



European
Commission



Action on **health** **inequalities** in the European Union

FINAL VERSION

*The EU Health Programme's contribution
to fostering solidarity in health and reducing
health inequalities in the European Union
2003–13*

Consumers,
Health and Food
Executive Agency

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Contents

FOREWORD	3
EXECUTIVE SUMMARY	4
EU HEALTH PROGRAMME SUPPORT TO TACKLE HEALTH INEQUALITIES	5
ACTIONS TO TACKLE HEALTH INEQUALITIES	7
Actors	10
Results of the health inequalities actions	16
Role in implementing the European Commission's policy document 'Solidarity in Health: Reducing Health inequalities in the EU'	18
Characteristics of the actions on health inequalities	20
What does this analysis of the features of actions tell us?	25
DETAILED OVERVIEW OF ACTIONS	26
Actions focusing on health gradients and gaps (HGG) (Cluster 1)	27
Actions mainly targeting at-risk groups (Cluster 2)	97
Actions focusing mainly on two specific vulnerable groups: migrants and ethnic minorities (Cluster 3)	135
ABBREVIATIONS	184

FOREWORD

Health inequalities start at birth and can persist throughout the lifespan. In the EU, inequalities in health between places and social groups are influenced by a number of factors, including gender, level of education, quality of work, level of pay and living conditions. For example, a woman in the EU can expect to live nearly six years longer than a man, and those with the highest level of education can live a decade or more longer than those with the lowest.

Vulnerable groups such as people living in extreme poverty, disadvantaged migrants, disadvantaged ethnic minority groups like the Roma community, people with disabilities and people suffering from illnesses that carry stigma, e.g. HIV/AIDS or mental illness, often have the most striking inequalities in health.

The Commission acknowledges the importance of addressing this challenge, and the need to invest in health to achieve the Europe 2020 objectives of smart, sustainable growth. The Commission's 2013 policy paper on 'Investing in Health'⁽¹⁾ urges Member States to invest in sustainable health systems, in people's health, and in reducing health inequalities. It argues that the greatest gains in health and social cohesion can be achieved by focusing efforts on these vulnerable groups, including by providing access to affordable, high-quality health services for all.

The Commission supports measures to address health inequalities within and between Member States by implementing the 2009 Communication Solidarity in Health: Reducing Health Inequalities in the EU⁽²⁾, by promoting Health in All Policies and by working with experts from countries inside and outside the EU. A progress report on implementation of this strategy was published in 2013⁽³⁾.

An important EU contribution to reduce health inequalities in Europe is ensured through the support of 'work on the ground', by co-funding projects and actions through our Health Programmes. Both the First Health Programme 2003–07 and the Second Health Programme 2008–13 promoted several strategic priorities to reduce health inequalities. As the Third Health Programme 2014–20 is even more geared towards contributing to the objectives of the Europe 2020 strategy, it will continue to address health inequalities as a priority, building on the achievements of the previous two Programmes.

To date, a total of 64 actions, involving nearly 700 organisations and institutions from all EU, EFTA and EEA countries and some candidate countries, have been funded through the First and Second Health Programmes. The corresponding EC co-funding amounting to €40 million has directly contributed to the effort to reduce health inequalities in the EU.

With this brochure, we are proud to share the results of a selection of co-funded projects from the last 10 years that demonstrate particular achievements in health inequalities. We are confident that the knowledge and best practices showcased in these pages, will serve to orient future strategies for reducing health inequalities in the EU.

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(1) SWD(2013) 43.

(2) COM(2009) 567.

(3) SWD(2013)328.

EXECUTIVE SUMMARY

Health inequalities in the EU are dependent on a myriad of determinants, related to differences in socio-economic status, gender and age. Furthermore, belonging to a minority group, such as migrants and Roma community citizens or patients suffering from a chronic illness that is socially stigmatised, like mental illness or HIV/AIDS infection, can lead to health inequalities.

The Solidarity in Health Communication (2009/567) recognised important priorities and challenges for reducing health inequalities in the EU. The Health Programmes are one of the Commission's instruments for implementing health inequalities policies. Both the First (2003–07) and the Second Health Programme (2008–13) promoted several strategic priorities to reduce health inequalities.

This brochure provides a comprehensive view of 38 selected actions presented as individual articles, covering the main public health issues addressed, the main results achieved, the benefits of working at EU level and key priorities for future interventions to reduce health inequalities within the European Union. This brochure is a good opportunity to share the results achieved by co-funded projects in the last 10 years and at the same time to use this new knowledge and these good practices to orient future strategies for reducing health inequalities in the EU.

In total, 64 actions were funded to tackle health inequalities, bringing together close to 700 organisations and institutions from all EU Member States, EFTA/EEA countries and some candidate countries.

The majority of the partners (60%) were public entities; conversely, most of the actions were led by a private, non-governmental organisation or in other cases by another governmental institution.

Most of the participants in the health inequalities actions came from EU-15 countries, with only one third of the partners coming from the EU-12 countries. The EU-15 countries with the largest participation were: Italy, the United Kingdom, the Netherlands, Germany and France.

The total amount allocated to the funding of 64 health inequalities actions was €70 million, of which €42 million was EC co-funding from the Health Programme.

The main results produced by these actions were Guides (70%), instruments for data collection (60%), platforms for exchange of knowledge (50%), and training packages (50%) for health professionals, community organisations or other groups.

When assessing the contribution of health inequalities actions to the achievement of the priorities identified under COM(2009) 567 'Solidarity in Health: Reducing Health Inequalities in the EU', it is clear that most of the actions contributed to priorities 1, 2, 3 and 4. However, for priority 5, the estimated contribution is smaller.

Of the four challenges identified in the Communication on health inequalities, challenges 1 and 3 were addressed by most of the actions with their contribution to defining data collection mechanisms or focusing on awareness raising and promotion of access and quality of health care for social groups with higher vulnerability. In contrast, less than 20% of the actions addressed challenges 2 and 4.

Analysing the main characteristics of the actions, the classification was threefold: what type of health inequalities, the key health issues and the type of interventions that were addressed. The analysis showed that the most frequent types of inequalities tackled were those assessing the health needs of vulnerable groups, by measuring the health gaps related to the socio-economic status, differences in inequalities related to age, between and within the EU Member States, etc. Another sub-category with high coverage was the one addressing migrant and ethnic minorities.

When health issues were studied, the most common public health problems examined were those related to behavioural risk factors, including the actions focusing on targeted health promotion and prevention actions to tackle health inequalities related to unhealthy lifestyles, nutrition, being overweight or obese, risk behaviour and smoking. Two other important categories addressed non-communicable diseases and infectious diseases, which were analysed in relation to the socio-economic differences and how they affect the most vulnerable groups.

As regards the type of interventions implemented, three quarters of all actions collected and analysed data on health inequalities and the health status of vulnerable groups. Two other categories of interventions were frequent: efforts to improve access to and quality of health care and activities on prevention and health promotion within the health system. A Health in All Policies approach was found in 40% of the actions, which have intersectoral collaboration.

EU Health Programme support to tackle health inequalities

In support of the European health inequalities policies, the EU Health Programme has funded several actions through both the community action in the field of public health (PHP 1) 2003–08 and the second programme of community action in the field of health (HP 2) 2008–13. Total Health Programme funding was €42 043 035, with €23 060 085 allocated to PHP 1 and €18 982 950 to HP 2.

To support the different policy priorities within the Health Programme, several financial mechanisms have been implemented through calls for proposals: projects, conferences, Joint Actions (JA), as well as Direct Grant Agreements (DGA) with international organisations and calls for tender.

The health inequalities brochure presents the mapping of actions funded under the European Health Programmes 2003–13, with particular attention paid to the results and outputs obtained and their contribution to the implementation of the EU health policy. It aims to provide a general description of how the actions funded by the EU Health Programmes from 2003–13 contributed to a reduction of health inequalities within and between the EU Member States and to show in particular how they supported the capacity building of the organisations active in the field of health inequalities, by addressing the needs of people with vulnerability in the European Union.

This brochure is divided into two main sections:

- Background on the health inequalities actions (partners' status, countries participating, funding, main results, evaluation of their contribution to health inequality policies, the types of actions implemented, etc.).
- A detailed overview of actions grouped into two main sub-categories: those actions addressing health gradients and health gaps and the actions targeting vulnerable groups.

To produce this brochure, several methods and means were used and were structured in the following phases:

An inventory: To start, an inventory of the health inequalities and vulnerable groups actions was prepared. A database was created by consulting the Health Programme database⁽⁴⁾. The search was done using specific key words, for example 'inequalities', 'social determinants', 'social exclusion', 'stigma', 'discrimination', 'vulnerable groups', 'migrants', 'ethnic minorities', 'Roma', 'gender', 'drug users', 'prisoners', etc. The initial mapping was extended through consultation with experts working at the Executive Agency and at the Directorate-General for Health and Consumers (SANCO)⁽⁵⁾.

(4) Health Programme Project database: <http://ec.europa.eu/eahc/projects/database.html>

(5) DG SANCO (Directorate-General for Health and Consumers) units responsible for Health inequalities portfolio: on Health Promotion and determinants (SANCO C4), Health Threats (SANCO C3) and Health Strategy and International (SANCO D1): http://ec.europa.eu/health/index_en.htm

In total, 64 actions were listed as addressing health inequalities and/or the health needs of people in particular vulnerable situations. The vulnerability of the socially excluded groups has a myriad of different determinants, including low socio-economic status, belonging to an ethnic minority group, being elderly or a young person at risk, or suffering from chronic diseases associated with stigma and discrimination, like HIV/AIDS, drug addiction or mental health.

The database containing the 64 actions was used for the descriptive and statistical analysis presenting actions funded under PHP I and HP 2.

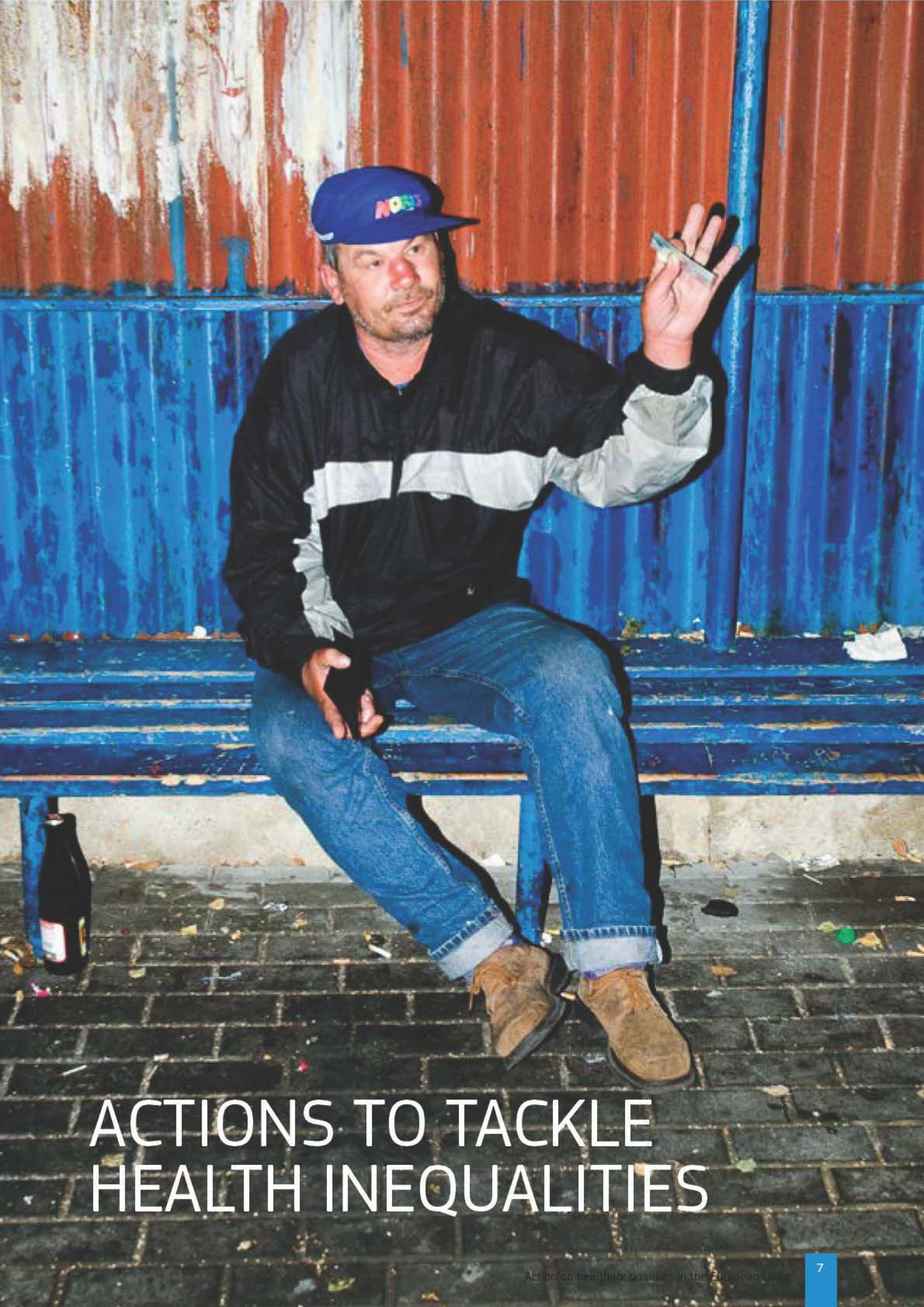
An online survey: The individual action's contribution to the implementation of the European Commission policies on health inequalities, with particular attention paid to COM(2009) 567 — Solidarity in Health: Reducing Health Inequalities in the EU⁽⁶⁾, was assessed using an online questionnaire. The questionnaire gathered information on how the actions contributed to promoting the reduction of health inequalities by supporting awareness raising, promoting and assisting exchange of information and knowledge between Member States, identifying and spreading good practices, facilitating the design of tailor-made policies for the specific issues prevailing in Member States and/or social groups in vulnerable situations and monitoring and evaluating the progress in the application of health inequalities policies at national and European level. 67% of the coordinators completed the questionnaire during the data collection phase of 3 months (October 2013 to January 2014). There was a low response rate for the

actions from the First Health Programme (2003–07), but questionnaires were completed by all actions from the Second Health Programme (2008–13).

Action summaries written by health inequalities experts: The questionnaires and the main outputs (reports, websites, etc.) of the individual actions were used by three external experts to prepare the scientific articles. The scientific writers were experts working on health inequalities in Europe, with previous experience of European project collaboration.

In total 38 articles have been produced, with the approval of the actions' coordinators. Eight of the articles cover recurrent actions, when European networks implemented different interventions with longer periods: Aids and Mobility (A&M and A&M 2007–10), Highly active prevention: scale up HIV/AIDS/STI prevention, diagnostic and therapy across sectors and borders in CEE and SEE (Bordernet and Bordernet), European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers (Tampep 7–Tampep 8), European Network Social Inclusion & Health (Correlation and Correlation II), European Perinatal Health Report (Europeristat II, III and ACT), EpiSouth+: a Network for the Control of Public Health Threats and other bio-security risks in the Mediterranean Region and Balkans (EpiSouth and EpiSouth plus), Reduction of Health Inequalities in the Roma and Roma community analysis of the situation in Europe, and the European Health and Life Expectancy Information System (EHLEIS I and II). The different phases of the actions were combined in a single article.

(6) COM(2009) 567 — Solidarity in Health: Reducing health inequalities in the EU:
<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0567:FIN:EN:PDF>



ACTIONS TO TACKLE HEALTH INEQUALITIES

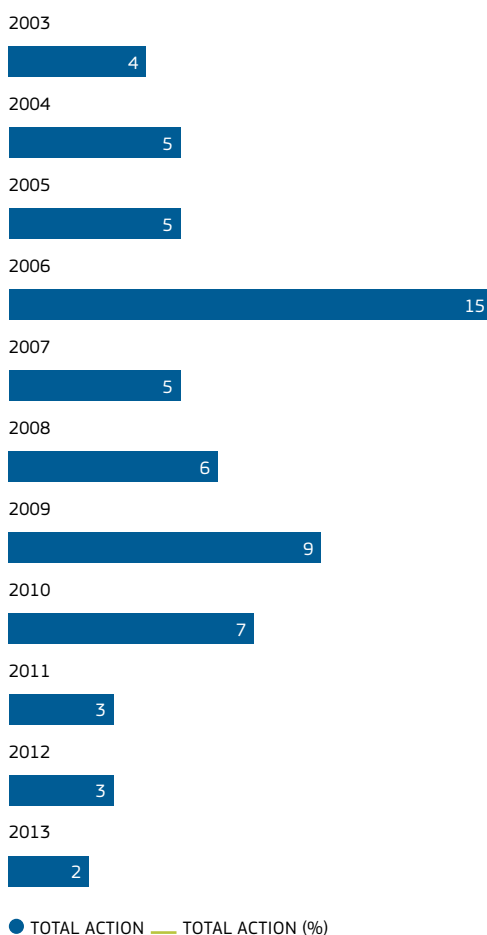
Health Programme funding mechanisms

HOW HAS THE HEALTH PROGRAMME SUPPORTED THE HEALTH INEQUALITY POLICY?

In total 64 actions from the period of 2003–13 were identified as contributing to the priorities addressing health inequalities and the needs of people in vulnerable situations in the EU.

Graph 1

Health inequalities actions 2003–13, number of actions and EC funding (million euros) per year



The health inequalities distribution over the 10 years shows that on average 5 actions were funded per year, and that there were two main peaks. The first occurred in 2006, with 15 actions funded, and another one in 2009–10, with 16 actions funded. This second peak can be related to the launch of strategic actions after the adoption of the Solidarity in Health Communication in October 2009, one main example being the funding of the health inequalities Joint Action, as part of the Call for proposals 2010.

Table 1

Health inequalities actions 2003–13, by financial mechanism

Financial instruments	PHP 1	PHP 1 (%)	HP 2	HP 2 (%)	Total	%
Project	33	97.0	20	66.6	53	82.8
Tender	0.0	0.0	5	16.6	5	7.8
Direct Grant Agreement	1	2.9	2	6.6	3	4.6
Joint Action	0.0	0.0	2	6.6	2	3.1
Conference	0.0	0.0	1	3.3	1	1.5
Total	34	100.0	30	100.0	64	100.0
Total %	53.1		46.8			

During the First Health Programme 2003–07, a total of 34 (53.13%) actions were funded; 33 projects and 1 Direct Grant Agreement (DGA) with WHO EURO were funded.

In the Second Health Programme, the financial mechanisms were diversified, with a total of 30 actions funded (46.88%). In this period, 2 Joint Actions, 20 projects, 2 Direct Grant Agreements (with WHO EURO and IOM), 1 conference and 5 tenders for the production of surveys and reports were funded.

The financial instruments used to support the implementation of the health inequalities actions are described in the following section.

PROJECTS

The projects are the most common financial instrument used to implement the health inequalities actions, with 53 networks funded (83% of the total actions funded). The projects are multi-beneficiary grants, which brought together experts from several European countries to implement a common action.

The mean number of partners for the projects varied between the First and the Second Health Programmes, with networks of on average 13 and 11 partners, respectively. The largest network funded was the Eurothine project — Tackling health inequalities in Europe: an integrated approach — which had 48 partners and was funded in 2003, while the smallest consortium was HEALTHEQUITY-2020, with 5 partners, funded in 2011.

The Eurothine project showed that health inequalities were substantial throughout the European Union in the 1990s, but that there were significant variations between countries in the magnitude of health inequalities. This suggests that there is great scope for reducing health inequalities. The Eurothine project was linked with the EURO-GBD-SE project⁽¹⁾. The potential for reduction of health inequalities in Europe (EURO-GBD-SE) project was funded in 2008, with the central aim being to measure the potential for reduction of health inequalities within and between EU countries.

(1) The potential for reduction of health inequalities in Europe (EURO-GBD-SE project): <http://www.euro-gbd-se.eu/index.php?id=373>

JOINT ACTIONS

The Joint Actions are a new financial mechanism created under the Second Health Programme 2008–13. The Joint Actions serve as instruments to implement actions with high policy relevance for European Member States and the European Commission and require their commitment through a multi-beneficiary grant, a multi-annual programme of actions and a large volume of funding.

The Joint Action on Health Inequalities aimed to help reduce health inequalities by developing knowledge for action on health inequalities, supporting the engagement of Member States, regions and other stakeholders in action to tackle socio-economic health inequalities, sharing learning between Member States and other actors and supporting the development of effective action to tackle socio-economic health inequalities at the European policy level.

The Joint Action on Health Inequalities⁽⁷⁾ was a policy initiative, which brought together 24 partners from 16 countries. **The EQUITY Joint Action final conference: on addressing health inequalities in 2014 and beyond** was held in Brussels on 23 January 2014⁽⁸⁾.

Another Joint Action — European Health and Life Expectancy Information System (EHLEIS)⁽⁹⁾ — worked on the analysis of socio-economic status and health inequalities, showing in particular the inequalities in health based on socio-economic status (SES), age and gender differences. The EHLEIS Joint Action was a large network with 21 partners from 11 countries.

(7) Joint Action on Health Inequalities: <http://eurohealthnet.eu/research/joint-action-health-inequalities>

(8) Final EQUITY ACTION conference outcomes, Health inequalities Joint action, Brussels, 23 January 2014: <http://eurohealthnet.eu/organisation/equity-action-high-level-conference-%E2%82%AC13>

(9) Joint Action European Health and Life Expectancy Information System (EHLEIS): <http://www.eurohex.eu/index.php?option=reports>

CONFERENCES

The European conferences are single beneficiary grants and aim to disseminate knowledge, promote exchange of good practices and address health topics in line with the Health Programme's annual priorities. The Health Programme funded two types of European conferences, the European Presidency conferences and other European Public Health conferences.

Two European presidency conferences addressing the health inequalities policies were organised with the support of the First Health Programme: the United Kingdom conference on Tackling health inequalities: governing for health (THIGH) (2004)⁽¹⁰⁾ and the Portuguese conference on Health and migrations in the EU: Better health for all in an inclusive society (2006)⁽¹¹⁾.

Under the work plan 2013, the Conference on Migrant and Ethnic Minority health and health care in the context of the current systemic crisis in Europe⁽¹²⁾ is funded. The Migrant Health conference will be organised by the Andalusian School of Public Health, in collaboration with the Migrant and ethnic minority health section from the European Public Health Association (EUPHA)⁽¹³⁾, on 10–12 April 2014, in Granada.

DIRECT GRANT AGREEMENTS

The international organisation Direct Grant Agreements (DGA) represent a very specific type of project, which has received 7.8% of the overall action funding. The international organisation grant funds activities in areas where the World Health Organisation (WHO) or the International Organisation for Migration (IOM) have a monopoly because the actions implemented are directly related to their mandate, requiring specific expertise on health inequalities or health needs of migrants and ethnic minorities, within the European Union.

TENDERS

The tenders are for the purchase of specific services, like the execution of works for the European Commission, the writing of reports, surveys, etc. A total of 5 tenders on health inequalities topics were funded under the Second Health Programme. Several major technical reports on health inequalities have been produced through tenders: The Impact of Structural Funds on Health Gains⁽¹⁴⁾, Health Inequalities in the EU (Marmot report)⁽¹⁵⁾, and the Health Status of the Roma Population were produced by European experts working together in consortia.

(10) http://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/pu_2.pdf

(11) http://ec.europa.eu/eahc/documents/news/technical_meetings/Health_of_Migrants_Pt_Presidency.pdf

(12) Migrant and Ethnic Minority health and health care in the context of the current systemic crisis: http://www.eupha-migranthealthconference.com/?page_id=1018

(13) European Public Health association — Migrant and ethnic minority health section: http://www.eupha.org/site/section_page.php?section_ref=5_MH

(14) The Health gain project: <http://www.healthgain.eu/health-indicators>

(15) The Health inequalities in the EU (Marmot report): http://ec.europa.eu/health/social_determinants/docs/healthinequalitiesineu_2013_en.pdf

Actors

In the Health Programme, the beneficiaries can have two main roles, either as main beneficiary (the coordinator) or as an associated beneficiary. They make up the network members, and both receive EC funding and provide their own contribution for the action's implementation. The partners can be public or private organisations and can have different structures, such as governmental, non-governmental, academic and international organisations. Other organisations can participate as collaborating partners, without financial benefits.

TYPE OF ORGANISATIONS CONTRIBUTING TO HEALTH INEQUALITIES ACTIONS

697 organisations were funded under the Health Programme actions aiming to reduce health inequalities in 2003–13. Of those, 421 (60%) partners were public organisations and 276 (40%) were private organisations.

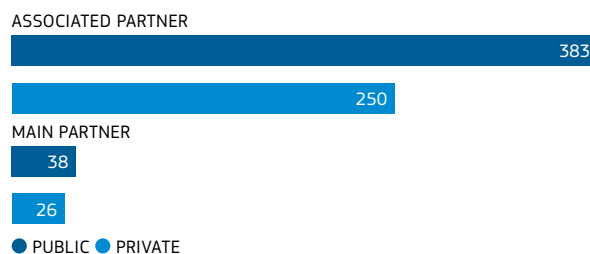
When studying the main partner status, we can see that same proportion, with 2/3 of the actions led by public organisations.

The public organisations play different functions in the EU Member States' health systems. They can be government institutions at national, regional and local authority level or academic institutions or international organisations.

Under the Health Programme, the main partner is the organisation responsible for the action coordination and project management and ensures the linkage with the European services (Executive Agency and European Commission). The main partner also represents the institution that brings together the network of experts, guides the technical content of the actions and ensures the achievement of the action's objectives.

Graph 2

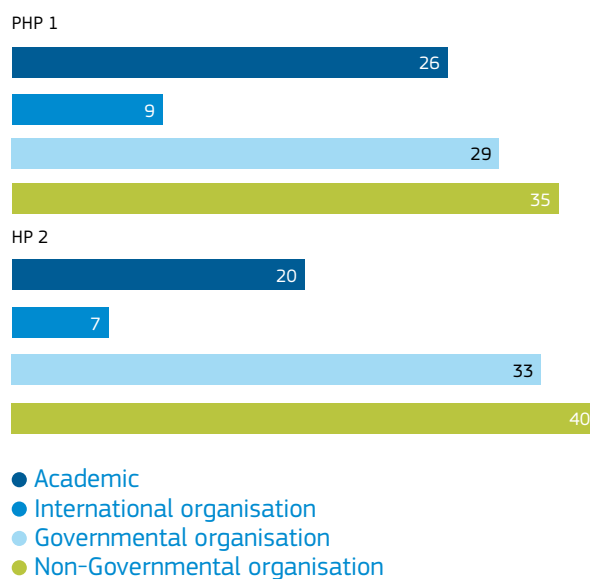
Health inequalities actions 2003–13, partners' status



64 organisations were leading a health inequalities action, and 633 organisations were associated partners.

Graph 3

Health inequalities actions 2003–13, main partners' type of organisation



Overall, the most frequent type of organisation for the main beneficiary was non-governmental organisation, representing 37.5%. This was followed by governmental (31.25%) and academic (23.44%) institutions. When comparing the organisations' participation in both Programmes, we observe a slight reduction of academic institutions' participation. This is compensated by the involvement of governmental organisations, possibly reflecting the importance of the Joint Actions in health inequalities and the type of priorities under the health inequalities funding for the Second Health Programme; the emphasis is on the orientation of the health policies by supporting interventions to assist the development of national health inequalities policies, including the effective use of Structural Funds to tackle the health gaps.



24 actions were coordinated by private entities registered as non-governmental organisations (NGOs) active at national and European level: 20 projects, 3 tenders and the EQUITY Joint Action.

Most of these actions dealt with the health topics addressing the needs of the most vulnerable population groups, tackling the prevention of communicable diseases (HIV/AIDS, STI and Tuberculosis, vaccine preventable diseases), or developing innovative strategies to reach the most affected socially excluded groups with healthy lifestyle interventions. These actions foster the link between health services and community organisations, using health mediators⁽¹⁶⁾, peer support⁽¹⁷⁾ and outreach⁽¹⁸⁾ strategies to facilitate access to prevention programmes for vulnerable groups, like the Roma, migrants and ethnic minorities, homeless people, drug users, sex workers, prisoners, etc. Another relevant example of an action led by a non-governmental organisation was the HealthPROelderly project⁽¹⁹⁾, which focused on the development of evidence-based guidelines on Health Promotion for Elderly: addressing social determinants, inequality and sustainability. These actions contributed to improving access to and quality of public health services, working in collaboration with the national health authorities.

A relevant example of a non-governmental organisation action was the **Improving access to health care for asylum seekers and undocumented migrants in the EU (AVERROES)** project, led by Médecins du Monde⁽¹⁾, France, which has supported the creation of the HUMA network⁽²⁾.

(1) Médecins du Monde: <http://www.medecinsdumonde.org/>

(2) HUMA Network — Improving access to health care for asylum seekers and undocumented migrants in the European Union: <http://www.epim.info/who-we-are/2008-2011-phase/undocumented-migrants/medecins-du-monde/>

20 actions were led by public bodies with governmental functions at the level of national, regional or local health authorities. These networks have produced relevant output related to the definition of indicators and also health information systems to support the study of socially excluded groups' health.

The government-led experts' networks have different methods for applying health impact assessments and health equity audits, creating the tools for the

preparation of health inequality action plans and Structural Funds projects and strengthening the collaboration between the different actors at regional and local level and between civil society and public health system organisations addressing health inequalities.

Different health inequalities actions were funded in subsequent years, supporting the European experts' network activities in a continuum of health inequality initiatives. This has ensured long-term policy development by implementing common intervention logic to tackle health inequalities in Europe.

We can recognise a direct relation between the following actions working on sharing knowledge and promoting good practices to tackle health inequalities in Europe:

Closing the Health Gap: Strategies for Action to tackle health inequalities in Europe project⁽²⁰⁾ and **Determine: an EU Consortium for Action on Socio-Economic Determinants of Health**⁽²¹⁾ project.

The Closing the gap project has created a European knowledge base and infrastructure to implement and strengthen strategies and actions to reduce health inequalities at different levels by sharing at the local level information and expertise as well as good practices, proven to be effective in helping to tackle health inequalities. These effective practices were collected to produce a European Directory of Good Practices. The Determine project allowed the expert network to continue work and produced the health inequalities good practice database, maintained by EuroHealthNet, on the Health Inequalities portal.

Regional health authorities have led 6 (9.37%) health inequalities actions, notably Healthy Regions (Healthy Regions — When Well-being Creates Economic Growth), INEQ-CITIES (Socio-economic inequalities in mortality: evidence and policies in cities of Europe), AIR (Addressing inequalities interventions in regions), SRAP (Addiction Prevention within Roma and Sinti Communities), ACTION-FOR-HEALTH and a tender for the development of training packages for health professionals to improve access to and quality of health services for migrants and ethnic minorities.

(16) Health mediators are people belonging to the vulnerable groups who share knowledge and experiences to promote health, reduce risk and increase access to health and social services. Examples can be the social mediators programmes working with migrants and ethnic minorities, Roma community, etc.

(17) Peer support — a type of health promotion intervention when people provide knowledge, experience, social or practical help to each other. It commonly refers to an initiative consisting of trained supporters, and can take a number of forms, such as peer mentoring, listening or counselling.

(18) Outreach activities are interventions conducted by outreach workers, peer educators, and/or health educators out on the streets, face-to-face, with individuals at risk. They are also called community interventions.

(19) Evidence-based guidelines on Health Promotion for Elderly: addressing social determinants, inequality and sustainability: http://www.healthproelderly.com/index_en.php

(20) Closing the Health Gap: Strategies for Action to tackle health inequalities in Europe project — led by the Bundeszentrale für gesundheitliche Aufklärung (BZgA), in Germany: <http://eurohealthnet.eu/research/closing-gap-2004-2007>

(21) DETERMINE final report — Mobilising Action for Health Equity in the EU: <http://eurohealthnet.eu/content/final-report-determine-consortium-story-determine-mobilising-action-health-equity-eu>

The training packages for health professionals' action will develop training modules and regional training courses, with the aim being to improve access and quality of health services for migrants and ethnic minorities, including the Roma; this is led by the Andalusian School of Public Health⁽¹⁾ (EASP). The EASP is a capacity building organisation, supported by the Andalusian regional authority. In the next two years, the MEM consortium will develop a training programme aiming to increase the European health professionals' cultural sensitivity skills. Several regional training courses will be implemented in 2015–16.

(1) Andalusian School of Public Health (EASP): <http://www.easp.es/>

The academic organisations have coordinated 15 European actions.

These actions have produced innovative methods on how to support the development of methodologies for the collection of data, based on indicators by age, sex, SES and geographic dimension, evaluate health status and inequalities interventions, etc. An example: the development of European indicators to monitor the health status of migrants, or strategies to improve access to and quality of health care for socially excluded groups, such as adolescents, migrants and minorities, and prisoners. Other actions addressed specific needs, such as the creation of an anti-stigma programme for mental health patients, a training and resource package for improving the sexual and reproductive health of people living with HIV/AIDS, good practices for promoting gender equity in health, and the strategies for screening for Hepatitis B and C among migrants in the European Union.

The Monitoring the health status of migrants within Europe (MEHO)⁽¹⁾ through the development of indicators project was led by the Erasmus medical centre, from Rotterdam University in the Netherlands. The main objective of the MEHO network was to develop indicators, in line with the European core indicators methodology (ECHI)⁽²⁾, to monitor the health status of immigrant and ethnic minority groups in Europe. This network of academic and public health authorities has generated a European overview of comparable and exchangeable data on the socio-demographic and health profile of immigrant/ethnic minority groups, particularly the Roma, for selected health problems. MEHO focuses on five critical health areas: mortality, cardiovascular diseases and diabetes, infectious diseases, cancer, and self-perceived health and health care use.

(1) Monitoring the health status of migrants within Europe (MEHO): <http://www.meho.eu.com/>
Erasmus Medical Center: <http://www.erasmusmc.nl/?lang=en>

(2) European Community Health Indicators (ECHI): <http://ec.europa.eu/health/indicators/echi/list/>

The Direct Grant Agreements have funded two main international organisations: the World Health Organisation (WHO) and the International Organisation for Migration, European Region offices.

The WHO Europe (EURO) office has received two Direct Grant Agreements to carry out the following actions: Equity in Health: Inequalities in Health System Performance and their social determinants in Europe — Tools for Assessment and Information Sharing (2006)⁽²²⁾, and European Review of Social Determinants and the Health Divide (2011).

The International Organisation for Migration (IOM) has received funding for two projects under the call for proposals 2006: AMAC (Assisting Migrants and Communities: analysis of social determinants of Health and Health Inequalities)⁽²³⁾ and PHBLM (Increasing Public Health Safety for the External Borders of an Enlarged EU).

Since 2012, the IOM has been a beneficiary of the Direct Grant Agreement EQUI-HEALTH, aimed at fostering health provision for migrants, the Roma and other vulnerable groups. The objective of the EQUI-HEALTH action is to improve the access to and appropriateness of health care services, health promotion and prevention to meet the needs of migrants, the Roma and other vulnerable ethnic minority groups, including irregular migrants residing in the EU/EEA.

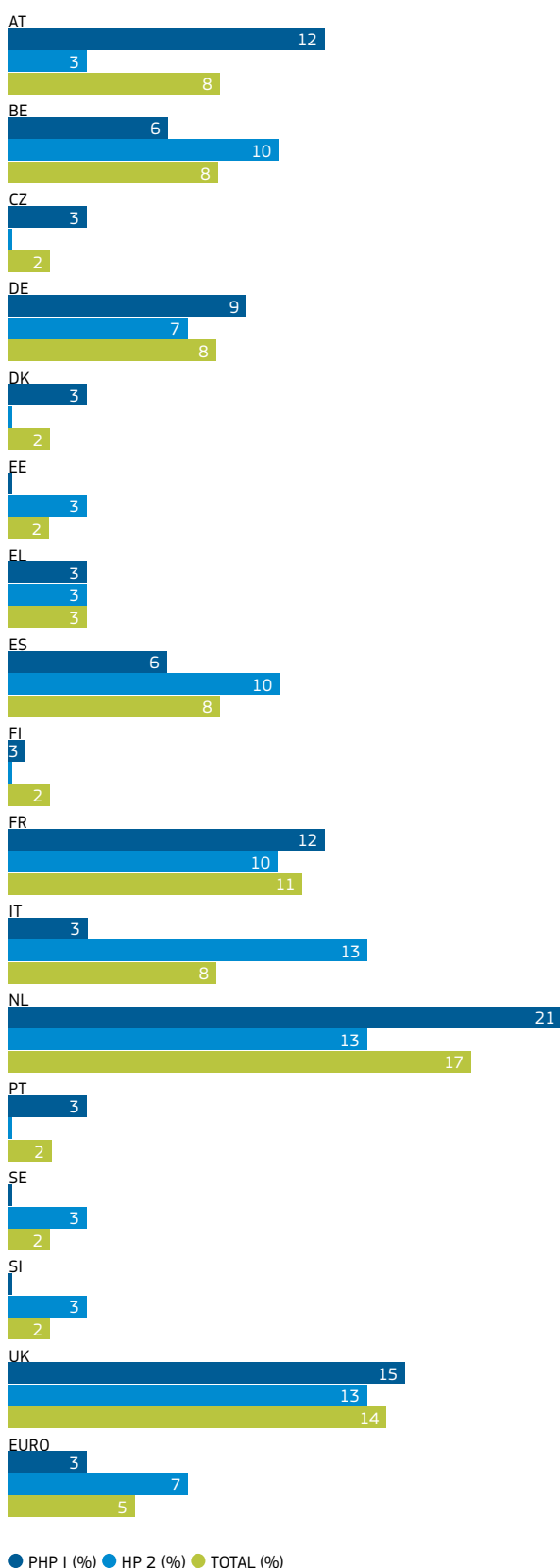


(22) Equity in Health: Inequalities in Health System Performance and their social determinants in Europe — Tools for Assessment and Information Sharing: <http://www.euro.who.int/en/data-and-evidence/equity-in-health-project/inequalities-in-health-system-performance-and-their-social-determinants-in-europe>

(23) AMAC (Assisting Migrants and Communities: analysis of social determinants of Health and Health Inequalities): <http://www.migrant-health-europe.org/index.php/component/content/article/66.html>

**MAIN PARTNER DISTRIBUTION BY EU COUNTRIES
(PHP 1 AND HP 2)**

Graph 4
Health inequalities actions 2003–13, main partners' country



17 countries (63.96% of 27 EU Member States) led at least one of the 64 health inequalities actions from 2003 to 2013. Eight countries from the EU-15 countries (the Netherlands, the United Kingdom, Belgium, Austria, Germany, Spain, Italy and France) led 51 (80%) of the actions funded.

The Netherlands was the most frequent main beneficiary with 11 (17%) actions funded, followed by the United Kingdom (9 actions, 14%) and France (6 actions, 9%). Five other countries, Austria, Belgium, Germany, Italy and Spain, each coordinated 5 actions. Greek organisations led two actions on European networks addressing migrant and ethnic minorities' health issues.

Three actions (5%) were led by organisations from the EU-12⁽²⁴⁾ countries. A valuable example was the EU Consortium for Action on Socio-Economic Determinants of Health (Determine) project⁽²⁵⁾ funded in 2006, led by the National Institute of Public Health from the Czech Republic.

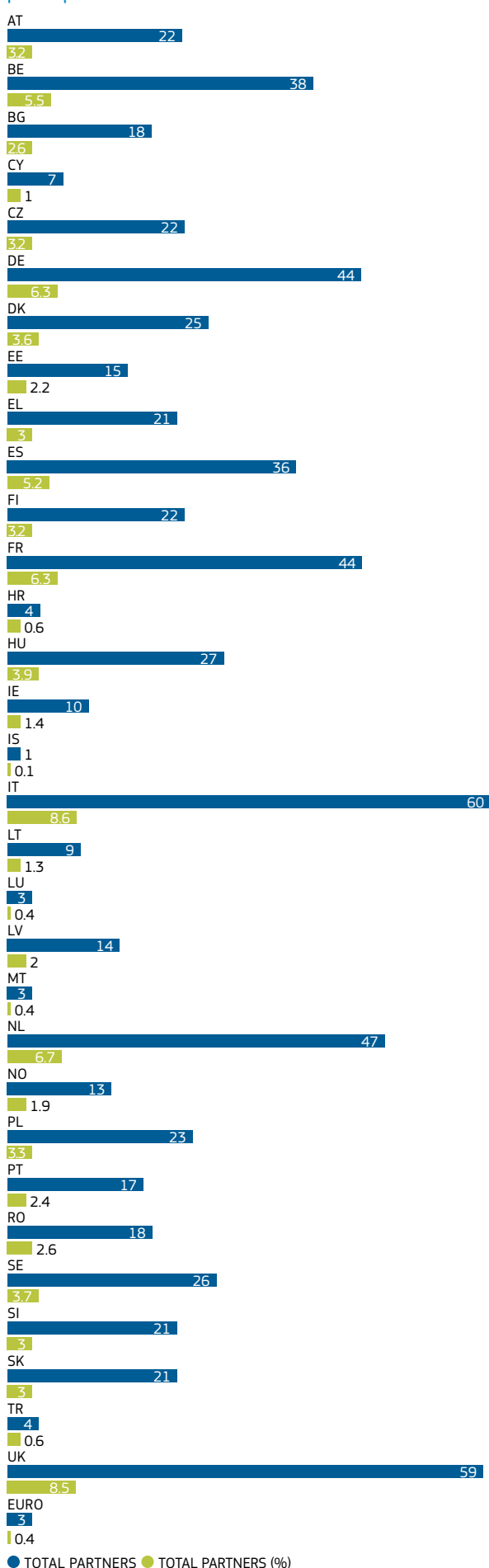
GEOGRAPHIC COVERAGE — COUNTRIES' PARTICIPATION IN HEALTH INEQUALITIES ACTIONS

In relation to the EU countries' participation, the distribution of the 697 partners shows that all 27 EU Member States, as well as EFTA/EEA countries and candidate countries participated in the 64 actions tackling health inequalities from 2003–13.

(24) EU-12 and EU-15 definitions — Glossary of the EU enlargement: http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Glossary
 (25) EU Consortium for Action on Socio-Economic Determinants of Health: <http://www.health-inequalities.eu/>

Graph 5

Health inequalities actions, 2003–13, by countries' participation



Most of the partners (70%) came from 13 countries (IT, UK, NL, DE, FR, ES, HU, SE, DK, PL, AT, CZ and FI). The largest participation, in the PHP 1 and HP 2, was from the following EU-15 countries: Italy (60), United Kingdom (59), the Netherlands (47), Germany (44) and France (44). Two of the EEA/EFTA countries, Norway (13) and Iceland (1), participated in the health inequalities networks. Turkey and Croatia joined the EU networks as candidate countries in 4 actions each. The EU-12 countries have had 197 organisations that joined the EU networks tackling health inequalities; the most represented countries were Hungary (27), Poland (23), the Czech Republic (22), Slovenia (21), Slovakia (21), Bulgaria (18) and Romania (18).

COUNTRIES' PARTICIPATION EU-15/EU-12

From the 697 partners that represented the EU countries' organisations⁽²⁶⁾, 472 (67.72%) partners came from EU-15 countries⁽²⁷⁾ and 197 (28.26%) partners were from the EU-12 countries⁽²⁸⁾ that joined the EU after 2004 and form part of the EU-27 countries. Fourteen (2%) organisations were from the EFTA/EEA⁽²⁹⁾ countries, mostly Norway. As candidate countries, Turkey and Croatia⁽³⁰⁾ participated with 8 (1.15%) organisations. The international organisations implemented 6 (0.86%) actions from the European Regional offices of WHO or IOM.

Table 2
Health inequalities actions 2003–13, by countries' participation EU-15/EU-12

Countries' participation	Total Number partners	%
EU-15	472	67.7
EU-12	197	28.2
EFTA/EEA	14	2.0
Candidate countries	8	1.1
International organisations	6	0.8
	697	100.0

(26) EU countries: http://europa.eu/about-eu/countries/index_en.htm

(27) EU-15 countries: Belgium (BE), Denmark (DK), France (FR), Germany (DE), Greece (EL), Ireland (IE), Italy (IT), Luxembourg (LU), Netherlands (NL), Portugal (PT), Spain (ES) and United Kingdom (UK).

(28) EU-12 countries: Those countries that joined the EU after 1 May 2004 — Cyprus (CY), Czech Republic (CZ), Estonia (EE), Hungary (HU), Latvia (LV), Lithuania (LT), Malta (MT), Poland (PL), Slovakia (SK), Slovenia (SI), Bulgaria (BG) and Romania (RO).

