regional distribution of services prove not to be a practical basis for the second phase of the project (e.g. because clearly too many or too few services have been selected) or the quality and completeness of the surveyed information mean that the outcome for individual filter criteria appear to be sustainable only to a limited extent, then the filter criteria must be modified.

Continuation of the work and development of a nationwide network of regional focal points

In order to maintain the “lively database” which was developed during the first project phase and to make its content and services useful to those involved in the regional practical work of health promotion for socially disadvantaged groups in the sense of offering a place to share and exchange information, a network of localised focal points should be set up in the second project phase. Their responsibilities will include setting up working parties on the topic of “health promotion for socially disadvantaged groups”. The groups themselves may be set up as official institutions within the regional committees for health promotion. With regard to their establishment and the actual work these regional focal points will carry out, reference should be made to the models in the joint design concept for implementing a second project phase which was submitted by the Association for Health Promotion Berlin and the Baden-Württemberg Regional Health Office in December 2002.

Literature

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- SVR – Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen (2001): Bedarfsgerechtigkeit und Wirtschaftlichkeit. Gutachten 2000/2001. SVR, Bonn.
- SVR – Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen (2003): Finanzierung, Nutzerorientierung und Qualität. Gutachten 2003. SVR, Bonn.

Abbreviations

| | |
|-------|---|
| ABM | Arbeitsbeschaffungsmaßnahme [job creation scheme] |
| BZgA | Bundeszentrale für gesundheitliche Aufklärung [Federal Centre for Health Education] |
| BZPH | Berliner Zentrum Public Health [Berlin Centre for Public Health] |
| E&C | Federal model programme "Entwicklung und Chancen junger Menschen in sozialen Brennpunkten" [Development and Opportunities for Young People in Areas with Social Problems] |
| LGA | Landesgesundheitsamt Baden-Württemberg [Baden-Württemberg Regional Health Office] |
| LVG | Landesvereinigung für Gesundheitsförderung [Regional Association for Health Promotion] |
| OPUS | Offenes Partizipationsnetz Schulgesundheit [Network of Schools to Promote Health] |
| PDF | Portable Document File (file format) |
| SAM | Strukturanpassungsmaßnahme [structural adaptation method] |
| SGB V | Fünftes Sozialgesetzbuch [Fifth Social Security Code] (statutory health insurance) |
| SPSS | Programm zur statistischen Datenauswertung [statistical evaluation programme] |
| SVR | Sachverständigenrat für die konzertierte Aktion im Gesundheitswesen [German Council for Concerted Action in Public Health] |

5.5 Appendix 1: Notes on the design of the questionnaires and on the implementation of the survey

In addition to the Internet-based research, data collected from eleven different sources were merged together. Establishing the sources of the data and making any necessary adjustments to the data (exclusion of duplicate information and irrelevant addresses) was in some cases very time-consuming. So as to achieve both a high quality of addresses and as comprehensive a coverage as possible, the questionnaires were sent out in two batches (cf. section “The website www.datenbank-gesundheitsprojekte.de”).

When the online questionnaire was being devised, particular value was placed on designing the structure of the survey tool, which consisted of cover and project sheets, and on the resulting user control being as transparent and simple as possible. In the first step, a new questionnaire for the responsible organisation (cover questionnaire) must be created or an existing one selected. In the second step, a project questionnaire assigned to this organisation can be created. After data entry has been successfully completed, each questionnaire is given an identification number and password, displayed on the screen and forwarded automatically by e-mail to the person who is going to fill it in. These access data enable the service providers to update the data they enter at any time.

The small number of queries that the survey office received from the users confirms that we have been largely successful in our ambitious aim of developing intuitive user control.

The website address www.datenbank-gesundheitsprojekte.de can be gradually developed in the future and increasingly made into an Internet platform for health promotion among socially disadvantaged people. Provision of an online search facility is a first step in this direction.

| Period of time | Number of times accessed over this period | Number of times accessed per day (weekly average) |
|----------------------|---|---|
| 07. 11.–10. 11. 2002 | 291 | 72.8 |
| 11. 11.–17. 11. 2002 | 516 | 73.7 |
| 18. 11.–24. 11. 2002 | 758 | 108.3 |
| 25. 11.–01. 12. 2002 | 728 | 104.0 |
| 02. 12.–08. 12. 2002 | 594 | 84.9 |
| 09. 12.–15. 12. 2002 | 1,657 | 236.7 |
| 16. 12.–22. 12. 2002 | 581 | 83.0 |

Table 1: Number of times the home page “www.datenbank-gesundheitsprojekte.de” was accessed during the survey period November/December 2002

| Federal state | Questionnaires sent out (total: 10,067) | Number of questionnaires sent per 100,000 inhabitants |
|-------------------------------|---|---|
| Berlin | 1,549 | 45.4 |
| Bremen | 148 | 27.7 |
| Thuringia | 709 | 26.7 |
| Hamburg | 222 | 13.7 |
| Mecklenburg-Western Pomerania | 262 | 13.5 |
| Brandenburg | 345 | 13.2 |
| Saarland | 136 | 12.9 |
| Schleswig-Holstein | 321 | 12.4 |
| Baden-Württemberg | 1,141 | 12.3 |
| Hesse | 656 | 11.9 |
| Rhineland-Palatinate | 434 | 11.7 |
| Lower Saxony | 785 | 10.7 |
| Saxony-Anhalt | 303 | 10.4 |
| North Rhine-Westphalia | 1,743 | 10.2 |
| Saxony | 419 | 8.7 |
| Bavaria | 894 | 7.8 |

Table 2: Questionnaires sent, listed according to region

Questionnaires sent and returned

Approximately 5,000 questionnaires were sent out nationwide on 4 November 2002 and a further 5,000 on 18 November 2002. The return deadline for the first batch of questionnaires was 22 November and for the second batch 4 December. Consequently, around two weeks were available for processing the questionnaires in each case. On 6 December, a reminder was sent to all those who had been sent questionnaires but had not yet replied. 16 December was set as a final deadline.