(29) EFTA/EEA countries: Iceland, Liechtenstein and Norway: <http://www.efta.int/eea>

(30) Croatia became a member of the EU on 1 July 2013: <http://ec.europa.eu/enlargement/countries/detailed-country-information/croatia/>



FUNDING OF HEALTH INEQUALITIES ACTIONS UNDER THE HEALTH PROGRAMME (PHP 1 AND HP 2)

The total funding for the 64 actions addressing health inequalities amounts to €70511361. The Health Programme budget contributed with a total of €42 million as the EC co-funding and partners' own contributions represented 40% of the total budget.

Table 3
Health inequalities actions 2003–13, EC contribution per financial instrument

Financial mechanism	EC co-funding 2003–13 (euros)	%
Project	35 731 060	84.9
DGA	2 383 000	5.6
Joint Action	2 337 157	5.5
Tender	1 551 818	3.6
Conference	40 000	0.1
Grand Total	42 043 035	

The most frequent way to support the health inequalities actions was the funding of projects to support networks with a total budget of €35.7 million representing 85% of the total EC co-funding. Another new mode to support

the Member State experts' networks is the funding of Joint Actions, which have become a common mechanism for funding high policy priorities. For the health inequalities actions, the two Joint Actions received €2.3 million as EC funding, representing 5.56%.

When a comparison was made between the European Commission's First and Second Health Programme funding for health inequalities, a decrease of €4 million was found. This possibly reflects the reduction in the number of actions funded, from 34 during the first period to 30 in the Second Health Programme.

Table 4
Total Health Programme funding and health inequalities 2003–13, EC co-funding in euros

Health Programme	Health inequality funding (euros)	Total budget (euros)	%
PHP 1	23 060 085	273 726 648.7	8.4
HP 2	18 982 950	297 752 116.7	6.3
Total	42 043 035	571 478 765.4	7.3

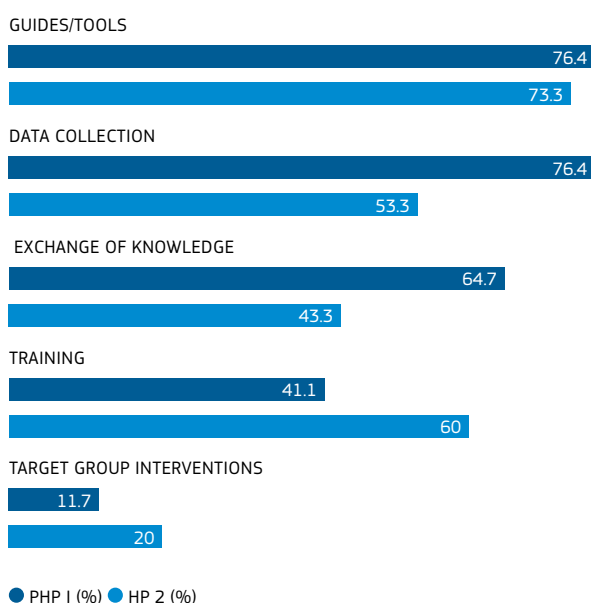
Health inequalities remain one of the main priorities of the European Health Programme, as it received on average 7% of the Health Programme total funding in 2003–13.

Results of the health inequalities actions

The main results produced by the health inequalities actions are the production of guides (75%), instruments for data collection (66%), platforms for exchange of knowledge (55%), training packages (50%) for health professionals and community organisations and other interventions directly working with the target group, at community level, etc.

Graph 6

Health inequalities actions 2003–13, main outputs by type



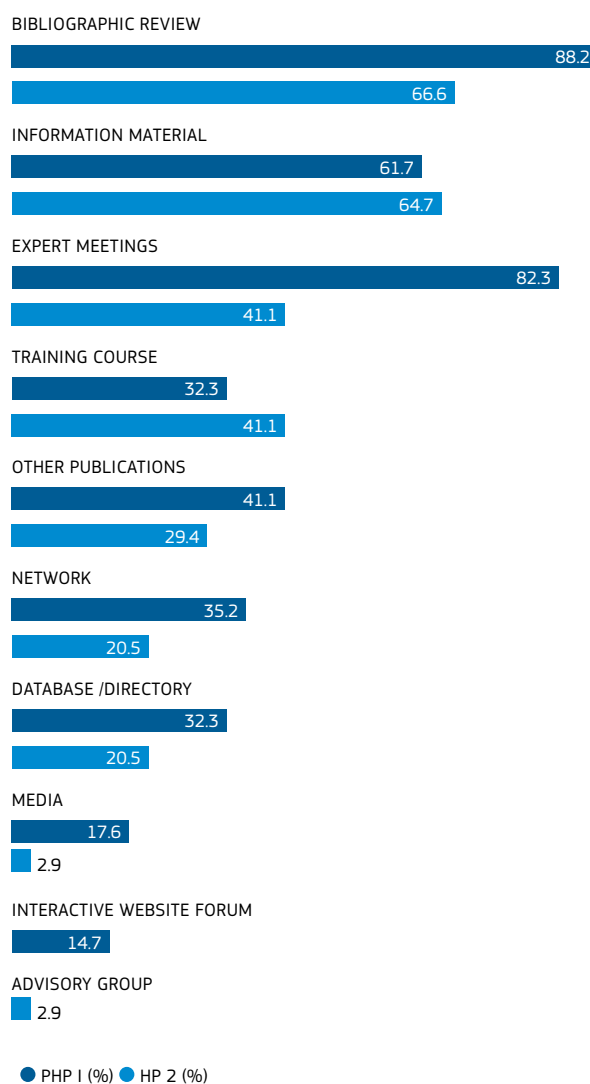
The key channels for the dissemination of the results are the production of bibliographic reviews, the production of information materials and the exchange between experts by participating in the European Networks. The bibliographic review is used to produce the scientific evidence on how the health problem affects the specific vulnerable groups and to identify what the existing barriers and good practices are in order to address the particular public health issue and what the policy context at national and European level is.

The health inequalities actions dissemination strategies used different means to inform the stakeholders at national and European level. They have produced websites, booklets, newsletters, factsheets and policy briefs to reach the politicians, health policy makers, patient organisations and members of the vulnerable groups. They have created training programmes and pilot projects and trained health professionals and community organisations during several training events.

The relevant good practices and key experts working on health inequalities have been identified and incorporated into project databases and directories, and/or brought together to exchange experiences in interactive websites/fora. Other expert networks have targeted the scientific community and produced scientific publications. A relevant example is the special issue produced by the European Journal of Public Health⁽³¹⁾, with contributions from several EU networks active in socio-economic inequalities and Migrant Health.

Graph 7

Health inequalities actions 2003–13, main channels of dissemination of results



(31) European Journal of Public Health, Vol. 16, No 4: <http://eurpub.oxfordjournals.org/content/16/4/toc>

In table 5, examples of guides and training packages produced for the actions funded under the Second Health Programme 2008–13 can be seen, together with their

website. All the public deliverables of the actions funded since 2003 can be found in the Executive Agency project database: <http://ec.europa.eu/eahc/projects/database.html>

Table 5

Guides and tools developed by the health inequalities 2008–13 programme

Year	Acronym	Guides	Training	Website
2008	EUROSUPPORT 6	TRP adapted intervention manuals	Online training tools and resource package (TRP) for HIV service providers	www.eurosupportstudy.net ; www.cissweb.com/
2008	Correlation II	Manual outreach and early intervention on youth drug use, peer support manual	Hepatitis C training tool	www.correlation-net.org/ ; www.digitalhealth.eu/
2009	Health 25		Health training and intervention programme on health promotion for disadvantaged youth	www.health25.eu
2009	SRAP	Health, prevention of addictions and Roma youth in Europe – A handbook and actions for practice	Training package for health care workers (capacity enhancement of social and health workers)	http://srap-project.eu/
2009	Imp.Ac.T	Guide manual on HIV/TB testing for DUs and migrants in low-threshold services	Training on HIV and TB rapid testing of DUs/migrants in low-threshold services	www.projectimpact.eu/
2009	BORDERNETwork	Guidelines for referral and management of HIV co-infections	Training seminars in 3 good practice models for ethnic groups	www.bordernet.eu/
2009	PROMOVAX	Toolkit for health professionals and other staff interacting with migrants		www.promovax.eu
2009	AURORA		Training course for health care professional and advocacy leaders	www.aurora-project.eu/
2010	Equity action	Training on health impact assessments, health equity audits and health inequality strategies	Training workshop for regions on tackling health inequalities	www.health-inequalities.org/
2010	Structural Funds for health gains	Health and regional development tool (the healthgain.eu tool)	Capacity building programme with four workshops to present the tool	www.healthgain.eu

Role in implementing the European Commission's policy document 'Solidarity in Health: Reducing Health inequalities in the EU'



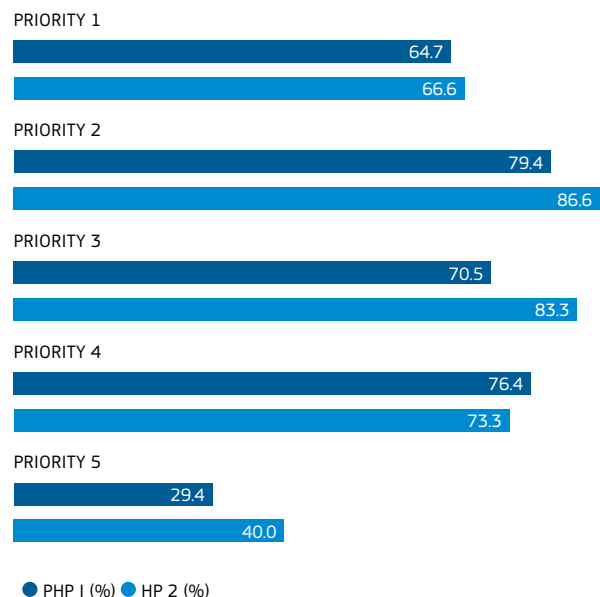
Communication (2009) 567 — Solidarity in Health: Reducing health inequalities in the EU⁽³²⁾ was adopted on 20 October 2009. Its recommendations were reinforced by the Council recommendation on closing the health gaps (2011/C 359/05) from 9 December 2011. The Health Programme work plans of subsequent years were designed to support the implementation of Communication (2009) Solidarity in Health. The five priorities defined are:

- Priority 1: Raising Awareness
- Priority 2: Promoting and assisting exchange of information and knowledge between Member States
- Priority 3: Identifying and spreading good practices
- Priority 4: Facilitating the design of tailor-made policies for the specific issues prevailing in Member States and/or special social groups
- Priority 5: Monitoring and evaluating the progress in application of health inequalities policies

The health inequalities actions' coordinators were invited to assess their contribution to the implementation of the Solidarity in Health (2009) Communication. 38 answers were received, and for the 26 remaining actions the Executive Agency experts responsible for the health inequality portfolio did the assessment based on the project outputs. The estimated health inequalities contribution to the Communication priorities is summarised in graph 8.

Graph 8

Health inequalities actions 2003–13, contribution to the implementation of COM(2009) 567 — Solidarity in Health: policy priorities



When comparing the actions' content to the priorities, it was found that the actions were in line with European priorities, as proposed under COM(2009) 567 — Solidarity in Health: Reducing health inequalities in the EU priorities. These findings are clear for priorities 1, 2, 3 and 4, where the contribution varies between 65 and 87% of all actions.

(32) Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions — Solidarity in health: reducing health inequalities in the EU — COM(2009) 567 final: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0567:FIN:EN:HTML>

However, for priority 5 the estimated contribution from the health inequalities actions is much lower. Priority 5, monitoring and evaluating the progress in application of health inequalities policies, has the lowest estimated contribution with only 34% of the actions.

In the Solidarity for Health Communication 2009, four key challenges were identified and are expected to be addressed to strengthen existing action to reduce health inequalities. The challenges per priority are presented as follows:

A. Improving the data and knowledge base and mechanisms for measuring, monitoring, evaluating and reporting

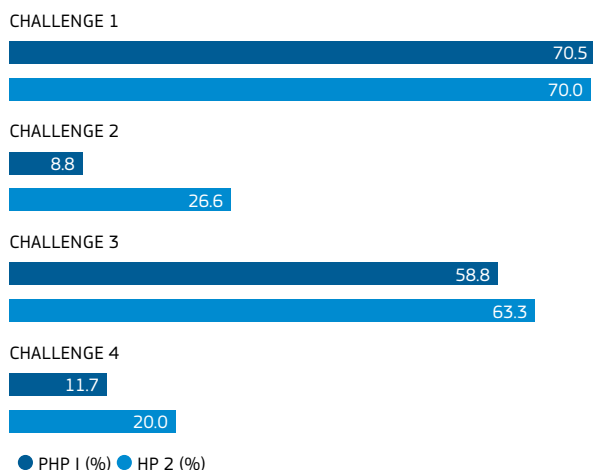
- Challenge 1: Support the further development and collection of data and health inequalities indicators by age, sex, socio-economic status (SES) and geographic dimension
- Challenge 2: Develop health inequality audit approaches through the Health Programme in a Joint Action with Member States willing to participate

B. Meeting the needs of vulnerable groups

- Challenge 3: Launch initiatives in collaboration with Member States to raise awareness and promote actions to improve access and appropriateness of health services, health promotion and preventive care for migrants and ethnic minorities and other vulnerable groups
- Challenge 4: Ensure that the reduction of health inequalities is fully addressed in future initiatives on healthy ageing

Graph 9

Health inequalities actions 2003–13, contribution to the implementation of COM(2009) 567 — Solidarity in Health: Reducing health inequalities in the key challenges



Of the four challenges identified in the Communication on health inequalities, it can be seen from graph 9 that challenge 1 was addressed by 70% of actions, with their contribution to the definition of data collection mechanisms for gathering information about health inequalities indicators. Challenge 3 represents the second most frequent actions (60.94%), focusing on awareness raising and promotion of access and quality of health care for social groups with higher vulnerability.

Challenge 2 aimed at developing health inequality audit approaches and was a call for a Joint Action addressing health inequalities in the EU. This was funded through the 2010 Work Plan, with funding of the Joint Action EQUITY on Health Inequalities, with the participation of 17 countries. In contrast, challenge 4, which called for the reduction of health inequalities by promoting the healthy ageing initiative, was considered to be addressed in less than 20% of the actions. However, in reality, challenge 4 was addressed by the launching of the European Healthy Ageing Partnership⁽³³⁾, which has been supporting several European actions funded under the Health Programme. The projects supporting the European Healthy Ageing Partnership have not been included in this brochure, but a few examples are presented in table 6.

Table 6

Examples of healthy ageing projects funded under the Health Programme 2008–13 that contributed to the implementation of COM(2009) 567 — Solidarity in Health: Reducing health inequalities Challenge 4

Year	Acronym	Ageing action's title
2013	HASIC	Healthy Ageing Supported by the Internet and the Community
2012	e-CAPACIT8	Strengthening occupational health professionals' capacities to improve the health of the ageing workforces
2012	EUROTACS	EUROpean Treatment & Reduction of Acute Coronary Syndromes cost analysis
2012	ICARE4EU	Innovating care for people with multiple chronic conditions in Europe
2012	MANAGE-CARE	Active Ageing with Type 2 Diabetes as Model for the Development and Implementation of Innovative Chronic Care Management in Europe
2010	ALCOVE	ALzheimer COoperative Valuation in Europe

These findings suggest that during the Second Programme 2008–13 a real effort was made to address the challenges identified by the Communication on Solidarity in Health.

(33) European Innovation Partnership on Active and Healthy Ageing (EIP on AHA), http://ec.europa.eu/health/ageing/innovation/index_en.htm

Characteristics of the actions on health inequalities



The 64 actions on health inequalities implemented during the First and Second Health Programmes (2003–13) were analysed in more detail on the basis of three features: the *type of health inequalities* they target, the *health issues* they address and the *type of interventions* they undertake or recommend. The way these three features were coded is described below: the categories used were based on those found in the actions themselves. Actions were given a score of 0 for categories that were not applicable and 1 for those that (to some degree) were.

A. Types of inequality targeted: this refers to the source of inequality addressed by the action. One way of characterising sources of inequality is in terms of variables such as SES, age, sex or country of residence. Another way is in terms of membership of a particular social group.

Most of the actions targeting *variables* as a source of inequality have socio-economic status (SES) as their main concern. These actions treat entire populations as their object

of study, examining the whole ‘social gradient’ instead of only the most deprived groups. An example of this approach is **Health inequalities in the EU (Marmot report)**⁽³⁴⁾, which advocates ‘proportionate universalism’ rather than interventions addressing only the most seriously disadvantaged. Such actions may also consider categorical variables such as sex or country of origin, but again they do not confine attention to the most disadvantaged: the object of the study is the whole population. Inequalities which relate to categorical variables are described as ‘gaps’ rather than ‘gradients’.

The second way of targeting actions focuses on *vulnerable social groups* rather than variables. Within these actions, two further categories may be distinguished: the first focuses on migrants (including undocumented migrants and asylum seekers) and/or ethnic minorities (including migrants and their descendents, or indigenous minority groups, like Roma and Sinti communities). The second category targets marginalised or socially excluded groups at risk of serious health problems, such as those living in poverty, drug users, prisoners, sex workers, people living with mental illness and people living with HIV/AIDS.

It should be noted that ‘age’ may be addressed in both of the above ways — either as a continuous variable, or in terms of membership of a group such as newborns, children, adolescents or the elderly.

B. Health issues addressed: the actions were categorised in terms of the health problems on which they focused. The following categories were distinguished:

- **Reproductive health** (the health of mothers and their offspring in pregnancy, childbirth and the immediate post-natal period);
- **Behavioural risk factors** (unhealthy lifestyles, being overweight or obese, lack of exercise, risk-taking behaviour and smoking);
- **Addiction** (alcohol addiction and abuse of illicit substances);
- **Non-communicable diseases** (e.g. CVD, diabetes, cancer and mental illnesses);

(34) Health inequalities in the EU (Marmot report): http://ec.europa.eu/health/social_determinants/docs/healthinequalitiesineu_2013_en.pdf

- *Infectious diseases* (HIV/AIDS, viral hepatitis, tuberculosis, sexually transmitted diseases and vaccine preventable diseases);
- *Life expectancy* ⁽³⁵⁾ and *healthy life years* ⁽³⁶⁾ (as recorded in national datasets);
- *Health status* and/or *perceived health*.

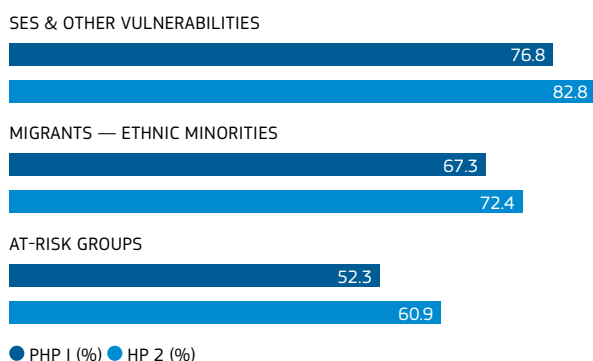
C. Types of intervention undertaken or recommended: these were classified into four main categories, again based on the sorts of interventions and methods found in the actions.

- Collecting and analysing data;
- Improving the accessibility and quality of health care through the development of ‘best practices’, including capacity building through training;
- Prevention and health promotion activities carried out by health services, including vaccination, screening, health education and harm reduction;
- Fostering intersectoral approaches to combating health inequalities by implementing the Health in All Policies approach (HiAP) ⁽³⁷⁾.

Graphs 10–12 show the percentage of actions in the First and Second Health Programmes in which attention paid to the above topics and categories is found.

TYPES OF INEQUALITY

Graph 10
Proportion of health inequalities actions (2003–13) by type of inequalities targeted

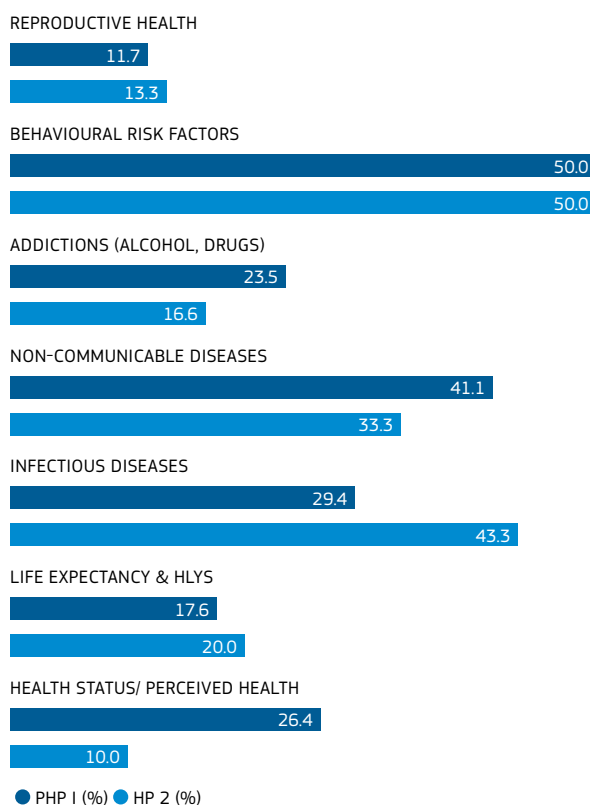


(35) Life expectancy: the average period that a person may expect to live.
 (36) Healthy life years: EU structural indicator Healthy Life Years (HLY) is disability-free life expectancy. It is based on limitations in daily activities and therefore measures the number of remaining years that a person of a particular age can expect to live without disability.
 (37) Health in All Policies (HiAP) is a policy strategy which targets the key social determinants of health through integrated policy responses across all relevant policy areas.

The fact that, in both programmes, the percentages add up to more than 100, indicates that many actions target more than one type of inequality. For example, an action targeting a vulnerable group may also consider the variable SES. In the Second Health Programme it appears from the graph that the three kinds of target overlap slightly more with each other, i.e. that targets are less differentiated. In cases of overlap it was sometimes difficult to distinguish between ‘primary’ and ‘secondary’ targets, so the degree of attention paid to each target was not assessed. For this reason it is hard to draw conclusions about the total amount of support in the Health Programme 2003–13 given to the three categories distinguished above.

HEALTH ISSUES

Graph 11
Health inequalities actions (2003–13) by health issues targeted



In the Second Health Programme, a higher percentage of actions was coded as focusing on behaviour risk factors and prevention of infectious diseases, while fewer actions dealt with non-communicable diseases and health status / perceived health.

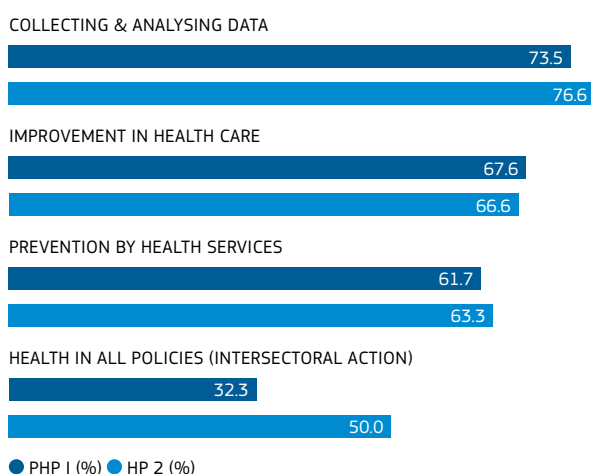
TYPES OF INTERVENTION

For the analysis of the type of interventions, the 64 actions were grouped into four main categories based on the type of activities implemented:

- Collection and analysis of data;
- Improvement of health care;
- Health promotion and prevention within the health care system;
- Health in All Policies approach by working across different sectors, for example actions carried out in schools, prisons, detention centres, etc.

Graph 12

Health inequalities actions (2003–13) by types of interventions



Three quarters of all actions deal with data collection and analysis, while a high proportion focus on improvements to health care and preventive activities carried out by health services. Preventive interventions outside the health sector itself, represented by the ‘Health in All Policies’ approach, are less commonly undertaken or recommended, but increased attention can be seen in the Second Health Programme.

RELATIONSHIPS BETWEEN FEATURES OF THE ACTIONS

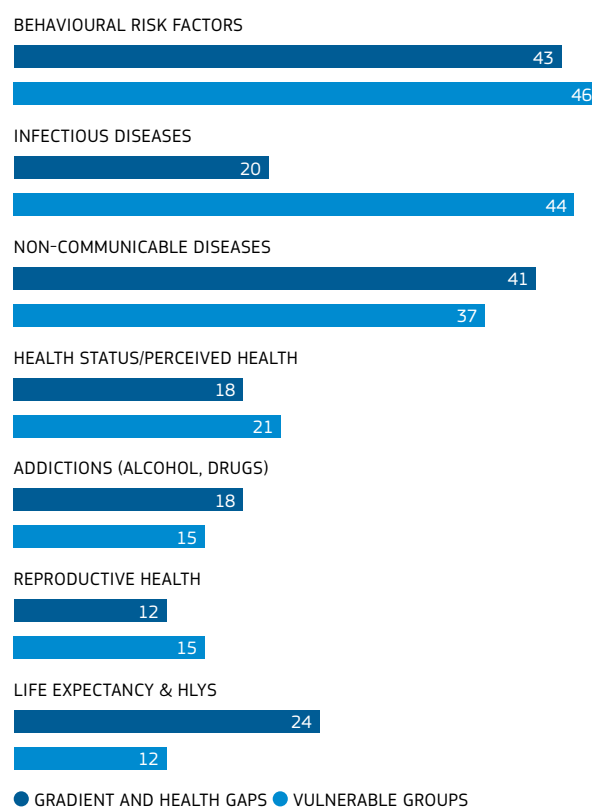
Further analyses were carried out on the features of the actions in order to discover the ways in which they were interrelated. The type of inequality targeted by an action determines to a considerable extent the health issues studied and the interventions undertaken or recommended. Clearly identifiable clusters can be found among the 64 actions, yielding interesting insights into the aims and assumptions informing work in this field. The findings of the mapping can be considered as an indication of existing gaps that it may be useful to address for future actions at national and European level.

To start with, the relationships between types of inequality, health issues and interventions were examined in turn. Many of the differences shown here are not very marked: this is because the characteristics of actions were coded simply in terms of their presence or absence, with no distinctions made as to the degree. An action focused entirely on migrants, for example, received the same weight as one paying incidental attention to this group. In spite of this, certain patterns can be discerned.

TARGETED INEQUALITIES AND HEALTH ISSUES

Graph 13

Health inequalities actions (2003–13), type of inequality targeted by health issues addressed



Here it can be seen that actions addressing health gradients and gaps are more likely to focus on behaviour risk factors, non-communicable diseases, life expectancy⁽³⁸⁾ and healthy life years⁽³⁹⁾. These are health issues for which population statistics are available in many countries. Conversely, actions focusing on vulnerable groups more often address health issues on reproductive health, infectious diseases, and health status/perceived health: such health problems are often closely associated with the risk behaviour of the vulnerable groups in question (e.g. blood-borne diseases and intravenous drug use).

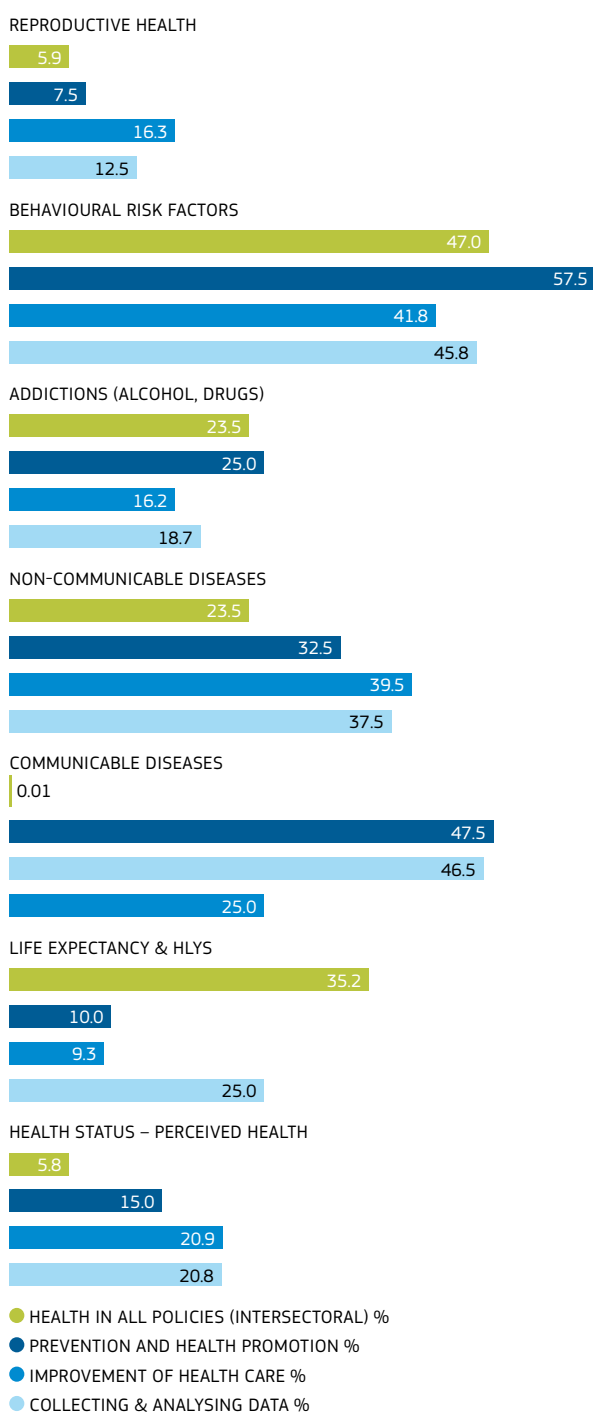
(38) Life expectancy: the average period that a person may expect to live.

(39) Healthy Life Years: EU structural indicator Healthy Life Years (HLY) is a disability-free life expectancy. It is based on limitations in daily activities and therefore measures the number of remaining years that a person of a particular age can expect to live without disability.

TARGETED INEQUALITIES AND INTERVENTIONS

Graph 14

Health inequalities actions (2003–13) by type of interventions versus type of health inequalities targeted

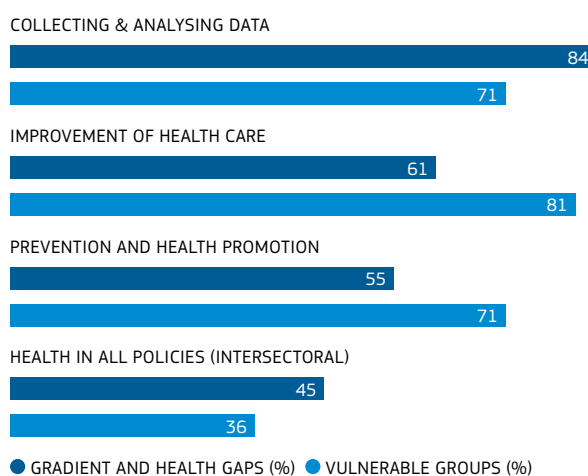


In general, it was found that actions focusing on vulnerable groups (migrants, ethnic minorities and ‘at-risk’ groups) are more likely to focus on improvements to health care (access and quality) and prevention or health promotion activities within the health sector. Conversely, those focusing on SES and other variables emphasise collecting and analysing data as well as intersectoral action.

HEALTH ISSUES AND INTERVENTIONS

Graph 15

Health inequalities actions (2003–13), health issues addressed by interventions undertaken or recommended



In graph 15, we see that different health issues are associated with different types of interventions.

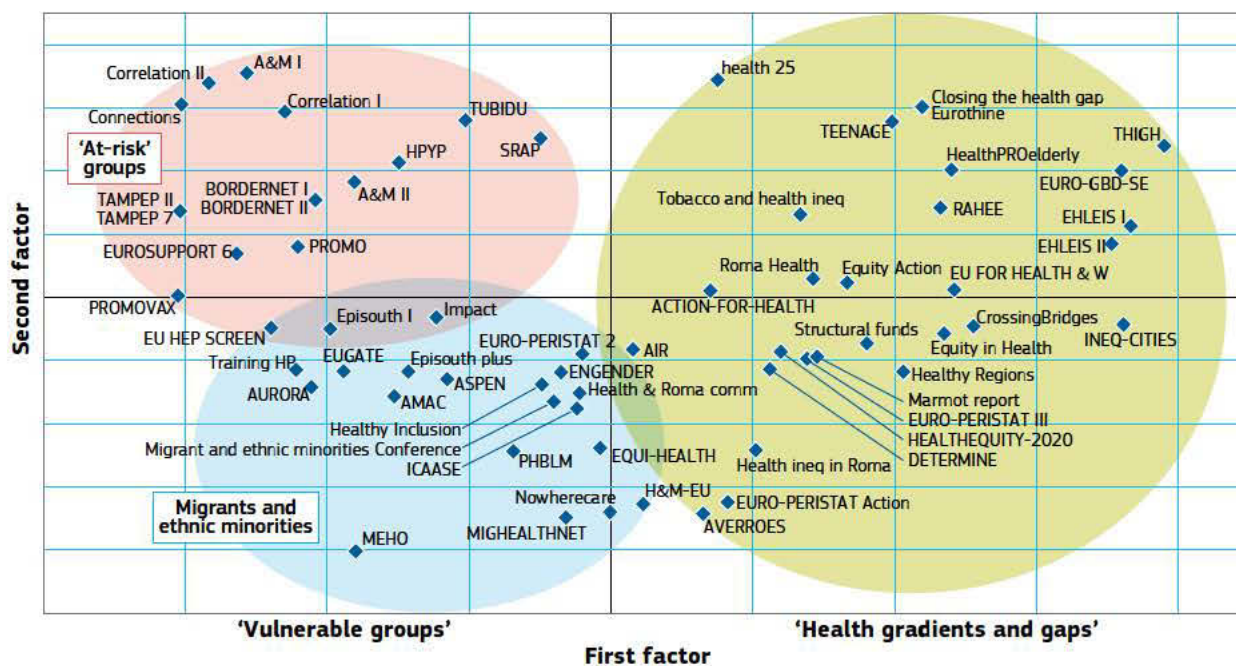
A focus on *reproductive health* is most often associated with interventions aimed at improving health care. *Behavioural risk factors* (which are the most commonly addressed health issue in all actions) are most often associated with prevention by health services and collecting / analysing data. The interventions seen as most relevant to *addictions* are intersectoral action and prevention by health services. By contrast, the response to *non-communicable diseases* most frequently concerns improvements to health care and the collection and analysis of data.

A striking finding is that actions focusing on *communicable diseases* were never coded as implementing or recommending intersectoral action; the most commonly associated interventions are prevention by health services and improvement of health care. *Life expectancy and HLYs* are strongly associated with intersectoral action and collecting / analysing data. Finally, *health status and perceived health* are associated with improving health care and with collecting and analysing data.

CLUSTERING OF THE ACTIONS

The fact that features of actions are interrelated suggests that it should be possible to identify clusters of actions in which the inequalities targeted, the health issues studied and the interventions adopted are similar. This was indeed the case, as graph 16 shows. A factor analysis was conducted to extract the two main factors responsible for variations in the actions. This made it possible to represent them in a two-dimensional space, in which the distance between two actions corresponds roughly to their similarity in terms of the characteristics discussed above.

Graph 16
Health inequalities actions (2003–13) presented in three clusters



In this graph, the horizontal dimension (corresponding to the first factor) distinguishes actions targeting ‘vulnerable groups’ (left) from those dealing with ‘health gradients and gaps’ (right). The vertical dimension distinguishes actions targeting ‘at-risk groups’ (upper left quadrant) from actions mostly addressing migrants and ethnic minorities (bottom left quadrant). However, the location of the actions on the graph is not simply a matter of the type of inequality targeted: it also depends on the health issues and types of intervention addressed.

The three clusters that have been circled represent different approaches to studying health equities. For convenience they can be labelled by the inequalities that most of them target, but they also embody different ways of working. This is brought about by the fact that two actions focusing on the health of Roma are ascribed to the cluster ‘health gradients and gaps’, because their approach is closer to the usual way of dealing with SES differences than it is to most of the actions targeting vulnerable groups.

The three main clusters thus correspond to recognisable lines of work on health inequalities. Broadly speaking, we can say that the two ‘vulnerable groups’ clusters represent a tradition that is close to the groups being targeted, working with and within the target community, and promotes best practices for providing immediate

access to health promotion and health services, rather than long-term structural solutions. In this group, actions addressing the health needs of migrants and/or ethnic minorities and marginalised or socially excluded groups at risk can be combined.

The ‘gradients and gaps’ cluster, on the other hand, is rooted in traditional epidemiology: it focuses on preventing health problems by intersectoral action rather than treating them. Actions in this cluster often involve extensive data collection and the construction of theoretical models, which are usually focused on informing decision makers responsible for (health) policy making.

When we consider the relation between the characteristics of actions and the challenges listed in the 2009 Communication Solidarity in Health, we note that actions in the ‘health gradients and gaps’ cluster tend to address challenge 1 (supporting the further development and collection of data on health inequalities and health status indicators by age, sex, SES and geographical differences). Challenge 3, on the other hand, is more often responded to by actions in the ‘vulnerable groups’ cluster. It concerns fostering the development of initiatives in collaboration with Member States to raise awareness and promote actions to improve the access to and appropriateness of health services, health promotion and preventive care for migrants and ethnic minorities and other vulnerable groups.

WHAT DOES THIS ANALYSIS OF THE FEATURES OF ACTIONS TELL US?

The foregoing analyses provide useful insights into the strengths of the actions on health inequalities, and point to ways in which their coverage can be improved.

Table 7
Differences of emphasis between the two main clusters

Type	'Vulnerable groups' cluster	'Health gradients and gaps' cluster
Inequalities targeted	Health problems of migrants, ethnic groups and 'at-risk' groups	Socio-economic differences and effects of sex, age and country of residence
Health problems addressed	Infectious diseases Addictions Non-communicable diseases (for ethnic groups)	Life expectancy Healthy life years Non-communicable diseases
Interventions undertaken or proposed	Improving health care (access, quality, training) Health promotion, harm reduction and prevention via health services	Collecting and analysing data Intersectoral action on social determinants of health

Analysing the characteristics of actions in this way can provide a starting point for discussion of the type of work needed to address health inequalities in Europe. To a certain extent, the patterns discovered are

understandable and even obvious: work on the SES gradient, for example, studies health problems for which comprehensive datasets are already available. However, one can ask whether this may lead to biases in our understanding of population health, which may need to be corrected by the collection of new data sources describing the health inequalities among vulnerable groups like migrants, ethnic minorities and at-risk groups. In addition, work in this cluster hardly ever pays attention to SES inequalities in the accessibility and quality of health services. There is evidence, however, that social class can adversely affect these variables and significantly impair health status.

Conversely, it is legitimate to ask why actions on 'vulnerable groups' pay relatively little attention to social determinants of health, intersectoral action, and collecting and analysing data. Fortunately there are exceptions, but there seems to be room for a more long-term, 'upstream' ⁽⁴⁰⁾ approach to the problems of these groups.

In the following section of the brochure, the individual health inequality actions are ordered according to the two main clusters defined above: 'vulnerable groups' and 'health gradients and gaps'. The 'vulnerable groups' cluster is further divided into actions dealing with migrants and ethnic minorities and those targeting 'at-risk' groups. Each cluster, as we have seen, is also characterised by typical health issues and types of intervention.

(40) Upstream factors — Factors affecting behaviour that are grounded in social structures and policies.



DETAILED OVERVIEW OF ACTIONS



Actions focusing on health gradients and gaps (HGG) (Cluster 1)

The main focus of these actions is on variables rather than vulnerable groups (though in the case of categorical variables such as sex or country, there is no distinction). Age differences can be treated either way: either as a continuous variable or in terms of groups (new-borns, children, adolescents and elderly people). These actions are presented in Cluster 1, representing the right side, green circle in graph 16.

All the actions in this cluster consider socio economic status (SES), or one of its indicators, as an important determinant of health. These actions tend to study whole populations rather than single vulnerable groups.

The sources of inequality targeted by these actions are mostly differences in SES and between countries and/

or regions. The main health issues which they focus on are life expectancy and healthy life years (HLYs): for such variables, data on whole populations are readily available. The type of intervention they deal with mostly concerns collecting and analysing data, in line with the priorities of the health information strand of the Health Programme.

Conversely, these actions are unlikely to be concerned with specific disadvantaged social groups, such as at-risk groups, migrants and ethnic minorities. They seldom focus on infectious diseases, improvement of health care access and quality, and prevention or health promotion by health services: their main concerns are more 'upstream', concerned with the social determinants of health and intersectoral action.

The prevention of socio-economic inequalities in health behaviour in adolescents in Europe:

TEENAGE

Keywords: inequalities, health behaviours, adolescents, equity, intervention

The idea was to develop evidence of the effectiveness of interventions for tackling physical inactivity, poor diet, smoking and excessive alcohol consumption among European adolescents in low socio-economic groups. The project also aimed to assess the transferability of these interventions throughout Europe and formulate policy recommendations to challenge socio-economic inequalities in health behaviour in European adolescents,

disseminating the results to EU, national and local policy makers, other European projects and practice networks.

A systematic search strategy was developed to identify existing interventions, and 12 studies with a predominance of school-based interventions were re-analysed. The results were translated into guidelines for further research and policy recommendations.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project provided a series of recommendations for European policies. It highlighted the need to reach further consensus on a small set of validated indicators of socio-economic position in adolescence. It stressed that every intervention aimed at the promotion of health behaviour in adolescence should include a measure of socio-economic position. The recommendations emphasised that a world-wide commitment to incorporating indicators of socio-economic position and to conducting subgroup analysis using these indicators could result in a wealth of information in a relatively short period of time. For the purpose of addressing inequalities in health behaviours, schools were considered an important setting. But current interventions could be improved, particularly with respect to involvement of parents and changes in the social and physical environment. A pragmatic approach needs to be combined with a strong body of research on the mechanisms relating socio-economic position to health behaviours in adolescence, and the specific factors involved in this.

Why was the public health problem addressed important for Europe?

Socio-economic inequalities in health-related behaviours are well described in literature, but evidence of effective interventions and policies to prevent the development of these inequalities was limited. Scarce evidence of approaches to reduce socio-economic inequalities in health was identified and even this mainly concentrated on addressing inequalities in adults. Project TEENAGE adopted a pragmatic approach by synthesising evidence from intervention studies in the general adolescent population, following stratified re-analyses using indicators of socio-economic position.

Objectives

The TEENAGE project aimed to generate and disseminate evidence on effective approaches for tackling socio-economic inequalities in health behaviours among adolescents. The evidence had to be relevant at a European level as well as at national and local levels.

Specific objectives:

- To develop evidence on the effectiveness of interventions to prevent physical inactivity, poor diet, smoking and alcohol consumption in adolescence in lower socio-economic groups across Europe.

- To assess the transferability of effective interventions in lower socio-economic groups from 'source' countries to other countries throughout Europe.
- To develop policy recommendations to tackle socio-economic inequalities in adolescents in lower socio-economic groups in Europe.
- To disseminate the results and to develop a European clearing house on preventing the development of inequalities in health among adolescents in Europe.

Methods

Through a systematic literature search, existing interventions aimed at promoting physical activity and a healthy diet, and preventing the uptake of smoking or alcohol were identified and re-evaluated as applicable to the general adolescent population in Europe. Studies in which indicators of socio-economic position were included were re-analysed and stratified according to socio-economic position. The results of this stratified analysis were summarised by behaviour, according to the type of intervention (health education, environmental interventions and policies) and by setting (individual, household, school and neighbourhood). Finally, the degree to which effective interventions could be transferred to other European countries was assessed.

A number of outputs were delivered in relation to each of the four specific objectives.

- A database with an overview of available interventions to prevent socio-economic inequalities in unhealthy behaviours of adolescents was created, including one report on the inclusion of an equity approach, four reports on behaviour-specific effectiveness of interventions to prevent socio-economic inequalities in unhealthy behaviours and four scientific papers.
- A report describing the tool for assessing the applicability and transferability of interventions on health-related behaviour was drawn up and a number of workshops on the applicability and transferability of interventions in lower socio-economic groups from one country to another were held.
- A report with policy recommendations based on the project findings as well as on the outcomes of the final conference was provided.
- A project website was created containing relevant outcomes of the project.

Achievements

The main aims of the project were achieved, including the selection of intervention studies through a systematic search strategy, the inclusion of the selected studies in the TEENAGE intervention database, the development of evidence-based recommendations to tailor prevention interventions to lower socio-economic sub-groups, the publication of a scientific article and the finalising of policy recommendations.

What effect have the results had on the policies and programmes of Member States and the EU?

TEENAGE can potentially impact on national or regional policies since countries may in the future require sub-group analyses of the kind used in this project to attempt to improve health in lower socio-economic groups. Using the results of the project would support further development of public health programmes and policies in the participating countries. Furthermore, a publication using the TEENAGE method was circulated among funding agencies following the conclusion of the project.

What were the benefits of working jointly at EU level?

TEENAGE brought together a carefully selected team of international researchers. The consortium consisted of five European research groups, including leading European researchers with strong complementary knowledge and skills required for carrying out TEENAGE; to share state-of-the-art best practice.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

A main priority area identified by the project is that, although inequalities in health-related behaviours are well described, evidence of effective interventions and policies to address these inequalities is currently limited.

Project website

- www.teenageproject.eu
- CHAFEA database:
www.ec.europa.eu/eahc/projects/database.html?prjno=2006323

Budget

- Total budget: €998 749
- EC contribution: €599 247

Duration

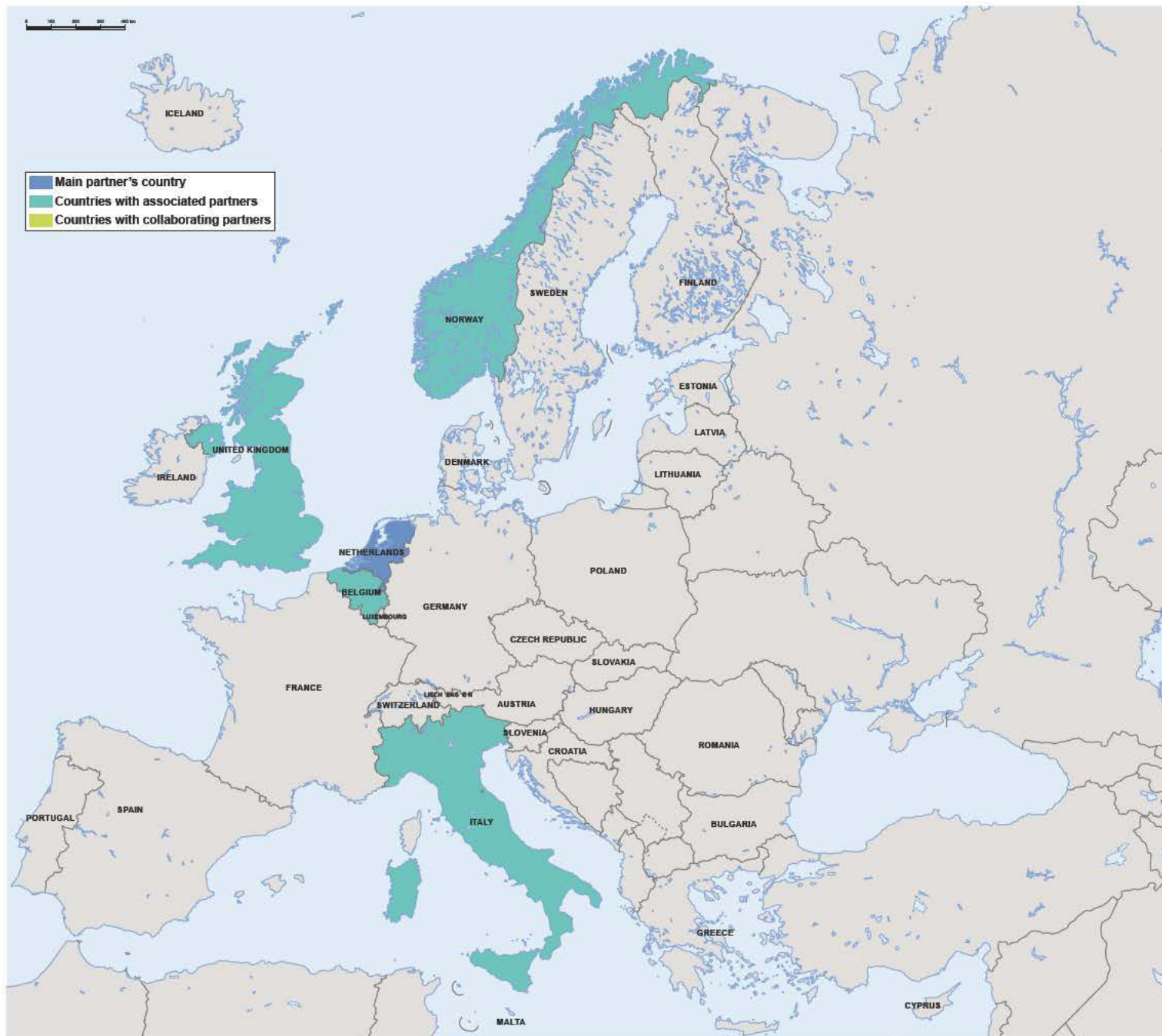
- 01.08.2007 – 01.04.2010
(32 months)

Main beneficiary

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Main partner:

Erasmus MC, University Medical Center Rotterdam,
Office AE/112, 3000 Rotterdam, the Netherlands

Associated partners:

- Ghent University, Belgium
- Università degli Studi del Piemonte Orientale, Italy
- University of Oslo, Norway
- Cardiff University, UK

Collaborating partners:

- NONE

Promoting gender equity in health:

ENGENDER

Keywords: public health, sex differences, gender, health policy, database

The ultimate objective of ENGENDER was to promote the development of more equitable health policies for women and men. Currently, there is a lack of information and expertise on improving gender equity, and little specific guidance for policy makers. The project aimed to remedy these shortcomings by: creating a sustainable European network on policies and

interventions tackling gender-based inequalities in health, to act as a forum for exchanging information and good practice; developing an online inventory of good practice in the EU; and promoting action and research on gender inequities in health, through six policy briefings and recommendations based on the inventory of good practice.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project addressed the gender-related inequities that exist in health outcomes and health service delivery. Gender discrimination in health systems may take the form of either identical responses to different needs, or different responses to identical needs. The project addressed priorities such as awareness-raising, promoting and assisting the exchange of information and knowledge between Member States, identifying and spreading good practice, and facilitating the design of tailor-made policies for the specific issues affecting men and women. It also supported the further development and collection of data and health inequalities indicators by sex and gender.

Why was the public health problem addressed important for Europe?

Sex and gender are important determinants of health, as well as being factors that must be taken into account during health care delivery. Despite legislation, gender-linked inequities affect many aspects of life in the EU. These inequities, which go hand in hand with sexual stereotyping, prevent both men and women from realising their full potential to live healthy lives. Sex and gender are therefore essential factors in health policy.

Objectives

The project aimed to improve awareness of effective, efficient policies and programmes to achieve gender equity in health, through three main routes: by setting up a European network, by making available an online database of good practice, and by writing and disseminating a set of six policy briefs. The project's target audiences included policy makers, politicians, researchers, NGOs and citizens, both within and outside the health sector.

Methods

Assisted by its European network of experts, ENGENDER examined the policy areas identified by the WHO Women and Gender Equity Knowledge Network, in order to identify 'good' and 'promising' practices in the European region. The partnership also considered the activities of other international agencies (including the UN, OECD and World Bank) in this area.

The project analysed examples of policies and programmes from all relevant policy sectors that promote equal opportunities for both women and men to live healthy lives. This involved a broad range of measures, such as legislation against sexual harassment at work, equal pay, prevention of work-related injuries, sanctions against violence against women, increasing women's participation in decision-making, health promotion programmes reflecting the realities of women's and men's lives, and measures to ensure equal availability of prevention or rehabilitation programmes and to improve access to health care.

Achievements

The project set up a network of some 50 experts in 20 countries to collect data on good practice. It also produced six policy briefs on key gender-related topics, for policy makers and other stakeholders trying to identify good practice and support information to promote positive gender policies for all citizens. The policy briefs dealt with structural gender inequality, gender stereotypes, gendered exposures and vulnerabilities, gendered politics, gender imbalances in health research and gender mainstreaming. The briefs were presented at a European Parliament event and have been made available online.

The project also set up an online database of good practice for gender equity in health, which currently hosts over 560 data files.

What effect have the results had on the policies and programmes of Member States and the EU?

The project has increased awareness of multiple issues connected with gender equity in health, and ways in which they can be tackled. The EU Parliament event was attended by decision-makers, health professionals, researchers and representatives of civil society. Decision-makers who attended committed themselves to advocate for the database in their political assignments. By demonstrating that gender equity is a question not only of human rights but also of public health, the project has helped to place this topic on the agenda of EU Member States.

What were the benefits of working jointly at EU level?

The project had partners in nine EU Member States and contributors in 20. This collaboration supported the implementation of EU legislation, especially concerning gender equity, promotion of best practice in all sectors, not only in health, and networking to create synergies and share knowledge and expertise between those working on these issues in different Member States.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

Interactions between gender and social determinants of health in Europe frequently lie outside the health policy sector, for example in social and family affairs, education, communication, human rights, labour market and employment, finance, environment, law and internal affairs. Therefore a firm commitment is needed for a multisectoral approach from all policy areas.

Women and men have different needs, and certain health conditions are sex-specific, calling for targeted health promotion and disease prevention messages. Moreover, health conditions that affect women and men differently must be considered differently in order to achieve diagnosis and treatment without bias or discrimination. As a result, tailor-made interventions that address specific needs of men and women in health and health care should be developed.

In addition, a better understanding is needed of the interaction between health, gender and other social determinants, such as education, living and working conditions, equal opportunity and lifestyle issues. More research is needed on sex differences in health, and how men and women experience health and health care. More attention should be given to differences within groups of men and women, such as single parents in low-status occupations, ethnic minorities, unemployed people in rural areas, and women and men whose needs are not at present met by health care services.

Project website

- www.engender.eurohealth.ie/

Budget

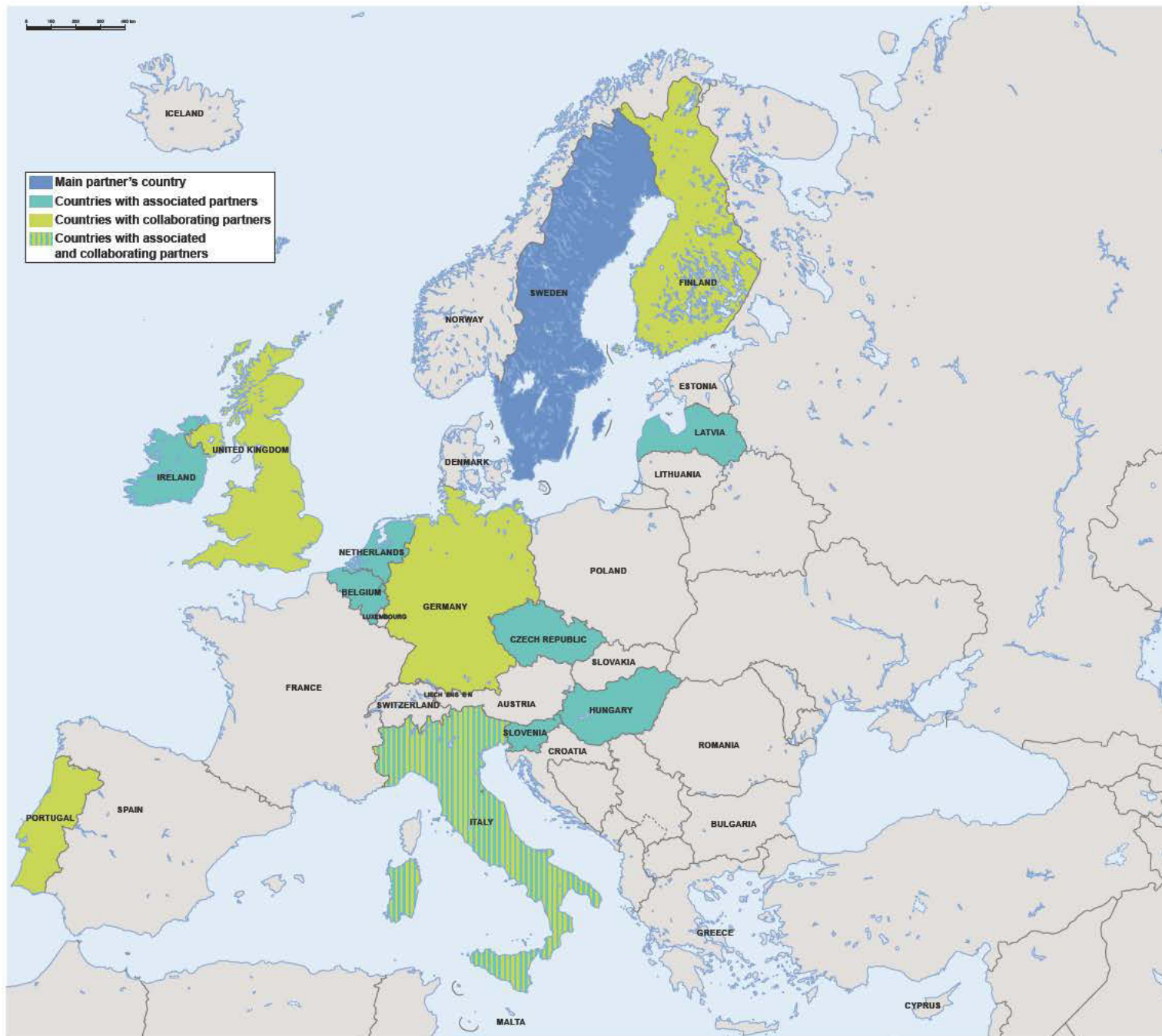
- Total budget: €718 000
- EC contribution: €344 047

Duration

- 01.11.2009 – 31.10.2011

Main beneficiary

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Main partner

Karolinska institutet, Stockholm
Sweden

Associated partners:

- European Men's Health Forum (EMHF), Belgium
- Státní zdravotní ústav (SZU), Czech Republic
- National Institute for Health Development (NIHD), Hungary
- European Institute of Women's Health (EIWH), Ireland
- Regione Del Veneto (REGVEN), Italy
- State Public Health Agency (SVA) (until 01/11/2009), Latvia
- Vasselbas Economic Centre (VEC) (from 01/11/2009), Latvia
- Maastricht University (UNIMAAS), Netherlands
- Inštitut za varovanje zdravja Republike Slovenije (Institute of Public Health), Slovenia
- Statens Folkhälsoinstitut (National Institute of Public Health), Sweden

Collaborating partners:

- EuroHealthNet
- EPHA
- WHO Europe
- Ministry of Health Portugal
- University of Tampere, Finland
- University of Brighton, UK
- Movimento Consumatori Italy
- Regione Toscana, Italy
- Medizinischen Fakultät der LMU München, Germany
- Landesvereinigung für Gesundheit und Akademie für Sozialmedizin Niedersachsen e.V., Saxony, Germany
- Medicine, Nursing and Health Sciences, Monash University, Australia

*The potential for reduction
of health inequalities in Europe:*

EURO-GBD-SE

Keywords: inequalities, socio-economic factors, health systems, modelling, risk factors

This project analysed the socio-economic health inequalities found in Europe, and used mathematical models to assess the potential for reducing inequalities in health outcomes and risk factors. Despite limitations in the available data, three important lessons emerged:

- The patterns of health inequalities observed in the 1990s persist and remain a major challenge.
- The quantitative contributions of specific risk factors to inequalities differ between European countries; different countries will therefore require different strategies to tackle health inequalities.
- Substantial gains in health could be achieved by reducing inequalities in risk factors.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project is directly relevant to the call for improved data collection. It also yielded valuable information about the way interventions and policies should be targeted in order to reduce health inequalities in Europe. Methodologies were pioneered that considerably advance evidence-based approaches to policy making. Moving beyond a 'one-size-fits-all' approach, the project showed that the different processes at work in different countries call for tailor-made policy responses.

Why was the public health problem(s) addressed important for Europe?

The project applied the concept of population attributable fraction (PAF) to health inequalities in Europe. This approach provides a way of estimating the extent to which health inequalities can in theory be reduced by interventions aimed at specific risk factors. New policies require considerable investment and this approach can help to ensure that resources are concentrated on strategies most likely to make a difference.

Objectives

The project had three objectives:

1. To provide updated estimates of the magnitude of socio-economic inequalities in health in Europe.
2. To estimate the contribution of risk factors to these health inequalities.
3. To estimate the extent to which health inequalities in Europe could in theory be reduced by policies and interventions aimed at socio-economic determinants and risk factors.

Methods

1. The project collected, harmonised and analysed data on socio-economic inequalities in mortality, self-reported morbidity and risk factors for 2000–2005 in all countries where comparable data were available. New data were collected for the Western Balkans.
2. The contribution of risk factors to health outcomes was calculated or estimated for each country. From 85 initial risk factors, nine factors satisfied all the project's requirements. Six were 'proximal' factors (smoking, physical inactivity, overweight, fruit and vegetable consumption, diabetes mellitus, and social participation) and three were 'distal' risk factors (income, economic activity and occupational class).
3. To assess the potential for reduction of health inequalities, the theoretical effect of changing the distributions of these proximal and distal factors was calculated.

Results were disseminated by means of international presentations, publications and press reports, and through the project website. Data-sets are also available to other researchers.

Achievements

The project delivered the following:

1. Updated estimates of the magnitude of socio-economic inequalities in health in Europe.
2. Estimates of the contribution of risk factors to these health inequalities. These contributions varied significantly between countries.
3. Estimates of the extent to which health inequalities in Europe could theoretically be addressed by policies and interventions. For example, among the proximal risk factors, smoking reduction had the greatest potential for decreasing inequalities in men; reduction of overweight and obesity had most potential among women.

Limitations were noted in the concrete policy recommendations that could be made. Even with the reduced set of nine risk factors, gaps in the data remained. In order to use the PAF method, many assumptions have to be made that cannot at present be supported empirically. However, the project represents an important methodological advance.

What effect have the results had on the policies and programmes of Member States and the EU?

It is too soon to expect specific impact on policies and programmes. Furthermore, many of the project's conclusions are provisional and hypothetical. In order to make robust policy recommendations, more complete epidemiological data would be necessary, in addition to better evidence about the effectiveness of different interventions. Moreover, since the PAF method depends on the assumption that the relationship between risk factors and health outcomes is a causal one (i.e. not subject to confounding by other factors), more detailed knowledge is required of how social determinants of health operate.

Despite these limitations, the project represents an important step forward in the methodology of health equity research. The dissemination of results among researchers is likely to have considerable implications for research and future policy development in Europe and more widely.

What were the benefits of working jointly at EU level?

The project required considerable resources in terms of expertise, data and financing, which could only be achieved by European collaboration. In addition, Europe provides an ideal location in which to analyse

health inequalities and their determinants — not only because data on inequalities in mortality, morbidity and risk factors are widely available, but also because European countries differ in their political, social, economic and epidemiological histories. By contrasting and comparing processes in different countries, European research can produce policy recommendations that are tailored to individual countries' circumstances.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

This project provided further evidence of the need to improve data collection regarding health inequalities and risk factors in Europe. As long as important gaps exist in relation to particular health outcomes, countries or risk factors, it will not be possible to compare the potential of different types of intervention.

Secondly, the project showed that a 'one-size-fits-all' approach to health equity policy is unlikely to succeed. Policies and interventions must be tailored to the different conditions found in each country and to the different processes that may underlie health inequities. There is great potential for reducing inequalities in mortality, but the most relevant entry points for policy differ between countries.

The project showed that in many countries, the effect of educational inequalities on mortality could be reduced by interventions aimed at smoking, physical activity, diabetes mellitus and activity status. In addition, health inequalities could probably be reduced substantially if countries exchanged experiences more systematically.

Project website

- www.euro-gbd-se.eu/

Budget

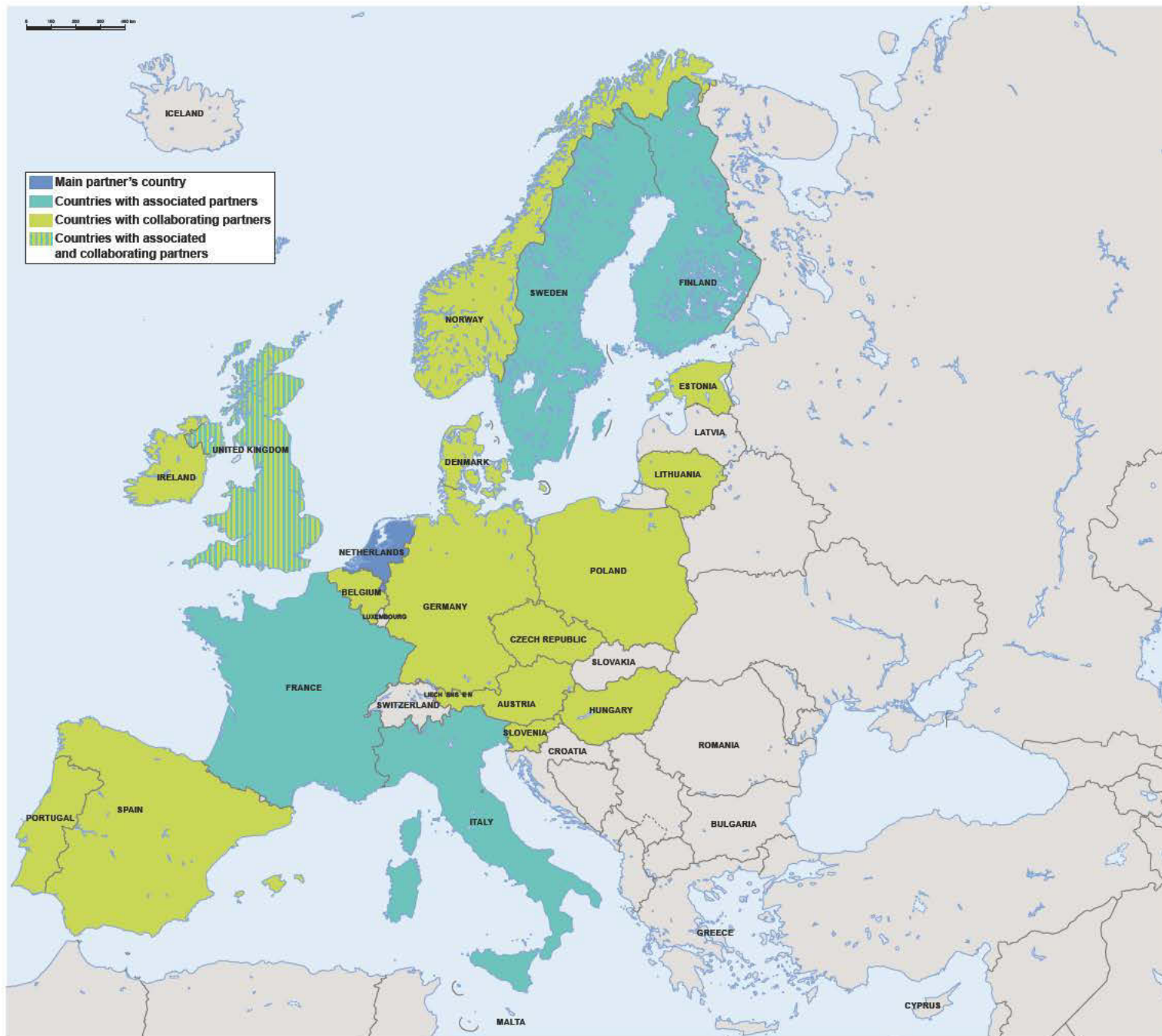
- Total budget: €1 249 917
- EC contribution: €749 950

Duration

- 01.07.2009 – 31.05.2012

Main beneficiary

- Erasmus Universitair Medisch Centrum, Rotterdam, The Netherlands.
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Main beneficiary:

Erasmus Universitair Medisch Centrum
S'Gravendijkwal 230 3015 CE Rotterdam
Netherlands

Associated partners:

- Azienda Sanitaria Locale TO 3, Italy
- Helsingin Yliopisto, University of Helsinki, Finland
- Institut national de la santé et de la recherche médicale, France
- Stockholm University, Sweden
- University of Bath, United Kingdom

Collaborating partners:

- Institut für Sozialmedizin und Epidemiologie Graz-AusTria
- Interface Demography, Centrum voor Sociology - Belgium
- Department of Demography and Geography, Charles University Praha – Czech republic

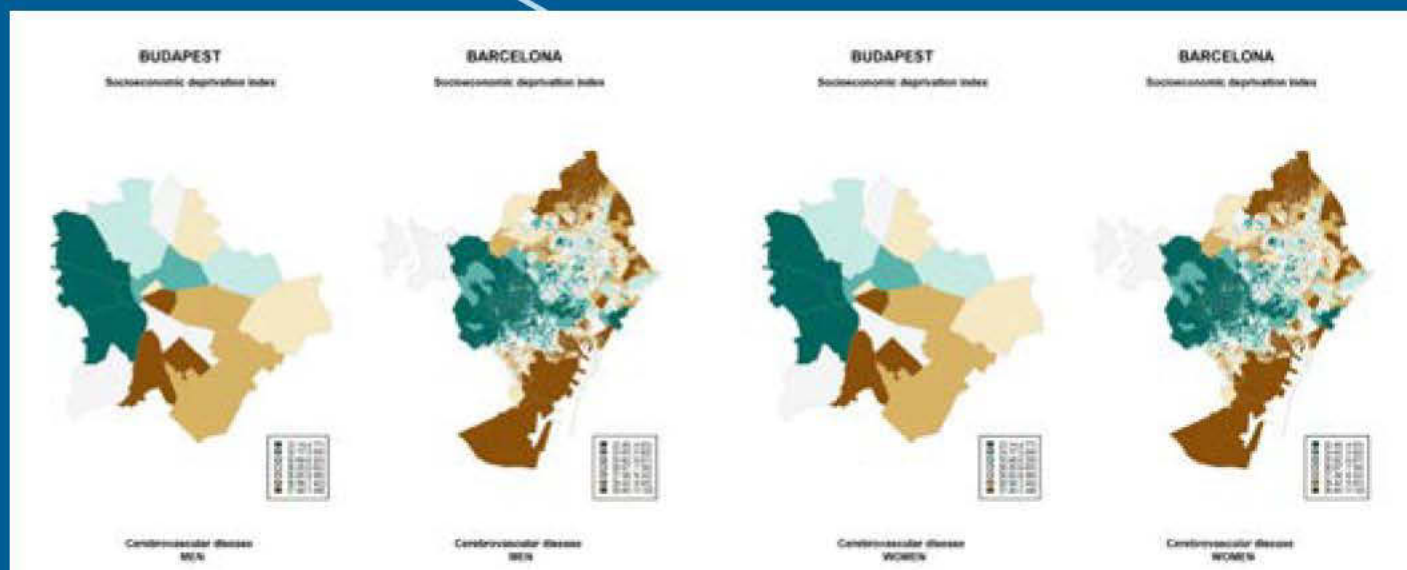
- Statistics Denmark Copenhagen- Denmark
- Institute for Health Development Tartu - Estonia
- GSF/Medis - Neuherberg-ober-Schleissheim - Germany
- Demographic Research Institute - HCSO Budapest - Hungary
- The Economic and Social Research Institute Dublin - Ireland
- Kaunas University of Medicine Kaunas - Lithuania
- Oslo University College Oslo - Norway
- National Institute of Hygiene Warsaw - Poland
- Universidade de Coimbra Coimbra - Portugal
- Department for Public Health Ljubljana - Slovenia
- Universidad Complutense de Madrid Madrid - Spain
- Health and Care Division, Office for National Statistics London - UK

Socio-economic Inequalities in Mortality: Evidence and Policies in Cities of Europe: **INEQ-CITIES**

Keywords: mortality, socio-economic factors, policy, cities, urban population

The INEQ-CITIES project aimed to: identify socio-economic inequalities in mortality in census tracts of 16 European cities; compare social and health policies undertaken in these cities including policies using EU Structural Funds to address inequalities; and make recommendations for monitoring and tackling health inequalities at city and neighbourhood level.

The project produced reports and resources providing evidence of health inequalities to inform action towards health equity at city level. INEQ-CITIES developed web-based resources with city maps that show social and geographical patterns of mortality causes, case studies of policies and interventions to reduce inequalities at city level, plus scientific articles.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project directly contributed to both the COM(2009) 567 Solidarity in Health and the Europe 2020 initiative. Most Europeans live in urban areas, but there are few studies analysing socio-economic inequalities in health across and within cities. The INEQ-CITIES project identified and analysed the main causes of mortality alongside social and health policies for future improvements.

Why was the public health problem(s) addressed important for Europe?

Disadvantaged groups have poor health and exhibit higher rates of morbidity and mortality than affluent groups. Given most Europeans live in cities, the processes occurring in urban areas are key to understanding economic, social, political and health transformations. In the last two decades studies have begun treating geographical areas as health determinant, but intra-urban inequalities in mortality have not been frequently analysed. Interventions to tackle health inequalities are rare. As the first regional study on health inequality across and within the cities of Europe, INEQ-CITIES wanted to understand more about how social inequalities in health exist amid different social and political contexts.

Objectives

- To collect socio-economic and mortality data (over five to ten years centred around 2005) to construct socio-economic and mortality indicators of the smaller areas of the 16 cities.
- To estimate inequalities in socio-economic and mortality indicators in these areas.
- To analyse the relationships between mortality and socio-economic indicators at area level.
- To estimate inequalities in avoidable mortality indicators across the smaller areas and to analyse the relationships between avoidable mortality and socio-economic indicators.

- To describe mortality inequalities across smaller areas, taking into account sex and age.
- To collect and analyse information related to interventions to tackle health inequalities.
- To collect and analyse information on social and health interventions to tackle inequalities in health that use Structural Funds.
- To make recommendations for monitoring and tackling health inequalities at city and smaller area level.

Methods

The project involved studying cross-sectional ecological mortality data from 16 cities in 13 EU countries. This required collaboration between public health and research bodies. Socio-economic and mortality data were collected to construct indicators for smaller areas of cities. Then the relationship between both mortality and avoidable mortality indicators and socio-economic indicators were analysed. The main causes of death and avoidable mortality for men and women were studied, looking at the expected number of deaths in each small area using age-specific European mortality rates.

Social and health policies aimed at reducing health inequalities at city level were also examined using a review of published literature, city authority reports, and questionnaires and interviews with policy makers. These interventions were analysed to compare the commitment of local authorities to reducing

health inequalities, and to make recommendations on further policies.

Important results were made available for policy decision makers, researchers, practitioners, and the general public. The project developed protocols for collecting data on mortality health inequalities and on policies and interventions at city level. There was also a protocol to construct indexes of deprivation, including instructions to run geographical analysis. Several stakeholders connected to city departments were involved through workshops, presentations, papers and information on the project website.

A main achievement was the atlas, an online resource demonstrating socio-economic inequalities in health and mortality in the 16 cities. It contains city maps showing social and geographical patterns of the main causes of death. Also, avoidable mortality maps and deprivation index maps were put online. For each cause of death, indicator maps displayed inequalities in mortality within cities.

Another important result was the inventory of policies and interventions aimed at tackling inequalities in health supported by EU Structural Funds. Using this inventory, INEQ-CITIES produced a series of case studies to learn more about the programmes that aimed to reduce health inequalities in Europe at the city level.

Achievements

The project achieved its main objectives, including: the collection and analyses of the leading causes of death and the main causes of avoidable mortality; the estimation of socio-economic indicators and mortality indicators in each city; the analysis of the relationship of socio-economic indicators with mortality indicators; and the review and comparative analysis of social and health policies to reduce and tackle health inequalities at city level.

This project showed that programmes aiming to reduce mortality should pay attention to reducing risk factors not only at individual level, but also at area level. Studies of this type may allow identification of geographical patterns and of areas with high mortality risk and poor socio-economic indicators, which would help when developing interventions to tackle inequalities. The knowledge generated could identify and promote models of good practice; although, to be effective, interventions and programmes must be adapted city by city.

What effect have the results had on the policies and programmes of Member States and the EU?

This project fitted into the priority area 'to promote health, including the reduction of health inequalities' of the Community Public Health Programme 2008–13, focussing in particular on 'public capacity building', and 'baseline assessment of capacity for the development, implementation and monitoring of public health policies at national and sub-national level in Europe.' In line with these objectives, the project provided evidence of health inequalities, and ideas to tackle these problems. Perhaps the most important impact of the project was to show the importance of health inequalities at city level and the level of smaller areas inside the cities.

What were the benefits of working jointly at EU level?

To compare data at city level is not possible with the usual sources of information. It was very important that partners from different cities shared data and knowledge.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The priority was the importance of putting health inequalities in urban areas on the scientific and political agenda. The project fostered the collection of mortality and socio-economic data by sex and geographic location and provided recommendations for addressing health inequalities.

Project website

- www.ucl.ac.uk/ineqcities/

Budget

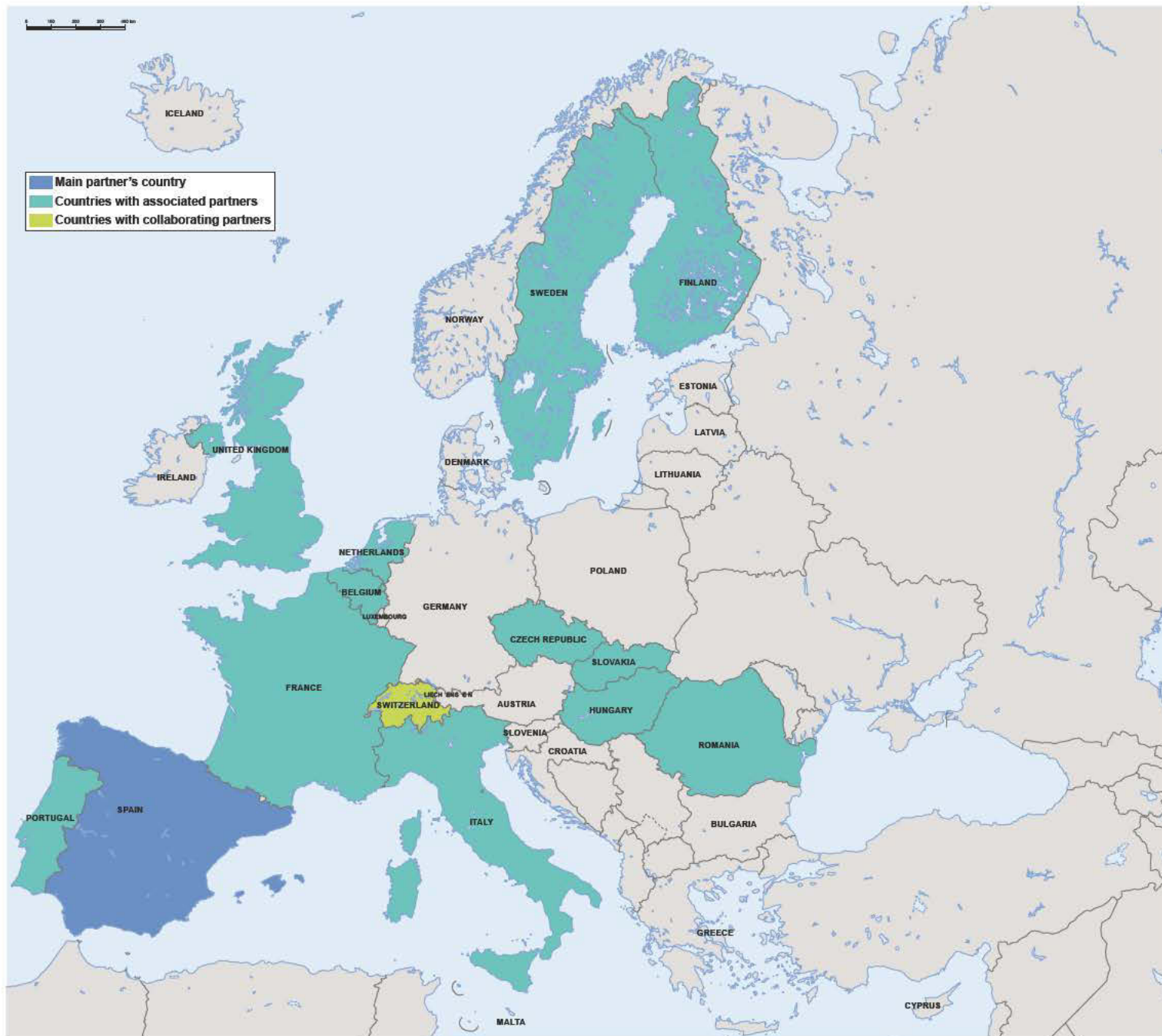
- Total budget: €915 930.44
- EC contribution: €549 558.27

Duration

- 01.09.2009 – 31.08.2012 (36 months)

Main beneficiary

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- Centrum för folkhälsa, Stockholmslänslandsting (CFF/SLL), Sweden
- Universitatea Babeș-Bolyai (UBB), Romania
- Univerzita Karlova v Praze (Charles University in Prague) (FSCUP), Czech Republic

Associated partners:

- Institut National de la Santé et de la Recherche Médicale (INSERM), France
- Interface Demography Vrije Universiteit Brussel (ID VUB), Belgium
- Népegésztudományi Kutatóintézet, Központi Statisztikai Hivatal (KSH NKI), Hungary
- Helsingin yliopisto (UH), Finland
- University College London (UCL), UK
- Universidad de Girona (UDG), Spain
- ASL TO3, Italy
- Instituto de Salud Pública de la Comunidad de Madrid (ISP), Spain
- Universidade de Coimbra, (FLUC), Portugal
- Univerzita P. J. Safarika (UPJS), Slovakia
- Erasmus MC (EMC), The Netherlands

Collaborating partners:

- Department of Health, Vasque Country, Spain;
- Johns Hopkins University, USA;
- Universitat Pompeu Fabra, Spain;
- Statistik Stadt Zürich, Switzerland;
- Universidad de Alicante, Spain

Addressing inequalities interventions in regions

Air Action

Keywords: health inequalities, primary care, health promotion, professional practice, ethnic groups

The AIR project aimed to help European, regional and local policy makers develop primary care health policy to reduce health inequalities. The project identified efficient and effective interventions addressing health inequalities in primary care, and reviewed strategies

and policies developed in European regions. A set of recommendations, based on the best practices identified, were developed for policy makers, health managers and health service professionals.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The AIR project contributed directly to the scope of action for the reduction of health inequalities in European regions. The project provided a range of illustrative practices, based on primary care, that contributed to the rebalancing of health inequalities. The project added to European databases on actions, strategies and policies piloted by European regions. Furthermore, the development of methods for the evaluation of health inequalities and the collected examples of good practice in primary care could be transferred to other areas. The project's recommendations and conclusions for health professionals and decision-makers could inform and improve regional health policies and actions.

Why was the public health problem addressed important for Europe?

Health inequalities in European regions persist among populations at different levels. Health inequalities can be defined as the presence of systematic disparities in health, often associated with unequal distribution of resources between more and less advantaged social groups. Despite health system reforms, increasing health expenditure and political willingness, health inequalities persist across Europe. Most regions indicated that health promotion and interventions targeted at disadvantaged groups were priorities. However, there appeared to be limited coordination and integration of strategies between national and regional levels. The AIR project focused on interventions to reduce inequalities in primary care settings in regions, on the basis that many prevention and health promotion actions could be implemented at a regional level through primary care providers.

Objectives

The main objective of the AIR project was to develop a set of tools to help European, regional and local policy makers implement policies to reduce health inequalities in primary care settings.

Specific objectives were:

- To identify best practices described in the literature;
- To carry out a survey in EU regions;
- To identify a comprehensive list of relevant actions;
- To assess the effectiveness of these actions;
- To develop a catalogue of good practices, with recommendations and guidelines;
- To disseminate the results of the project.

Methods

The project first identified primary care practices and strategies contributing to reduced health inequalities, through a systematic literature review. A Europe-wide survey was conducted to collect information on strategies, policies and interventions aimed at reducing health inequalities through primary care settings in European regions. The most promising interventions were selected and assessed. From these analyses, the project's final recommendations were developed.

As well as a website, newsletter, final technical reports, scientific publications and other dissemination tools, the AIR project developed the following outputs:

- A literature review of primary health care interventions that reduce health inequalities;
- A survey report on actions and policies which contributed to reducing health inequalities through primary care settings in EU regions;
- A report on selected interventions, recommendations and best practice guidelines.

Achievements

The project identified a range of approaches that could be used to reduce health inequalities at regional levels through primary care providers. Results were made available to organisations working on social determinants of health inequalities, including health professionals, CEOs, decision-makers, political representatives and project managers. The long-term objectives of the project could be achieved if the project's results and tools are used to enhance activities addressing health inequalities and to ensure better access to health care for all citizens. The project also provided valuable information on how inequalities can be assessed, as well as knowledge about effective interventions, facilitating factors and how barriers can be overcome.

What effect have the results had on the policies and programmes of Member States and the EU?

The final conclusions and recommendations of the AIR project called for policy measures beyond the scope of the health system, since most determinants of health and health inequalities have social and economic origins. The 'Health in All Policies' (HIAP) approach is therefore crucial, and national, regional, and local policies and programmes should take into account the economic and social needs of disadvantaged populations rather than just access to health care or health promotion.

Furthermore, the project's conclusions highlighted the fact that interventions to reduce health inequalities should always be based on a thorough needs assessment. This assessment should involve repre-

sentatives of the target population, to help adapt the content and means of intervention to specific cultural and social characteristics. All relevant actors, organisations, sectors and disciplines, including evaluation scientists, should be involved from the outset.

What were the benefits of working jointly at EU level?

The wider vision provided by examining European strategies enhanced the applicability of recommended policies and interventions for effective regional work.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

In the current difficult economic context, access to primary care services has become an even greater priority for minimising health inequalities. However, the project highlighted the fact that factors such as gatekeeping, free care, lower co-payment and geographical accessibility in primary care services must be driven by political will at national as well as regional levels.

Project website

- www.air.healthinequalities.eu

Budget

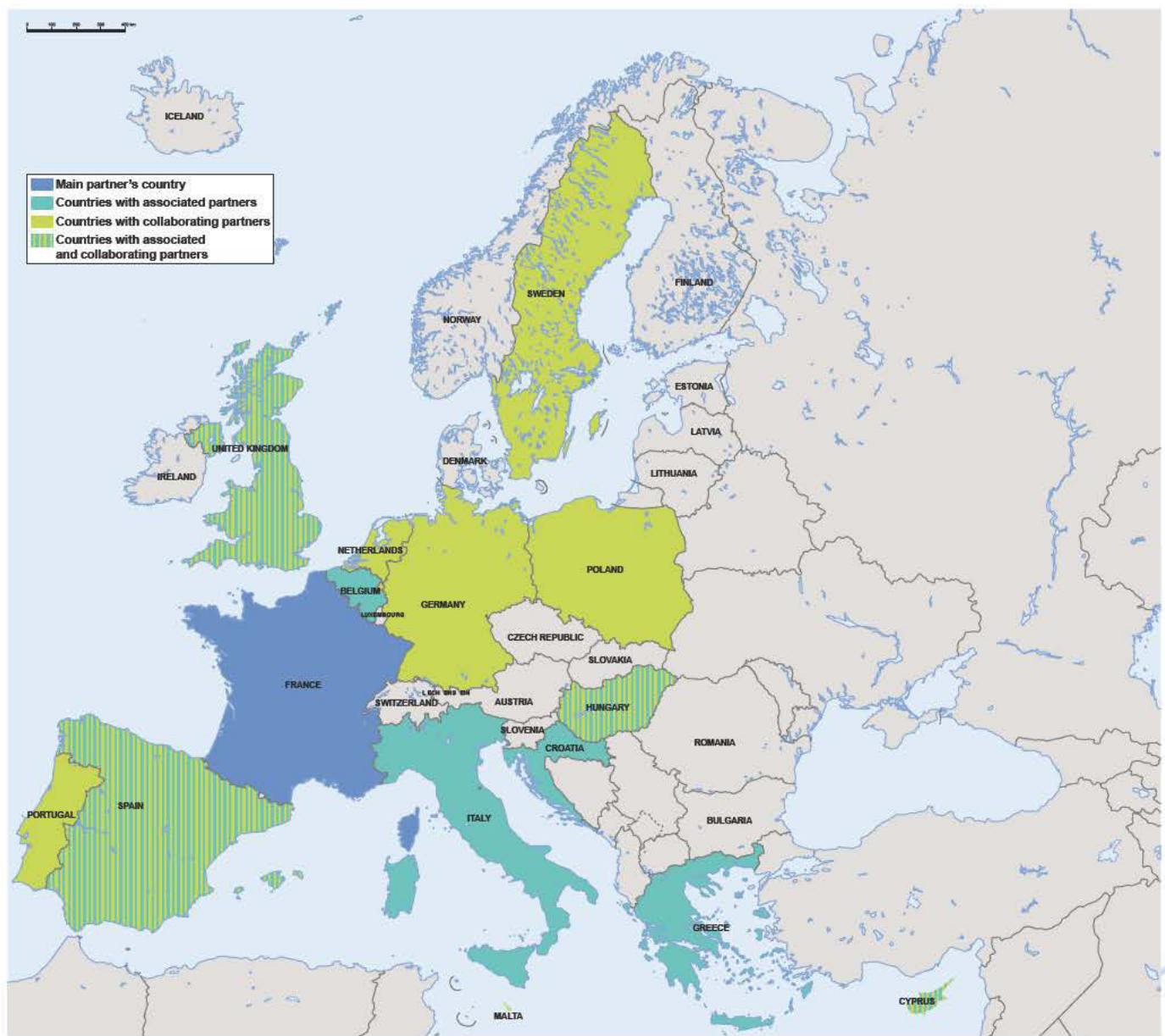
- Total budget: €884 746
- EC contribution: €474 391

Duration

- 02.11.2009 – 30.06.2012

Main beneficiary

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Main beneficiary:

Conseil régional of Aquitaine, Bordeaux, France

Associated partners:

- IRDES: Institut de recherche et de documentation en économie de la santé, France.
- MeS: Scuola Superiore Sant'Anna di Pisa, Italy.
- EASP: Escuela Andaluza de Salud Pública, Spain.
- HS: Hainaut Santé, Belgium.
- DEKUT: Dekut Debreceni Kutatasfejlesztési Debrecen, Hungary.
- UVS2: Université Bordeaux Segalen / ISPED: Institut de Santé Publique, d'Epidémiologie et de Développement, France.
- DPHEM: Department of Health Nottingham/NHS East Midlands, United Kingdom.
- UCY: University of Cyprus, Cyprus.
- ResearchLink: ResearchLink sprl, Belgium.
- DUNE: Dubrovnik Neretva County Regional Development Agency, Croatia.
- PEHRG: Poverty, Equity and Health Research Group -University of Perugia, Italy.
- URIT: Umbria Region Perugia, Italy.
- RT: Tuscany Region Florence, Italy.
- GEORAMA: Georama NGO, Greece.