When the address data was collated, an attempt was made to give as nationwide and as representative an overview as possible. *Table 2* shows the distribution of the questionnaires sent out to the 16 Federal states, sorted into mailings per 100,000 inhabitants. The relative prevalence of mailings in the Berlin region can be easily explained by the particularly good access to the field which is available to the contractor, the Association of Health Promotion Berlin. However, explanations cannot be found as easily for the differences in the “mailing density” for the other Federal states. There were collations of regional addresses from Thuringia, Baden-Württemberg and Lower Saxony as well as Berlin; however in the latter two cases, there was by no means a disproportionately high “mailing density”.

| Period of time | Frequency (total 3,627) | Percentage | Cumulative percentage |
|----------------------|-------------------------|------------|-----------------------|
| 07. 11.–10. 11. 2002 | 142 | 3.9 | 3.9 |
| 11. 11.–17. 11. 2002 | 267 | 7.4 | 11.3 |
| 18. 11.–24. 11. 2002 | 395 | 10.9 | 22.2 |
| 25. 11.–01. 12. 2002 | 416 | 11.5 | 33.6 |
| 02. 12.–08. 12. 2002 | 547 | 15.1 | 48.7 |
| 09. 12.–15. 12. 2002 | 1,442 | 39.8 | 88.5 |
| 16. 12.–22. 12. 2002 | 395 | 10.9 | 99.4 |
| 23. 12.–29. 12. 2002 | 19 | 0.5 | 99.9 |
| 30. 12.–31. 12. 2002 | 4 | 0.1 | 100.0 |

Table 3: Questionnaires returned by 31 December 2002

The distribution of the questionnaires returned by 31 December 2002 is shown in *Table 3*.¹ The impact of the reminder sent on 6 December in terms of spurring people into action, together with the presentation of the survey given at the “Poverty and Health” conference on 6 and 7 December can be clearly seen from the number of questionnaires returned in the week 9–15 December 2002. (cf. also *Table 1* on p. 101).

Survey hotline work

After the first 5,000 questionnaires had been sent out on Monday 4 November 2002, enquiries – predominantly by telephone – had been received by the middle of that week. Even at the end of the first week, numerous e-mails also arrived at the survey office, accompanied by a lively response in the form of faxes and letters.

Initially, the answering and registration of all the responses received after sending out the questionnaires took up a reasonable proportion of the survey office’s work and there was sufficient time to record in the database the questionnaires sent back by post. After the second 5,000 questionnaires had been mailed out, however, the amount of work doubled from mid-November 2002 onwards. After the reminder had been sent out at the beginning of December, the number of questionnaires returned and the number of enquiries received increased several times over. All telephone enquiries and requests for assistance were fielded on three lines for about 10 hours per day (between 08.00 and 18.00) and were answered either immediately or by a competent member of staff ringing straight back.

¹ Table 3 shows the questionnaires returned by post, fax or e-mail (postmark or date of receipt). It does not take into account questionnaires returned via the online option only since the possibility of subsequent updating means that a definitive date cannot be assigned. This produces a smaller number of returned questionnaires than in Table 2 (see page 75).

During these two weeks in December, one employee was responsible solely for answering the electronic enquiries since more than 500 e-mails reached the survey office as a direct response to the reminder letter. During the period of the first project phase, more than 1,200 e-mails were received.

As Christmas approached, the number of returned questionnaires gradually dropped to its initial low level. Even ten weeks after the end of the (extended) return period, the survey office received daily telephone calls, completed questionnaires, electronic enquiries and faxes.

Entry of the questionnaires into the database by the survey office

As far as time permitted, the staff at the survey office entered the questionnaires received by post into the database in parallel to answering queries. The unexpected demands placed on the hotline beyond the time that the survey was intended to end (mid-December 2002) resulted in the entry of the questionnaires not becoming a key activity until January 2003.

In addition to the recording of what in some cases was detailed “free text” information in the organiser’s and project questionnaires it quickly became apparent that in many cases it was necessary to clarify ambiguities by speaking to the relevant organisation in order to ensure consistency and quality of the data recorded. Enquiries by telephone were needed if

- the statement by the relevant organisation on publication of the data was missing on the last page of the questionnaire
- there were contradictions with regard to the allocation of projects and organisations (e.g. the organiser’s questionnaire contained details on the project, but not on the organisation)
- the relevance of multiple organiser or project questionnaires submitted for the same organisation needed to be clarified or
- questionnaires that had been received but were incomplete had to be completed.

By the end of February 2003, over 1,600 questionnaires were entered into the database by the survey office.

5.6 Appendix 2: Outline and project questionnaire documents

BZgA – Bundeszentrale für gesundheitliche Aufklärung
[Federal Centre for Health Education]

Gesundheit Berlin e.V. [Association for Health Promotion Berlin]
Landesarbeitsgemeinschaft für Gesundheitsförderung
[Regional Association for Health Promotion]

**Projects and Measures for Health Promotion among Socially Disadvantaged People
in the Federal Republic of Germany**

Outline questionnaire

A Survey by the Federal Centre for Health Education (BZgA)

You can also fill in the questionnaires online:
www.datenbank-gesundheitsprojekte.de



**Bundeszentrale
für
gesundheitliche
Aufklärung**

Gesundheit Berlin e.V.
Landesarbeitsgemeinschaft für
Gesundheitsförderung



**Projekte und Maßnahmen
zur Gesundheitsförderung bei sozial Benachteiligten
in der Bundesrepublik Deutschland**

Mantelfragebogen

Eine Erhebung der Bundeszentrale für gesundheitliche Aufklärung (BZgA)

Sie können die Fragebögen auch online ausfüllen:

www.datenbank-gesundheitsprojekte.de

Gesundheit Berlin e.V. / Straßburger Str. 56 / 10405 Berlin / Tel.: 030 - 4431 9081/-82 / Fax: 030 - 4431 9083
www.datenbank-gesundheitsprojekte.de / Mail: info@datenbank-gesundheitsprojekte.de

5

Information on the organisation/institution

- Name of organisation/institution
- ID no. of organisation/institution (if known)
- Abbreviation
- Street
- Post code
- Town
- Region
- Telephone number
- Fax number
- E-mail
- Web address
- Questionnaire filled in on (date)
- Questionnaire filled in by
Name
Position
- Contact for further questions
Name
Position
Direct dial no.
E-mail
(if different from above)

Angaben zur Organisation / Institution

| | |
|--|--|
| Name der Organisation/Institution | |
| ID-Nr. der Organisation/Institution (wenn bekannt) | |
| Kurzbezeichnung | |
| Straße | |
| Postleitzahl | |
| Ort | |
| Bundesland | |
| Telefon | |
| Telefax | |
| E-Mail | |
| www | |
| Fragebogen ausgefüllt am | |
| Fragebogen ausgefüllt durch Name Funktion | |
| Ansprechpartner/in für weitere Fragen Name Funktion Tel.-Durchwahl E-Mail (wenn anders als oben angegeben) | |

Brief description of the organisation/institution

(if an information leaflet is available, please attach)

Tasks, aims, focus of your organisation's work

[if you need more space, please use a separate sheet]

Information on sponsorship/financing

[if you need more space, please use a separate sheet]

Kurzbeschreibung der Organisation / Institution

(falls Informationsbroschüre vorhanden, bitte beifügen)

Ihre Aufgaben, Ziele, Arbeitsschwerpunkte

[wenn Sie mehr Platz benötigen, bitte gesondertes Blatt benutzen]

Angaben zur Trägerschaft / Finanzierung

[wenn Sie mehr Platz benötigen, bitte gesondertes Blatt benutzen]

Gesundheit Berlin e.V. / Straßburger Str. 56 / 10405 Berlin / Tel.: 030 - 4431 9081/-82 / Fax: 030 - 4431 9083
www.datenbank-gesundheitsprojekte.de / Mail: info@datenbank-gesundheitsprojekte.de



Please help us with our research and tell us about other projects/measures being implemented by other institutions/organisations that we should include in the survey

Title of the project
Contact person
Address
Tel.
E-mail

Title of the project
Contact person
Address
Tel.
E-mail

Title of the project
Contact person
Address
Tel.
E-mail

Title of the project
Contact person
Address
Tel.
E-mail

[if you need more space, please use a separate sheet]

- We agree to the information we have provided about our institution and our services being published
- We do not agree to the information we have provided being published
[signature, stamp if applicable]

Thank you very much for your cooperation!