Collaborating partners:

- County Council Gävleborg, Sweden.
- EUPHA: European Public Health Association, Netherlands.
- ARS Aquitaine: Agence Régionale de Santé d'Aquitaine, France.
- Lincolnshire Primary Care Trust, England.
- SAS: Servicio Andaluz de Salud, Spain.
- URPS: Union Régionale des Professionnels de Santé d'Aquitaine, France.
- Leicestershire County and Rutland PCT, England. Leicester County Council, England.
- Debrecen University, Hungary.
- MS-LSA: Ministry of Health and Social Affairs Saxony-Anhalt, Germany.
- UOMS: University of Applied Sciences Magdebourg-Stendal, Germany.
- CSJA: Consejería de Salud – Junta de Andalucía, Spain.
- RUBSI: Research center in behaviour and social issues, Cyprus.
- JPII: John Paul II Hospital in Krakow, Poland.
- MSP: Ministry for Social Policy – Health, Elderly, Community Care, Malta.
- ARS Algarve: Administração Regional de Saúde do Algarve – IP, Portugal.



Developing methodologies and building capacity to advance the implementation of HiAP and achieve health equity:

Crossing Bridges

Keywords: health in all policies, determinants, socio-economic factors, public health, inequalities

The Crossing Bridges project set out to improve understanding of approaches to implement 'Health in All Policies' (HiAP) at EU and Member State level. HiAP is the principle that, since health is strongly influenced by people's living conditions, all policy sectors that affect these conditions should consider the health impact of their decisions. By 'crossing bridges' to other sectors, the health sector should play a leading role in implementing this principle. At present, however, little is known about how the public health sector can best work with other sectors to promote health.

In this project, methodologies to implement HiAP were studied and key needs identified. Convincing examples were analysed where the health sector collaborated with education, transport and agriculture sectors. The project resulted in an overview of good practice, a training course, a conference, and a publication — 'Health for All Policies: Working together for Health and Well-being' — in three versions and nine languages.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The importance of policies in all sectors for reducing health inequalities is repeatedly stressed in *Solidarity in Health*, which ascribes inequalities to a wide range of factors, including living conditions, education, occupation and income. The Crossing Bridges project raised awareness of the importance of an intersectoral approach. It disseminated knowledge about general principles and examples of good practice, using a range of different methods and reaching multiple stakeholders in 16 Member States.

Why was the public health problem addressed important for Europe?

Without an intersectoral approach, there is limited potential to improve the general level of health in the EU or to reduce health inequalities. Since social and living conditions are major determinants of health, and few of these conditions are determined by the health sector itself, it is vital for all sectors to consider the health impact of their policies. Health promotion has to reach beyond encouraging behaviour change to tackle the more 'distal' or 'upstream' determinants of health.

Objectives

The project first set out to review methods used to stimulate HiAP and to identify good practice. A review was also carried out of capacity-building needs in the countries studied. Finally, a training programme was developed to address these needs and equip the public health workforce to promote HiAP strategies. The overall aim was to empower the health sector to stimulate the adoption of healthy policies in other sectors.

Methods

A Needs Assessment Questionnaire was developed and completed by partners, while groups were set up in the areas of transport and planning and education. Project partners identified examples of effective and potentially transferable HiAP approaches, tools and mechanisms. A separate study was also undertaken of the EU School Fruit Scheme (in which the agriculture and education sectors collaborated). This work fed into the development of 'train the trainer' workshops, attended by representatives of all participating organisations, who then delivered training in their own countries. Ten trainers from eight countries attended the workshops, and training was delivered to 120 participants in eight countries. All project outcomes were presented in a short publication, which was translated and made available on the web.

Results were mainly disseminated to organisations working in public health. Project partners disseminated results among their own networks, while the coordinating partner EuroHealthNet made material available via its own extensive networks, including global e-mail lists and at a final conference in Brussels.

Achievements

The project identified examples of good practice, assessed needs for capacity-building, and designed and delivered a training programme to promote HiAP among public health workers. A publication, 'Health for All Policies: Working together for Health and Well-being', was developed in three versions. These publications and other reports were translated into nine languages (German, Greek, Hungarian, Italian, Dutch, Slovenian, Czech, Polish and Welsh).

The goal of these activities was to help workers in the health system to become advocates for HiAP. A major challenge was that many partners found it difficult to identify good examples of HiAP, suggesting there is much potential for development of this approach.

The novelty of the HiAP approach in Europe presented major challenges to the project. Chief among these was the lack of experience and expertise in persuading policy makers outside the health sector to consider the health impact of their decisions. The project showed that, at present, most EU Member States' health systems lack the capacity and knowledge to effectively engage other sectors.

What effect have the results had on the policies and programmes of Member States and the EU?

Project participants engaged with policy makers in their countries. Project publications were also designed to communicate information about HiAP to a broad audience, including policy makers outside the health sector.

The project was of lasting value in promoting HiAP, as its outcomes have been integrated into the work of the members of EuroHealthNet. Many project partners have the capacity to influence public health policy in their country and may have applied Crossing Bridges' outcomes in the same way.

What were the benefits of working jointly at EU level?

Reorienting health systems to adopt the HiAP approach remains difficult. Among Member States, there are wide differences in the willingness to con-

sider HiAP. An EU-level exchange to promote good practice and exchange learning, as well as to stimulate the practical implementation and development of these concepts, is therefore essential to the overall improvement of health policies and programmes in the EU. The project has stimulated networking on this theme, both within and between countries.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

Progress will depend on the willingness of health authorities at EU, national and sub-national levels to pursue this approach in a strategic manner. This requires strong convincing messages, approaches and evidence of effectiveness. The work carried out in this project is a start, but much more is required to reinforce and develop capacities. There is therefore great potential for further exchange of learning and capacity-building relating to the health sector's role in ensuring that all relevant sectors contribute to better health outcomes for all, particularly people in vulnerable situations.

Project website

- www.health-inequalities.eu/HEALTH-EQUITY/EN/projects/crossing_bridges/

Budget

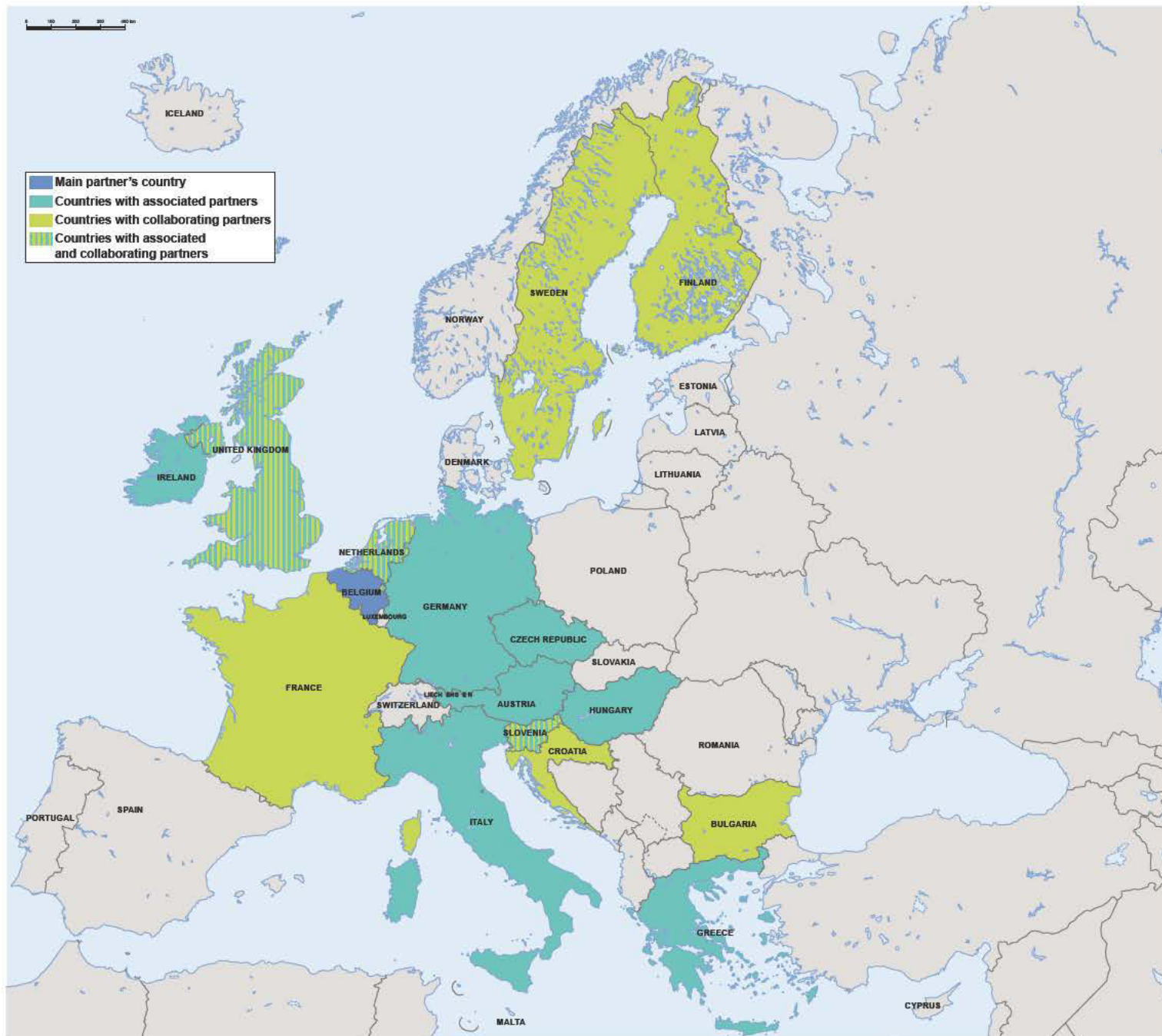
- Total budget: €490 094
- EC contribution: €291 304

Duration

- 01.01.2011 – 30.06.2012

Main beneficiary

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- Website: www.eurohealthnet.org



Main beneficiary:

EuroHealthNet
67 Rue de la Loi, 1040 Brussels, Belgium

Associated partners:

- Gesundheit Österreich GmbH (GOG) - AT
- Flemish Institute for Health Promotion and Disease Prevention (VIGeZ) - BE
- National Institute of Public Health (SZU) - CZ
- NHS Sefton, England - UK
- Federal Center for Health Education (BZgA) - DE
- Institute of Preventive Medicine, Environmental and Occupational Health (PROLEPSIS) -EL
- National Institute for Health Development (OEFI) - HU
- Institute of Public Health Ireland (IPH) - IE
- Verona University Hospital - IT
- Netherlands Institute for Health Promotion (NIPH) - NL
- National Institute of Public Health and Hygiene (NIPH-NIH) - NL

- National Institute of Public Health (NIPH-IVZ) - SI
- Public Health Wales - UK

Collaborating partners:

- Health Action Partnership International (HAPI) - International
- International Union of Health Promotion and Education (IUHPE) - International
- FOD Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu - BE
- National Center of Public Health Protection - BG
- Finnish Centre for Health Promotion - FI
- National Institute for Health and Welfare (THL) - FI
- Institut National de Prevention et d'Education pour la Santé (INPES) - FR
- Zavod za Javno Zdravstvo Karlovske Zupanije - HR
- Zavod za zdravstvo varstvo Murska Sobota (ZZV MS) - SI
- Rijksinstituut voor Volksgezondheid en Milieu-NL
- NHS Health Scotland - UK
- Karolinska Institutet - SE



*Health Promotion for Disadvantaged Youth,
Health 2 you in 5 countries*

Health 25

Keywords: health literacy, health inequalities, healthy lifestyles, disadvantaged youth, capacity building

Health25 aimed to improve levels of health literacy and promote healthy lifestyles among young people who are either unemployed or not in formal education or training, often referred to as NEETs (Not in Employment, Education or Training). A multi-disciplinary health training and intervention programme was created, involving psychology, sociology, education and health promotion.

The project trialled a health promotion and training programme in five partner countries to help young unemployed people to exercise, improve their diet, become more aware of alcohol and tobacco usage, and develop social competences. Guidelines were produced to help coaches, mentors and organisers of health training and intervention programmes with techniques to engage, motivate and educate participants.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project contributed to both the COM(2009) 567 and the Europe 2020 initiatives in addressing the social determinants of health inequalities of a particularly vulnerable group. Apart from their disadvantages in terms of health risk and life opportunities, the target group was also difficult to reach and motivate to participate in health promotion activities. Current systems employing traditional approaches have not worked well. Indeed, mainstream health promotion programmes run the risk of increasing the gap and further marginalising this target group.

Why was the public health problem(s) addressed important for Europe?

The reduction of socially determined health inequalities is a major challenge. Youths who are not in employment, education or training (NEETs) have a much greater likelihood of experiencing unequal opportunities to access health services and health promotion interventions. This group comprises not only young people with identifiable characteristics that act as barriers to participation in employment, education and training (e.g. tobacco usage, over-consumption of alcohol, sedentary lifestyles and potential substance misuse), but also those who may be disadvantaged by other 'contextual' factors. These include: parental background, including socio-economic status, and educational attainment; as well as geographical considerations such as rural settings and life in areas of high deprivation.

Objectives

The aim was to improve the health of targeted 16–20 year-olds. Their active contribution was sought by fostering their participation and empowerment in relation to their own health. The project sought to address the social determinants of health and to improve individual potential and life chances of the target group. Activities therefore focussed on individual lifestyle, social and community influence, living and working conditions, and socio-economic and environmental factors.

Specific objectives:

- Literature review and survey.
- Development of the pedagogical and psychological concept for the target group.
- Development of a health training and intervention programme.
- Synthesis of the holistic health training and intervention programmes for 16–20 year-olds.
- Pilot implementation of the holistic health training and intervention programme.

Methods

The project required an interdisciplinary methodological approach relating to various scientific disciplines (medicine, physical medicine, social medicine and public health, sports science, social pedagogy, motivation psychology, food and nutrition). Also emphasised was the active participation of the target group and the involvement of stakeholders such as parents, friends, social workers, public health organisations, labour market services and municipalities. This entailed three phases: communication to attract and reach the target group, motivation to foster participation in the training and intervention programme, and information to raise awareness about healthy life styles.

The project developed three main products:

- A literature review and survey conducted in the five partner countries, providing a description of the individual, environmental, socio-economic and cultural differences between these young people.
- The psychological and educational concept adopted by the coaches and organisers of health promotion and training programmes to improve self-esteem, motivation and behavioural change.
- The final holistic health training and intervention programme, based on a multi-disciplinary approach using a combination of psychological, educational and health promotion techniques.

Achievements

The project achieved its main objectives. The literature review and the survey were carried out in the 5 countries involved; the pedagogical/psychological concept was developed, reviewed by experts in the field and finally adopted; the holistic health and training programme was pilot tested and used in relevant organisations.

NEETs benefited socially, mentally and physically, and through raised self-esteem. Most adopted a healthier lifestyle: stopping smoking, introducing better diets, reducing fast-food intake, having breakfast, and doing sports activities. The Health Training Intervention Programme became part of the measures employed at job centres. This project has also been able to address, in addition to traditional lifestyle themes such as nutrition and tobacco control, some of the wider social determinants of health, in particular education and employment.

What effect have the results had on the policies and programmes of Member States and the EU?

The project can boast promotion of best practice with the development of a health training and intervention programme. It is transferable to other European countries because it includes guidelines for trainers and coaches, and case studies. The project also exhibited cross-sector EU added value because deliverables and outputs are relevant to individuals and organisations outside the field of public health.

To ensure implementation of the health training and intervention programme at health centres, job centres and sports clubs, NEETs have to be supported in Health25 activities by financing for sports equipment and membership fees at sports clubs and by encouraging attendance in additional activities like smoking cessation projects offered by the national social security system.

What were the benefits of working jointly at EU level?

A greater understanding was developed of NEETs' experiences nationally and internationally, and of the impact on health of promoting physical, motivational and social activities. At an individual level, the project highlighted ideas for: involving NEETs in the Health Training and Intervention Programme; working with local health centres, job centres, public employment services, sports clubs and schools; and coordinating with the national social security system.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The main priority was to empower NEETs to improve their lifestyle, change their habits, live healthier, raise their self-esteem, and thus bring them closer to the labour market through education or vocational training. The project offers a novel way of intervening on both lifestyle risk factors and social determinants of health to tackle health inequalities.

Project website

- www.health25.eu

Budget

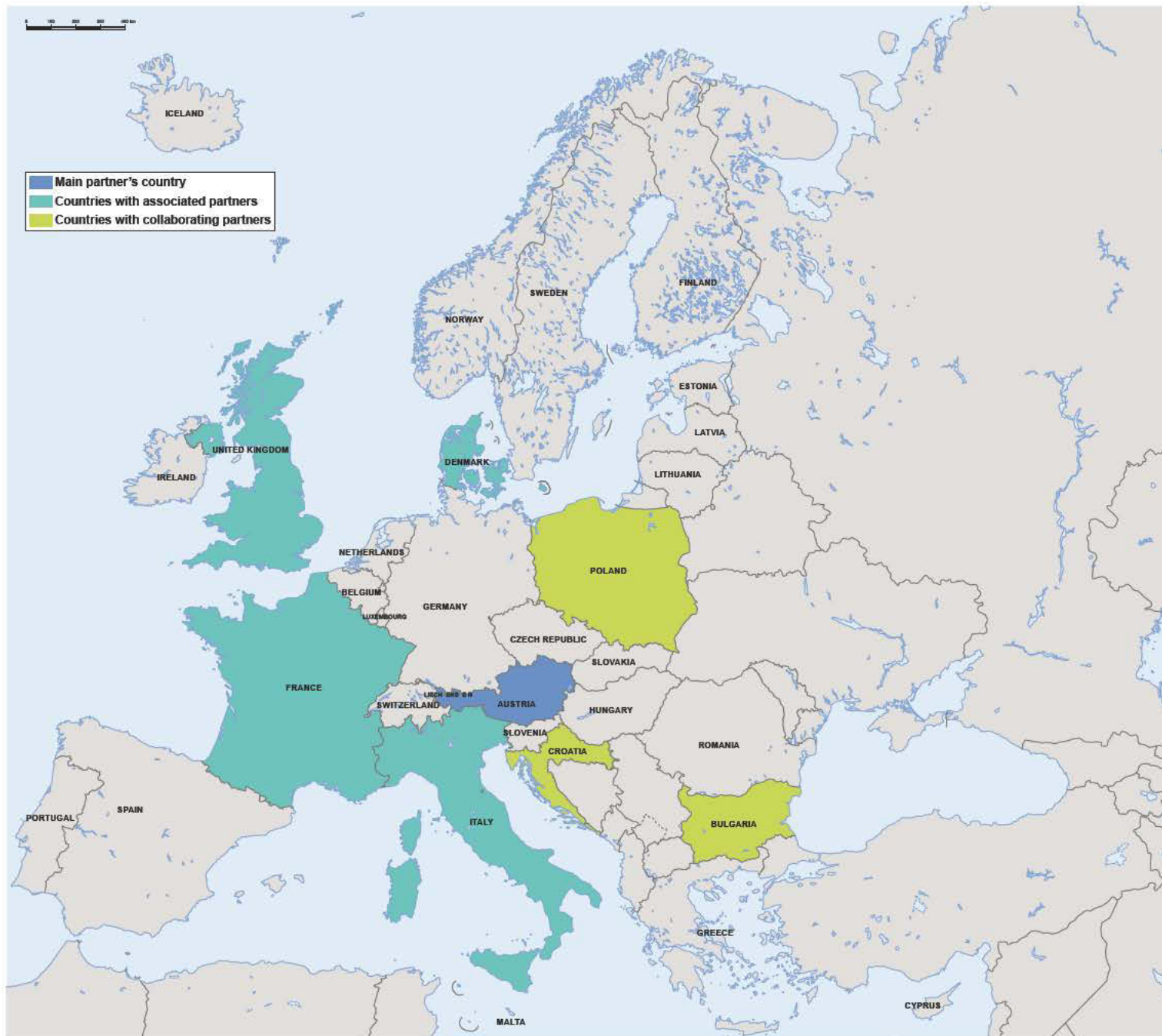
- Total budget: €671 218.99
- EC contribution: €402 729.60

Duration

- 01.02.2011 – 31.01.2014
(36 months)

Main beneficiary

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Main partner:

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Associated partners:

- Centre Regional pour le Développement local, la formation et l'Insertion des Jeunes, France
- Heart of Mersey, UK
- Vardekommune/The municipality of Varde, Denmark
- Institut für Arbeitsmarktbetreuung und -forschung Steiermark, Austria
- Azienda Ospedaliero Universitaria Ospedali Riuniti Ancona, Italy
- BBRZ Österreich, Austria

Collaborating partners:

- Medical University Graz, Department for Social Medicine and Public Health, Austria
- Breza, udruga za rad s mladima, Croatia
- National Institute of Cardiology, Department of Epidemiology, Cardiovascular Diseases, Health Promotion, Poland
- Marie Curie Association, Bulgaria



Promoting better health for mothers and babies through routine European monitoring of perinatal health and health care:

EURO-PERISTAT Action

Keywords: inequalities, maternal health, perinatal health, collection of best practices, health care

The aim of this series of projects, carried out in four phases starting in 1999, was to organise a Europe-wide system for collecting and reporting data on perinatal health, using a standard system of indicators enabling data to be compared between countries and over time. Analysis of these data can identify the factors underlying poor perinatal health and in-

dicade how countries can improve outcomes. A network of experts and institutions was established to define suitable indicators and sources of data. The number of countries involved was also expanded in each phase. Major reports were published in 2008 and 2013, which identified considerable inequalities both within and between countries.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The projects raised awareness of the issue of perinatal health, as well as promoting and assisting exchange of information and knowledge between Member States concerning the collection of suitable data, thus identifying and spreading good practices. The regular monitoring of indicators makes it possible to evaluate the effects of policy changes. The main contribution of the projects was to improve data collection, a prerequisite for health inequality audits. Indicators were created for mothers' education, occupation and country of origin, though not for migration status or ethnicity. However, country of origin can sometimes throw light on the latter two factors. Apart from the fact that mothers and newborn babies can be regarded as a 'vulnerable group', the project focused on variables distributed over the whole population, rather than specific groups.

Why was the public health problem addressed important for Europe?

Promoting healthy pregnancy and safe childbirth is an important goal of all European health care systems. Despite significant improvements in recent decades, mothers and their babies are still at risk during the perinatal period. Babies born too early are more likely to die than those born at term. They are also more likely to have health conditions that carry long-term consequences for their quality of life, their families, and for health and social services. The same is true for babies born with severe congenital anomalies. Many have important medical, social and educational needs. Stillbirths have not decreased to the same extent as neonatal deaths, and their causes remain largely unknown. Maternal deaths are rare but tragic events, particularly because many are associated with substandard care.

Recent research has also found connections between perinatal health and chronic diseases of adulthood. Babies affected by foetal growth restriction are more likely to develop diabetes and metabolic syndrome as adults. These links make the monitoring of perinatal health outcomes more important than ever.

Objectives

- The first **PERISTAT** project, started in 1999, was set up to develop indicators for monitoring perinatal health in Europe.

- **EURO-PERISTAT 2** integrated new Member States, established new indicators, developed methods for compiling high-quality indicators, and designed a reporting methodology.
- **EURO-PERISTAT III** produced the first European Perinatal Health Report in 2008, based on data collected in 2004 from 25 countries and including policy-relevant analyses of maternal and child health outcomes, care provision, inequalities and migrant health. The project also developed an Action Plan for Sustainable Perinatal Health Reporting with recommendations about the nature of an information network.
- **EURO-PERISTAT Action** collected and analysed data for 2010 and published the second European Perinatal Health Report in 2013, using data from 26 Member States plus Iceland, Norway and Switzerland.

Methods

The original PERISTAT project established a basic set of indicators. These indicators were expanded and refined during successive projects. They were grouped into four themes: foetal, neonatal and child health; maternal health; population characteristics and risk factors; and health services. The second project defined core or essential indicators for monitoring perinatal health as well as recommended or desirable indicators.

Methodologies were also developed for building reporting systems in each country, capable of collating and harmonising data from multiple sources.

Methods were then developed to organise and analyse data. Benchmarks were established in each country for the main indicators of perinatal health; the analyses also offered insight into the factors affecting perinatal health and into promising strategies for improving it.

Achievements

The projects established a high-quality internationally recognised and sustainable European perinatal health information system that compiles and analyses data on a regular basis. The EURO-PERISTAT organisation has official representation from 29 countries across Europe and a large network of contributing experts.

Published findings show widespread inequalities in Europe, although indicators vary between countries and no country tops every list. Death rates in childbirth and in the first year of childhood decreased throughout Europe between 2004 and 2010 but still show considerable differences, along with differences in population characteristics and maternity and neonatal care. Wide variations in obstetric practices raise questions about the role of scientific evidence in clinical decision-making.

What effect have the results had on the policies and programmes of Member States and the EU?

Project publications have encouraged a more evidence-based approach to policies on perinatal health, and have drawn attention to areas that need improvement. Since data from 2004 and 2010 have been published, it has been possible to track changes and to see whether policy changes have had the intended effects. The projects have made an essential contribution to improving the 'state-of-the-art' in perinatal health in Europe.

What were the benefits of working jointly at EU level?

These benefits concern mainly economies of scale (pooling resources to improve monitoring methods), promotion of best practice, benchmarking and networking. In scientific terms, the existence of wide variations in population characteristics, care practices and perinatal outcomes provides a 'natural experiment', allowing many insights to be gained into the factors affecting perinatal health.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

More attention needs to be given to improving reporting systems in Europe. Many countries need to improve the range and quality of the data they collect. Better data will make it easier to establish the causes of observed differences in perinatal health, to evaluate the different policies and practices adopted in each country, to recommend policy changes, and to evaluate their outcomes.

Project website

- www.europeristat.com

Budget

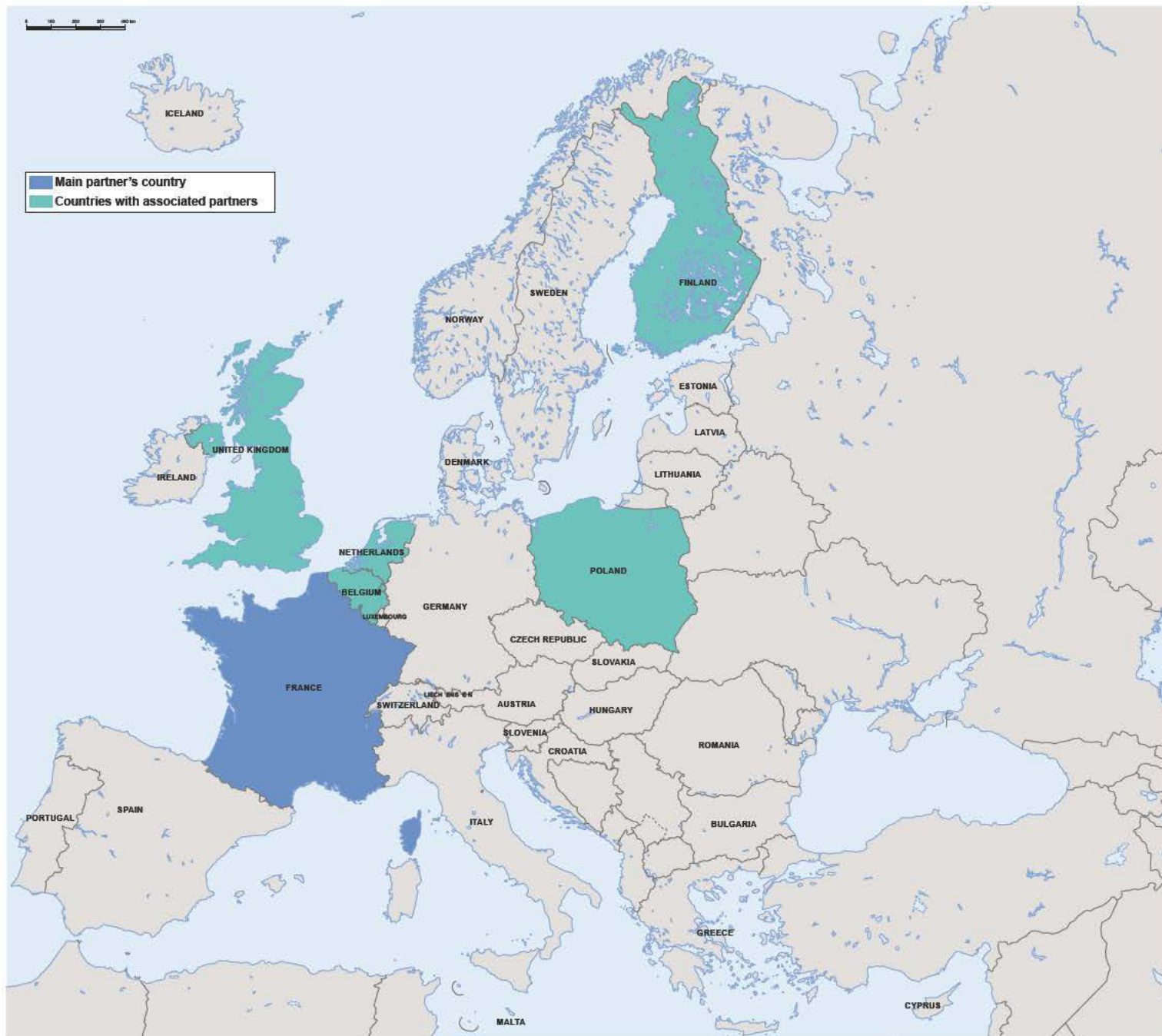
- Total budget: €1 012 930
- EC contribution: €607 343

Duration

- 01.04.2011 – 31.03.2014

Main beneficiary

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Main partner:

Institut National de la Santé et de la Recherche Médicale (INSERM), Paris, France

Associated partners:

- Instytut Matki i Dziecka (National Research Institute of Mother and Child), Poland
- Nederlandse Organisatie voor Toegepast Natuurwetenschappelijk Onderzoek (Netherlands Organisation for Applied Scientific Research), Netherlands
- Terveystieteiden ja hyvinvoinnin laitos, Finland
- The City University, United Kingdom
- Université libre de Bruxelles, Belgium

European Health and Life Expectancy Information: **EHLEIS**

Keywords: healthy life years, life expectancy, disability, self-perceived health, chronic diseases

Life expectancy in the European Union is steadily increasing, but there are large differences between the Member States and between men and women. Even larger differences occur between the Member States in terms of life years in good health, which is when people do not suffer from chronic conditions or disability. Healthy Life Years (HLY) is the one key health indicator in Europe that is strictly comparable, and it has been implemented by the European Health and Life Expectancy Information System (EHLEIS) in order to improve and harmonise its calculation.

The EHLEIS project was carried out from 2007 to 2010. The subsequent phase is the EHLEIS Joint Action, which began in 2011 and is set to finish in 2014. The Joint Action will support EHLEIS by consolidating the existing information system through yearly HLY calculations and dissemination, and by monitoring trends.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The EHLEIS network contributes directly to the EU's First and Second Health Programmes, which aim to promote health — specifically increasing healthy life years and promoting healthy ageing — and reduce health inequalities while improving information and knowledge about health. In addition, it will facilitate the design of tailor-made policies for specific issues by collecting data on health inequalities and social determinants. Therefore EHLEIS contributes to the aims of the EC Communication Solidarity in Health (2009), as well as to the objectives of the European Year for Active Ageing 2012 and the European Innovation Partnership on Active and Healthy Ageing.

Why was the public health problem addressed important for Europe?

Life expectancy at birth has steadily increased over the last decade in the Member States by more than three years for men and two years for women, leading to the population ageing at an accelerating rate. However, the Member States show large differences, widening for men from 13 years in 1997 to 14 years in 2007. For women, the difference in life expectancy between Member States reduced from nine years to eight between 1997 and 2007. There is also a six-year difference between the life expectancy at birth for men and women.

The differences between Member States reach 20 years when years of life in good health, without chronic morbidity or disability, are taken into account. There is, therefore, a major issue to be addressed if all the Member States are to improve their life expectancy in line with the best performers.

Objectives

The objective of the EHLEIS project was to monitor and explore gender gaps and inequalities in health expectancies between Member States. The EHLEIS Joint Action set out to consolidate the existing EHLEIS information system and to analyse trends and differences in life expectancy across the EU. The information is also being used to analyse the relationship between life expectancy and socio-economic conditions. This will help to promote the use of HLYs as a key indicator in Member States' health policies, and also allow for

the development of an alternative measure of population health that would be usable internationally for comparison with the USA and Japan.

Methods

Both the actions used a wide range of methods, including computational, web and standard demographic techniques as the basis for consolidating the information system. The substantive analysis of trends and gaps used statistical techniques and multi-level analyses. The work towards maximising the usability and pan-European comparability of healthy life years (HLY) requires the JA partners to resolve differences in the definition of the indicator used to measure disability, known as the Global Activity Limitation Indicator (GALI), and also to examine the differences in HLY in terms of the origin and age group.

Achievements

The EHLEIS project created an online information system of health and life expectancy to aid in monitoring and exploring gender gaps and inequalities in health expectancies between Member States. Its successful completion led to the optimisation of health data usage. In addition, use of the European Health Information System has been increased. The project's actions have also helped to promote use of the EU's new Healthy Life Years structural indicator. The in-depth analyses carried out contributed to a greater understanding of the gender gaps and inequalities in health expectancies between EU Member States.

The main outcome of the Joint Action will be the consolidated EHLEIS information system allowing on-line calculation of health indicators (prevalence, life and health expectancies including HLY). New statistical tools have been developed and technical reports have been published. Plus, scientific analyses explore geographical variations in HLY within Europe, trends over time, social differentials in HLY between Member States, and calibration with European Health Interview Survey (EHIS) data and GALI indicators for disability. Finally, the partners are developing a blueprint for an internationally harmonised summary measure of population health.

What effect have the results had on the policies and programmes of Member States and the EU?

Promoting the wider use of HLY in national policy making — even in non-health areas like fiscal policy — was a central priority for both phases of EHLEIS. Readily accessible scientific material will be provided to the health professional and research communities through databases, technical reports and scientific publications, which will add to the papers already published by EHLEIS.

Increasing involvement of Member States in health monitoring is one of the main priorities of the JA. The JA partners are involved in production of their annual country report on health expectancies, and translation into national languages. The EU Member States started using the information system with their own national data to compute health expectancies by sub-national geographic areas; Belgium, Denmark, France the Netherlands and the United Kingdom can be named as examples.

What were the benefits of working jointly at EU level?

EHLEIS has clearly improved the dissemination, understanding and use of summary measures of population health, including the HLY. Ten Member States have already started coordinating their research programmes on health expectancies. Almost all other Member States are participating in the production and translation of their country reports.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

In general, it can be stated that the action highlights the importance of accurate and comprehensive data for tackling health inequalities at the European, national and sub-national levels. Furthermore, it emphasises the appropriateness of HLY as the main indicator for monitoring health in Europe.

EHLEIS PHASE I

Project website

- www.eurohex.eu

Budget

- Total budget: €1 109 399
- EC contribution: €647 805

Duration

- 01.07.2007 – 30.06.2010

Main beneficiary

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EHLEIS Joint Action PHASE II

Budget

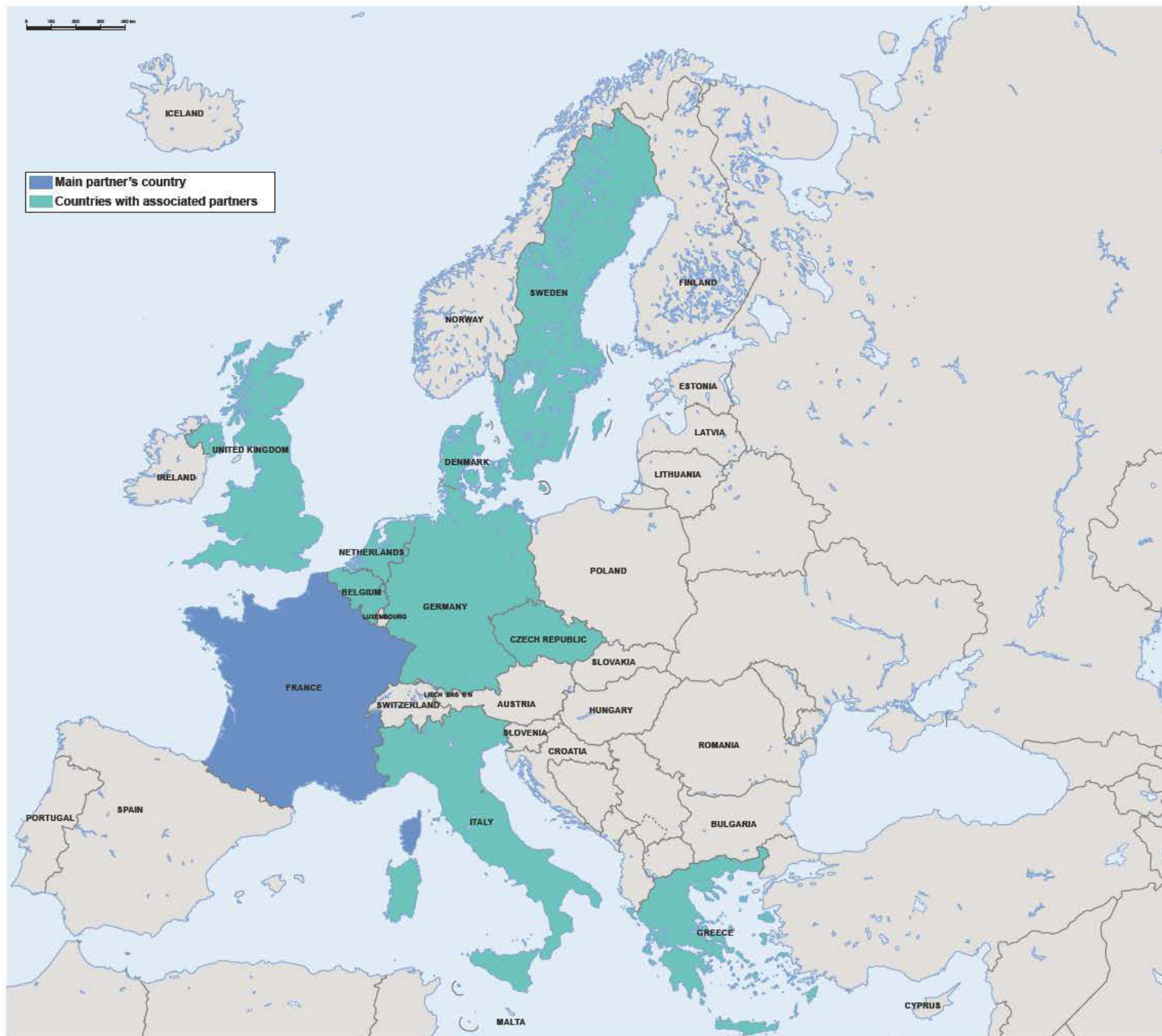
- Total budget: €2 717 138
- EC contribution: €643 259

Duration

- 24.04.2011 – 19.04.2014

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Main partner

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- Centraal Bureau voor de Statistiek, Netherlands
- Centre Régional de Lutte Contre le Cancer, France
- Dipartimento di Studi Sociali, Economici, Attuariali e Demografici, Sapienza, Italy
- Erasmus MC Rotterdam, Netherlands
- Institut National d'Etudes Démographiques, France
- Institut Scientifique de Santé Publique / Wetenschappelijk instituut volksgezondheid, Belgium
- Institut Thématique Multi-Organisme Santé Publique, France
- Office for National Statistics, United Kingdom
- Rijksinstituut voor Volksgezondheid en Milieu, Netherlands
- Robert Koch Institute, Germany
- Socialstyrelsen/The National Board of Health and Welfare, Sweden
- Sundhedsstyrelsen, Denmark, Denmark
- Syddansk Universitet, Denmark
- National Institute of Public Health - Syddansk Universitet, Denmark
- University of Newcastle upon Tyne, United Kingdom
- Universität Rostock, Germany
- Université de Montpellier 2 Sciences et Techniques, France
- Ústav zdravotnických informací a statistiky České republiky / Institute of Health Information and Statistics of the Czech Republic, Czech Republic
- Hellenic Statistical Authority, Greece



Joint Action on Health Inequalities

Equity Action

Keywords: inequalities, socio-economic factors, health impact assessment, determinants, public health

Equity Action Joint Action aims to tackle health inequalities at EU, national, regional and local level, by involving multiple stakeholders across a range of policy areas.

Equity Action aimed to develop evidence of what is successful in reducing health inequalities by:

- Developing knowledge for effective action on health inequalities;
- Supporting the engagement of Member States, regions and other stakeholders to tackle socio-economic and geographic health inequalities;
- Sharing learning between Member States and other stakeholders;
- Supporting the development of effective action to tackle socio-economic health inequalities at European policy level.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

Equity Action supports Solidarity in Health: by developing health inequality audit approaches with Member States; by including health inequalities as one of the priority areas within the cooperation arrangements on health between the European regions and the Commission; by enabling Member States to make better use of cohesion policy and Structural Funds to support activities addressing factors that contribute to health inequalities; and by engaging stakeholders at European level to promote the dissemination of good practice. Furthermore, the action responds directly to the 2010 Work Plan on health inequalities, and is a direct outcome of deliberations between Member States and the European Commission on how to deliver a structured programme of work.

Why was the public health problem addressed important for Europe?

Health inequalities are unfair distributions of health across societies, or systematic differences in health between social groups. They illustrate that many people are being denied the resources and capabilities for health and are therefore unable to achieve their full health potential. While health inequalities exist in all societies, the steepness of the health gradient differs across regions and between EU Member States. These differences reflect the financial, economic, social, health and other policies and programmes implemented within countries. Therefore, to target the key social determinants of health to reduce health inequalities, an integrated approach across policy making sectors is required — the ‘Health in All Policies’ approach.

Objectives

The main objective was to increase engagement and mutual learning on tackling socio-economic determinants of health inequalities across Member States. Specific objectives were:

- To promote a ‘Health Equity in All Policies’ approach, through tools such as health impact assessments with an equity focus (HIAef) and health equity audits (HEA).
- To share knowledge of the contribution of sub-national policies to reducing health inequalities, by supporting a network of regions/subnational entities and developing a guidance tool for regions.

- To raise awareness and exchange experience about how EU Structural Funds can be used to reduce health inequalities, and to propose measures to include in 2014–20 Structural Funds to enable them to be used more readily to address health inequalities.
- To facilitate the transfer of evidence to policy makers through a scientific and technical reference group network.
- To engage wider stakeholders in addressing health inequalities, including policy makers, academics, civil society and NGOs.

Methods

The Joint Action aimed to develop a common understanding of a ‘Health in All Policies’ approach, and its application at EU, Member State and subnational level. A consensus was sought on methodologies for conducting a policy-orientated HIAef and HEA. Each participating country piloted either an HIAef or HEA, whereas HEAs were carried out at European level. This entailed reviewing current practice, identifying effective practice, and collaboratively defining the components of the assessment tool. Processes for developing an effective cross-government health equity focus were discussed. A regional network was established to identify, through a case study approach, the focus, information, resources, drivers, opportunities and barriers to regional action on health inequalities, and access to Structural Funds. At the close of the action, recommendations will be made to inform the future drafting of Structural Funds.

Achievements

The action helped to keep health inequalities high on Member State agendas and enabled participating countries to develop a stronger equity focus. It also fostered a greater engagement of regions and influenced the drafting of 2014–20 Structural Funds guidelines. In addition, EU-wide stakeholder debates allowed for an international exchange of experiences on stakeholder engagement, inter-sectoral work and health equity.

The main benefit was more inclusive thinking about the broad range of health inequalities affected by policies in the countries involved. The HIAs should have direct benefits, helping to identify winners and losers in particular policies and by identifying effective action. The Structural Funds strand should enhance health in those regions that use learning to access Structural Funds more effectively for health.

What effect have the results had on the policies and programmes of Member States and the EU?

The action's outcomes had a positive effect on Member State policies and programmes, as countries were assisted in moving beyond the analysis of health inequalities into implementation of the building blocks that will make action possible. For example, several countries have established stakeholder groups for the first time, others have set up cross-governmental groups and some countries have developed training on equity-focused HIAs. Moreover, many countries have analysed for the first time how to make greater use of Structural Funds.

The action's impact on policies and programmes varies by country. However, results were used in the development of public health policies in participating countries.

What were the benefits of working jointly at EU level?

Benefits included networking to learn about effective approaches used in different countries. Bringing together the health inequalities research community helped to define foci for reviews of evidence and to set out a possible EU research agenda. Importantly,

an international and national exchange of experience of good practice of stakeholder engagement and inter-sectoral work benefits the promotion of health equity.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

Priorities for health inequality reduction include the following:

- To develop and embed HIA and HEA processes.
- To further explore cross-government working through online facilitated discussion.
- To develop stakeholder networks in each Member State.
- To consider further training of medical personnel in health inequalities and wider social determinants, and how to improve health through action on those.
- To make stronger links between productivity, GDP and health inequalities.

Project website

- www.equityaction-project.eu

Budget

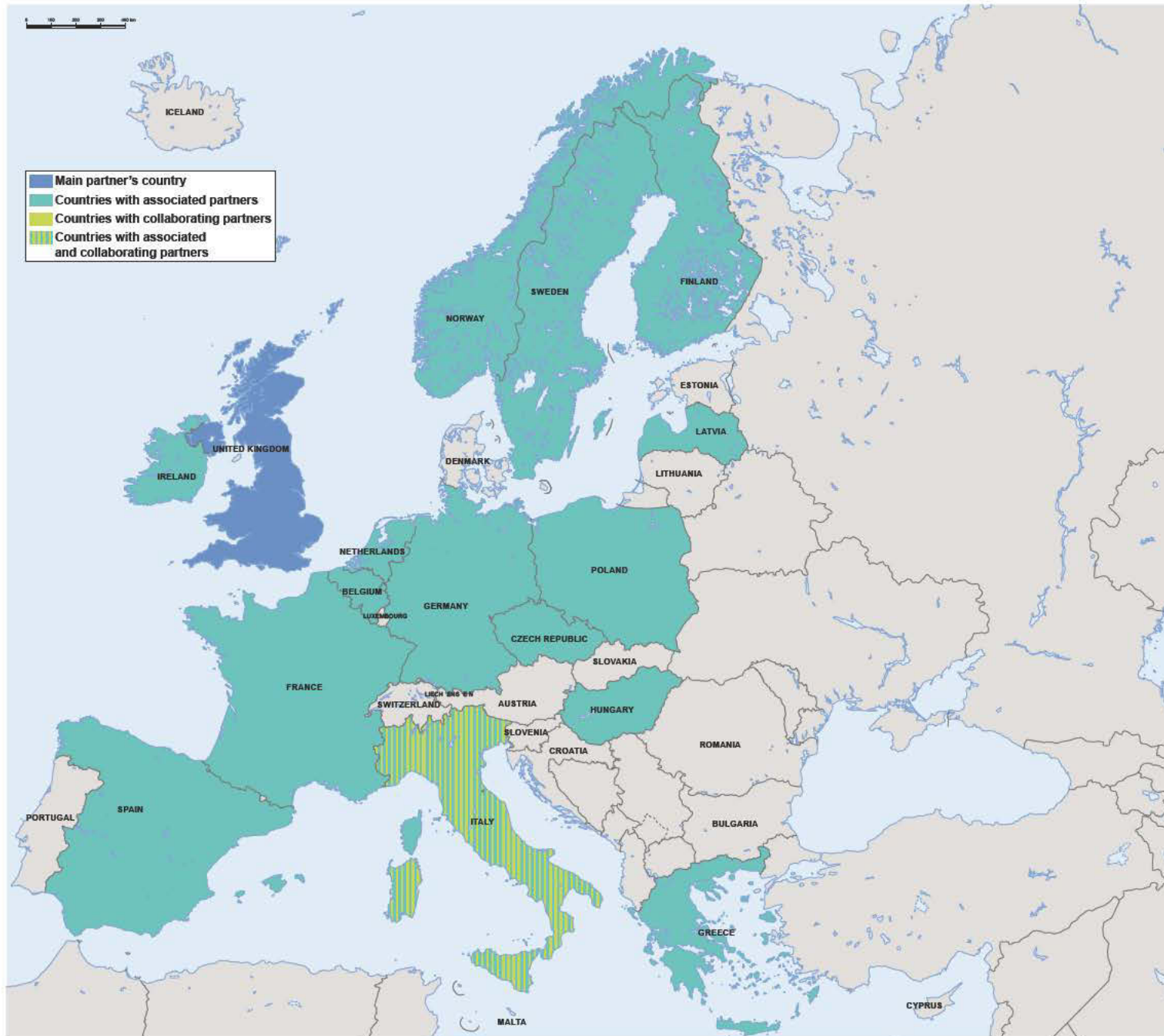
- Total budget: €3 614 939
- EC contribution: €1 699 999

Duration

- 14.02.2011 – 14.02.2014

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Main partner:

UK Health Forum, UK

Associated partners:

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- National Institute of Public Health, Czech Republic
- Department of Health, England
- National Institute for Health and Welfare, Finland
- Direction Générale de la Santé, France,
- Federal Centre for Health Education, Germany,
- National Centre for Social Research, Greece
- National Institute for Health Development, Hungary,
- Institute of Public Health in Ireland, Ireland
- Azienda Sanitaria Locale TO3, Torino, Italy,
- Azienda Ospedaliera Universitaria Integrata, Verona, Italy,
- Agenzie Nazionale per i Servizi Sanitari Regionali, Italy,

- Centre for Disease Prevention and Control of Latvia, Latvia
- National institute for public health and environment, The Netherlands
- Norwegian Directorate of Health, Norway
- National Institute of Public Health – National Institute of Hygiene, Poland
- The Scottish Executive, Scotland
- Directorate General for Public Health and Foreign Health. Ministry of Health and Social Policy Spain,
- La Fundacion Vasca de Innovacion e Investigation Sanitarias, Spain
- Swedish National Institute of Public Health, Sweden,
- Region Västra Götaland, Sweden,
- National Institute of Public Health, Wales

Collaborating partners:

- WHO European Office for Investment for Health and Development, Venice, Italy

Report on health inequalities in the EU (Marmot report)

Keywords: health status disparities, health inequities, public policy, national government, local government

The aim was to produce a high-level overview of recent evidence concerning health inequalities in the EU, and a critical examination of policy responses at EU and national levels. Recommendations were made for the guidance of the EC and individual Member States. The report was jointly written by five agencies concerned with health inequalities, led by Sir Michael Marmot. It was commissioned via an open call for tender.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

This bird's-eye view of health inequalities reviews the extent of such inequalities, policy measures to tackle them, and trends over the last few years (in particular connected with the economic crisis). The report identifies progress and areas where more needs to be done. It provides information about measures taken before and after the 2009 publication of the EC Communication Solidarity in Health: Reducing Health Inequalities in the EU. It also provides a comprehensive set of recommendations.

By providing an overview of health inequalities, the report enables policy makers at all levels to identify areas of particular need and improve their strategies for addressing them. It permits Member States to compare their own challenges and responses with those of others. Although the report's main emphasis is on age, sex, socio-economic status and geographical differences, it also calls for improved data collection and policy responses concerning vulnerable migrants and ethnic groups.

Why was the public health problem addressed important for Europe?

The European Commission regards the extent of the health inequalities between people living in different parts of the European Union and between socially advantaged and disadvantaged citizens as a challenge to the EU's commitments to solidarity, social and economic cohesion, human rights and equality of opportunity. The recommendations of the 2009 Communication laid the foundations for sustained action. This report strengthens the evidence base which should underlie such action.

Objectives

The main objective of this contract was to produce a comprehensive report on health inequalities and the actions being taken to combat them in the European Union.

The objectives of the work are:

- To document and review the health inequalities situation in the EU including recent trends.
- To document and review the policy response to health inequalities at EU, national and where relevant sub-national levels.
- To provide an analysis and commentary including implications and suggestions for possible future actions.

Methods

The report's overview of health inequalities is based on:

- Health Inequalities Situation in the EU — statistical analysis of recent data signalling trends in the patterns found, plus a review of literature since 2006.

- Policy response to health inequalities — an assessment of the policy responses at EU, national and sub-national levels, based on interviews with experts and policy makers.
- Commentary and recommendations — proposals on action needed at EU, national and sub-national levels.

Achievements

As well as reviewing health inequalities and their social determinants, the review examined recent actions by the EU and Member States to promote health equity. Three clusters were formed. The number of countries in each cluster is given in brackets:

- Relatively positive and active response to health inequalities (7)
- Variable response to health inequalities (15)
- Relatively undeveloped response to health inequalities (6)

Regarding data collection, the study identified indicators that currently best describe inequalities in health and its social determinants. It also highlighted key policy areas for which there is a lack of adequate information. To further the development of health inequality auditing the report identified examples of good practice, as well as gaps in carrying out such audits and acting on the results.

The report argues for raising awareness and promoting actions to improve access and appropriateness of health services, health promotion and preventive care for migrants, ethnic minorities and other vulnerable groups, as well as strengthening the evidence base for such actions.

The reduction of health inequalities was stressed as a goal in future initiatives on healthy ageing. The report takes a life course approach to healthy ageing — identifying health expectancy as a key indicator for healthy living.

The following steps are being taken to disseminate the report:

Material from the report has been used in the pre-release of results to the EU expert group on health inequalities. Results have been incorporated in published EC staff papers and in other briefing material. Findings are being shared with WHO and will be used in post-publication presentations.

Findings will also be incorporated in public talks by Sir Michael Marmot, other Institute staff, EuroHealthNet, Heart Forum and HAPI.

What effect have the results had on the policies and programmes of Member States and the EU?

It is too early to expect any effects on policies and programmes. The report was only published online on 11 December 2013 on the public health portal of DG Health & Consumers.

The following are impacts which the report hopes to achieve:

- Reactions: the degree of increased interest in health inequalities among Member States and the public health community; the acceptance of activities and methods needed to address these inequalities; the adaptation of the approach to national and local health inequality reviews.
- Learning: knowledge gained about the health inequality situation by public health professionals and others; changes in their aspirations as a result.
- Actions: actions taken on health inequalities, influenced by the report.
- Systems and environmental change: changes brought about in social, economic and environmental conditions through the report's policy recommendations.
- Health outcomes: ultimately a reduction in indicators of health inequalities and social determinants as a result of implementing the report's recommendations.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The study established the following priorities for Member States:

- The need to lead on clear and comprehensive strategies to redress the current patterns and magnitude of health inequalities.
- Ensuring the coherence and effectiveness of action to reduce health inequalities at all levels of government and across all sectors and stakeholders.
- Ensuring that capacity exists for coherent and effective implementation of action on health inequalities.
- Ensuring improvement in the availability and use of data needed to identify priorities, plan action, monitor trends and evaluate what actions are most effective. Where countries are doing very little, doing something would help. Where some action is being taken, they should be doing more. And even those countries identified as leaders could be doing better.

The priority action for the Commission is leadership to stimulate these actions and build capacity to tackle health inequalities.

Project website

- www.instituteoftheequity.org/projects/eu-review

Budget

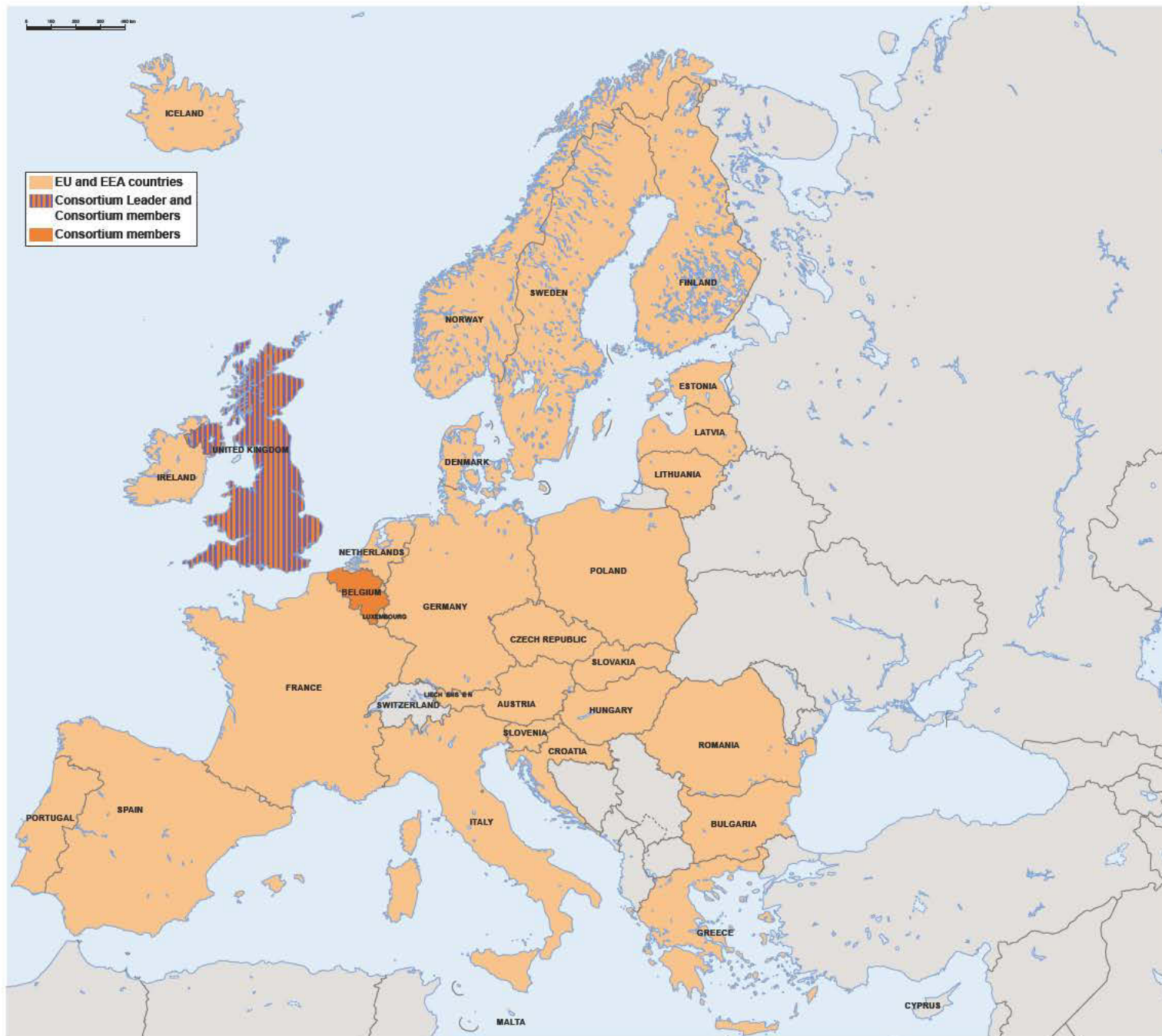
- Total budget: €250 000
- EC contribution: €250 000

Duration

- 11.11.2010 – 11.05.2012 (18 months)

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- National Health Forum, UK
- EuroHealthNet, Belgium

The impact of Structural Funds on Health Gains

Keywords: health in all policies, inequalities, planning health and welfare, Structural Funds on Health, best practices

Health Gains aimed to build greater understanding of the links between public health and other funding priorities of the EU Structural Funds. The team developed an online guide and associated case studies designed to assist managing authorities and regions in ensuring that their Structural Fund programming in non-health sectors can effectively generate health gains. In addition, a series of capacity building workshops in Brussels, Budapest, Cornwall and Sicily introduced the conceptual framework to a wide range of public officials at national, local and regional levels. Communication was a central theme of this work, identifying and reaching out to key stakeholders in order to pass on the key messages.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

Health is a strong contributor to regional economic development and social cohesion. Health inequalities — including the context of social cohesion and the territorial mapping of poverty — are key themes for the EU 2014–20 programmes. The web-based guide aimed to demonstrate how these issues are related and how they can be effectively addressed. It provides specific sections and pages describing EU policy frameworks for Structural Funds and health and the linkages between non-health investments and health outcomes, including financial and output indicators that could help to understand the scope of a given problem and assess the impact of actions.

Objectives

The goal was to support the integration of health considerations into the programming and implementation of EU Cohesion Policy funds, and in particular to identify and link the health gains that come from non-health investments. For example, how could investment in walking or cycling paths promote health gains? How could training for better jobs support long-term health gains? How can programme managers identify existing and potential benefits?

The specific objectives of the project were:

- To review and analyse how health considerations were taken into account in the design and development of non-health investments in Cohesion Policy funds in the relevant spending period (2007 to 2013).
- To develop a web-based guide to health gains from Structural Fund spending, intended to help programme managers, decision-makers and health professionals address health considerations in the next spending period (from 2014 on).
- To pilot, test and validate the guide with officials in selected EU regions.
- To build capacity in the regions through a series of workshops.

Methods

The methodology used was based on activities carried out in relation to the three main work packages: the case studies, the web-based guide and capacity building and dissemination.

Ten regional case studies were researched and drafted, drawing on interviews with officials and stakeholders at regional and local levels, as well as national officials. The case studies provided valuable input to the web-based guide, and the lessons learned and experience documented from them formed a basis for its design and approach. Important information about the linkages between health and Structural Funds in practice served as a basis for developing the web-based guide. These case studies were made available on the project website together with an overview of the lessons learned from them.

The preparation of the web-based guide was a central activity for the project. The information in the guide, and in particular on the funding section, were drawn from a literature review on the links between Structural Fund (SF) funding and health and well-being, and from case studies exploring the ways in which regions address health in SF programmes. The funding section contained detailed 'causal pathways' using the DPSEEA (Driving force, Pressure, States, Exposure, Effect, Actions) model that demonstrates the relationship between human health and social, economic and environmental factors. These were presented as issues that could be addressed by Structural Fund investments, providing opportunities to contribute towards better health.

The work on capacity building and dissemination included both website design, the organisation of the four workshops, further dissemination activities, and the preparation of a dissemination strategy. Each workshop brought together participants from a range of EU Member States; each focused on a specific issue related to the overall theme, such as institutional capacity, health gains in the transition to a low-carbon economy, and community-led development.

Achievements

The main achievement was the creation and dissemination of the web-based guide for programme managers, decision-makers and health professionals seeking to address health issues and assessing possible health gains from future Structural Fund spending.

It is too early to assess the actual impact on Member States' policies, as the overriding objective of the project is to inform considerations for Structural Fund spending in the next spending period from 2014 onwards.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The involvement of stakeholders from various European regions ensured the information contained in the web-based guide, and in particular on the funding section, is of general European relevance.

The project aimed to disseminate a guide to generally improve understanding of how health gains can be achieved by Structural Fund spending. A range of environmental, social and economic issues — such as unemployment in low-income and peripheral regions and social problems in urban neighbourhoods — lead to disproportionate health impacts on lower income populations and vulnerable groups. In turn, efforts to address health gains when programming Structural Fund spending may particularly benefit those in vulnerable situations.

Project website

- www.healthgain.eu

Budget

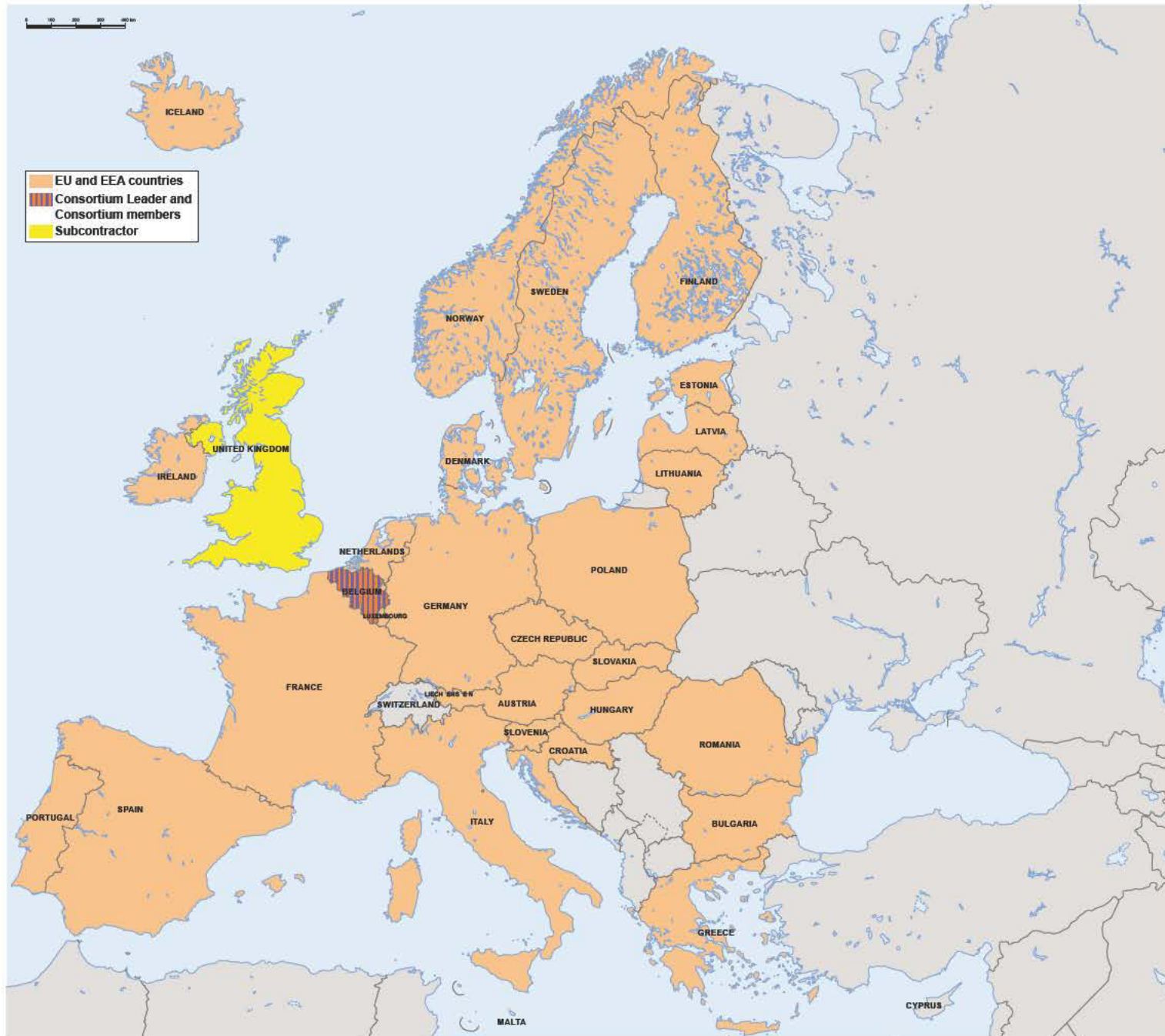
- Total: €467 570

Duration

- 20.05.2010 – 20.03.2012
(22 months)

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Consortium Leader:

Milieu Ltd., Brussels, Belgium

Consortium members:

- Tamarack Limited, Belgium

Subcontractor:

- Sydesy Limited, UK

Reducing Health Inequalities

Preparation for Action Plans and Structural Funds Project – HEALTHEQUITY-2020 (HE2020)

Keywords: inequalities, socio-economic factors, access to health care, capacity building, regional health policy

The general objective is to help EU Member States and regions develop evidence-based action plans on reducing health inequalities that also inform use of Structural Funds in the next programming period. Overall, the project considers investment action to reduce inequalities within and beyond the health sector. This will combine available evidence and learning on social determinants of health, plus health and Structural Funds with social innovation to inform knowledge exchange and capacity building.

The project builds on EUREGIO III and other initiatives to inform about entry points to actions, including health and Structural Funds, analysis of determinants of health inequalities using available data, views of what works in reducing health inequalities, and tools for health equity-related impact assessment.

Project results will be used to inform 2014–20 Structural Fund negotiations, including finalisation and implementation of strategic guidelines and priorities for thematic/regional operational programmes in the EU-10 and mid-term review of EU-10 national reform programmes (2014).



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

Following the regional focus of EU policies and strategies like Cohesion Policy 2014–20 and Europe 2020, this project takes a regional perspective and addresses the fundamental principles of Together for Health 2008–13, the goals of Solidarity in Health 2009, and the new Health for Growth Programme 2014–20. In particular, the project contributes towards implementing the EC Communication on health inequalities to ‘review the possibilities to assist Member States to make better use of EU Cohesion policy and Structural Funds to support activities to address factors contributing to health inequalities.’ Furthermore, in line with Europe 2020, the project supports the use of Structural Funds for health gains and social innovation — and the emerging emphasis on achieving added value from EU investments as part of Cohesion Policy 2014–20.

Why was the public health problem addressed important for Europe?

Socio-economic disadvantage is strongly linked with ill health; bringing a health disadvantage to socio-economically marginalised regions. Strategies to address this must be improved to tackle social determinants. Ultimately, the unequal distribution of societal resources has to be eliminated through national and regional policies.

Structural Funds could help make large-scale changes. However, to be effective action plans need to be evidence-based, where evidence is available, and include social innovations if evidence is limited. Despite the available resources, as yet there is no clear method for drawing up evidence-based action plans.

Objectives

HEALTHY-2020 aims to assist Member States/regions in developing evidence-based action plans on reducing health inequalities, which also inform the use of Structural Funds in the next cycle. This will be done by achieving the following specific objectives:

- To develop and test a toolkit to facilitate the process of evidence-based action planning.
- To develop an accessible and interactive online website and database.

- To build capacity and competency that respects different starting points of Member States or regions.
- To support participating regions in developing action plans on health inequalities that also inform their use of Structural Funds.
- To maximise information exchange and sharing of good practice.
- To ensure sustainability and longer term benefits.

Methods

A variety of methods are foreseen to achieve the results of the project. These include a toolkit sensitive to differing needs and supplemented by a practical knowledge database with good practice case examples. Also, there are action learning workshops and follow-up action learning sets to increase knowledge and capacity of local stakeholders. Additionally, evidence-based regional action plans integrated into regional development plans are involved, alongside intensive, targeted dissemination activities, an interactive website and an online database.

The main outputs include: a database with a menu of search terms linked to objectives of relevant EU policies; a toolkit for needs assessment, Health Impact Assessment (HIA) and assessing the impact on population health and economic performance; four learning workshop actions and ten action plans developed by partner regions.

The project will produce an easy-to-read final report, five peer review papers for high impact journals and three professional articles. Furthermore, e-mails and website information have been used to reach policy makers, practitioners who deal with health inequalities, and citizens. This was done at both national and regional level, as well as citizen level, to ensure that members of the public's points of view were heard in the regional planning process.

Achievements

HE2020 has built a database of case studies to inform local actions on access to health care, health-related behaviour and living and working conditions. The project has informed on action taken by Structural Funds beneficiaries. Participating regions are expected to validate project outputs and products and prepare region-specific evidence-based and financially sustainable action plans integrated with regional development plans. The project has provided guidance for planning and implementing actions where evidence is limited, and helped cascade learning into other regions to inform preparation for the next SF cycle.

The Health 2020 European policy framework emphasises policies to promote equity. Health equity considerations are incorporated in the design and delivery of health and non-health sector investments. This is a condition for sustainable development and a better quality of life and well-being.

To ensure project results become sustainable, a minimum of three participating regions will have strengthened their action plans through a project/systems-level initiative addressing one or more priority actions. At least four participating regions will review existing regional policy/strategy. Structural Funds managing authorities, ministries of health and European Commission line directorates can use project findings to improve their use of Structural Funds at regional and national levels.

What effect have the results had on the policies and programmes of Member States and the EU?

Activities addressing economic and social conditions have indirect influences on health. HE2020 supports the use of Structural Funds for health gains and social innovation — and for the emerging emphasis on achieving added value from EU investments as part

of Cohesion Policy 2014–20. Project results will be used to inform negotiations for 2014–20. The developed evidence-based and social innovation-informed action plans and the database of good practices will support the implementation of EU legislation, economies of scale, promotion of best practice and benchmarking for decision-making.

What were the benefits of working jointly at EU level?

Working jointly brought an exchange of knowledge and data, helping cross-disciplinary working and leading to capacity building. There is active participation of population groups and civilian organisations locally, regionally and nationally. Similarly, the involvement of European stakeholders, ministries of health and social affairs, and development agencies, is fundamental.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

To raise awareness and promote actions to improve access and appropriateness of health services, health promotion and preventive care for migrants, ethnic minorities and other vulnerable groups. Some participating regions have already identified Roma, elderly and rural populations, as the most vulnerable ones and are planning to work on these groups.

Project website

- www.healthequity2020.eu

Budget

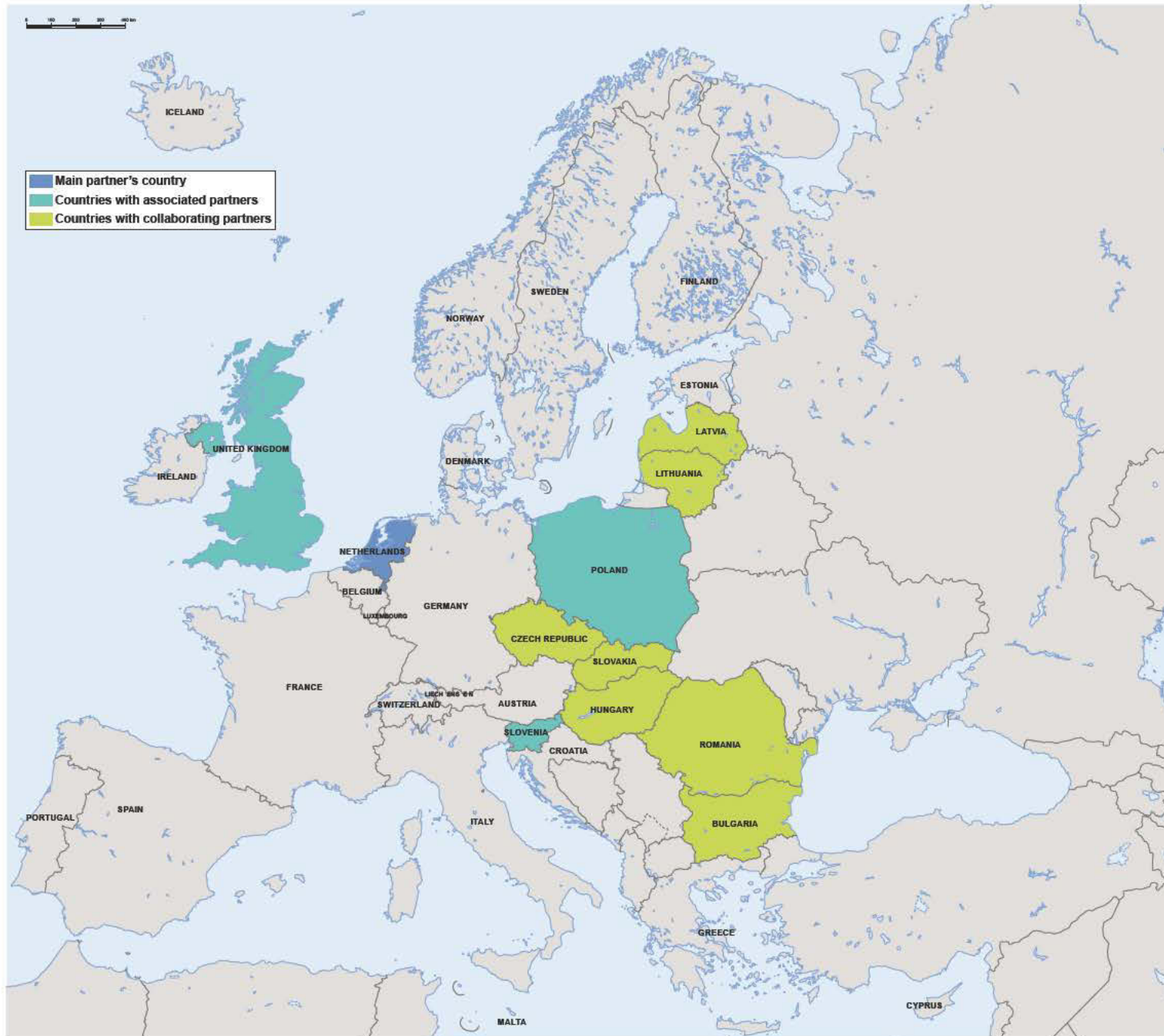
- Total budget: €1 146 674
- EC contribution: €688 004

Duration

- 01/07/2012 – 01/07/2015 (36 months)

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Main partner:

Maastricht University, The Netherlands

Associated partners:

- Health ClusterNET, UK
- Erasmus MC, Department of Public Health, The Netherlands
- Medical University of Lodz, Poland
- Centre for Health and Development Murska Sobota, Slovenia

Collaborating partners:

- Klaipėda District, Klaipėda District Municipality Public Health Bureau, Lithuania
- North Eastern Great Plain, University of Debrecen, Faculty of Public health, Department Of Health Systems Management And Quality Management For Health Care, Hungary

- Whole country (NUTS2 level), Ministry of Health, EU Financing, Planning and Control Unit, Department of Budget and Investments (EU Funds Departments), Latvia
- Vysočina, Brussels Regional Office, Czech Republic
- Stara Zagora Region, Regional Health Inspectorate (RHI), Bulgaria
- Covasna, County Council, Romania
- Self-governing region of Trenčín, Slovakia
- Tallin University, Estonia



*Reducing health inequalities: preparation for action plans
and Structural Funds projects:*

ACTION-FOR-HEALTH

Keywords: health promotion, inequalities, public health practice, regional health planning, needs assessment

This project focuses on improving health and quality of life by tackling health inequalities through health promotion. The objective is to increase the capacity of stakeholders at regional level to effectively tackle health inequalities and to improve their access to the EU's Structural Funds to do so by sharing knowledge and experience.

The project team aimed to prepare strategic regional action plans for seven EU countries. This strategic objective was then to be implemented in each country/region. This bottom-up approach to tackling health inequalities could then be transferred to other regions in the same country.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project raises awareness of health inequalities and builds capacity to tackle them at regional level among authorities, health care professionals, experts and the general public. In doing so it contributes to the aims of the Solidarity in Health Communication and the Europe 2020 Strategy. The project achieved its objectives by facilitating the exchange of knowledge and the development of good practices addressing health inequalities and the use of Structural Funds to do so. The bottom-up approach that was applied can be adapted to other regions.

Why was the public health problem addressed important for Europe?

Policy makers are not sufficiently aware of the causes and consequences of health inequalities. This makes it difficult to bring players together to tackle the issue through effective forms of cooperation between sectors. This is particularly true of Eastern European countries where the transition from the former system to capitalism and the huge social and economic changes this has brought has increased the gap between different social and economic groups. Health inequalities are often perceived as solely the result of an individual's own choices and not as the result of a variety of factors, some of which are structural and out of their control. The project reinforces the need to increase awareness among stakeholders and increase their capacity to tackle health inequalities.

Objectives

The project has two main objectives:

- Increase the capacity of project partners to tackle health inequalities.
- Develop effective action plans to address them at regional level via public health promotion.

In order to achieve this, a comprehensive picture of the situation in each region/country was produced. An action plan was then developed to ensure a systematic approach. The action plans were developed using a common methodology but tailored to enable a systematic approach to tackling health inequalities and

to take into account the cultural specificities of individual regions. They were also sufficiently flexible to be adapted to changing circumstances.

Specific objectives:

- Carry out situation overview and needs assessments with regard to basic socio-economic factors, health determinants and SF Plan at country level and in one chosen region.
- Identify examples of good practice for tackling health inequalities in partner and EU countries.
- Increase the capacity of public health professionals to reduce health inequalities.
- Prepare action plans to tackle health inequalities through health promotion at regional level. (Cost-effective plans compatible with Structural Fund's eligibility criteria).
- Implement one objective from each action plan in each country/region as a pilot.
- Increase public health capacity to reduce health inequalities by using the Structural Funds.

Methods

All partners conducted a situation analysis and assessment of needs both at national level and in one region. Major public health problems, including an overview of sanitary situations, were identified and national objectives in Structural Funds identified.

In each region, a set of common indicators and examples of good practices to tackle health priorities were identified. Summer school and training sessions were organised based on recognised educational methods with a view to improving the capacity of project partners to tackle health inequalities and to try and ensure the action plans could be effectively implemented.

Achievements

The results of the analysis of the situation on a national/regional level and the identification of good practices have been published. The seven action plans were completed by the end of 2013 and Slovenia has piloted the transfer of the bottom-up approach from one region to another.

The main tools used to increase the capacity of project partners were training and a Summer School, both of which have been completed. A publication on the Structural Funds and health inequalities has been prepared while the publication on preparation and implementation of action plans and the distance learning tool will be ready by the end of the project.

As a result of this project the target group is more knowledgeable and more skilled in dealing with health promotion, health inequalities and the Structural Funds. This should improve individual and community control over determinants of health and the community's ability to tackle these problems in the regions involved in the project. The excessive number of people dying from non-communicable diseases was identified as a priority for action to reduce health inequalities in European regions.

In order to make results more sustainable, the project consortium developed a distance learning tool and other material accessible to the wider public via the project website. Established networks and partnerships at regional level should also ensure continuity and transferability of policies and practices. The pilot implementation of one strategic objective serves as evidence of the effectiveness of the action plan for other stakeholders and public health professionals and is motivation to continue.

What effect have the results had on the policies and programmes of Member States and the EU?

The main impact of the project is on a regional level, where increased capacity to tackle health inequalities

and use Structural Funds to do so is most needed. The bottom-up approach and the regional action plans are expected to have an impact on the policy decision-making process at regional level. The horizontal transfer of this approach within these countries could have an impact on the national and EU level in the future.

What were the benefits of working jointly at EU level?

Working jointly and exchanging knowledge and experiences are fundamental to achieving project goals for both individual partners and partnerships. All partners established new, or strengthened existing, networks in their respective countries. The project was able to merge different experiences and knowledge from a wide variety of partners into a meaningful whole. This included partners from old and new Member States, Eastern, Western and Southern Europe as well as organisations from the public and private sectors.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The project identifies the priority for actions to reduce health inequalities in the European regions involved. Actions aimed at achieving this goal should be more comprehensive and universal, and tailored to specific needs of particular vulnerable groups whilst respecting cultural differences within and between countries.

Project website

- www.action-for-health.eu

Budget

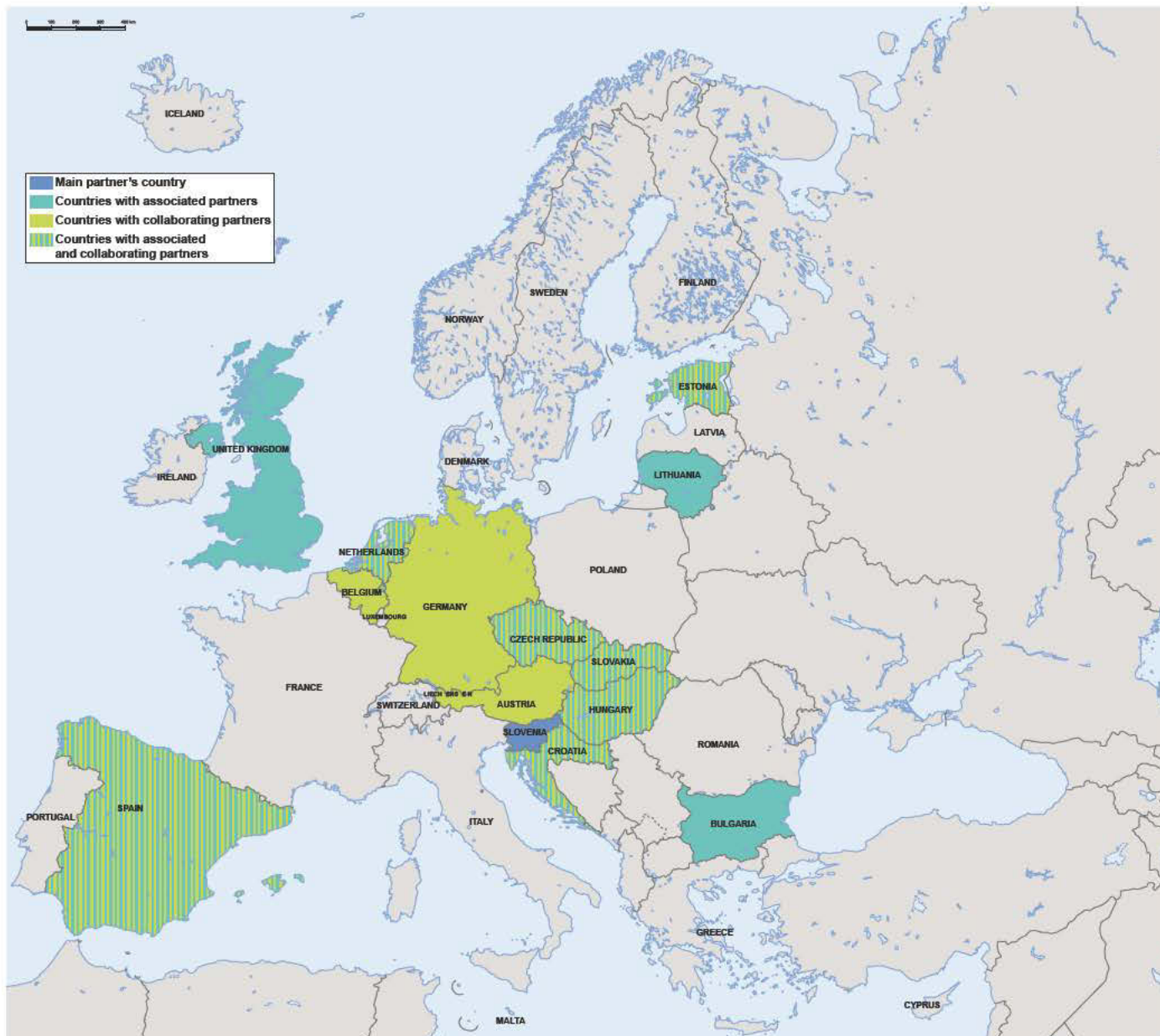
- Total budget: €988 420
- EC contribution: €588 863

Duration

- 15.08.2012 – 14.08.2014

Main beneficiary

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Main partner:

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- National Institute for Health Development (OEFI) - Hungary
- National Centre of Public Health and Analysis (NCPHA) - Bulgaria
- University of Brighton Higher Education Corporation (UOB) - UK
- University of Trnava (TU) - Slovakia,
- Dutch Institute for Health Care Improvement CBO - The Netherlands
- Estonian-Swedish Mental Health and Suicidology Institute (ERSI) - Estonia
- Institute of Hygiene (HI) - Lithuania

Collaborating partners:

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- National Institute for Child Health, Budapest, Hungary
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- Rotes Kreuz Bad Radkersburg, Bad Radkesburg, Austria
- Public Health Department-Ministry of Social Affairs, Tallin, Estonia
- National Institute of Public Health (NIPH), Department of Psychosocial Determinants of Health, Prague, Czech Republic

WHO Europe Direct Grant Agreement on the European Review of Social Determinants and the Health Divide

Keywords: social determinants of health, health inequalities indicators, health policy, health information systems

A number of studies — most recently the WHO European Review of Social Determinants and the Health Divide — have demonstrated the existence of large, socially determined health inequalities in the WHO European Region.

Work carried out using a direct grant from the European Commission aims to address the critical shortcomings in capacity and implementation which impede action on the social determinants of

health and health inequities. It will do so in three main ways: by producing policy briefs based on the WHO European Review; by setting up an online Health Inequalities Atlas; and by offering guidance to policy makers on applying a 'Health in All Policies' approach to health inequalities.

This action continues a collaboration between the European Commission and the WHO Regional Office for Europe which began in 2007.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The action seeks to raise awareness of health inequities and social determinants of health among policy makers working on priority public health areas, thereby promoting the exchange of information and knowledge between Member States.