Bitte unterstützen Sie unsere Recherche und nennen Sie uns weitere Projekte / Maßnahmen anderer Institutionen / Organisationen, die wir in die Erhebung einbeziehen sollen.

Titel des Projekts _____

Ansprechpartner _____

Anschrift
Tel.-Nr.
E-mail

Titel des Projekts _____

Ansprechpartner _____

Anschrift
Tel.-Nr.
E-mail

Titel des Projekts _____

Ansprechpartner _____

Anschrift
Tel.-Nr.
E-mail

Titel des Projekts _____

Ansprechpartner _____

Anschrift
Tel.-Nr.
E-mail

[wenn Sie mehr Platz benötigen, bitte gesondertes Blatt benutzen]

Wir sind mit der Veröffentlichung unserer Angaben zur Institution und zu den Angeboten einverstanden.

Wir sind mit der Veröffentlichung unserer Angaben nicht einverstanden.

Unterschrift, ggf. Stempel

Vielen Dank für Ihre Mitarbeit!

Gesundheit Berlin e.V. / Straßburger Str. 56 / 10405 Berlin / Tel.: 030 - 4431 9081/-82 / Fax: 030 - 4431 9083
www.datenbank-gesundheitsprojekte.de / Mail: info@datenbank-gesundheitsprojekte.de



Information on the project/measure

• If you are telling us about several projects/measures, please complete a separate questionnaire for each service (either make photocopies of this form first, or download from our website).

By going to the web address www.datenbank-gesundheitsprojekte.de you can also complete the questionnaires online quickly and easily. We would encourage you to use this "paperless" method of response as it avoids errors when the data is transferred.

The project/measure

- is currently being carried out
- is at the planning stage
- was completed within the last 3 years

Name of organisation

ID no. of organisation (if known)

Title of project/measure

Project manager/contact person (if different from in cover questionnaire)

Name:

Street:

Postcode/town

Telephone no.:

Fax:

E-mail:

1. Information on the project/measure**1.1 Please give a brief description of the project measure using key words**

Please provide us with any relevant material containing information (e.g. flyers or brochures) on the project/measure as an enclosure or attachment.

1.2 Does your project/measure follow an approach that is related to daily life/circumstances (so-called "setting" approach)

- Yes
- In some cases
- No

2. Which key players were/are involved in developing the project/measure?

Angaben zum Projekt / zur Maßnahme

- Falls Sie über mehrere Projekte / Maßnahmen berichten, füllen Sie bitte für jedes Angebot einen separaten Fragebogen aus (zuvor kopieren oder von unserer Website herunterladen).
Unter der Internet-Adresse www.datenbank-gesundheitsprojekte.de können Sie die Fragebögen auch einfach und schnell online ausfüllen. Wir möchten Sie sehr bitten, diese „papierlose“ Möglichkeit der Rückmeldung zu nutzen, da sie mögliche Übertragungsfehler vermeidet.

Das Projekt / die Maßnahme

- wird aktuell durchgeführt ist geplant wurde innerhalb der letzten 3 Jahre abgeschlossen

| | |
|---|---|
| Name des Trägers | ID-Nr. des Trägers (wenn bekannt) |
| Titel des Projekts / der Maßnahme | |
| Projektleitung / Ansprechpartner (wenn anders als im Mantelfragebogen) | |
| Name: _____ | Telefon: _____ |
| Strasse: _____ | Fax: _____ |
| PLZ / Ort: _____ | Mail: _____ |
| 1. Informationen zum Projekt / der Maßnahme | |
| 1.1 Bitte beschreiben Sie stichwortartig das Projekt / die Maßnahme | |
| Bitte fügen Sie ggf. Informationsmaterialien (z.B. Flyer oder Broschüren) zum Projekt / zur Maßnahme als Anlage bei | |
| 1.2 Verfolgen Sie mit Ihrem Projekt / Ihrer Maßnahme einen Lebenswelt-bezogenen (sog. „Setting-“) Ansatz? | |
| <input type="checkbox"/> Ja <input type="checkbox"/> Teilweise <input type="checkbox"/> Nein | |
| 2. Welche Akteure waren bzw. sind an der Entwicklung des Projekts / der Maßnahme beteiligt? | |
| | |

Gesundheit Berlin e.V. / Straßburger Str. 56 / 10405 Berlin / Tel.: 030 - 4431 9081/-82 / Fax: 030 - 4431 9083
www.datenbank-gesundheitsprojekte.de / Mail: info@datenbank-gesundheitsprojekte.de

5

3. Which aims are you pursuing with your project/measure? (you may give more than one answer)

3.1 Improving individuals' health behaviour, in relation to:

- Prevention of AIDS
- Alcohol consumption
- Coping resources (e.g. for resolving conflicts)
- Nutrition
- Preventing violence
- Illegal drugs
- Use of medication
- Smoking
- Sexual behaviour
- Sport and physical activity
- Combating stress
- Accident prevention
- Other, please specify:

3.2 Strengthening health and social resources, please specify:

- Counselling on budgeting/debts
- Dealing with violence/aggression
- Assistance with finding a job
- Assistance with finding a place to live
- Assistance with looking after children
- Protection of children/young people
- Pregnancy/preparation for childbirth
- Counselling in social matters
- Language training
- Improvement of social integration
- Strengthening social support
- Other, please specify:

3.3 Improvement in the extent to which healthcare is made use of, please specify:

- Vaccination
- Participation in early detection tests
- Participation in check ups
- Other, please specify:

3.4 Improvement in conditions in home, living environment, district, e.g. measures to combat:

- Bad smells
- Noise
- Damp, mould, unhygienic conditions
- Accidents
- Neglect, impoverishment, formation of ghettos
- Other, please specify:

3.5 Improvement in conditions at the workplace, please specify:

- Narrow scope for decision-making
- Noise
- Dirt
- Accidents
- Unfavourable working hours
- Other, please specify:

3.6 Improvement in opportunities for leisure in the district, e.g. in relation to playgrounds, sports grounds, areas of open space, please specify:

3.7 Improvement in conditions in daycare centres for children, please specify:

3.8 Improvement in conditions at school, please specify:

3. Welche Ziele verfolgen Sie mit Ihrem Projekt / Ihrer Maßnahme? (Mehrfachnennungen möglich) **3.1 Verbesserung des individuellen Gesundheitsverhaltens, bezogen auf:**

- | | |
|---|--|
| <input type="checkbox"/> AIDS-Prävention | <input type="checkbox"/> Sexualverhalten |
| <input type="checkbox"/> Alkoholkonsum | <input type="checkbox"/> Sport und Bewegung |
| <input type="checkbox"/> Bewältigungsressourcen (z.B. zur Konfliktlösung) | <input type="checkbox"/> Stressbewältigung |
| <input type="checkbox"/> Ernährung | <input type="checkbox"/> Unfallprävention |
| <input type="checkbox"/> Gewaltprävention | <input type="checkbox"/> Sonstige, und zwar: |
| <input type="checkbox"/> Illegale Drogen | _____ |
| <input type="checkbox"/> Medikamentenkonsum | _____ |
| <input type="checkbox"/> Rauchen | _____ |

 3.2 Stärkung der gesundheitlichen und sozialen Ressourcen, und zwar:

- | | |
|--|--|
| <input type="checkbox"/> Budget- / Schuldnerberatung | <input type="checkbox"/> Sozialberatung |
| <input type="checkbox"/> Gewalt- / Aggressionsbewältigung | <input type="checkbox"/> Sprachunterricht |
| <input type="checkbox"/> Hilfe bei der Arbeitsplatzsuche | <input type="checkbox"/> Stärkung der sozialen Unterstützung |
| <input type="checkbox"/> Hilfe bei der Wohnungssuche | <input type="checkbox"/> Verbesserung der sozialen Integration |
| <input type="checkbox"/> Hilfe bei Kinderbetreuung | <input type="checkbox"/> Sonstige, und zwar: |
| <input type="checkbox"/> Kinder- / Jugendschutz | _____ |
| <input type="checkbox"/> Schwangerschaft / Geburtsvorbereitung | _____ |

 3.3 Verbesserung der Inanspruchnahme der gesundheitlichen Versorgung, und zwar:

- | | |
|--|--|
| <input type="checkbox"/> Impfungen | <input type="checkbox"/> Sonstige, und zwar: |
| <input type="checkbox"/> Teilnahme an Früherkennungsuntersuchungen | _____ |
| <input type="checkbox"/> Teilnahme an Vorsorgeuntersuchungen | _____ |

 3.4 Verbesserung der Bedingungen in Wohnung, Wohnumgebung, Stadtteil, z.B. Maßnahmen gegen:

- | | |
|---|--|
| <input type="checkbox"/> Gestank | <input type="checkbox"/> Verwahrlosung, Verelendung, Gettoisierung |
| <input type="checkbox"/> Lärm | <input type="checkbox"/> Sonstige, und zwar: |
| <input type="checkbox"/> Nässe, Schimmel, unhygienische Bedingungen | _____ |
| <input type="checkbox"/> Unfälle | _____ |

 3.5 Verbesserung der Bedingungen am Arbeitsplatz, und zwar:

- | | |
|--|---|
| <input type="checkbox"/> Geringer Entscheidungsspielraum | <input type="checkbox"/> Ungünstige Arbeitszeiten |
| <input type="checkbox"/> Lärm | <input type="checkbox"/> Sonstige, und zwar: |
| <input type="checkbox"/> Schmutz | _____ |
| <input type="checkbox"/> Unfälle | _____ |

 3.6 Verbesserung der Freizeitmöglichkeiten im Stadtteil, z.B. bezogen auf Spiel- und Sportplätze, Freiflächen, und zwar: **3.7 Verbesserung der Bedingungen in der Kindertagesstätte, und zwar:** **3.8 Verbesserung der Bedingungen in der Schule, und zwar:**

4. What kind of service is it? (you may give more than one answer)

- Campaign day
- Exhibition
- Advice service
- Education service/training programme
- Provision of materials
- Leisure opportunities
- "Health day"/"health week"
- Work in a district/community development/neighbourhood management
- Conference/meetings (or series of meetings)
- Supply service (e.g. lunch)
- Other, please specify:

5. What is the duration of the project/measure and what is its timeframe?

5.1 Duration of project/measure

Start/planned start:

(Month/year)

End/planned end:

(Month/year)

- No end planned, service is being continued

5.2 Frequency and number of services

- One-off services, number:
- Daily services, number:
- Weekly services, number:
- Monthly services, number:
- Other:
- Not applicable

6. Please state the target groups at which the project/measure is directed: (you may give more than one answer)

6.1 The service is targeted at the following age groups:

- Babies (< 1 year)
- Infants and pre-school children (1–5 years)
- School children (6–10 years)
- School children (11–14 years)
- Young people (15–18 years)
- Young adults (19–29 years)

- Adults (30–59 years)
- Senior citizens (from 60 years)

6.2 The project encompasses gender-specific services for

- Boys/men
- Girls/women
- No gender-specific services

6.3 Particularly targeted at

- Single parents
- Unemployed people
- Asylum seekers
- Resettlers
- People who live in areas with social problems
- Parents living in stressful situations
- Refugees
- Illegal immigrants
- Families with a large number of children
- Migrants

- Migrants with poor knowledge of German
- People with a very low professional status (e.g. unskilled workers)
- People with a very low income (e.g. those receiving social benefits)
- Persons with a very low level of school education (e.g. people who have not passed school-leaving examinations)
- Prostitutes
- Convicts
- Homeless people
- Others, please specify:

| | |
|---|--|
| 4. Um welche Angebotsart handelt es sich? (Mehrfachnennung möglich) | |
| <input type="checkbox"/> Aktionstag <input type="checkbox"/> Ausstellung <input type="checkbox"/> Beratungsangebot <input type="checkbox"/> Bildungsangebot / Schulungsprogramm <input type="checkbox"/> Erstellung von Materialien <input type="checkbox"/> Freizeitangebot <input type="checkbox"/> Gesundheitstag / -woche | <input type="checkbox"/> Stadteitarbeit / Gemeinwesenentwicklung / Quartiersmanagement <input type="checkbox"/> Tagung / Veranstaltung(sreihe) <input type="checkbox"/> Versorgungsangebot (z.B. Mittagstisch) <input type="checkbox"/> Sonstiges, und zwar: _____ _____ |
| 5. Welche Laufzeit und welchen zeitlichen Umfang hat das Projekt / die Maßnahme? | |
| 5.1 Laufzeit des Projektes / der Maßnahme Beginn / geplanter Beginn: _____ (Monat / Jahr) Ende / geplantes Ende: _____ (Monat / Jahr) <input type="checkbox"/> Kein Ende geplant, Angebot wird fortgeführt | 5.2 Frequenz und Anzahl Ihrer Angebote <input type="checkbox"/> Einmalige Angebote, Anzahl: ____ <input type="checkbox"/> Tägliche Angebote, Anzahl: ____ <input type="checkbox"/> Wöchentliche Angebote, Anzahl: ____ <input type="checkbox"/> Monatliche Angebote, Anzahl: ____ <input type="checkbox"/> Anderes: _____ <input type="checkbox"/> Trifft nicht zu |
| 6. Bitte geben Sie die Zielgruppe(n) des Projekts / der Maßnahme an: (Mehrfachnennungen möglich) | |
| 6.1 Das Angebot richtet sich an folgende Altersgruppen: <input type="checkbox"/> Säuglinge (<1 Jahr) <input type="checkbox"/> Klein- u. Vorschulkinder (1-5 Jahre) <input type="checkbox"/> Schulkinder (6-10 Jahre) <input type="checkbox"/> Schulkinder (11-14 J.) <input type="checkbox"/> Jugendliche (15-18 J.) <input type="checkbox"/> Junge Erwachsene (19-29 Jahre) <input type="checkbox"/> Erwachsene (30-59 Jahre) <input type="checkbox"/> Senioren (ab 60 Jahre) | 6.2 Das Projekt umfasst geschlechtsspezifische Angebote für <input type="checkbox"/> Jungen / Männer <input type="checkbox"/> Mädchen / Frauen <input type="checkbox"/> Keine geschlechtsspezifischen Angebote |
| 6.3 Insbesondere für <input type="checkbox"/> Alleinerziehende <input type="checkbox"/> Arbeitslose <input type="checkbox"/> Asylbewerber/innen <input type="checkbox"/> Aussiedler/innen <input type="checkbox"/> Bewohner/innen von sozialen Brennpunkten <input type="checkbox"/> Eltern in Belastungssituationen <input type="checkbox"/> Flüchtlinge <input type="checkbox"/> „Illegale“ <input type="checkbox"/> Kinderreiche Familien <input type="checkbox"/> Migranten/innen <input type="checkbox"/> Migranten/innen mit schlechten Deutschkenntnissen <input type="checkbox"/> Personen mit sehr niedrigem beruflichen Status (z.B. ungelernete Arbeiter/innen) <input type="checkbox"/> Personen mit sehr niedrigem Einkommen (z.B. Sozialhilfeempfänger/innen) | |
| <input type="checkbox"/> Personen mit sehr niedriger Schulbildung (z.B. Personen ohne qualifizierten Hauptschulabschluss) <input type="checkbox"/> Prostituierte <input type="checkbox"/> Strafgefangene <input type="checkbox"/> Wohnungslose <input type="checkbox"/> Sonstige, und zwar: _____ _____ _____ | |



7. Which multipliers/facilitators are involved in the project/measure?

(you may give more than one answer)

- Doctors
- Trainers
- Advisers
- Parents
- Educators involved in personal and social development
- No multipliers/facilitators involved
- Experts
- Midwives
- Youth workers
- Nurses/carers
- Course directors
- Teachers
- Facilitators (e.g. interpreters for ethnic minorities)
- Peers/contemporaries
- Psychologists
- Social workers/social educationalists
- Other, please specify:

8. Which cooperation partners do you work together with as part of the project/measure?

Or in which area of work is the service? (you may give more than one answer)

- Medical associations
- Advice centres
- Health office
- Health conference
- Remand centres
- Midwives
- Youth welfare office
- Homes/meeting places for young people
- Day-care centres
- Church communities/church-based organisations
- Hospitals
- Health insurance schemes
- Help in the neighbourhood/district initiatives
- Located doctors
- Police
- Regional working parties
- Schools
- Self-help groups
- Social welfare authority
- Sports clubs
- Companies, please specify:
- Charitable organisations
- Other, please specify:
- No cooperation partners

9. How is your project/measure financed? (you may give more than one answer)

- **Public resources**, please specify
- Federal government resources
- Federal state resources
- Local authority resources
- Job creation scheme
- Structural adaptation measures
- **Health insurance funds**, please specify (if known)
- in accordance with Section 20.1 of the SGB V (Primary prevention)
- in accordance with Section 20.4 of the SGB V (Promotion of self-help)
- in accordance with Section 65b of the SGB V (Patient information)
- Money from sponsors
- Money from foundations
- Donations
- Voluntary services/volunteers
- Contributions from participants
- Club subscription fees
- Others, please specify

| 7. Welche Multiplikatoren / Mediatoren sind im Rahmen des Projekts / der Maßnahme involviert? (Mehrfachnennungen möglich) | |
|--|--|
| <input type="checkbox"/> Ärzte / Ärztinnen <input type="checkbox"/> Ausbilder/innen <input type="checkbox"/> Berater/innen <input type="checkbox"/> Eltern <input type="checkbox"/> Erzieher/innen <input type="checkbox"/> Fachöffentlichkeit <input type="checkbox"/> Hebammen <input type="checkbox"/> Jugendarbeiter/innen <input type="checkbox"/> Krankenschwestern / -pfleger <input type="checkbox"/> Kursleiter/innen <input type="checkbox"/> Lehrer/innen | <input type="checkbox"/> Mediatoren (z.B. Dolmetscher/innen, ethnische Mittler/innen) <input type="checkbox"/> Peers / Gleichaltrige <input type="checkbox"/> Psychologen/innen <input type="checkbox"/> Sozialarbeiter/innen / Sozialpädagogen/innen <input type="checkbox"/> Sonstige, und zwar: _____ _____ _____ <input type="checkbox"/> Keine Multiplikatoren / Mediatoren involviert |
| 8. Mit welchen Kooperationspartnern arbeiten Sie im Rahmen des Projekts / der Maßnahme zusammen bzw. in welchem Arbeitsfeld ist das Angebot angesiedelt? (Mehrfachnennungen möglich) | |
| <input type="checkbox"/> Ärzteverbände <input type="checkbox"/> Beratungsstellen <input type="checkbox"/> Gesundheitsamt <input type="checkbox"/> Gesundheitskonferenz <input type="checkbox"/> Haftanstalten <input type="checkbox"/> Hebammen <input type="checkbox"/> Jugendamt <input type="checkbox"/> Jugendhäuser / Jugendtreffs <input type="checkbox"/> Kindergärten <input type="checkbox"/> Kirchengemeinden / kirchliche Einrichtungen <input type="checkbox"/> Krankenhäuser <input type="checkbox"/> Krankenkassen <input type="checkbox"/> Nachbarschaftshilfe / Stadtteilinitiativen <input type="checkbox"/> Niedergelassene Ärzte / Ärztinnen | <input type="checkbox"/> Polizei <input type="checkbox"/> Regionale Arbeitsgemeinschaften <input type="checkbox"/> Schulen <input type="checkbox"/> Selbsthilfegruppen <input type="checkbox"/> Sozialamt <input type="checkbox"/> Sportvereine <input type="checkbox"/> Unternehmen / Firmen, und zwar: _____ <input type="checkbox"/> Wohlfahrtsverbände <input type="checkbox"/> Sonstige, und zwar: _____ _____ <input type="checkbox"/> Keine Kooperationspartner |
| 9. Wie finanziert sich Ihr Projekt / Ihre Maßnahme? (Mehrfachnennungen möglich) | |
| <input type="checkbox"/> Öffentliche Mittel , und zwar <input type="checkbox"/> Bundesmittel <input type="checkbox"/> Landesmittel <input type="checkbox"/> Kommunale Mittel <input type="checkbox"/> Arbeitsbeschaffungsmaßnahme (ABM) <input type="checkbox"/> Strukturanpassungsmaßnahme (SAM) <input type="checkbox"/> Krankenkassen , und zwar (wenn bekannt) <input type="checkbox"/> nach § 20.1 SGB V (Primärprävention) <input type="checkbox"/> nach § 20.4 SGB V (Selbsthilfeförderung) <input type="checkbox"/> nach § 65b SGB V (Patienteninformation) | <input type="checkbox"/> Sponsorengelder <input type="checkbox"/> Stiftungsgelder <input type="checkbox"/> Spenden <input type="checkbox"/> Freiwilligendienste / Ehrenamtliche <input type="checkbox"/> Teilnehmer/innenbeiträge <input type="checkbox"/> Vereinsgelder <input type="checkbox"/> Sonstige, und zwar _____ _____ _____ |