Activities will therefore contribute to the implementation of EC Communication Solidarity in Health (2009). Addressing the capacity and implementation gap on socially determined inequalities is critical to addressing the large health inequalities within and between countries.

Why was the public health problem addressed important for Europe?

Action to reduce health inequities in Europe by tackling the social determinants of health is hampered by a lack of capacity and implementation. This project will equip policy makers so they can plan initiatives that promote equity and evaluate their effectiveness.

Objectives

The action aims to produce information, guidance and practical tools for policy makers in order to strengthen their capacity to further implement actions to tackle health inequities. It will do so by:

- Formulating clear policy guidance on addressing inequities in major public health issues;
- Making data available via a web-based Health Inequalities Atlas;
- Increasing the capacity of policy makers at national, regional and local level to address health inequalities.

Methods

Findings from the WHO European Review of Social Determinants and the Health Divide, concerning several priority public health topics including obesity, tobacco, alcohol and injury will be translated into policy guidance. Guidance will also be provided on how to take an overarching approach to addressing health inequities. This guidance will emphasise governance

arrangements to support action on social determinants, and include practical examples from European contexts.

The web-based Health Inequalities Atlas will be based on publicly available, sub-nationally disaggregated data from diverse sources. This will be used to generate indicators of health inequalities and their determinants, and will also incorporate a facility for monitoring trends.

Capacity building for policy makers will be furthered by disseminating the above tools through policy dialogues, as well as by integrating them into existing WHO capacity building programmes and technical work.

The primary target group for the policy guidance tools are policy makers and programme managers responsible for priority public health issues listed above. Examples of groups involved in testing the tools include WHO European Region national Ministry of Health focal points on tobacco, alcohol and nutrition, the European Obesity Forum and the WHO Regions for Health Network. WHO technical leads, WHO Collaborating Centres and the EU expert group on health inequalities were also involved.

To encourage wider dissemination, the finished tools will be made available on the WHO website. This will make them accessible to a wider readership — including civil society, academia and the media — in order to facilitate greater public engagement, awareness and debate on health inequities within the region. A variety of dissemination events will also be organised.

Achievements

The action has already produced draft policy guidance tools on strategies to reduce inequities in relation to tobacco, obesity, injury and alcohol. Guidance has also been released on how to take a comprehensive approach to addressing health inequities. These tools have been extensively piloted and discussed with key stakeholders. The Health Inequalities Atlas is available online and is undergoing further refinement, with extra features and improved accessibility.

What effect have the results had on the policies and programmes of Member States and the EU?

As the action is still in progress, it has not had time to generate much impact on policies. However, a formal policy dialogue with key stakeholders at sub-national level has taken place. This dialogue has concerned strategies to reduce inequities in relation to tobacco, obesity, injury, alcohol, as well as the development of a comprehensive approach to addressing health inequities. Dialogues with policy makers at national and European levels took place during the development and testing of the policy guidance documents.

The action is expected to strengthen understanding of the specific nature and extent of health inequalities within the 53 Member States of the WHO European Region. It will clarify the options for policy makers and provide easily accessible empirical evidence to back up policies. Specifically, it will strengthen the case for a 'Health in All Policies' approach and increase the capacity of policy makers to advocate for its adoption.

What were the benefits of working jointly at EU level?

The development of policy guidance for addressing health inequities promotes best practice, and the online data atlas tool supports Member States in benchmarking for decision making. In addition, the policy dialogues on the completed products support the promotion of best practice as well as networking among the policy community in Europe.

This action facilitated the sharing of information and the development of understanding between the EU and WHO Europe as part of an ongoing relationship and a long history of collaboration on health inequities.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

Two key priorities have emerged through this work that needs further attention and development:

- The urgent need for Member States to collect data which can be disaggregated by social group, at both national and sub-national level;
- The need for improved evidence to evaluate the impact of policies and interventions on different social groups.

Project website

- www.euro.who.int/en/data-and-evidence/equity-in-health-project

Budget

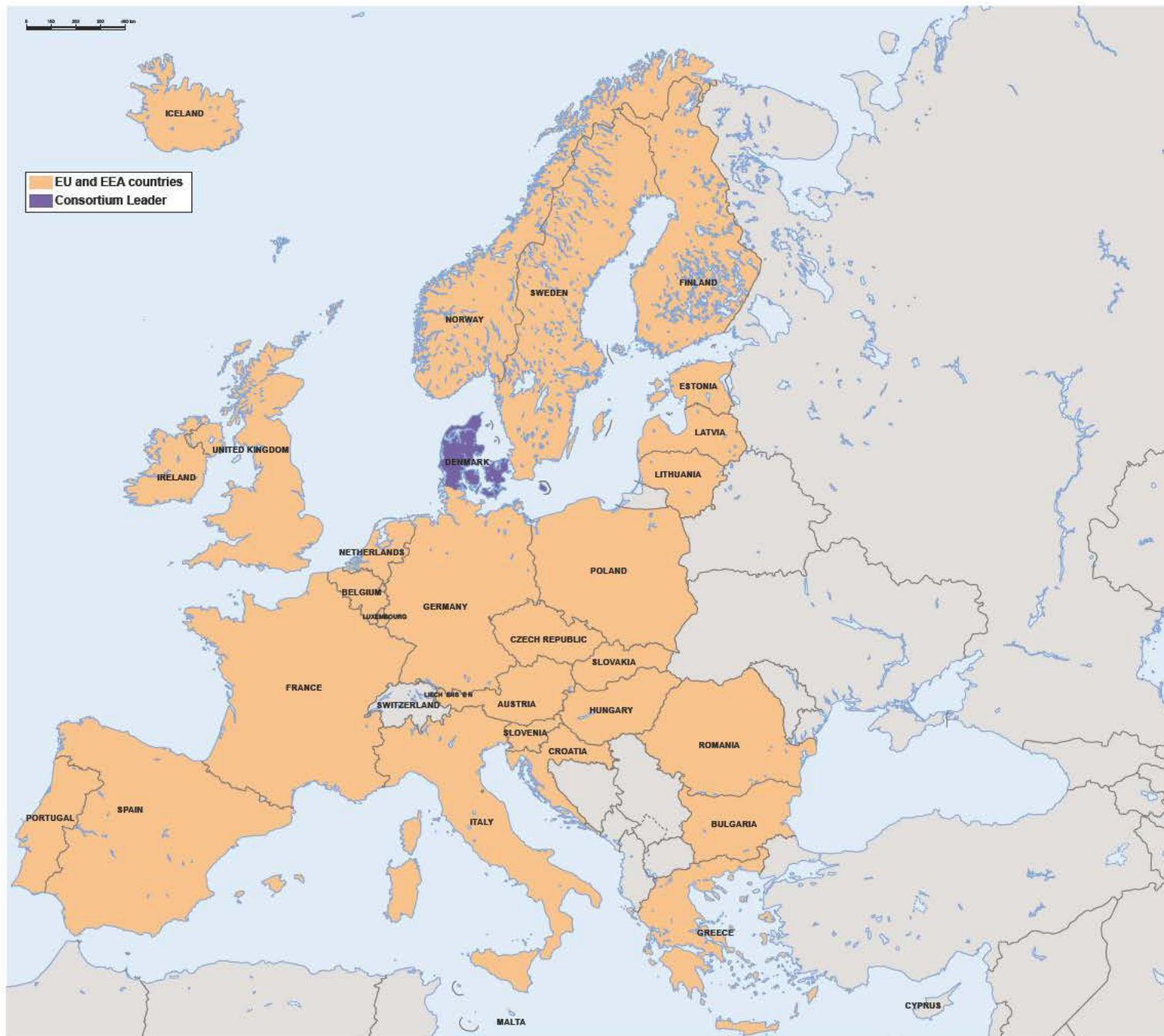
- Total budget: €666 636
- EC contribution: €400 000

Duration

- 01.01.2012 – 30.06.2014

Beneficiary

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- Single beneficiary direct grant.



Consortium Leader:

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Tobacco and Health Inequalities

Keywords: tobacco, smoking, inequalities, socio-economic factors, minority groups

Tobacco consumption is one of the main reasons that certain vulnerable and disadvantaged groups in the EU have worse health problems than the general population. However, adopting tobacco control measures may be ineffective for such groups and there is a risk of making inequalities even more pronounced. The aim of the project is to strengthen equitable health policies by identifying good practice in tobacco control, which would curb health inequalities.

To achieve this aim, research on tobacco consumption in relevant socio-demographic groups in the EU and the contribution of tobacco to health inequalities experienced by these groups was reviewed. Interventions to reduce tobacco use were then analysed, and interventions in other fields of health promotion designed to reduce inequalities were reviewed. Finally, recommendations were made for policy development. The results gave a clearer picture of the social determinants of tobacco use, particularly relating to income, education, gender and minority status, and the measures needed to ensure that the benefits of tobacco control reach vulnerable and disadvantaged groups

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project relates to the EC Communication Solidarity in Health by raising awareness of how tobacco use links with health inequalities and the types of intervention which can reduce tobacco use. It also promotes knowledge exchange between Member States, and identifies and spreads good practice. In this way it facilitates the design of policies for reducing tobacco use which will be equally effective among disadvantaged and vulnerable groups, or even more so. The project also collated and analysed data on differences in tobacco consumption by socio-economic and demographic indicators, as well health promotion interventions, from European and non-European sources. Because certain tobacco-related diseases are particularly detrimental to the health of the elderly, the project also contributes to equitable policies on healthy ageing.

Why was the public health problem addressed important for Europe?

According to the European Commission, tobacco represents the single largest avoidable risk to health in EU countries, accounting for nearly 700 000 premature deaths each year. Around 50% of smokers die prematurely; on average 14 years earlier than would be expected. Many cancers and cardiovascular or respiratory diseases are linked to tobacco use, which causes more problems than alcohol, drugs, high blood pressure, excess weight or high cholesterol. Despite considerable progress, the number of smokers in the EU is still high; at 28% of the general population and 29% among those aged 15–24.

Tobacco use is particularly prevalent in disadvantaged and vulnerable social groups. This is a long-term trend, notably in advanced economies. These groups also tend to have less access and exposure to health promotion activities. It is therefore essential to develop 'diversity-proof' approaches to reducing smoking rates.

Objectives

The main aim of the study is to help reduce health inequality by identifying best practices in tobacco control among socially disadvantaged and vulnera-

ble groups (defined in terms of education, income, gender, age and ethnic minority membership). Such groups often smoke more, but are more difficult to reach and influence by health promotion interventions. Therefore there is a need not only to discover effective measures for reducing tobacco use, but also to ensure that these have equitable effects.

Methods

The study was undertaken by means of a review of research literature. Studies on three topics were systematically reviewed and analysed:

- Differences between socio-demographic groups in the EU concerning the consumption of tobacco, as well as the role of tobacco in health inequalities.
- Interventions to reduce tobacco use and the impact on health inequalities.
- Intervention in other fields of health promotion (alcohol abuse, diet, physical activity and nutrition) and the implications for action on tobacco-related health inequalities.

Finally, the conclusions and implications for policy development were discussed.

Achievements

The project is still underway, so the following results are provisional.

- While men in the EU smoke more than women, the decline in men's tobacco consumption from 2005 to 2012 was much more marked, especially in the 35–44 and 45–54 age groups. The clearest socio-economic differences relate to income and perceived social status: the less well-off smoke more, and this gap is widening. A higher level of education is associated with less smoking. The prevalence of smoking is significantly higher among vulnerable ethnic groups, in particular the Roma population.
- The literature review of interventions aimed at reducing smoking provides evidence that certain methods (including medication, smoke-free homes, taxation, labelling and behaviour therapy) are effective and cost-effective, but differ in their impact according to socio-demographic groups. Only interventions specifically targeted and adapted to vulnerable groups tend to reduce health inequalities.
- The review of health promotion activities to address other health risks showed that although the interventions were effective, some did not reduce health inequalities — they exacerbated them. Evidence suggests that community-based interventions, increased taxation and targeted educational interventions can curb health inequalities. On the other hand, individually tailored interventions, non-targeted media campaigns and use of printed communication material as well as work place based interventions are more effective in higher socio-economic groups and can thus widen health inequalities.

Provisional recommendations indicate that interventions should be specifically targeted at groups with health disadvantage, perhaps entailing ethnic language mass-media campaigns and the involvement of community groups to 'own' such interventions. Attention must also be paid to wider socio-economic inequities affecting tobacco consumption.

What effect have the results had on the policies and programmes of Member States and the EU?

Often, the groups with the most health disadvantages are less influenced by health promotion. The report also points out that interventions must consider wider social determinants of health. Psychosocial stress and lack of social support may be a link between social disadvantage and smoking. Finally, the report shows the urgent need for more research.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The report underlines the need to focus on disadvantaged and vulnerable groups when designing tobacco control policy. Tobacco use explains a significant proportion of health disadvantages suffered by people with low socio-economic status. However, the same groups often have less access to preventive services, and health promotion initiatives may have less influence on them. To ensure that health promotion intervention does not increase health inequalities, it is essential to consider these factors. Moreover, a 'Health in All Policies' approach is required to tackle the disadvantages contributing to increased tobacco consumption.

Project website

- www.matrixknowledge.com

Budget

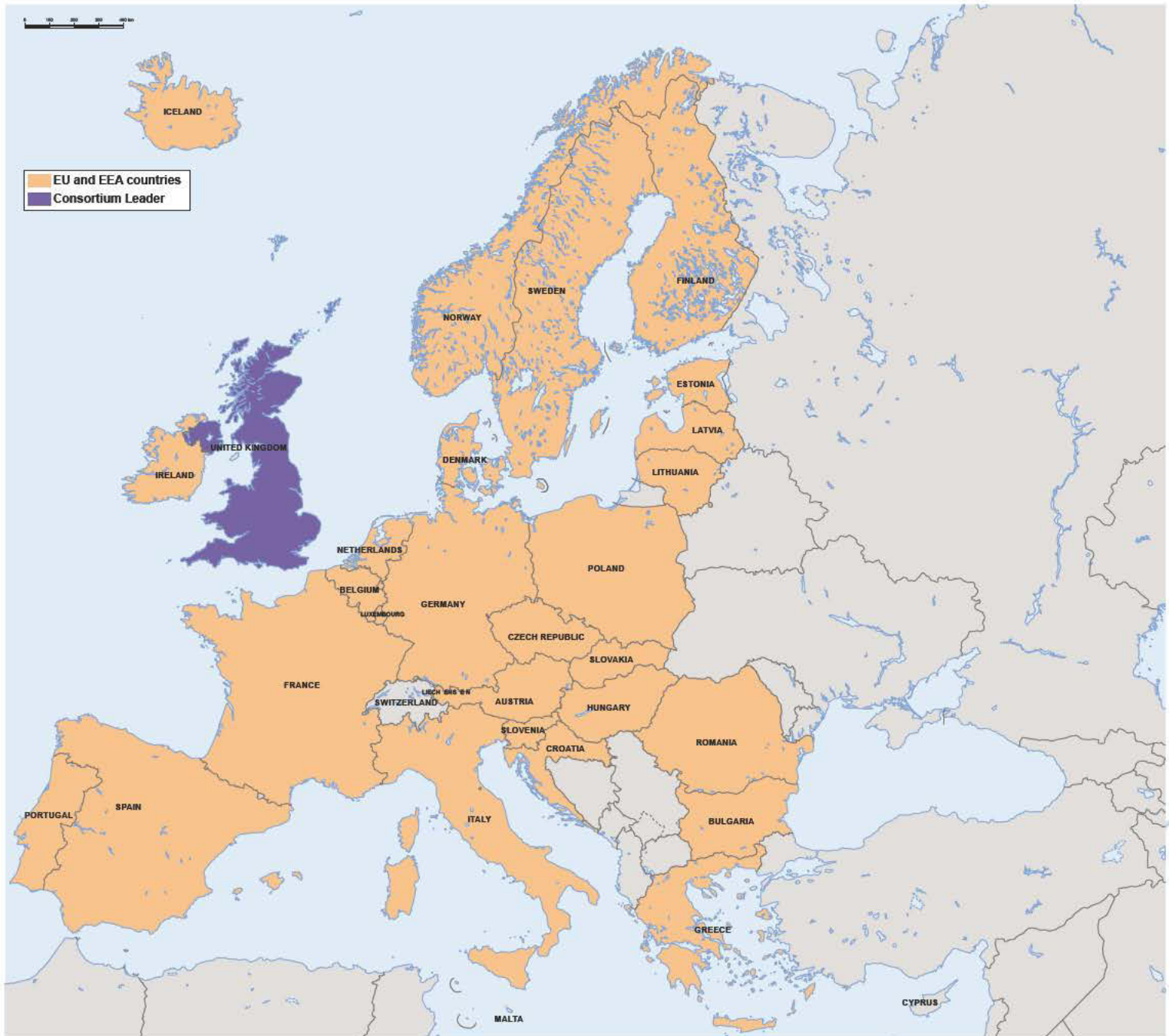
- Total budget: €138 250
- EC contribution: €138 250

Duration

- 10.01.2013 – 30.06.2014

Main beneficiary

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Roma Health

Reports on health status of the Roma population in the EU and the monitoring of data collection in the area of Roma health in Member States

Keywords: Romany, gypsies, mortality, communicable diseases, chronic disease, health services needs and demand

The continuing shortage of data on Roma health is a major obstacle for current inclusion strategies. This study aims to review data and investigate the measures being taken or planned to collect information on Roma health. The objective is to improve knowledge of Roma health and inform initiatives to address the serious health disadvantages suffered by this group. It follows the project Health and the Roma Community (2007–09) and reinforces the EU Framework for Roma Integration Strategies up to 2020 (2011).

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The EC Communication Solidarity in health (2009) identified Roma as a vulnerable ethnic minority experiencing serious health disadvantages, and recommended action to address this. In line with the recommendation, the EU Framework for Roma Integration Strategies up to 2020 (2011) selected health, education, employment and housing as 'crucial areas' on which National Roma Integration Strategies (NRIS) should be focused.

However, without adequate data it is hard to identify priorities for action or evaluate the success of interventions. Solidarity in health does not identify ethnicity as an indicator of health inequalities, and it is impossible to tackle the health disadvantages of ethnic minorities in the absence of disaggregated health data. The study reviewed data sources on Roma health in the 31 countries, EU-28 plus EEA/EFTA. It also examined present and planned policies concerning collection of such information, and made recommendations regarding good practice.

Why was the public health problem addressed important for Europe?

The Roma are Europe's largest and most vulnerable minority. Their lower socio-economic status, social exclusion and discrimination they face mean their health is considerably worse than that of most citizens. The EC, many other international organisations, IGOs and NGOs have called for urgent action to tackle Roma health problems and their underlying social causes.

Objectives

The objective of the study was to review data on Roma health in the 31 (EU-28 plus EEA/EFTA) countries; data was taken largely from the last five years. The review examined the prevalence and incidence of health problems, health-related lifestyles, access to health care and use of preventive services, factors related to women's roles and factors affecting health such as housing, sanitation, employment and education.

A second aim was to examine current and future activities used to collect and use health data. This data is required to monitor progress in implementing National Roma Integration Strategies in the area of health.

Methods

Information was collected from studies by national and international bodies, using a specially designed data extraction tool. Eight EU Member States with a relatively high Roma population (the Czech Republic, Slovakia, Croatia, Hungary, Bulgaria, Romania, Greece and Spain), and three containing many migrant Roma (France, the United Kingdom and Italy), were used as case studies. This information collected focused on:

- Mortality and life expectancy
- Prevalence of major infectious diseases
- Prevalence of major chronic diseases
- Healthy lifestyles
- Access and use of health services and prevention programmes
- Health factors related to the role of women
- Environmental and other socio-economic factors

To improve data validity, national and regional Roma health stakeholders were consulted.

Practitioners, policy makers and other stakeholders across nations were asked about good practice in data collection. This Delphi exercise revealed consensus of opinions. The project was carried out in consultation with the Fundamental Rights Agency (FRA), which was also collecting data on Roma health.

Achievements

The data confirmed existing findings, but highlighted gaps in current knowledge. An average ten-year difference in life expectancy between Roma and non-Roma was found, plus evidence linking inequalities to social conditions. Roma had an increased risk of communicable and non-communicable diseases, while smoking and obesity were more common. Barriers to accessing health care were identified, and there were indications that the economic crisis is exacerbating health problems.

Stakeholders showed general dissatisfaction with the quality of data collection available to support efforts to improve Roma health. More should be invested to monitor the NRIS aimed at improving health.

What effect have the results had on the policies and programmes of Member States and the EU?

It is hoped that the study's most immediate and practical contribution will be to the monitoring of Member States' National Roma Integration Strategies relating to health. The review of existing health data will make it easier to design and carry out evaluations of these strategies.

The results may also increase awareness of the urgency and seriousness of Roma health problems. This can be achieved by the 31 Country Reports with Roma health data, and by the 11 case study reports.

What were the benefits of working jointly at EU level?

Since the report concerns a dispersed population group, working at European level was essential and unavoidable. However, the interests of Roma would have been better served by including non-EU/EEA/EFTA countries. Comparison of findings between countries — and the exchange of knowledge and good practice — can improve insight into the problems of Roma health, and further the search for solutions.

This project was particularly valuable because its focus included all EU/EEA/EFTA countries, not just those

with a traditionally high Roma population. Although most Roma are sedentary, increasing numbers migrate around Europe. Recent experiences show that they may encounter even greater social exclusion and discrimination as migrants than in their countries of origin.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The project makes recommendations concerning the monitoring of National Roma Integration Strategies relating to health. It calls for increased investment in the monitoring process, as well as the adoption of so-called SMART indicators rather than vague or overly ambitious aims. Using Cohesion Policy Technical Assistance would be beneficial. In line with this, it recommends a focus on measuring access to and utilisation of health services (including proxies like immunisation coverage), rather than attempting to measure health outcomes. Migrant Roma should receive more attention than hitherto. The importance of participation and engagement of the Roma community was strongly emphasised, as was the need to collaborate with NGOs and grassroots organisations.

Project website

- www.matrixknowledge.com/

Budget

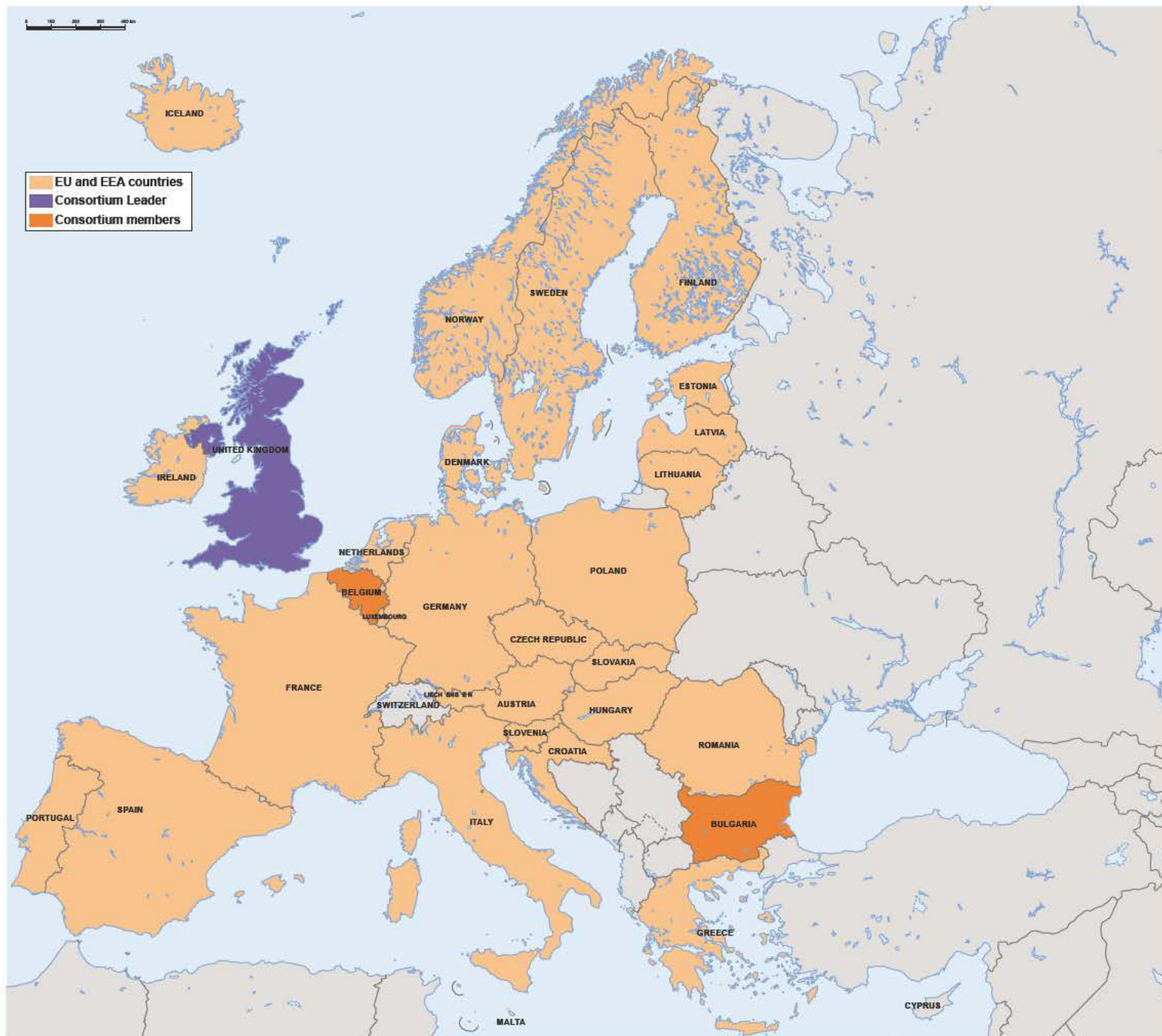
- Total budget: €99 500
- EC contribution: €99 500

Duration

- 15.12.2012 – 15.12.2013
(12 months)

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Consortium members:

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- Center for Study of Democracy (CSD) Bulgaria



Actions mainly targeting at-risk groups (Cluster 2)

Cluster 2 presents the actions addressing vulnerable 'at-risk groups'.

These actions focus on sex differences and women's issues, communicable diseases (especially blood-borne diseases), health behaviours and addictions. They consist mainly of actions concerned with sex workers, intravenous drug users and people living with HIV/AIDS. Many of them also focus on adolescents and young adults. The actions addressing the health needs of those vulnerable groups most at risk are grouped in Cluster 2, represented in graph 16 as the red circle (upper left quadrant).

These groups are characterised by lifestyles that require targeting health promotion and prevention programmes, to reduce risky behaviour and prevent and treat the diseases associated with it.

Although the target groups may be hard to reach, requiring adapted strategies to offer health services to the community, like using outreach strategies, they are not hard to define. The risky behaviour and the need for access to health services, for prevention, treatment and

care are evident, and sufficient evidence of the measures to reduce harm exists. For drug users, the harm reduction scientific evidence was reviewed by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)⁽⁴¹⁾.

Health promotion and access to health services, and the availability of prevention materials for at-risk individuals (condoms, needle exchange programmes, opioid substitution treatment (OST), vaccinations, testing and access to treatment for blood-borne infections (HIV/AIDS, viral hepatitis, sexually transmitted diseases)), are dealt with by health services and community organisations. These interventions can be characterised as harm reduction actions, designed to promote health promotion and reduction of risk, at the same time studying risky behaviour, barriers in the health service and solutions to ensure access to and quality of care, decreasing stigma and discrimination in the health services and in the community, and analysing the intersectoral aspects of the health problem, including legal implications. They also operate 'close to the ground', i.e. in the community in close contact with the target groups.

(41) <http://www.emcdda.europa.eu/publications/monographs/harm-reduction>

Integrated responses to drugs and infections across European criminal justice systems

Connections

Keywords: communicable diseases, prevention, drug users, prisons, criminal justice system

The Connections project aimed to contribute to the development of more effective, inclusive, accessible and equivalent HIV/AIDS (and other drug-related diseases) and drug prevention policies and services for 'at-risk' populations throughout the criminal justice systems of EU Member States and candidate countries. The project facilitated the introduction and

promotion at national and European level of more effective, comprehensive, evidence-based policies and services to respond to drugs and infections, in prison and within the wider context of the criminal justice system. Approaches and priorities based on public health and human rights guided the project towards the promotion of comprehensive continuity of care.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project aimed to reduce health inequalities affecting drug-using prisoners in the criminal justice system. The project drew on the principle of 'equality of treatment' between prison and the community. It focused on a particularly disadvantaged section of society — people with a drug misuse problem involved in the criminal justice system, who often face multiple social, health and economic problems.

Why was the public health problem(s) addressed important for Europe?

Although drug use and related infections such as HIV/AIDS and hepatitis present significant challenges for prisons, public health authorities, law enforcement and national governments, European epidemiological data on drug use and infections in prison and the criminal justice system are limited. Available evidence shows that, compared with the general population, drug users are overrepresented in arrest figures and in prisons, while high rates of re-offending bring this population into frequent contact with the criminal justice system. Yet the criminal justice systems of many Member States lack the expertise to respond effectively and halt the cycle of re-offending. International recommendations and guidelines informed by research call for multidisciplinary and multisectoral responses to address the needs of offending drug users and to prevent the spread of drug-related infections, in prisons and thus to the community as a whole.

Objectives

The Connections project focused on promoting dialogue between civil society organisations, academics and criminal justice agencies, with a view to

improving cooperation between these sectors at regional, country and European level. The goal was to identify good practice in policies and services in the area of HIV/AIDS and other drug-related infection prevention within the criminal justice system.

Specific objectives were:

- To facilitate networking among relevant stakeholders and to disseminate good practices;
- To improve the capacity of criminal justice system professionals working with drug users to implement prevention strategies within their areas of competence;
- To promote practical exchanges of good practice and support a 'learning from doing' approach;
- To support evidence-based multiagency policy dialogue and developments at national level;
- To inform policy development at EU level;
- To collect and disseminate evidence-based research and introduce new research studies in less-explored fields.

Methods

Networking, for example through conferences and newsletters, formed the core of the project. Training academies and local training sessions were used to build capacity. Study visits and work placements were organised to encourage exchange of experience. To support policy development, a compilation of EU good practices was developed and, at a national level, pilot projects on harm reduction were run in the criminal justice systems of three countries (Hungary, Poland and Romania). Two research reports, 'Ethnicity, drugs, HIV and the prisons of Europe' and 'Towards a continuum of care in the EU criminal justice system — a survey of prisoners' needs', were also produced.

Achievements

The project's main achievements were: an increased knowledge base on the responses of criminal justice systems to drugs and infections in prison; sensitisation of policy makers at national and EU levels to the importance of drugs and infection prevention in prisons, with evidence-based recommendations and specific examples of successful programmes; increased knowledge and capacity of staff involved in service design and delivery; and strengthened networking among stakeholders working in the area of drugs, HIV/AIDS and prevention of other drug-related infections in criminal justice systems.

The main public health benefit for the target group was increased access to drug treatment and infection prevention services, reducing health risks linked to drug use during incarceration with a consequent expected improvement in the general health status of prisoners.

What effect have the results had on the policies and programmes of Member States and the EU?

The main impact of the project was to keep prison health on the agenda of policy makers and to support the call for 'equivalence of health services' between prison and the community, at national and EU level. The aim of the project was to collect evidence to show which interventions could be considered effective, feasible and human rights-based, and to advocate for their introduction. However, implementation of policies and services will depend on local stakeholders' decision-making processes.

What were the benefits of working jointly at EU level?

The benefits of collective work and joint research included dissemination of information, easier reference to European and international guidelines on prison health and links with daily practice of prison work, as well as increased dialogue between different stakeholders at country and European level, and the sharing of experience and approaches. Project partners collaborated in a series of European networks focusing on drugs and infection prevention and treatment in prison. These networks enabled partners to accumulate solid experience and develop a broad knowledge base, a large network of contacts and a strong foundation, and they were involved in the development and implementation of European and international guidelines on prison health in Europe.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The project revealed how continuous work is needed to sustain the 'principle of equivalence' in the provision of health services in prison, particularly considering the rise in the prison population and a worrying trend that prisons are becoming the institution where increasingly vulnerable people are kept, with few external resources.

Project website

- <http://connections.accessproject.eu/>

Budget

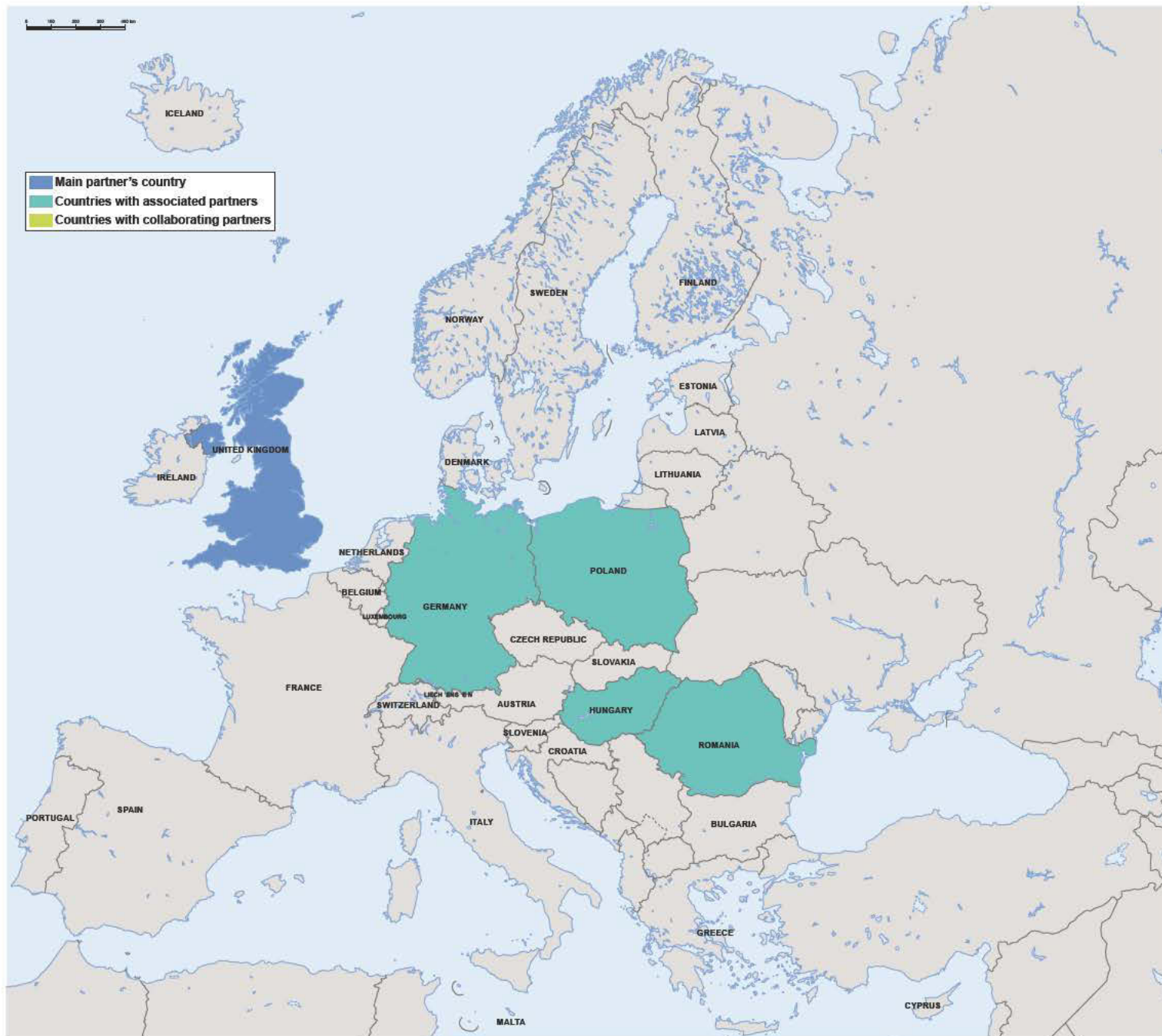
- Total budget: €1 647 201
- EC contribution: €851 236

Duration

- 01.09.2007 – 31.08.2010

Main beneficiary

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Main partner:

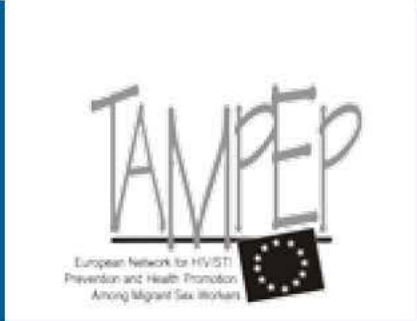
The European Institute of Social Services (EISS) of the University of Kent, UK

Associated partners:

- Hungarian Civil Liberty Union, Hungary
- ARAS, Romania
- Probacja, Poland
- Rugby House, UK
- The research centre T3E, UK
- University of Applied Sciences, Frankfurt/Main, Germany

Collaborating partners:

- Collaborating partners included national prison administrations, health authorities, international organisations and NGOs in the EU. 'Connections' continues to work closely with the WHO Health in Prison Project, the WHO Euro Office, EMCDDA, UNODC, AFEW, IHRD/OSI, the IDPC of the Beckley Foundation, HEUNI, IHRA and the Council of Europe.



European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers

TAMPEP

Keywords: HIV/AIDS, STI, sex workers, access to health care, migrant women

TAMPEP is an international networking and intervention project operating in 25 European countries. It acts as an observatory in relation to the dynamics of migrant prostitution across Europe. TAMPEP's activities aim to enhance the capacity of services to respond to sex workers' needs. It also helps to coordinate policy recommendations at national and European level relating to social and public health issues that are of concern to migrant and mobile sex workers in Europe.

TAMPEP activities focusing on the prevention of HIV and STI (Sexually Transmitted Infections) among migrant and mobile sex workers have been funded under the EU Health Programmes and have produced encouraging results. Projects combining research, education, outreach and cultural mediation target organisations working with sex workers and sex workers themselves. The goal is to enhance their knowledge and capacity regarding HIV/STI prevention.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The TAMPEP network and projects target a vulnerable and socially excluded population in Europe: sex workers, and in particular migrant sex workers. TAMPEP's objectives were to promote HIV prevention and access to prevention services for sex workers and to empower these underserved groups to adopt less risky and healthier lifestyles, so as to reduce health and social inequalities in Europe.

TAMPEP therefore contributes to the EU's goals of reducing inequalities in European society as outlined in the Commission's Communication: Solidarity in Health: Reducing health inequalities in the EU — COM(2009) 567 — and the Europe 2020 initiative.

Why was the public health problem addressed important for Europe?

It is often assumed that sex workers are at increased risk of HIV and other STIs and that they play a major role in transmitting STIs. While scientific evidence does not support this view, it is essential for sex workers to be empowered to practise safer sex. However, state systems of control often hinder health promotion and other service provision to sex workers, and make their working conditions dangerous. In different European countries sex workers do not qualify for health services for various reasons. Migrant sex workers often lack legal papers and are therefore excluded from the welfare system. In addition, the health system rarely provides adapted, inclusive services for this group.

Objectives

TAMPEP's specific objectives were to:

- Consolidate and further develop targeted HIV/STI prevention measures and health promotion interventions for migrant and mobile sex workers in Europe.
- Provide an overview of the situation of sex workers in Europe looking at the legal framework regarding sex work, HIV and migration, and the barriers which restrict sex workers' access to prevention measures and care.

- Facilitate the sharing of knowledge, experience and good practices among service providers and community-based organisations at European level.
- Enhance the capacity of the 25 participating organisations to implement effective prevention interventions within a sub-regional and cross-border cooperation model.
- Promote human rights and equality in public health policies which will increase sex workers' access to health services.

Methods

The TAMPEP project combined community-based research, targeted intervention, advocacy and the direct participation of sex workers in the project activities.

An assessment of the European prostitution scene was carried out through the collection of qualitative and quantitative data on the sex worker population. Demographics, forms of prostitution, mobility trends, living, working and health conditions, risk behaviour and vulnerability to HIV/AIDS were all examined in 23 EU Member States, plus Norway and Switzerland. The research was supplemented with a survey of the legal framework, policy developments and good practices in prevention and health promotion for sex workers.

To promote prevention activities the project produced information leaflets and peer education material, and implemented direct activities with migrant sex workers through its cooperating partners. For the implementation of the outreach and street work, TAMPEP methodology included the involvement of cultural mediators and peer educators, and the development of multilingual information and education material for sex workers.

Achievements

TAMPEP made it easier to share knowledge and experiences at national, regional and European levels between governmental service providers, community-based organisations and international agencies. It identified good practice strategies and tools while promoting the implementation of HIV prevention activities for migrant and mobile sex workers.

The project compiled a report on existing legislation, policies and trends. It also provided a map of the prostitution scene in 25 European countries, looking at the main factors of vulnerability for sex workers and the barriers they face in accessing health and social services.

The main objective of the project was achieved through the development, dissemination and implementation of HIV/STI prevention strategies and tools. The manual 'Work Safe in Sex Work' included examples of good practices for HIV/STI prevention, in particular outreach activities, peer education, campaigns for clients and advocacy campaigns. A resource for sex workers in English, French, Spanish and Russian was made available online: www.services4sexworkers.eu. It provides a list of social and health care services available to sex workers in the largest cities of 25 partner countries.

What effect have the results had on the policies and programmes of Member States and the EU?

TAMPEP's experience and expertise in combating the social exclusion of sex workers has strengthened the national response in participating countries. The project has enhanced the capacity of stakeholders to promote HIV/STI prevention among sex workers. TAMPEP members have directly contributed to HIV/STI primary prevention by making it easier for sex workers to access appropriate legal, health and social services.

What were the benefits of working jointly at EU level?

TAMPEP has been crucial in increasing cooperation at transnational and European level between organisations in the countries of origin, transition and destination of sex workers — and in supporting the implementation of effective prevention strategies for this group.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

Addressing discrimination against migrants and restrictive legislation around prostitution which excludes sex workers from legal, social and health support is a precondition for reducing health inequalities. TAMPEP identifies the need for a policy framework that will not weaken but rather strengthen sex workers' capacity to control their working and living conditions, ensuring that sex workers have access to HIV/STI prevention and care.