10. Is the project to be documented?

Documentation

- Not intended
- Planned
- In progress
- Documentation exists, namely

- Internal documentation
- External documentation
- Documentation has been published under the title
- Can be obtained from:

11. Is the project/measure being evaluated?

Evaluation

- Not intended
- Planned
- In progress
- Evaluation exists, namely

- Internal evaluation
- External evaluation
- Evaluation has been published under the title
- Can be obtained from:

Your comments on/experience in the project/measure

[if you need more space, please use the reverse of the last sheet]

Your comments on the questionnaire

[if you need more space, please use the reverse of the last sheet]

Thank you very much for your cooperation!

Additional space for your answers

[Please quote the number of the question that you are referring to]

Zusätzlicher Raum für Ihre Antworten

[Bitte geben Sie jeweils die Nummer der Frage an, auf die Sie sich beziehen]

5.7 Appendix 3: Copies of the letters

5

Gesundheit Berlin e.V. [Association for Health Promotion Berlin]
Landesarbeitsgemeinschaft für Gesundheitsförderung [Regional Association for Health Promotion]

Gesundheit Berlin e.V., Straßburger Str. 56, 10405 Berlin
<Address>

Straßburger Str. 56, D-10405 Berlin
Tel: 030 4431 90 81/82
Fax: 030 4431 90 83
info@datenbank-gesundheitsprojekte.de
www.datenbank-gesundheitsprojekte.de

Berlin, 4 November 2002

Nationwide survey of health promotion services for socially disadvantaged people
Your organisation number: <ID>; your password for the online questionnaire: <password>

<Salutation>

On behalf of the Federal Centre for Health Education (BZgA), the Association for Health Promotion Berlin is carrying out a survey of projects and measures that are aimed at promoting the health of socially disadvantaged people in the Federal Republic of Germany. In future, a nationwide overview, in the form of a database that can be searched via the Internet, will be available to you and all other people involved.

The aim of the survey is to provide a reliable overview of measures and projects which can help improve the health behaviour of individuals, strengthen health-related resources and create general conditions that encourage a healthier lifestyle. In particular, those projects will be recorded which are partly or primarily directed at people whose circumstances are difficult or stressful.

We need your help if we are to obtain reliable results and thus place significantly more emphasis on health promotion for socially disadvantaged people.

Please return the completed questionnaires to us by 22 November 2002 or complete the online questionnaire which you can access at www.datenbank-gesundheitsprojekte.de by this date. Please reply (by telephone, e-mail or fax) even if your work does not comprise any health-promoting activities for socially disadvantaged people.

Do not hesitate to contact us if you have any queries. Thank you for your support.

Kind regards

[Signature]
Dr Raimund Geene, Project Manager

[Signature]
Holger Kilian, Project Coordinator

Online questionnaire at www.datenbank-gesundheitsprojekte.de, please reply by 22.11.2002



Gesundheit Berlin e.V., Straßburger Str. 56, 10405 Berlin

<Adresse>

Straßburger Str. 56, 10405 Berlin
Fon 0 30-44 31 90-81 / -82
Fax 0 30-44 31 90-83
info@datenbank-gesundheitsprojekte.de
www.datenbank-gesundheitsprojekte.de

Berlin, 4. November 2002

Bundesweite Bestandsaufnahme gesundheitsfördernder Angebote für sozial Benachteiligte
Ihre Träger-Nummer: <ID>; Ihr Passwort für den Online-Fragebogen: <Passwort>

<Anrede>,

im Auftrag der Bundeszentrale für gesundheitliche Aufklärung (BZgA) führt Gesundheit Berlin e.V. eine Bestandsaufnahme von Projekten und Maßnahmen zur Gesundheitsförderung bei sozial Benachteiligten in der Bundesrepublik Deutschland durch. Für Sie und alle anderen Akteure soll zukünftig ein bundesweiter Überblick in Form einer über das Internet recherchierbaren Datenbank zur Verfügung stehen.

Die Bestandsaufnahme möchte eine qualifizierte Übersicht über Maßnahmen und Projekte bieten, die dazu beitragen, das individuelle Gesundheitsverhalten zu verbessern, gesundheitliche Ressourcen zu stärken und Rahmenbedingungen für eine gesündere Lebensweise zu ermöglichen. Insbesondere diejenigen Projekte sollen erfasst werden, die sich teilweise oder vorwiegend an Menschen in schwierigen und belastenden Lebenssituationen wenden.

Wir sind auf Ihre Mithilfe angewiesen, um verlässliche Ergebnisse zu erhalten und mithin der Gesundheitsförderung für sozial Benachteiligte ein deutlicheres Gewicht zu geben!

Bitte schicken Sie die ausgefüllten Fragebögen **bis zum 22.11.2002** an uns zurück bzw. füllen Sie den Online-Fragebogen unter www.datenbank-gesundheitsprojekte.de bis zu diesem Termin aus. Geben Sie uns bitte auch dann eine Rückmeldung (telefonisch, per E-Mail oder Fax), wenn Ihre Arbeit keine gesundheitsfördernden Angebote für sozial Benachteiligte umfasst.

Für Rückfragen stehen wir gerne zur Verfügung und danken für Ihre Unterstützung!

Mit freundlichen Grüßen

Dr. Raimund Geene, Projektleiter

Holger Kilian, Projektkoordinator

Online-Fragebogen unter www.datenbank-gesundheitsprojekte.de, Rückmeldung bitte bis 22.11.2002

Information on

Survey of projects and measures for health promotion among socially disadvantaged people in the Federal Republic of Germany

Thus far, the existence of little or inadequate data has hindered health promotion for socially disadvantaged people

It is indisputable that there is a link between social disadvantage and negative effects on health. However, there are insufficient and inadequate data and information about existing, planned and evaluated projects and measures and intervention measures to resolve this health problem.