Project website

- www.tampep.eu

Phase I

Budget

- Total budget: €992 960
- EC contribution: €595 776

Duration

- 01.01.2005 – 01.01.2007

Phase II

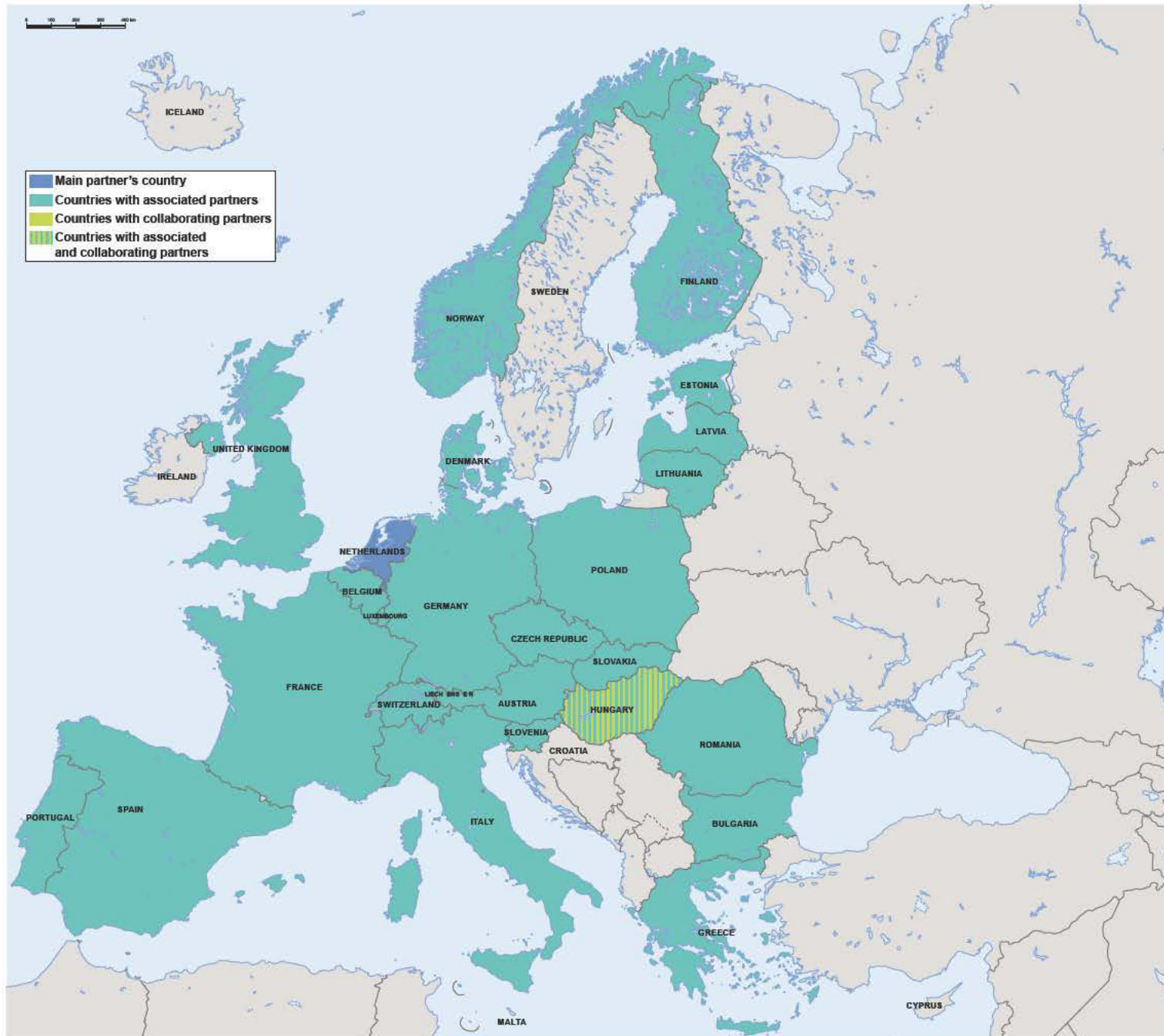
- Total budget: €967 181
- EC contribution: €578 744

Duration

- 01.12.2007 – 30.11.2009

Main beneficiary

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Main partner:

TAMPEP International Foundation, Amsterdam, The Netherlands

Associated partners:

- LEFÖ (Austria)
- Espace P... (Belgium)
- HESED (Bulgaria)
- R-R (Czech Republic)
- Servicestyrelsen (Denmark)
- AIDS- Tugikeskus (Estonia)
- Pro-tukipiste ry (Finland)
- Association Autres Regards (France)
- P.A.S.T.T (France)
- Amnesty for Women (Germany)
- ACT UP DRASE HELLAS (Greece)
- SEA (Hungary)
- CDCP Onlus (Italy)
- S/O GENDERS (Latvia)
- LAC (Lithuania)

- Dropln Croix-Rouge (Luxembourg)
- TAMPEP International Foundation (Netherlands)
- Pro Sentret, Oslo komune (Norway)
- TADA (Poland)
- ARS Norte (Portugal)
- ARAS (Romania)
- OZ ODYSEUS (Slovakia)
- HETAIRA (Spain)
- SCOT-PEP (United Kingdom)
- Aspasié (Switzerland)
- CARS (Slovenia)

Collaborating partners:

- World Health Organization Regional Office for Europe, STI/HIV/AIDS Programme, Copenhagen
- UNFPA, New York
- Sexual Health and Rights Program Open Society Institute, New York
- Open Society Institute Budapest
- International Committee on the Rights of Sex Workers in Europe (ICRSE)

AIDS & Mobility Europe 2007–10

Keywords: HIV/AIDS, emigration and immigration, capacity building, evaluation, policy

The AIDS & Mobility Europe project aimed to **reduce the vulnerability of migrant and mobile populations to HIV infection**. The project focused on young people aged 16–25, who are particularly vulnerable to sexually transmitted infections (including HIV) but also have a high capacity to adapt and to influence their social environment. By adopting the 'With Migrants for Migrants' (MiMi) approach, in which transcultural mediators are trained to organ-

ise information and education sessions with target groups, the project aimed to improve health literacy and awareness by involving migrants in delivering health promotion to their own communities. Partners in six European countries worked with migrant communities and relevant stakeholders to train transcultural mediators to reduce discrimination and stigma, to improve HIV-related knowledge and to promote behaviour change to reduce risk of infection.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project promoted the exchange of knowledge and good practice in six Member States. Its overall goal was to improve migrants' access to prevention services, to explicitly include migrants and ethnic minorities in national HIV/AIDS plans, to promote participatory and migrant-empowering approaches, to institutionalise successful practices in public health care systems, and to build capacity in groups working with migrants through training and coaching on intercultural communication. The project addressed some of the key challenges that can help to reduce health inequalities by collecting data and information from young migrants who participated in the community information sessions organised in the six participating countries.

Why was the public health problem addressed important for Europe?

Migrants and ethnic minorities are vulnerable groups particularly affected by HIV/AIDS health inequalities and by poverty and social exclusion. Structural barriers to prevention, treatment and care severely affect migrant groups, especially the young, who have traditionally been hard to reach in health care promotion and HIV prevention efforts, because of their poor access to information as well as structural, linguistic and cultural barriers.

Objectives

The AIDS & Mobility project aimed to **reduce the vulnerability of migrant and mobile populations in Europe to HIV**, through the development, implementation and promotion of appropriate policies and measures within a Europe-wide network of experts.

The project's specific objectives were:

- To develop an innovative health education model for migrants and ethnic minorities.
- To implement structured transcultural mediator training and to conduct educational group sessions on HIV/AIDS.
- To strengthen the existing networks of HIV prevention among migrants.

- To evaluate the project and disseminate results.
- To design strategies to promote sustainability and to influence European and national policy making.

Methods

The project implemented a set of learning activities at national and regional levels, with pan-European methodologies and guidance. Community-based research and advocacy activities were based on the principles of migrant participation and empowerment. A multilevel stakeholder approach was adopted, involving public service providers, AIDS NGOs, migrant NGOs, community members, policy makers, researchers, transcultural mediators and young migrants.

A standardised curriculum was used to train mediators in six countries. After training, mediators organised community-based and multilingual HIV prevention sessions. Regional networks were developed, and acted as platforms for transcultural mediator training. Some 116 mediators were trained, and conducted 240 community information sessions with 3 427 participants. Other outputs included reports on educational programmes for HIV prevention in migrants, and the strategies adopted by project partners. The project also developed resource material in 15 languages, including a guidebook, master toolkit and policy recommendations.

Achievements

The project has expanded capacity in HIV prevention in Europe, through the implementation of an innovative education programme based on the 'With Migrants for Migrants' (MiMi) programme for training transcultural mediators. Numerous migrants with low levels of language skills and educational background were engaged in their natural environments and in their native languages. Target group knowledge of topics such as HIV, STIs, hepatitis, harm reduction and reproductive health was increased. Communities also gained increased confidence in health services and professionals. Furthermore, local health authorities, institutions and professionals developed enhanced capacity to work with transcultural mediators and their communities.

The involvement of new partners and interactions with other projects (e.g. TAMPEP) ensured the ongoing development of cultural mediator training. Finally, a sustainability plan was prepared to empower migrant and minority communities, build social cohesion, encourage civic society participation, promote the status of transcultural mediators, and provide a cost-effective method of HIV prevention in the context of migration.

What effect have the results had on the policies and programmes of Member States and the EU?

Ideally, the concept of transcultural mediation would become an integral part of European/national prevention strategies, and migrants and ethnic minorities would be recognised as potentially requiring targeted approaches. EU policies and programmes are expected to promote the adoption of evidence-based education models and interventions, and to mainstream HIV prevention for young migrants while empowering migrants to become leaders in the field of HIV prevention, as in the AIDS & Mobility project. In order to support this, AIDS & Mobility policy recommendations were presented to policy makers and other stakeholders at a seminar held at the European Parliament.

What were the benefits of working jointly at EU level?

The AIDS & Mobility project developed recommendations addressing EU institutions, arguing for full access to health care for migrants in Europe and greater coordination of HIV-related policies and programmes at the EU level, to increase collaboration and synergies and thereby enhance policy coherence and funding effectiveness.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The success of this project supports Europe-wide implementation. Its methods are also transferable to other health topics, such as infectious diseases, drug addiction, mental health and social inclusion, and to other vulnerable groups (e.g. Roma, refugees and ethnic minorities).

Project website

- www.aidsmobility.org

Budget

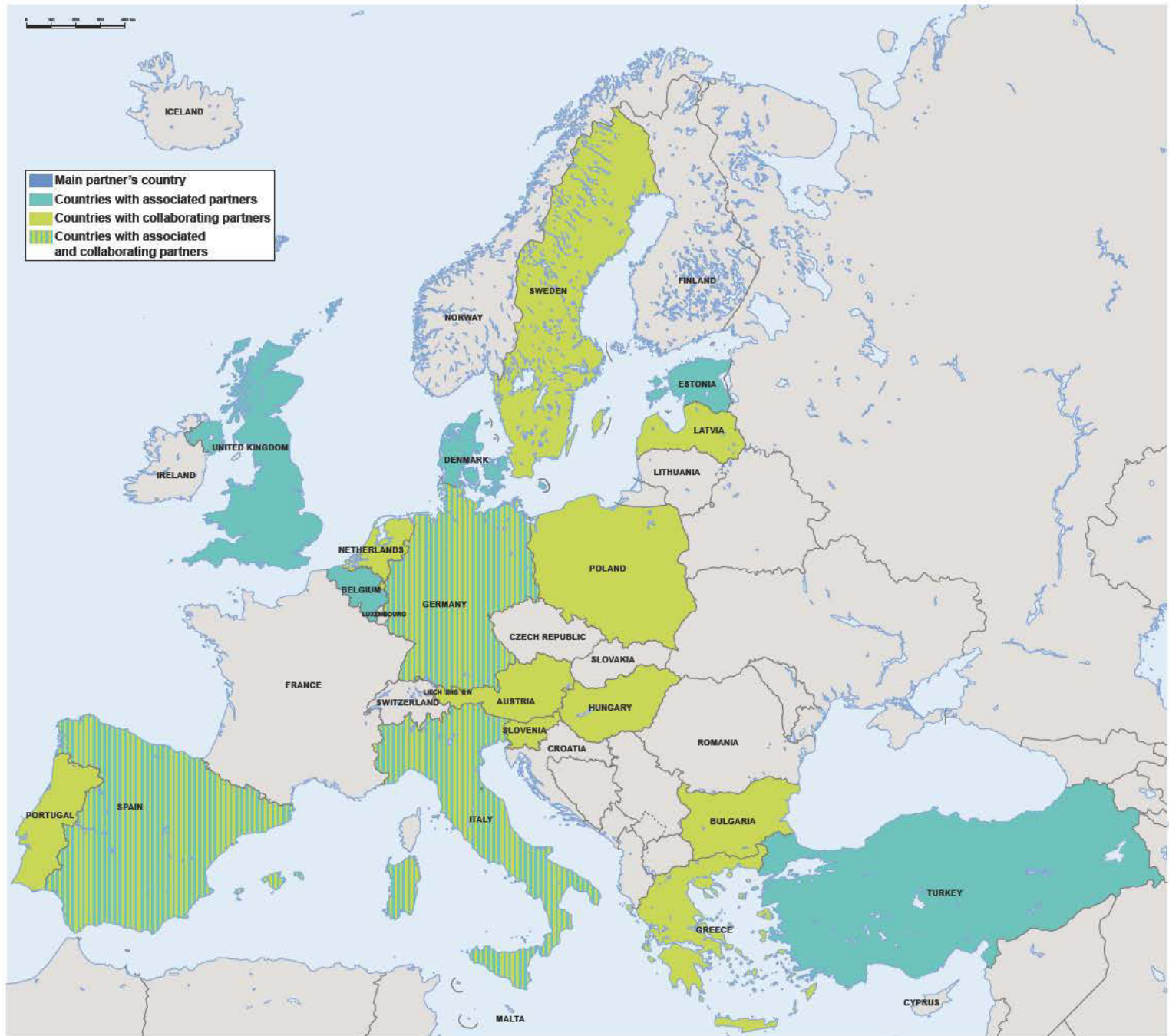
- Total budget: €346 181
- EC contribution: €207 709

Duration

- 15.07.2008 – 14.07.2011

Main beneficiary

- Ethno-Medizinisches Zentrum e.V. (EMZ), Königstraße 6, 30175 Hannover, Germany.
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Main partner:

Ethno-Medizinisches Zentrum e.V. (EMZ, Hannover)
Königstraße 6, 30175 Hannover, Germany

Associated partners:

- European AIDS Treatment Group (EATG, Brussels), Belgium
- Fondet til bekaempelse af aids (AIDS-Fondet, Copenhagen), Denmark
- International Organization for Migration (IOM, Brussels), Belgium
- National Institute for Health, Migration and Poverty (NIHMP, Rome), Italy
- MTU AIDS-I Tugikeskus (AISC, AIDS INFORMATION & SUPPORT CENTER, Tallin), Estonia
- Naz Project London (NPL, London), UK
- Yeniden Sağlık ve Eğitim Derneği (Yeniden, Istanbul), Turkey
- Terrence Higgins Trust (THT, London associated partner until 2009), UK

Collaborating partners:

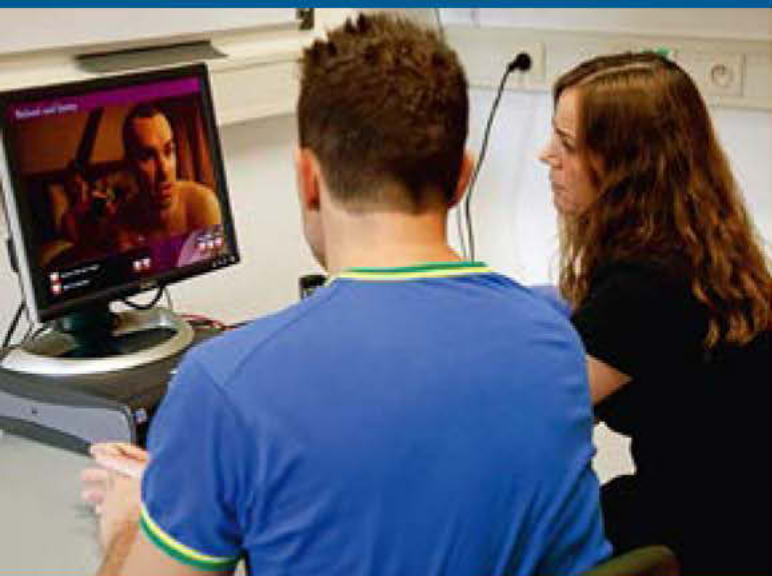
- DIA+LOGS Riga, Latvia
- HIV-Sweden Stockholm, Sweden
- Sex Education Foundation Budapest, Hungary
- PREZES FUNDACJI / Patients Safety Lodz, Poland
- Istituto Superiore di Sanita Rome, Italy
- National School of Public Health Athens, Greece
- Correlation Network Amsterdam, The Netherlands
- Secretaria del Plan Nacional sobre el SIDA Madrid, Spain
- Plus and Minus Foundation Varna, Bulgaria
- AIDS Hilfe Wien Vienna, Austria
- Institute For Public Health Ljubljana, Slovenia
- Deutsche AIDS-Hilfe e.V. Berlin, Germany
- GAT, Grupo Portugues de Activistas Lisboa, Portugal
- Ashoka Deutschland GmbH Frankfurt am Main, Germany
- UNAPRO La Laguna, Spain



*Developing a training and resource package
for improving the sexual and reproductive health
of people living with HIV/AIDS:*

EUROSUPPORT 6

Keywords: behavioural science, HIV infections, reproductive health, safe sex, sexually transmitted diseases



The project aimed to improve the sexual and reproductive health and rights of people living with HIV, thus contributing to 'positive prevention' (prevention for and by people living with HIV). It aimed to prevent onward HIV transmission and other sexually transmitted infections (STIs) among target groups by enabling service providers in HIV care settings to deliver effective sexual and reproductive health services (i.e. sexual risk reduction and fertility-related services). The project developed computer-assisted counselling tools aimed at preventing onwards HIV transmission to uninfected sexual partners or partners of unknown serostatus, reducing STIs among the target groups, and improving their overall sexual and reproductive health.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project's priority target groups, men having sex with men (MSM) and migrants living with HIV, are key populations vulnerable to HIV, as reflected in European HIV epidemiological data. Many migrants living with HIV suffer from double stigma and discrimination. By improving the sexual and reproductive health and rights of this target group, the project contributed to fighting social exclusion and reducing social and health inequalities. Similarly, the project's other target group, MSM, still do not enjoy the same rights as heterosexual men in some regions of Europe. Enabling service providers to deliver effective interventions may also have reduced stigma and discrimination and created an environment more conducive to health behaviour change.

Why was the public health problem addressed important for Europe?

Thanks to combination therapies, HIV infection is now a manageable chronic disease. Without adequate support to adopt and maintain safer sexual behaviours, people living with HIV may facilitate the evolution and spread of drug-resistant HIV strains and form a potential source of HIV infection. Most of the new HIV infections in Europe occur through unprotected sexual contacts (primarily among MSM and heterosexual partners), so meeting the sexual and reproductive health service needs of people living with HIV is a public health priority. Service providers require reliable tools that enable them to address sexual and reproductive health issues effectively.

Objectives

The project aimed to improve the sexual and reproductive health of people living with HIV by enabling service providers to deliver effective interventions with a focus on sexual risk reduction. The project also contributed to 'positive prevention' for MSM and migrants, by developing tailored prevention packages for care settings.

The specific aims of the project were:

- To develop evidence-based and theory-guided target group-specific interventions to improve the sexual and reproductive health of people living with HIV;

- To develop an evidence-based training and resource package for service providers in clinical care and community-based settings;
- To develop a policy tool specifying the elements needed to integrate sexual and reproductive health-related and positive prevention services into routine HIV care;
- To expand and maintain a network to promote sexual and reproductive health and positive prevention in Europe.

Methods

The project partners designed, implemented, evaluated and disseminated a training and resource package (TRP), containing tailored counselling interventions targeting HIV-positive MSM and migrants. The TRP was based on computerised interactive learning materials, Computerised Intervention for Safer Sex (CISS). A combined evaluation approach was adopted using a randomised controlled trial design together with a process evaluation, to assess the feasibility of working with the CISS in care settings and to gather the views of service providers and people living with HIV.

The TRP comprised an interactive set of computerised counselling tools (e.g. self-assessments for sexual risk, video clips, slide shows), an implementation manual, a reference guide summarising the evidence base for positive prevention and a trainer's manual.

A network of collaborative partners was created to maximise the implementation of the project outputs.

Achievements

The project achieved a reduction in sexual risk behaviour, measured as self-reported increased condom use. The intervention showed a 30% sexual risk reduction in the intervention group. Service providers also showed an increased capacity to deliver effective sexual and reproductive health interventions, as measured by self-reported indicators: 91% of participating service providers reported increased empathy with their clients relating to their sexual behaviour, and 84% reported increased self-confidence in sexual health counselling.

What effect have the results had on the policies and programmes of Member States and the EU?

Considerable interest has already been shown in the project's results by the ECDC and the WHO, as well as at a regional level (e.g. City Council of Madrid). As a concrete example, the Belgian national HIV plan drew on the project's work to develop specific actions to improve the quality of life of people living with HIV and decrease HIV-related discrimination.

The target populations can benefit directly from the project results, as the quality of sexual health counselling is expected to increase if service providers integrate the CISS into their routine HIV care. Service providers can now be better equipped to deliver tailored interventions, in an unbiased and non-judgmental way, and to support people living with HIV in taking informed decisions about their sexual and reproductive health.

What were the benefits of working jointly at EU level?

The partnership benefited from the input of all partners in designing, implementing and evaluating the intervention, with each partner contributing specific expertise. The partnership enabled participating countries to produce a TRP based on cross-cultural theoretical constructs, but adapted to local needs. Furthermore, the partners benefited from mutual learning and exchange, for instance in the case of sexuality counselling and the participation of target group members, ensuring their input into the development of materials.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

Future work should focus on developing 'combination prevention' addressing barriers at multiple levels (individual, service provision and structural). Future priorities should include reducing HIV stigma and structural determinants of discrimination, with embedded sexual and reproductive health and rights interventions. Interventions delivered in health care settings may not reach those most in need (e.g. undocumented migrants); community-based interventions focusing on self-management to empower people living with HIV should complement such interventions.

Project website

- www.eurosupportstudy.net

Budget

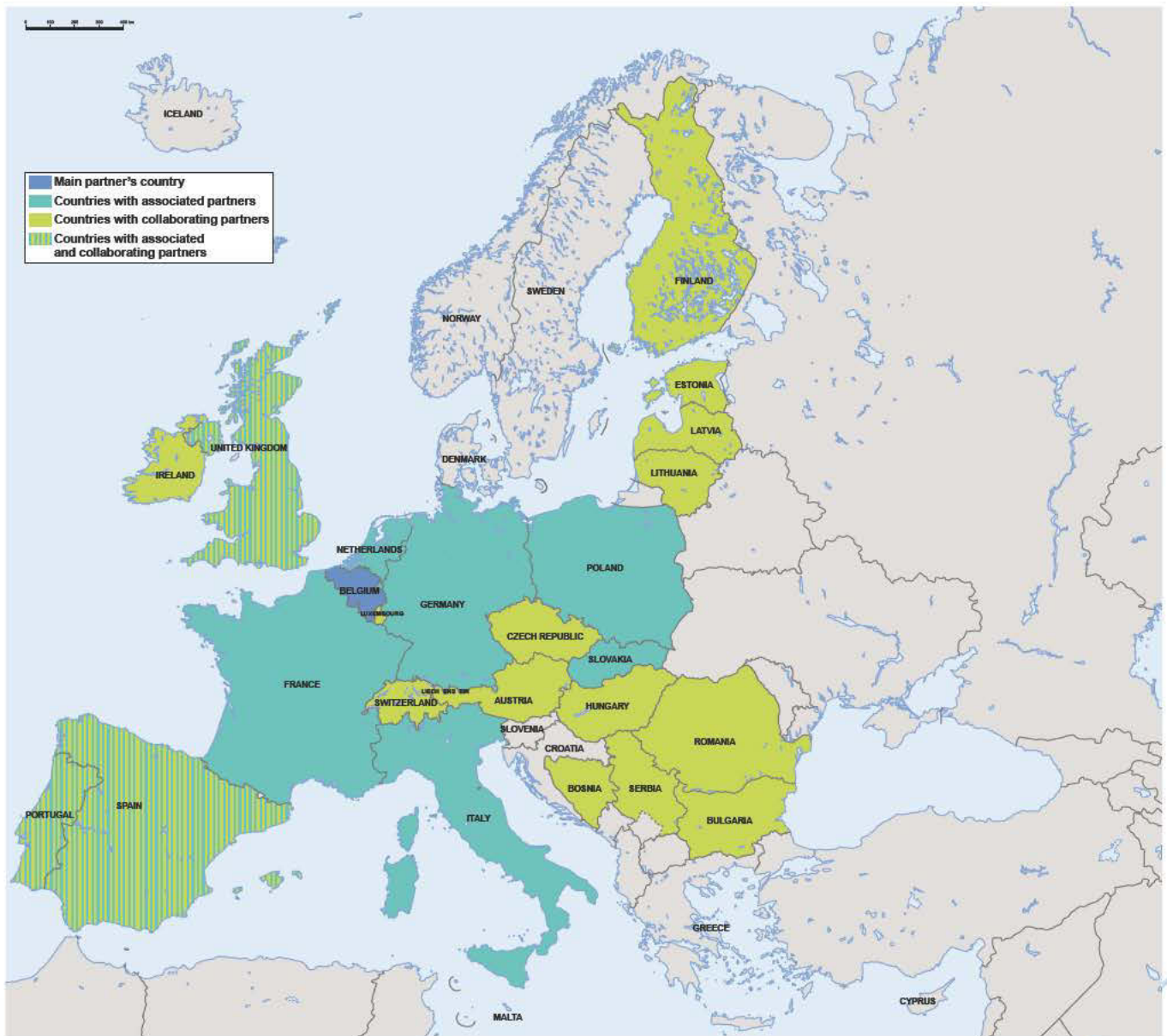
- Total budget: €1 370 131
- EC contribution: €674 209

Duration

- 01.03.2009 – 28.02.2013

Main beneficiary

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Main partner:

Institute of Tropical Medicine, Dept. Clinical Science, Nationalestraat 155, B-2000, Antwerpen, Belgium

Associated partners:

- Sensoa VZW, Belgium
- Klinikum der Universität München, Germany
- Aides, France
- Fondazione Centro San Raffaele del Monte Tabor, Italy
- Maastricht University, The Netherlands
- University of Zielona Gora, Poland
- Instituto de Higiene e Medicina Tropical, Portugal
- Slovak Medical University, Slovakia
- Universidad Complutense de Madrid, Spain
- Central and North West London NHS Foundation Trust, UK

Collaborating partners:

- St. Pierre CHU, Belgium
- Terrence Higgins Trust, UK
- Sex Education Foundation, Hungary
- AIDS Berodung (Croix-Rouge), Luxembourg
- Positivo, Portugal
- DIA+LOGS, Latvia
- Estonian Network of People Living with HIV, Estonia

- ARAS — Romanian Association Against AIDS, Romania
- Positive East, UK
- GMI Partnership / The Metro Centre, UK
- SER +, Portugal
- The Sexual Health Centre Cork, Ireland
- JAZAS — Association Against AIDS, Serbia
- AIDS HILFE Wien, Austria
- European Centre for social welfare policy and research, Austria
- Latvia's Association for Family Planning, Latvia
- Pennine Acute Hospitals NHS Trust, UK
- HIV-Foundation / The Finnish AIDS Council, Finland
- Planning and Sexual Health Association, Lithuania
- Charles University, 1st Medical Faculty, Institute of Sexology, Prague, Czech Republic
- Association for Sexual and Reproductive Health XY, Bosnia and Herzegovina
- Bulgarian Family Planning and Sexual Health Association, Bulgaria
- Naz Project, UK
- Grupo Português de Activistas sobre Tratamentos VIH/SIDA Pedro Santos (GAT), Portugal
- Otto Wagner Spital, Austria
- Centro de Promoción de Hábitos Saludables, Spain
- Department of Internal Medicine, Switzerland

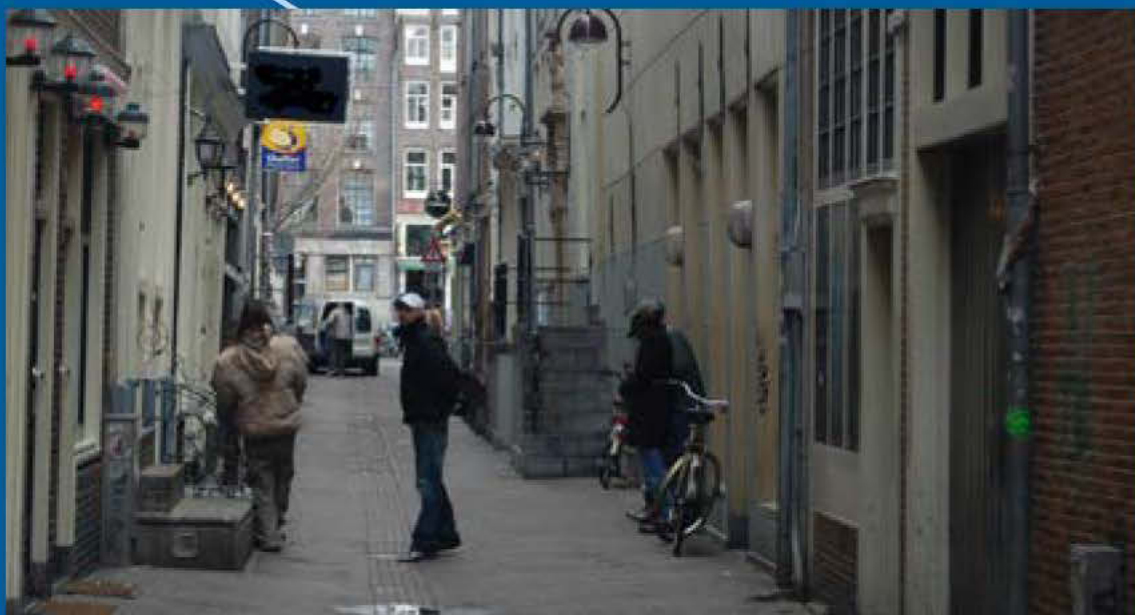


European Network on Health and Social Inclusion: Correlation I and II

Keywords: health services accessibility, social marginalisation, blood-borne pathogens, communicable diseases, prevention

The Correlation projects aimed to develop and implement effective strategies to provide health and social services to marginalised people in hard-to-reach situations and those showing high-risk behaviours. An expertise centre was established at the centre of a network encompassing numerous EU Member States, to identify and disseminate ex-

pertise and good practice. The project was carried out in two phases (2005–2008 and 2009–2012). The first phase identified major gaps and inequalities in access to health and social services, while the second phase focused particularly on blood-borne infectious diseases, notably hepatitis C and HIV/AIDS.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The projects raised awareness of the health needs of target groups and of strategies for meeting those needs. This was achieved through seminars, conferences and policy dialogue meetings, as well as published reports, articles, email alerts and a newsletter. The projects set up focal points in each partner country to collect and exchange relevant data. Their main objective was to identify and exchange good practices, facilitating the design of tailored policies for marginalised groups in all Member States.

Why were the public health problems addressed important for Europe?

The target group consisted of people at high risk of infectious disease (in particular blood-borne infections) who are not well reached by mainstream health care, prevention and health promotion. This particularly applies to intravenous drug users, sex workers, irregular migrants, homeless people, and young people experiencing marginalisation and poverty. This issue is important for Europe because it concerns health problems with potentially serious consequences for both those directly affected and public health more generally. At the same time the economic crisis has increased levels of poverty in Europe and led to cuts in health and welfare provisions. The project enabled organisations throughout Europe to join forces in responding to this public health challenge.

Objectives

The projects aimed to develop, implement and disseminate effective strategies for providing health and social services to people in hard-to-reach situations and those showing high-risk behaviour. It also planned to set up an expertise centre and a network for sharing information and research-based models

of good practice for health service delivery, health promotion, drug demand reduction and strategies for preventing blood-borne infections. It also set out to gather relevant data and epidemiological information, to improve the comparability of data at the European level, and to provide guidelines and training for service providers and users.

The Correlation network provides a forum for service providers, self-help organisations, researchers and decision-makers to identify, evaluate and disseminate promising health policies and practices.

Methods

The Correlation interventions encompassed three project streams: research and data collection; policy-based activities (national and European policy meetings to stimulate dialogue between service users, service providers and policy makers); and implementation and evaluation of interventions, to identify good practice.

The first phase of the project was carried out with 17 partners in 13 countries, while the second phase involved a fresh team of 11 partners in 8 countries (all but two of them new).

Achievements

The projects established an effective and visible network in the field of social inclusion and health, attracting many partners from diverse backgrounds, supporting mutual exchange and collaboration. Activities implemented by partner organisations had direct impact on target groups (e.g. improved early intervention methods, training of trainers, peer-support, e-counselling, policy dialogues). Guidelines for street-worker, peer-support and outreach services were developed and implemented. Similar organisations in the field are likely to benefit by adapting the project's methods and tools.

Due to extensive target group participation, the projects significantly contributed to the recognition of peer work and the development of peer work activities in the field of social inclusion and health.

Policy-level recommendations were prepared and debated at national and European events, including the HIV/AIDS Correlation Policy Dialogue in the European Parliament.

What effect have the results had on the policies and programmes of Member States and the EU?

Especially in the second phase, the projects focused on engagement with policy makers to influence policy agendas. It is likely that policy dialogue meetings at national and European level, as well as the bilateral contacts with policy makers, influenced policy discussions.

What were the benefits of working jointly at EU level?

The main benefits were promotion of best practice and networking. The projects led to better understanding of the dynamics of marginalisation and health and social inclusion, and contributed to improved services for marginalised groups — issues that exist to varying degrees in all Member States. Typically, they are addressed by a wide range of governmental and non-governmental organisations, which may not be well coordinated even at a national level. Knowledge and expertise is thus highly fragmented. Projects such as these can be seen as 'defragmenting' this knowledge and making it more accessible, as well as enabling groups to coordinate their efforts.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

Tackling health problems resulting from social marginalisation requires specific responses. The accessibility of health care, prevention and health promotion can be highly problematic, making low-threshold outreach programmes necessary. These approaches have to be innovative and multidisciplinary, combining insights and experience from different fields. It is also important to involve and empower target groups. Grassroots initiatives that can show evidence of their effectiveness should be anchored in policies to ensure their sustainability. Particular priorities identified by these projects are:

- overcoming barriers to hepatitis C treatment for drug users;
- stimulating re-integration of vulnerable people by setting up labour and self-conducted enterprises;
- developing harm reduction interventions for the groups most at risk.

Project website

- www.correlation-net.org

Phase I

Budget

- Total: €1 358 333
- EC Contribution: €815 000

Duration

- 01.04.2005 – 31.03.2008

Phase II

Budget

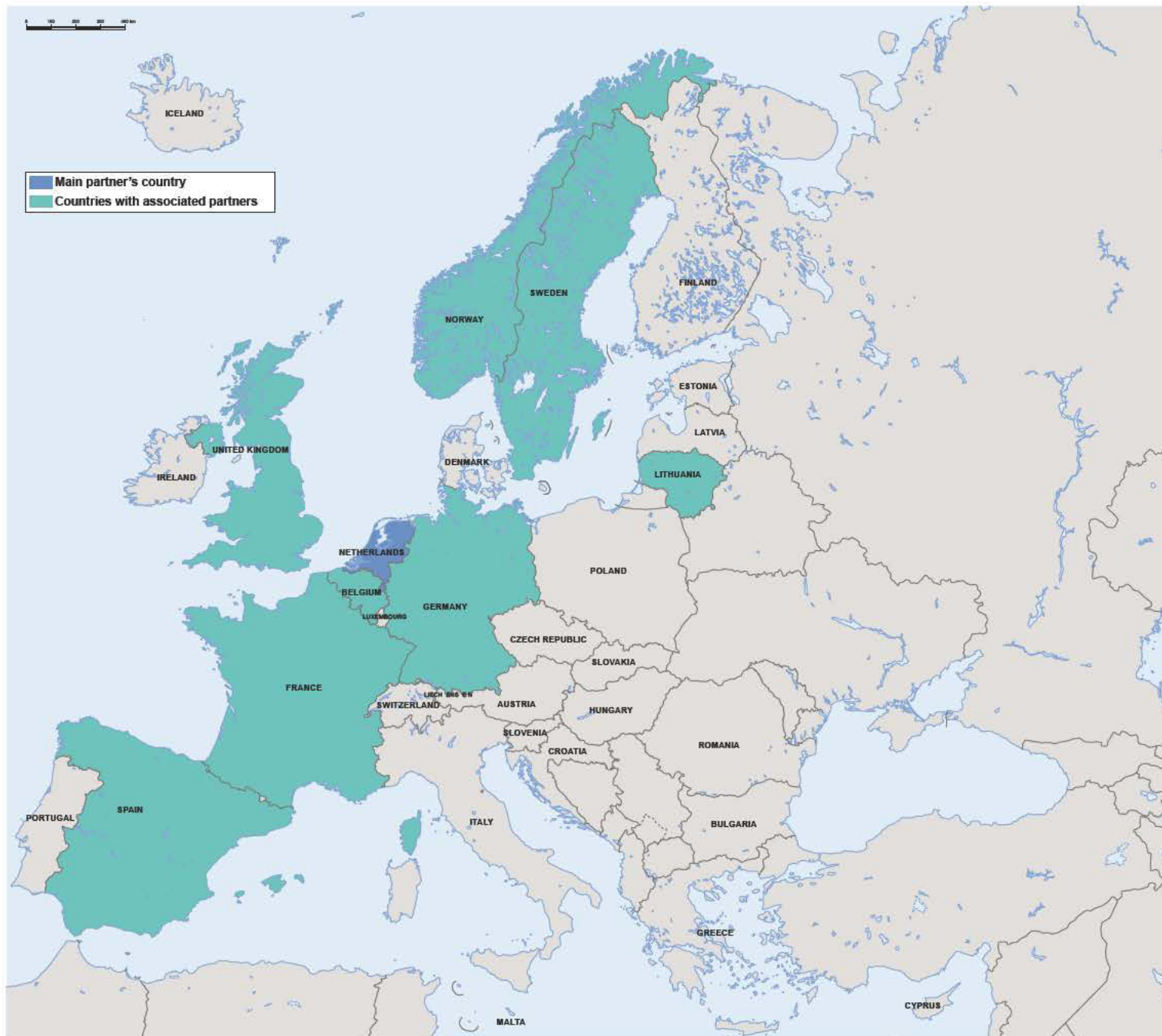
- Total: €1 511 273
- EC Contribution: €900 000

Duration

- 01.04.2009 – 31.03.2010

Main beneficiary

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Main partner:

Foundation Regenboog Groep (FRG)
1013 GE Amsterdam
The Netherlands

Associated partners:

- Belgium: European AIDS Treatment Group (EATG)
- France: Auto Support et reduction des risques parmi les Usagers de Drogues (ASUD)
- Germany: Fixpunkt — Verein für suchtbegleitende Hilfen e. V. (FIXPUNKT)
- Lithuania: Central and Eastern European Harm Reduction Network (EHRN)
- Netherlands: Rotterdam Public Health Service (MPHS)
- Netherlands: Stichting Foundation CVO (CVO)
- Netherlands: Trimbos Instituut, Netherlands Institute of Mental Health and Addiction (TRIMBOS)
- Norway: Oslo kommune, Rusmiddelstatens kompetansesenter — The Competence Centre of the City of Oslo Agency for Alcohol and Drug Addiction Services (CC-AADAS)
- Spain: Government of Catalonia, Department of Health (DHAGC)
- Sweden: Svenska Brukarföreningen — Swedish Drug Users Union (SBF)
- UK: Developing Initiatives for Support in the Community (DISC)



Improving Access to TB and HIV Testing for marginalised groups:

Imp.Ac.T

Keywords: tuberculosis, HIV, testing, access to care, outreach services, drug users



The main objective of the Imp.Ac.T project was to increase access to testing, prevention and treatment for HIV/AIDS and tuberculosis (TB) for hard-to-reach groups, like drug users (DUs).

The project developed a model to improve the effectiveness of HIV and TB testing and counselling among DUs and recommended a new type of provider-initiated counselling for TB and HIV testing. Rapid HIV and TB tests were offered to problem drug users in street units, drop-in centres and other low-threshold services in four European cities: Bratislava, Prague, Rome and Turin. The people who tested positive were referred to collaborating clinics for diagnosis confirmation and treatment.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

Imp.Ac.T addressed the need to improve access to HIV and TB testing and treatment for high-risk groups. It has therefore contributed to the reduction of health and social inequalities in accordance with the goals set by the Europe 2020 initiative and the strategy for Solidarity in Health: Reducing health inequalities in the EU (COM(2009) 567).

The project has helped to improve the access of drug users by promoting a provider-initiated testing strategy based on outreach interventions, which aims to address the stigma and discrimination that DUs are exposed to. It has also contributed to reducing the gap between drug users and health care services. It targeted health professionals, social workers, practitioners and policy makers with training, and developed protocols for the provision of HIV/TB testing among hard-to-reach groups.

Why was the public health problem addressed important for Europe?

HIV/AIDS and TB co-infection remain among the leading communicable diseases in Europe, and are associated with persistently high costs of treatment and care — and shortened life expectancy. Diagnosing people who are HIV infected is a prerequisite for the provision of treatment, care and support. However, evidence highlights that many opportunities are being missed to diagnose HIV and TB infections in the EU, particularly among high-risk groups like DUs.

There is an evident need to gain a better insight into the HIV/TB epidemic — especially among the most vulnerable populations — and to promote appropriate testing strategies and linkage to care services for these groups.

Objectives

The project's objectives included:

- Developing a model for improving the effectiveness of HIV/TB testing and counselling among DUs and migrant DUs based on novel types of provider-initiated actions;
- Facilitating access to treatment and care for the most marginalised groups by promoting closer cooperation between organisations working with DUs and public health care services;

- Increasing the percentage of DUs and migrant DUs who have access to HIV and TB testing, as well as promoting early recognition of HIV and TB and timely entry into care;
- Promoting healthier ways of life and risk reduction among DUs and migrant DUs, through pre- and post-counselling, and by making it easier to access health centres.

Methods

The project used outreach work as a tool to promote a new model of provider-initiated counselling and testing. A common methodology was developed and used by all partners, both for testing uptake and data collection. HIV and TB testing was carried out among DUs attending low-threshold services such as needle exchange points, street units, drop-in centres, night shelters and substitution treatment programmes. For TB, a clinical screening was conducted by health professionals in order to identify suspected cases. Those who received a preliminary positive test were referred to the collaborating clinical centres for confirmatory testing and, eventually, treatment.

For the implementation of the pilot screening, multi-disciplinary staff were trained on good practices for HIV and TB testing, as well as the provision of counselling and referral to treatment services.

Achievements

Imp.Ac.T. provided new information on the HIV and TB situation in Europe, the prevalence and incidence rate among DUs, and the perceived barriers preventing DUs from accessing HIV/TB testing, treatment and care.

The project provided valuable experience combining street intervention and data collection. In total, 4 855 people were approached, of whom 2 352 were interviewed and tested; almost all were problematic drug users (PDUs). In total 19 HIV cases were detected. Almost 20% of the people tested had never been tested for HIV before. The provision of testing in low-threshold services was therefore effective as a way of reaching hard-to-reach groups. Moreover, while no TB cases were detected, the project increased awareness about the disease among both outreach workers and the target group.

The project developed and disseminated a 'Training Manual on HIV/TB rapid testing of DUs/migrants in low-threshold services' (available in English, Italian, Slovak and Czech), and a 'Guide Manual on HIV and TB Testing for DUs and migrants in low-threshold services', which includes best practices and lessons learned.

What effect have the results had on the policies and programmes of Member States and the EU?

The project developed a new comparable registration system for assessing and monitoring the trend of HIV and TB infection among high risk groups, such as DUs, that can give a more reliable overview of the HIV and TB epidemics.

The project proposed a methodology for more cost-effective public health interventions and advocated a change in HIV and TB public control strategies which should focus more on reaching out to the most-at-risk groups and ensuring equal access of these groups to treatment, care and support.

The close cooperation with public clinical services, as well as local and national authorities, has contributed to the development of more patient-oriented services and targeted interventions for these risk groups at local and national level.

What were the benefits of working jointly at EU level?

The project involved organisations from four European countries: Czech Republic, Italy, the Netherlands and Slovakia. The geographical, cultural and social diversity of the partner countries made possible the evaluation of the pilot tested model for HIV and TB testing for IDUs and migrants — in different contexts. Thus the project produced evidence-based testing and treatment guidelines which may be replicated in other European countries.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The project identified the need to adapt public health programmes and systems to the requirements of hard-to-reach groups, in particular through outreach HIV and TB activities. The project recognised adherence to treatment as a particular challenge for these groups and highlighted the need to allocate more resources for the follow-up of patients who belong to hard-to-reach groups by increasing cooperation between low-threshold services and the mainstream health care system.

Project website

- www.projectimpact.eu

Budget

- Total budget: €684 967
- EC contribution: €410 980

Duration

- 01.09.2010 – 31.12.2012

Main beneficiary

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Main partner:

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1-00151 ROMA
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Associated partners:

- Foundation Regenboog Groep, Amsterdam, Netherlands
- Obcianske zdruzenie ODYSEUS, Bratislava, Slovakia
- SANANIM, Prague, Czech Republic
- Associazione Gruppo Abele O.N.L.U.S., Turin, Italy 00198 Rome, Italy

Collaborating partners:

- National Institute of Infective Diseases 'Lazzaro Spallanzani' — Rome, Italy
- Hospital for infective diseases 'Amedeo di Savoia' — Turin, Italy
- Klinika infektologie a geografickej mediciny FNŠP — Bratislava, Slovakia
- AIDS centrum FN Bulovka — Prague, Czech Republic
- Azylové centrum České společnosti AIDS pomoc — Prague, Czech Republic

Highly active prevention: scale up HIV/AIDS/STI prevention, diagnostic and therapy across sectors and border in CEE and SEE

BORDERNET*work*

Keywords: prevention, community-based approach, quality improvement, health planning, vulnerable populations

First launched in 2004 along the German-Polish border, BORDERNETwork developed into an interdisciplinary cross-border network project for implementing 'highly active prevention' to scale up responses to HIV/AIDS and sexually transmitted infections (STIs) in eight EU Member States. The objective was to integrate the three core strands of combination prevention of HIV/AIDS: prevention, diagnosis and treatment. Through this approach, the project aimed to reduce health and social inequalities among vulnerable groups, promoting human rights and gender and social equity.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project collected evidence on the health situation of most at-risk groups and piloted measures to improve diagnostic/referral procedures. Moreover, diverse 'health inequalities' were tackled, contributing to improved access to prevention and care for all citizens regardless of income, social status and cultural background. Thanks to its geographical focus, the project addressed the challenge of growing health disparities in expanding Europe. The project also promoted the exchange of information about inequalities in the access to prevention and care for highly marginalised individuals, such as migrants and Roma people.

Why were the public health problems addressed important for Europe?