Against this background, the Federal Centre for Health Education (BZgA) has commissioned the Association for Health Promotion Berlin with drawing up a nationwide, reliable overview of projects and measures for health promotion among socially disadvantaged people.

The survey makes use of the experience gained in smaller reviews that already exist and is supported by a working party of specialists from Germany and abroad.

The overview of the diverse area of health promotion for socially disadvantaged people is to be achieved by means of a broad survey using a questionnaire. (The questionnaires can also be filled in quickly and easily online at www.datenbank-gesundheitsprojekte.de).

A "lively database" on the Internet will in future serve as a practical tool: networking, information and the exchange of experience and knowledge will be simplified.

The result will be a "lively database" available on the Internet from the start of 2003. It will allow users to search for addresses and information on the services and projects, thereby promoting networking and the exchange of information. This enables a simpler, more effective collaboration of key persons in the area of "health promotion among socially disadvantaged people".

Who is going to be involved in the survey?

The survey aims to record information on projects and measures for health promotion and illness prevention directed at people (children, young people, adults, families) whose living conditions are difficult or stressful. Often, the main players are not fully aware that they make a daily contribution to health promotion among socially disadvantaged people. The survey is to involve, for example, projects and measures for people with a very low level of school education, people with a very low income (e.g. those on social benefits), unemployed people, services for people living in regions and districts which, for reasons relating to provision and infrastructure, have a particular need for development (e.g. areas with social problems), services for single parents, measures and projects for immigrants with poor knowledge of German, people who have resettled in Germany, asylum seekers, illegal migrants, prostitutes, convicts and the homeless.



Bundeszentrale
für
gesundheitliche
Aufklärung

Informationen zur

Bestandsaufnahme von Projekten und Maßnahmen zur Gesundheitsförderung bei sozial Benachteiligten in der Bundesrepublik Deutschland

Wenige und unzureichende Daten erschweren bislang die Gesundheitsförderung für sozial Benachteiligte

Der Zusammenhang zwischen sozialer Benachteiligung und negativen Auswirkungen auf die Gesundheit ist unbestritten.

Es gibt allerdings nur wenige und unzureichende Daten und Informationen über bestehende, geplante oder bereits evaluierte Projekte und Interventionsmaßnahmen zur Lösung dieses Gesundheitsproblems.

Vor diesem Hintergrund hat die Bundeszentrale für gesundheitliche Aufklärung (BZgA) Gesundheit Berlin e.V. mit der Erstellung eines bundesweiten qualifizierten Überblicks über Projekte und Maßnahmen zur Gesundheitsförderung bei sozial Benachteiligten beauftragt.

Die Bestandsaufnahme knüpft an den Erfahrungen aus vorhandenen Teilüberblicken an und wird durch einen Arbeitskreis von bundesdeutschen und internationalen Fachleuten begleitet.

Der Überblick über die facettenreiche Landschaft der Gesundheitsförderung für sozial Benachteiligte soll mit einer breit angelegten Erhebung per Fragebogen erreicht werden. (Die Fragebögen sind auch schnell und einfach online ausfüllbar unter www.datenbank-gesundheitsprojekte.de).

Eine „lebendige Datenbank“ im Internet dient zukünftig als praktisches Werkzeug: Vernetzung, Information sowie der Erfahrungs- und Wissensaustausch werden vereinfacht

Ergebnis soll eine ab Anfang 2003 nutzbare „lebendige Datenbank“ im Internet sein. Mit ihr können Adressen und Informationen zu den Angeboten und Projekten recherchiert werden, um so die Vernetzung und den Informationsaustausch zu fördern. Daraus kann auch eine einfachere und bessere Zusammenarbeit der Akteure im Bereich „Gesundheitsförderung bei sozial Benachteiligten“ erwachsen.

Wer soll sich an der Erhebung beteiligen?

Im Rahmen der Bestandsaufnahme sollen Projekte und Maßnahmen der Gesundheitsförderung und Prävention erfasst werden, die sich an Menschen (Kinder, Jugendliche, Erwachsene, Familien) in schwierigen und belastenden Lebenssituationen wenden. Oftmals ist den Akteuren vor Ort nicht unmittelbar bewusst, dass sie tagtäglich einen Beitrag zur Gesundheitsförderung bei sozial Benachteiligten leisten. An der Erhebung beteiligen sollen sich z.B. Projekte und Maßnahmen für Personen mit sehr niedriger Schulbildung, Personen mit sehr niedrigem Einkommen (z.B. Sozialhilfeempfänger/innen), Arbeitslose, Angebote für Bewohner/innen von Regionen und Stadtgebieten, die aufgrund der Ausstattung und Infrastruktur einen besonderen Entwicklungsbedarf haben (z.B. soziale Brennpunkte), Angebote für Alleinerziehende, Maßnahmen und Projekte für Migranten/innen mit schlechten Deutschkenntnissen, Aussiedler/innen, Asylbewerber/innen, „Illegale“, Prostituierte, Strafgefangene, Wohnungslose.

The projects and services may for example have the following aims:

- Improving the health behaviour of individuals, for example in relation to smoking, alcohol consumption, nutrition, sport, combating stress, sexual behaviour, violence/aggression
- Strengthening of health and social resources, for example measures to provide social support such as support for children, parent groups, job creation schemes, advice on dealing with money
- Improvement in conditions in houses and living environment (damp, mould, unhygienic conditions, noise, accident prevention)
- Improvement of conditions in the workplace/at school/in day-care centres/in leisure activities
- Measures/projects for improving the extent to which people make use of health services (e.g. participation in check ups/early detection tests)
- Improvement in collaboration and networking of different service providers for people whose living conditions are difficult or stressful.

Information on the questionnaire

The questionnaire consists of:

- a) an outline questionnaire for recording details about your institution/organisation and the main focuses of your work
- b) a documentation questionnaire for differentiated description of your projects and measures.
We have only enclosed one project documentation sheet with this letter. We would ask you to use a copy of this sheet for each additional project or measure.

The BZgA and Association for Health Promotion Berlin need your help!

The BZgA and Association for Health Promotion Berlin need your help so that the survey can give as accurate a depiction as possible of the diverse projects and measures that exist in Germany and work in a very wide variety of fields.

Please take part in the survey if you carry out health promotion projects or measures for socially disadvantaged people or are planning them.

Please also give information on the survey to projects and measures that you know about (questionnaires and information are available on the Internet at www.datenbank-gesundheitsprojekte.de) and inform the survey office mentioned below about this. Naturally, we can also incorporate entire lists without any problem.

Additional information on the survey:

www.datenbank-gesundheitsprojekte.de
(you can download the questionnaire from here and fill it in online)
and from

Gesundheit Berlin e.V.
Straßburger Straße 56, D-10405 Berlin
Tel: +49 (0)30 4431 90 81/82, Fax: 49 (0)30 443190 83
E-mail: info@datenbank-gesundheitsprojekte.de
Internet: www.datenbank-gesundheitsprojekte.de

Cologne, November 2002

Die Projekte und Angebote können beispielsweise folgende Ziele haben:

- Verbesserung des individuellen Gesundheitsverhaltens, z.B. bezogen auf Rauchen, Alkoholkonsum, Ernährung, Sport, Stressbewältigung, Sexualverhalten; Gewalt/Aggression
- Stärkung der gesundheitlichen und sozialen Ressourcen, z.B. Maßnahmen der sozialen Unterstützung wie Kinderbetreuung, Elternkreis, Arbeitsplatzbeschaffung, Budgetberatung
- Verbesserung der Bedingungen in Wohnung und Wohnumgebung (Feuchtigkeit, Schimmel, unhygienische Bedingungen, Lärm, Unfallprävention)
- Verbesserung der Bedingungen am Arbeitsplatz / in der Schule / im Kindergarten / im Freizeitbereich
- Maßnahmen / Projekte zur Verbesserung der Inanspruchnahme von Leistungen des Gesundheitssystems (z.B. Teilnahme an Vorsorge- / Früherkennungsuntersuchungen)
- Verbesserung der Zusammenarbeit und Vernetzung verschiedener Leistungsanbieter für Menschen, die in schwierigen und belastenden Lebenssituationen leben

Informationen zum Fragebogen

Der Fragebogen besteht aus:

- a) Einem Mantelfragebogen zur Erfassung von Angaben zu Ihrer Institution / Organisation und Ihren Arbeitsschwerpunkten.
- b) Einem Dokumentationsbogen zur differenzierten Beschreibung Ihrer Projekte und Maßnahmen. Wir haben diesem Schreiben nur einen Projektdokumentationsbogen beigelegt. Wir bitten Sie, für jedes weitere Projekt bzw. jede weitere Maßnahme eine Kopie dieses Bogens zu verwenden.

Die BZgA und Gesundheit Berlin e.V. bitten um Ihre Mithilfe!

Die BZgA und Gesundheit Berlin e.V. bitten um Ihre Mithilfe, damit die Erhebung die vielseitigen und in den unterschiedlichsten Feldern arbeitenden Projekte und Maßnahmen in Deutschland möglichst genau abbilden kann.

Bitte beteiligen Sie sich an der Erhebung, falls Sie Projekte oder Maßnahmen der Gesundheitsförderung bei sozial Benachteiligten durchführen oder planen.

Bitte informieren Sie auch Ihnen bekannte Projekte und Maßnahmen über die Erhebung. (Fragebögen und Informationen stehen im Internet unter www.datenbank-gesundheitsprojekte.de) und teilen Sie diese dem unten stehenden Erhebungsbüro mit. Natürlich werden auch ganze Listen problemlos übernommen.

Weitere Informationen zur Erhebung:

www.datenbank-gesundheitsprojekte.de

(hier kann der Fragebogen heruntergeladen bzw. online ausgefüllt werden)

und bei

Gesundheit Berlin e.V.
Straßburger Straße 56, 10405 Berlin
Tel. 030-4431 90-81/82, Fax 030-443190-83
E-Mail: info@datenbank-gesundheitsprojekte.de
Internet: www.datenbank-gesundheitsprojekte.de

Köln, November 2002



Gesundheit Berlin e.V. [Association for Health Promotion Berlin]
Landesarbeitsgemeinschaft für Gesundheitsförderung [Regional Association for Health Promotion]

Gesundheit Berlin e.V., Straßburger Str. 56, D-10405 Berlin
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info@datenbank-gesundheitsprojekte.de
www.datenbank-gesundheitsprojekte.de

Berlin, 6 November 2002

Nationwide survey of health promotion services for socially disadvantaged people
Your identification number: <ID>; (please quote in your reply)

<Salutation>

In November we sent you a questionnaire as part of our survey of projects and measures for health promotion among socially disadvantaged people. Unfortunately we did not receive a reply from you by 4 December.

To be able to obtain a useful overview of health promotion services for socially disadvantaged people we need your assistance. We would therefore ask you to return the questionnaire to us by 16.12.2002 at the latest.

Please would you also let us know even if you do not have any health promotion services for socially disadvantaged people. All you need to do is send us a brief reply by phone, fax, e-mail or post, quoting the identification number above if you can.

The questionnaire is also available for download as a pdf file and as an online form on the Internet. You can find information on this at www.datenbank-gesundheitsprojekte.de

Please do not hesitate to contact us if you have any questions!

Kind regards

[Signature]
Dr Raimund Geene
Project Manager

[Signature]
Holger Kilian
Project Coordinator

P.S. If you have received this letter and you have already taken part in the survey, please accept our apologies for this oversight and thank you for your help!



Gesundheit Berlin e.V., Straßburger Str. 56, 10405 Berlin
<ID>

<Adresse>

Straßburger Straße 56, 10405 Berlin
Tel. 030-44 31 90-81 / -82
Fax 030-44 31 90-83
info@datenbank-gesundheitsprojekte.de
www.datenbank-gesundheitsprojekte.de

Berlin, 06.12.2002

Bundesweite Bestandsaufnahme gesundheitsfördernder Angebote bei sozial Benachteiligten
Ihre Kenn-Nummer: <ID> (bitte bei Rückmeldungen angeben)

<Anrede>,

im November haben wir Ihnen im Rahmen unserer Bestandsaufnahme von Projekten und Maßnahmen der Gesundheitsförderung bei sozial Benachteiligten einen Fragebogen zugeschickt. Leider haben wir bis zum 04.12. noch keine Rückmeldung von Ihnen erhalten.

Um einen aussagekräftigen Überblick über die gesundheitsfördernden Angebote für sozial Benachteiligte zu erhalten, sind wir auf Ihre Beteiligung angewiesen. Deshalb bitten wir Sie, uns den Fragebogen bis spätestens zum **16.12.2002** zurückzuschicken.

Informieren Sie uns bitte auch, wenn Sie keine gesundheitsfördernden Angebote für sozial Benachteiligte machen! Es genügt eine kurze Rückmeldung per Telefon, Fax, Mail oder Post, möglichst unter Angabe der oben angegebenen Kennnummer.

Weiterhin steht der Fragebogen zum Herunterladen als PDF-Datei und als Online-Formular im Internet bereit. Informationen hierzu finden Sie unter www.datenbank-gesundheitsprojekte.de.

Für Fragen stehen wir Ihnen selbstverständlich gerne zur Verfügung!

Mit freundlichen Grüßen

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P.S.: Falls Sie dieses Schreiben erhalten obwohl Sie sich bereits an der Erhebung beteiligt haben, bitten wir Sie, dieses Versehen zu entschuldigen und bedanken uns für Ihre Unterstützung!



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