HIV/AIDS and other STIs are significant health issues for groups such as people who inject drugs, sex workers, minorities and the young. The different epidemiological patterns between the EU and neighbouring countries, coupled with the high mobility of people, emphasise the need for cross-border cooperation. However, in HIV prevention, it is still a challenge to overcome structural barriers between disciplines and sectors. Even within a single thematic field such as HIV/AIDS, cooperation gaps exist between prevention and treatment experts, social scientists and social workers as well as doctors, members of civil society and community representatives.

Objectives

The overarching goal was to improve prevention, diagnosis and treatment of HIV/AIDS (including co-infections) and STIs by bridging gaps in practice, policies and cross-country cooperation, and by enhancing capacity for interdisciplinary responses. With highly active prevention as the main vehicle for decreasing HIV rates, the project had six interlinked objectives:

1. To enhance interdisciplinary networks and implement highly active prevention on a national, regional and cross-border level;

2. To advance research, and to bridge research and practice for effective HIV combination prevention;
3. To intensify efforts for early diagnosis in the most at-risk groups and reduce the numbers unaware of their HIV infection status;
4. To augment the country-specific evidence on treatment and care of HIV, co-infections and viral hepatitis, and to enhance integration between national systems;
5. To improve prevention and sexual health for ethnic minorities and migrants through capacity building in participatory prevention models;
6. To improve the quality of youth prevention interventions.

Methods

Combination prevention integrates biomedical, behavioural and structural strategies to reduce new HIV infections, following the UNAIDS 2010 strategy. Structural and behavioural strategies, applied in diverse local contexts in eight countries, combined improvements in health care structures, research to fill gaps in knowledge, and intersectoral cooperation. Pilot prevention interventions addressed individuals, social networks and entire communities. All methods aimed to promote participation of beneficiaries and improve social inclusion.

Achievements

Impact was seen in multiple areas. In research and prevention, links between epidemiological, behavioural research and prevention practice were strengthened. In diagnosis, early HIV and STI testing were integrated into holistic approaches. For management of HIV and hepatitis co-infections, two cross-country medical workshops were organised and a manual of educational materials and practice-driven recommendations was compiled.

In community-based prevention, participatory prevention approaches among migrants and ethnic minorities were developed, and complemented by interventions involving civil society and affected communities. The counselling competence of medical staff in sexual health was also strengthened.

The project showed that HIV/STI early diagnosis services should be offered in innovative settings, and be based on interdisciplinary collaboration with input from most at-risk group members. Pilot services reached new, less visible members of key population groups. The prevention activities did not focus on affected communities as target groups, but involved them as co-authors and social agents of change.

What effect have the results had on the policies and programmes of Member States and the EU?

A unique feature of the project was the integration of HIV/STI prevention, diagnosis and therapy, which should be a priority for future EU policy on prevention. HIV/AIDS and STI prevention should be embedded in comprehensive approaches to sexual health promotion. Furthermore, prevention and universal access to treatment should be seen as fundamental to the human rights of underprivileged communities.

What were the benefits of working jointly at EU level?

The partnership gained from effective networking between first-hand service providers, researchers, public health experts, treatment units and clients/patient groups. The ground-up philosophy of the project ensured participatory involvement, mutual learning and shared development of activities. The project encompassed both cooperation across the five cross-border model regions, involving regional authorities in eight countries, and fact-finding missions to four neighbouring countries (Moldova, Ukraine, Bosnia and Herzegovina, and Serbia).

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The project identified three core priorities: first, addressing multiple intersections of vulnerability and risks with research and combination prevention interventions; secondly, the development of practice-driven strategies to reduce social inequities in health; finally, community development and inclusion approaches, development of training programmes for participation, access to education, life and social skills competence, intercultural diversity and humility. The groups with the greatest needs are sex workers, women and men using drugs, and migrants/ethnic minorities (especially Roma).

Project website

- www.bordernet.eu

Budget

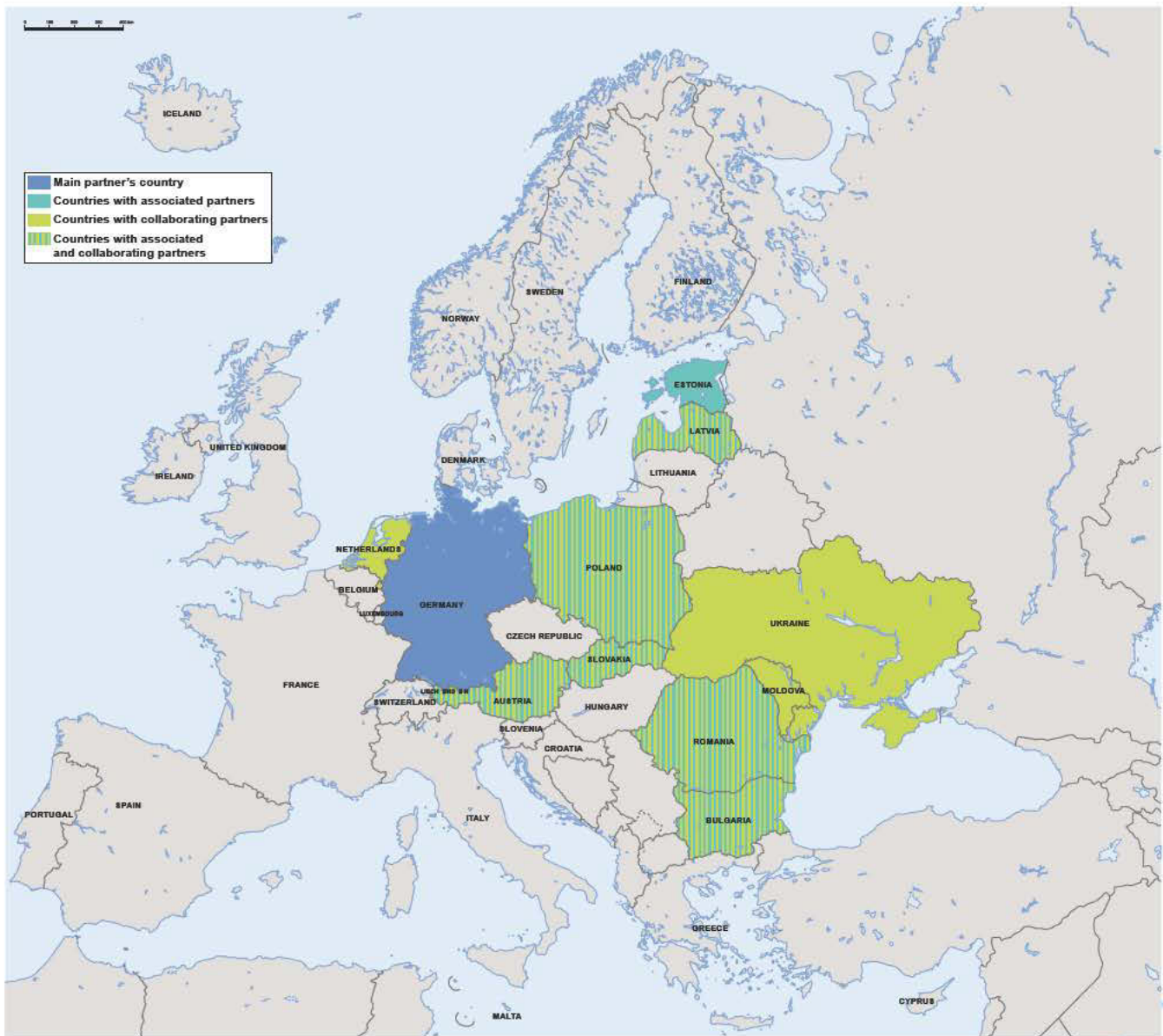
- Total budget: €2 073 000
- EC contribution: €1 172 000

Duration

- 01.01.2010 – 30.12.2012

Main beneficiary

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Main partner:

SPI Forschung/SPI Research GMBH (SPI), Berlin, Germany

Associated partners:

- AIDS Hilfe Wien — (AHW), Austria
- Health and Social Environment Foundation — (HESED), Bulgaria
- National Institute for Health Development — (NIHD), Estonia
- AIDS I Tugikeskus — (AISC), Estonia
- Robert Koch-Institut — (RKI), Germany
- Verein zu Förderung der Prävention im AIDS und Suchtbereich in Mecklenburg Vorpommern E.V. (MAT-LAKOST), Germany
- AIDS-Hilfe Potsdam e.V. — (AHP), Germany
- Latvia's Association for Family Planning and Sexual Health — 'Papardes Zieds', (PZ), Latvia
- Samodzielny Publiczny Wojewodzki Szpital Zespólny Szczecin — (SPWSZ), Poland
- Stowarzyszenie POMOST Rzeszowie — (POMOST), Poland
- Asociația Română Anti SIDA — (ARAS), Romania
- Civil Association PRIMA — (C.A. PRIMA), Slovakia

Collaborating partners:

- Bundeszentrale für gesundheitliche Aufklärung — BZgA, Germany

- Bundesministerium für Gesundheit — BMG, Germany
- Kompetenz-Netz HIV/AIDS — KompNet, Germany
- Deutsche AIDS-Hilfe — DAH, Germany
- Tannenhof Berlin-Brandenburg e.V. — THBB, Germany
- Fachhochschule Kärnten, Austria
- CORRELATION II Network, Foundation De REGENBOOG GROEP, The Netherlands
- University of Zielona Góra — UNZG, Poland
- Slovak Medical University, National Reference Centre for HIV/AIDS — NRC, Slovak Republic
- Lviv Regional AIDS Centre — LRAC, Ukraine
- Bulgarian Ministry of Health, Department 'Prevention and Control of AIDS, Tuberculosis and STIs', 'Prevention and Control of HIV/AIDS' Programme, Bulgaria
- National Centre for Infectious and Parasitic Diseases, Bulgaria
- Institute of Public Health, Centre for Prevention and Control of STIs, Romania
- HUMANITARIAN ACTION, Russia
- League of PLH of Moldova, Moldova
- AIDS Action EUROPE, SOA Aids Nederland, The Netherlands
- Spitalul Clinic Colentina Sos, Romania
- Infectology Centre of Latvia, Latvia

Health Promotion for Young Prisoners:

HPYP

Keywords: health promotion, communicable disease prevention, drug users, prisons, youth

The project Health Promotion for Young Prisoners (HPYP) aimed at developing and improving health promotion for young vulnerable people in the prison setting. It focused specifically on producing and using a health promotion toolkit for young prisoners across EU Member States. The toolkit addressed health related factors regarding infectious diseases, sexual

health and mental health, as well as the prevention and treatment of drug use. The target group included young people (up to 24 years old) on remand and those serving sentences, including particularly vulnerable groups such as women, migrants, ethnic minorities and problem drug users.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

Contributions to the 'Solidarity in Health' strategy and the Europe 2020 initiative: The project aimed to reduce health inequalities affecting young prisoners in the criminal justice system. The project can be inserted in a wider political debate on mental health, social exclusion and health of young people. The project's goals (develop and improve health promotion for young vulnerable people in the prison setting activities) and results are in line with the aims and objectives of the Solidarity in Health Communication (2009).

Why were the public health problems addressed important for Europe?

Health problems of prisoners are exacerbated by rising prison populations. Young prisoners have needs distinct from other fellow prisoners; they are more disadvantaged than their counterparts in the community and there is a negative impact on their health. There is a clear need for prisons to respond with health promotion interventions to address health inequalities, endorsing the principle that time spent in custody should aid disease prevention and promote health. However, there seemed to be little understanding about the methods of effectively promoting healthy living messages among this particularly disadvantaged and vulnerable group of prisoners.

Objectives

The project aimed to develop and improve health promotion for young people in custody. More specifically, it aimed to develop and implement a health promotion toolkit for young people in prison and other secure settings. The term 'health promotion' in this project covered existing policies, practices and initiatives that can help young offenders (prisoners) to stay healthy and to improve their health.

The project aimed to gain and compile an overview of the availability and range of specific health promotion activities as well as their importance, as rated by prison staff and young offenders themselves.

The specific objectives of the HPYP project were:

- To identify existing health promotion for young prisoners documents and other literature at a national and international level;
- To gather the views of young prisoners on health promotion, to understand their specific needs and demands as regards health promotion, and to be able to develop effective strategies and needed service provision.
- To gather the views of prison staff on health promotion, to raise awareness of their current role in this field and find out what tools they need to deliver health messages in this setting.
- To evaluate existing health promotion — including best practice, gaps in practice, and continuity of health promotion after release.
- To develop and pilot a toolkit on health promotion for young prisoners.

Methods

Using a participatory approach, the development of the toolkit on health promotion was based on the views and needs of vulnerable young people in prison as well as on those of prison staff and representatives from NGOs. These professionals are the people who could deliver health promotion in the prison

setting. Methods used to achieve objectives included: literature reviews and document analyses; needs assessment of young prisoners and prison staff using anonymous questionnaires; focus groups with young people in the prison setting further exploring questions arising from the needs assessment; and qualitative interviews with prison staff and members of NGOs further exploring their role and needs in providing health promotion.

Along with the dissemination of tools and final reports, the HPYP project produced the following main deliverables:

- A comprehensive literature review based on available data relating to health and health promotion of young offenders in the partner countries.
- A toolkit for implementing health promotion in prison for young prisoners.
- National research reports containing the results of the quantitative survey among prison staff and young offenders, the qualitative individual interviews with prison staff, plus the focus group interviews with young prisoners.

Achievements

The project delivered a promotion toolkit for young prisoners. It was pilot-tested in Bulgaria, the Czech Republic, Estonia, Latvia and Romania, and then further developed and disseminated to a range of professionals and organisations in EU Member States working with young vulnerable people in prison.

The main public health benefit for the target group was the increased access to targeted health promotion activities. However, to ensure sustainability of these results, an increase in both financial and human resources to further improve collaboration between prisons, NGOs and other external stakeholders was recommended. The project team also emphasised that health promotion programmes should also focus on developing prisoners' life skills. These could include communication skills, vocational training, relationship building, social skills, developing self-esteem and assertiveness to prepare them for a better quality of life after their release.

What effect have the results had on the policies and programmes of Member States and the EU?

The main impact of the project was to keep young prisoners' health on the agenda of policy makers and to support the call for health promotion within prison systems at national and EU level. The HPYP project is expected to have both short-term and long-term health outcomes. In the short term the project helped

increase the knowledge and skills base of prison and health professionals in improving the identification of health promotion needs of young prisoners. The use of the toolkit could change health promotion implementation and encourage professionals and stakeholders to support changes in prison policies geared to enhancing health promotion.

What were the benefits of working jointly at EU level?

The main benefits of the HPYP project implementation were the use of comparable methods for the situation analysis and the resulting increased understanding of the needs of young people in prison settings. Exchange of practices and knowledge among EU country experts working in prison health was an added benefit.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The main priority evidenced by the project was that health promotion activities should be further developed based on the needs identified by participants in this research and by building on current examples of good practice in various countries. According to the project results, there was also a need to define national and EU standards of policy measures concerning health promotion in prisons, as currently there appears to be little consistency of approach either within or between countries.

Project website

- www.hpyp.eu

Budget

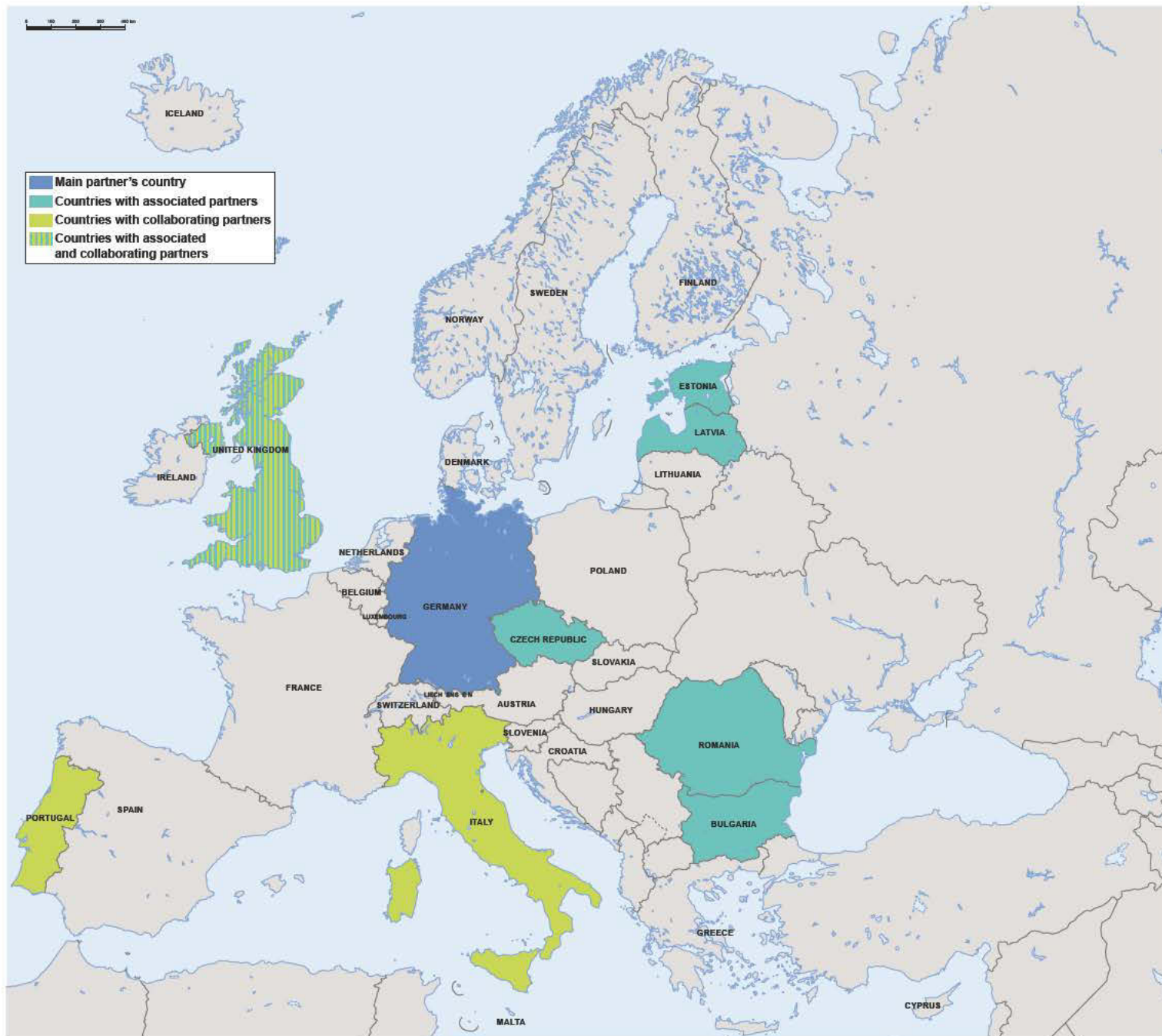
- Total budget: €624 971
- EC contribution: €499 976

Duration

- 01.04.2010 – 31.03.2013
(36 months)

Main beneficiary

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Main partner:

WAID — The Scientific Institute of the Medical Association of German Doctors, Bonn, Germany

Associated partners:

- Birmingham City University (BCU), Birmingham, England
- Association of Varna Organizations for Drug Prevention (AVODP), Varna, Bulgaria
- Convictus Eesti, Tallinn, Estonia
- Latvia's Association for Family Planning and Sexual Health 'Papardes zieds', Riga, Latvia
- University of Prague, Centre for Addictology, Prague, Czech Republic
- Association of Schools of Social Work in Romania (ASSW), Bucharest, Romania

Collaborating partners:

- European AIDS Treatment Group Contact
- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Portugal

- G.A.T. — Grupo Portugues de Activistas sobre Tratamentos de VIH/SIDA-Pedro Santos, Portugal
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Empowering Civil Society and the Public Health System to Fight Tuberculosis Epidemic among Vulnerable Groups

TUBIDU

Keywords: tuberculosis, testing, People Who Inject Drugs, People Living with HIV, multidrug-resistant TB

The TUBIDU project's main objective was to contribute to the prevention of the Tuberculosis (TB) epidemic among PWID (People Who Inject Drugs) and PLHIV (People Living with HIV). The project sought to increase synergies among community-based organisations and public health services, and to enhance their capacity to target hard-to-reach groups.

The project helped to develop international and national networks and has therefore made it easier to exchange knowledge and experiences. It has also improved cooperation among organisations and experts. The project produced guidance, recommendations and training materials for community-based organisations that seek to empower harm reduction services, to work on TB prevention and to improve access and adherence to treatment for PWID and PLHIV.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

TUBIDU aimed at reducing health inequalities by promoting TB prevention and care among some of the most vulnerable and excluded social groups, such as PWID and PLHIV. The project objectives therefore contributed directly to the Europe 2020 initiative and the strategy for Solidarity in Health: Reducing health inequalities in the EU, as outlined in the European Commission's Communication COM(2009) 567.

The project targeted community-based organisations, health and social care services, public health institutions, local and national policy makers, and PWID and PLHIV communities. It aimed at increasing the access of vulnerable, high-risk groups to TB prevention and care.

Why was the public health problem addressed important for Europe?

The project addressed the rise in TB-HIV co-infections, which is a major public health concern for Europe, particularly Eastern Europe. Bulgaria, Romania and the Baltic countries suffer some of the highest TB and HIV incidence rates in the EU, and TB is the main AIDS-defining disease in these regions. They also experience very high levels of multidrug-resistant TB and injection drug use. In the participating countries — Estonia, Latvia, Romania and Bulgaria — the number of PWID is estimated at 70 200 and the number of PLHIV is over 37 000.

Research shows that both groups — PWID in particular — face many barriers when trying to access TB testing. Obstacles relate to individual and behavioural characteristics as well as the institutional and organisational profiles of health and social care systems.

Objectives

The project aimed to raise awareness and develop the skills of health and social care providers, in particular community-based organisations and communities of PWID and PLHIV, with regards to TB testing and treatment. Project objectives included:

- Enhancing horizontal, vertical and cross-border collaboration among stakeholders in the fields of TB/HIV prevention and treatment, and intravenous drug use.

- Identifying barriers experienced by PWID and PLHIV in accessing TB and HIV health related services.
- Raising awareness regarding TB and HIV prevention, treatment and care among stakeholders, which include vulnerable groups such as PWID and PLHIV, community-based organisations, health and social care professionals and policy makers.
- Developing guidance on TB prevention activities for community-based organisations working with PWID and PLHIV.

Methods

TUBIDU project activities focused on capacity building and on enhancing the cooperation among community-based organisations, public health and social care systems to improve TB prevention in high-risk groups.

The methodology for the development of training materials and guidance included a literature review to assess related policies, practices and services. Field research (quantitative and qualitative) was also carried out to assess the target group's knowledge, attitudes and behaviour regarding TB and HIV. Following a thorough assessment of training needs, feedback from participants in national and international networking meetings was incorporated into the training programme and materials. National and international experts provided feedback on the guidelines using the Delphi technique.

International network meetings, including study tours, were organised to promote a hands-on approach. Participants from all stakeholder groups were involved in order to maximise networking and synergy effects.

Achievements

The project helped to raise awareness, increase capacity and promote networking among health, social care providers and civil society actors who work with PWID, PLHIV, TB and HIV.

The networking meetings addressed topics such as community involvement and integration of services for PWID, intensified case finding and good practices for service provision. In addition, three international and several national training sessions took place with the participation of providers from community-based organisations and health care services working with PWID and PLHIV.

The project has produced guidance on promoting prevention and care for TB among vulnerable groups, especially PWID and PLHIV. A TB handbook and training materials will also be made available in different languages.

What effect have the results had on the policies and programmes of Member States and the EU?

Project results and recommendations target civil society and public health actors along with policy makers, and are helping to inform national health programmes for the provision of TB services for vulnerable groups. In Estonia the guidance produced by TUBIDU was used to plan TB prevention measures in the National Health Plan 2009–20.

TUBIDU has also empowered national networks of organisations in the field of harm reduction to address TB related issues. In Latvia the project helped to widen the existing TB prevention network, bringing together community-based organisations, social workers, municipalities and HIV counselling centres from across the country.

What were the benefits of working jointly at EU level?

The countries participating in the consortium face similar challenges regarding TB and HIV co-infection and PWID. This project offered experts and practitioners from these countries the opportunity to exchange practices and experiences, and to enhance synergies by working together to produce innovative and scientifically sound guidance and training material. The project enhanced the capacity of public health services and civil society actors to address the TB epidemic in PWID and PLHIV at national and international level.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

TUBIDU identified the need to target TB prevention activities among vulnerable groups, in particular PWID and PLHIV. To this end it recognised the need to improve cooperation between public health systems and community-based organisations in order to reduce the barriers PWID face in getting screened and treated for TB.

Project website

- <http://www.tai.ee/en/tubidu>

Budget

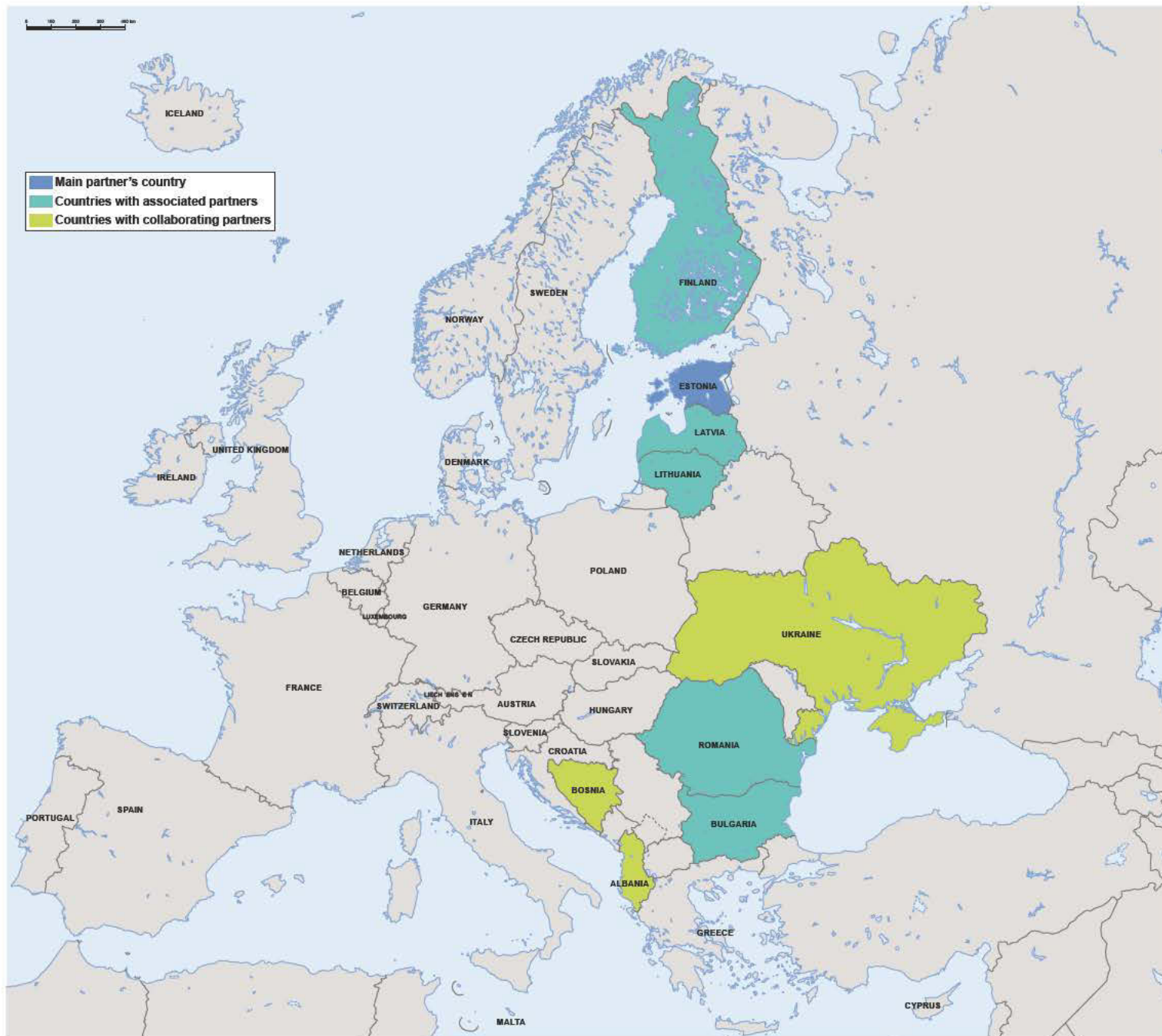
- Total budget: €881 509
- EC contribution: €694 693

Duration

- 01.06.2011 – 31.05.2013

Main beneficiary

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Main partner:

National Institute for Health Development, Tallinn, Estonia

Associated partners:

- 'Dose of Love' Association (DoL, Bulgaria)
- Fundatia Apelul Ingerului Roman (RAA, Romania)
- Tuberculosis Foundation of Latvia (LTBF, Latvia)
- MTÜ Eesti HIV-positiivsete Võrgustik (EHPV, Estonia)
- Institute of Hygiene (IH, Lithuania)
- Finnish Lung Health Association (FILHA, Finland)

Collaborating partners:

- Leningrad Oblast AIDS Centre (LOAC, Russia)
- International HIV/AIDS Alliance in Ukraine (IHAAU, Ukraine)
- National Centre for Tuberculosis and Lung Diseases (NCTLD, Georgia)
- World Vision Albania (WVA, Albania)
- World Vision Bosnia, Bosnia and Herzegovina (WVBH, Bosnia, Bosnia and Herzegovina)



Actions focusing mainly on two specific vulnerable groups: migrants and ethnic minorities (Cluster 3)

These actions also focus on vulnerable groups, but they are more likely to focus on migrants and ethnic minorities than on 'at-risk' groups. They are represented in Cluster 3, shown in the blue circle, bottom left quadrant.

They are also concerned with a broader range of health issues (both communicable and non-communicable or chronic diseases being of interest), and are more

concerned with the social context of health problems — especially the effects of discrimination. The type of interventions they tend to favour are focused on improving health care, in particular access to care (especially for undocumented migrants and ethnic minorities) and quality of care (e.g. 'cultural competence' of health care professionals), as well as access to targeted prevention and health promotion programmes delivered by health services.

*Information network on good practice in health care
for migrants and minorities:*

MIGHEALTHNET

Keywords: migrants, health care access, minorities, interactive databases, good practices

By promoting the exchange of information and expertise — both within and between countries — the project aimed to support health care services in the provision of adequate care to an increasingly diverse European population. MIGHEALTHNET sought to give professionals, policy makers, researchers, educators, and representatives of migrant and minority groups, easy access to a dynamically evolving body of knowledge and expertise.

Each participating country set up a wiki — or interactive website — containing information concerning migration and health. The wikis allow exchanges between European and national networks and stakeholders in the field. By facilitating the transfer of knowledge and expertise, and by stimulating network formation within and between European countries, the project further developed good practices concerning the health of migrants and minorities. On completion of the project, 'State-of-the-Art Reports' summarising the situation in each country were included in the wikis.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

By supporting Member States in the development of policy measures aimed at improving the access and quality of care for migrants through the exchange of information and expertise, this project contributed to the strategy for Solidarity in Health: Reducing health inequalities in the EU — COM(2009) 567 — and to the Europe 2020 initiative.

To enable health systems to respond adequately to the challenges of migration, MIGHEALTHNET provided a virtual network of expertise in three main areas: migrant health status, migrant health policies and migrant access to health services. The project wanted to create a critical mass which could inform policy exchanges on the basis of evidence and experience.

Why was the public health problem addressed important for Europe?

Increasing diversity in European populations is creating an urgent need for the exchange of expertise, information and good practices on health care for migrants and minorities. However, it is difficult to obtain such information at national and European levels. To respond to this challenge, MIGHEALTHNET aimed to both stimulate the development of good practices by promoting the exchange of information and expertise, and assist in the formation of scientific and professional communities concerned with migrant and minority health.

Objectives

The MIGHEALTHNET project sought to stimulate the exchange of knowledge on migrant and minority health through the development of wikis, which act as interactive databases, in the language of each of the 16 participating countries. These wikis contained the following:

- Background information concerning migrant and minority populations;
- Data on the state of health of migrants and minorities;
- Information about health care systems and the entitlement of migrants and minorities to health care;

- Details on health care accessibility;
- Quality of care: good practices to improve the matching of service provision to the needs of migrants and minorities;
- Achieving change: information about centres of expertise, plus general reports and policy documents, journals, training programmes and e-mail groups.

The project also aimed to create a central wiki in English linking up all national wikis and presenting Europe-wide information and material. Finally, state-of-the-art reports had to be produced by each country, containing a compilation of the available information and resources regarding migrant and minority health policies and current practices.

Methods

MIGHEALTHNET's objectives were achieved through: the organisation of national and European meetings; reviewing information and material related to migrant health across the EU; and actually creating wikis in each associated and collaborating country.

The project therefore set up wikis in 16 countries. The wikis contain information about individuals, organisations and resources dealing with migrant health and health care. The wikis were linked to each other and to a central site. They were also made available to the general public.

State-of-the-Art reports, providing a summary of the main findings that emerged from the information, from 12 countries were produced and uploaded onto the website. The project also produced conference announcements, press releases, partners meetings, information material, and lists of stakeholders and potential contacts.

Key stakeholders and target groups involved in the project process included experts in the field, health service providers, NGOs, migrant organisations, policy makers and international agencies.

Achievements

The national dissemination meetings generated great interest in all the participating countries, and the state-of-the-art reports presented a thorough picture of the main migration-related issues. The wikis are expected to continue to grow and to be used more frequently.

Several partners secured the continuation of the wikis by hosting the wiki in the server of their organisation. Furthermore, the similarity in structure of each country's wiki, the availability of Google Translate, and the ease with which new registered users can upload documents on the wikis, provide an optimistic future for broader dissemination of the project.

Through the wikis, migrants and minority groups have the opportunity to obtain information related to health care access and policy regulation in their host countries. These groups can also use the wikis to find out about organisations, which offer assistance as well as information about their community representatives.

What effect have the results had on the policies and programmes of Member States and the EU?

The access to available information and resources in 16 EU Member States regarding migrant and minority health policies and practices should have a potentially positive impact on European and national policies and programmes. Judging from the large number of hits the wikis received after they were opened to the public, there has been great interest in the information provided. However, although the issue of migrant

health is a priority in many EU countries, the financial crisis and the subsequent austerity measures — especially in the Member States of southern Europe — could hinder the effective incorporation of the project's results into programmes and policies.

What were the benefits of working jointly at EU level?

The exchange of information among the project partners was beneficial, in the sense that each country was able to share and learn from each other's experiences about migrant health care issues. Individual partners had the opportunity to share their expertise and discuss findings with partners from different professional backgrounds on a European level, comparing different national policy and practice approaches.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

This project stressed the necessity of improving the level and exchange of information and knowledge of migrant health, as well as of their rights and accessibility to health care.

Project website

- www.mighealth.net

Budget

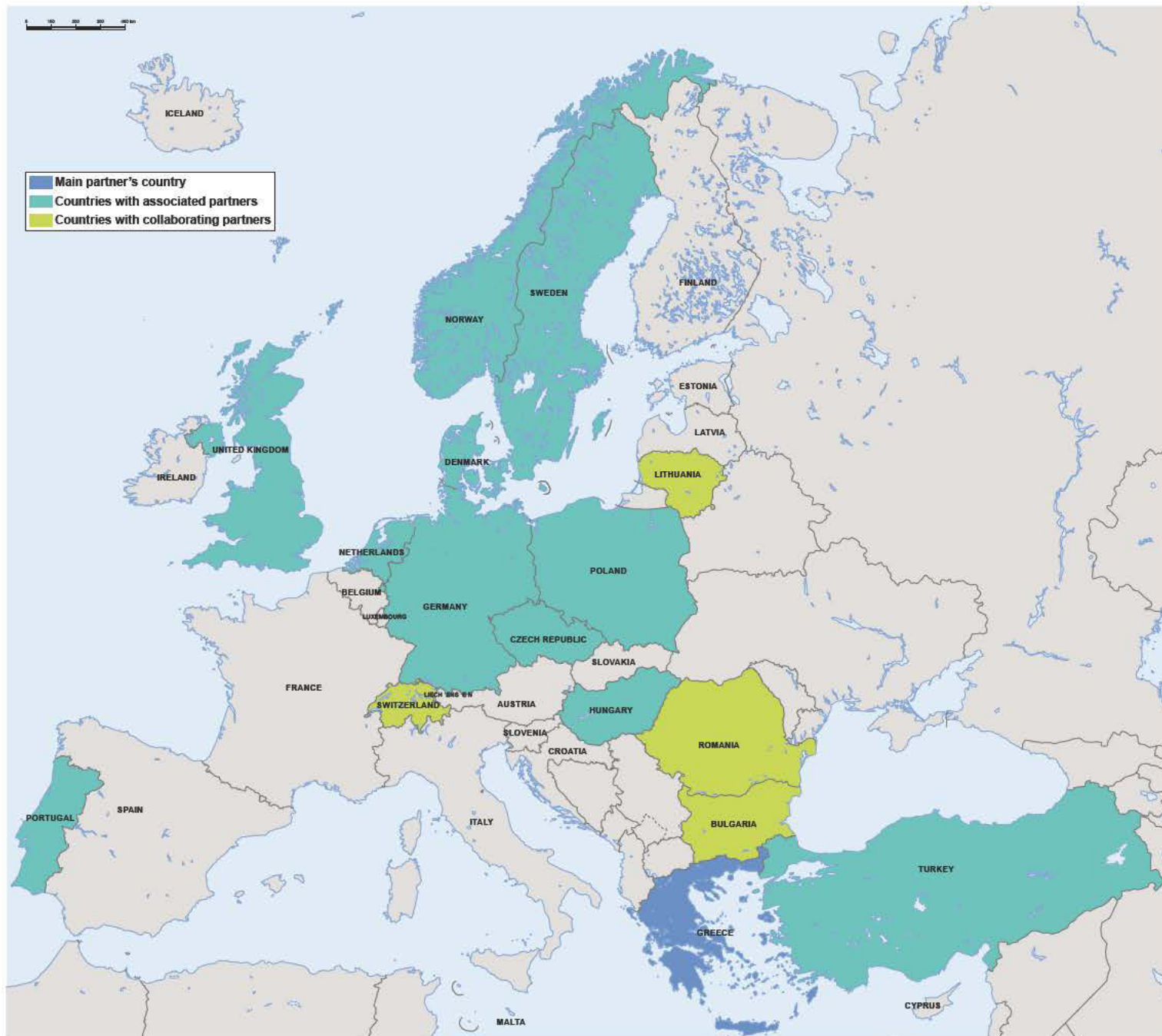
- Total budget: €645 681
- EC contribution: €381 442

Duration

- 25.04.2007 – 24.04.2009

Main beneficiary

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- Dr Elena Riza, Project coordinator, 75 Mikras Asias str., 11527 Goudi, Athens, Greece.
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Main partner:

National Kapodistrian University of Athens

Associated partners:

- Utrecht University (The Netherlands)
- Baskent University (Turkey)
- Queen Mary University of London (UK)
- Middlesex University (UK)
- Universitaet Bielefeld (Germany)
- University of Southern Denmark (Denmark)
- Faculdade de Letras da Universidade de Lisboa (Portugal)
- Uniwersytet Jagiellonski Collegium Medicum (Poland)
- Internationell Migration och Etniska Relationer (Sweden)
- Semmelweis University College of Health Care (Hungary)
- Ulleval University Hospital (Norway)
- Univerzita Karlova v Praze (Czech Republic)

Collaborating partners:

- Kaunas University of Medicine (Lithuania)
- Bulgarian Helsinki Committee (Bulgaria)
- Université de Genève (Switzerland)
- University of Medicine and Pharmacy (Romania)

Enhancing Public Health Safety Along the New Eastern European Border:

PHBLM

Keywords: vulnerable population, emigration and immigration, public health, border crossing, detention centres

This project sought to improve public health across the EU by tackling public health problems on the Union's Eastern border, where the conditions for the Schengen agreement are still being implemented. By focusing on migrants' health, the project was

designed to assess the public health risks linked to migration and the conditions of detention and also ensure migrants receive the appropriate health care. The project also addressed issues related to the occupational health of border staff and managers.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

This project was the first to focus on migrants' health, the occupational health of border staff and public health issues. It is directly relevant to EU and international strategic documents such as the implementation of Decision No 2119/98/EC, Decision No 2000/57/EC, Council Directive 2003/9/EC laying down minimum standards for receiving asylum seekers, and WHO's International Health Regulations (2005). Issues of regional relevance linked to border management, migration and health were addressed for the first time. These include provision of health services, data collection, development of training for health professionals and border police on migration and health, and national and regional coordination between ministries of health and interior.

Why was the public health problem(s) addressed important for Europe?

While migration pressures and detention conditions on the southern borders require continued attention, the enlargement of the Schengen area also brings new migration-related health challenges to the Member States on the new EU eastern border. Health systems and border services need to address public health concerns and rights of migrants, and maintain border workers' occupational health. The PHBLM project sought to support partner countries' accession to the Schengen area and work towards a harmonised approach to migration health.

Objectives

The PHBLM project's aims were: to minimise the public health risks of migration along EU borders; to analyse and document the current public health situation regarding border management in the EU countries forming the new eastern Schengen border; to promote the human rights-based provision of appropriate and adequate health care to migrants and occupational health assistance to border management personnel through training, public health guidelines and structural changes; and to disseminate project results.

Specific objectives were to:

- Develop a methodology to assess health hazards and public health-related border management conditions.
- Perform a situation analysis in 20 border sectors (in Hungary, Poland and Slovakia).

- Prepare a situation analysis report.
- Develop public health policy guidelines for border management and detention procedures.
- Develop recommendations for the implementation of structural changes to public health services in border regions.
- Develop multidisciplinary training materials and test them in a regional workshop.
- Disseminate the training materials and guidelines through country-level consultations with governmental bodies of EU Member States, and to hold a one-day EU-level dissemination event.

Methods

The project started with an assessment of conditions in the region, followed by the development of training materials for border officials and health professionals working with migrants. Finally, the project produced guidelines for border management and detention procedures and recommendations for structural changes in public health services in the border regions' targeted countries: Hungary, Slovakia, Poland and Romania (for certain activities).

Based on a new methodology, a situational analysis involved checkpoints and detention centres. There was also a collection of existing data and statistics, preliminary analysis, a Knowledge Attitude and Practices (KAP) survey of border officials, and field visits. The situational analysis outcomes informed the development of guidelines and training modules' materials for border officials and health professionals, which were piloted at regional level. Finally,

project results and recommendations were disseminated through consultation with governmental bodies of EU Member States and an EU seminar.

Deliverables included:

- A protocol for the assessment of public health conditions, related health hazards and capacity of the border management structures.
- A template for a migrant health database to standardise collection of migration-related health data.
- A situation analysis report of current border management procedures and structures, with regard to human public health.
- Guidelines for border management and detention procedures involving migrants.
- Recommendations for structural changes to improve public health-related border management procedures.
- Training modules and materials on border management, migration health and right to health care.

Achievements

The project achieved its primary aims and generated useful tools and educational resources. It established networks and enhanced capacity for collaborative working, in Member States and internationally. The main public health benefits are seen in an increased knowledge of health risks and an improved monitoring capacity in border management and reception of migrants at the eastern Schengen border. Also, there was improved information on migrants' health needs and referral mechanisms, enhanced preparedness and capacity for handling migration and mobility, as well as strategies to overcome health concerns of arriving migrants. Project results were sustained through links with governmental bodies. Partnerships were formed with other national and international entities such as CoE, regional networks, academic partners and EU agencies (ECDC and Frontex) to share experiences.

What effect have the results had on the policies and programmes of Member States and the EU?

The dissemination of project results and recommendations raised awareness among Member States' governments of the health impact of migration and the need to develop health policies. Also, the recom-

mended project guidelines for border management and detention procedures can improve public health safety around the eastern Schengen border, and thus for the entire EU.

What were the benefits of working jointly at EU level?

The project built several strong partnerships at national and regional level. Firstly, the needs of different stakeholders were identified, especially in terms of training, coordinating work and data collection beyond the individual Member States. Knowledge sharing was a positive outcome. One partner confirmed that as a consequence of the project their Ministry of Health had expanded its work on border management and health issues, while the EU border management agency (Frontex) followed up with a recommendation for the training needs of border police staff and revised its curriculum for training border guards; adding sections relating to health in line with the PHBLM project results.

The PHBLM training materials were used for training exercises with health professionals in Europe and globally on migration and health, implemented by the IOM and partners.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The main priority was to help border regions meet the health needs of migrants, staff and communities in border areas and detention centres; through coordination and cooperation among organisations and individuals working in detention centres. These include immigration authorities, border police, local and regional authorities, health services and NGOs.

Project website

- www.iom.int

Budget

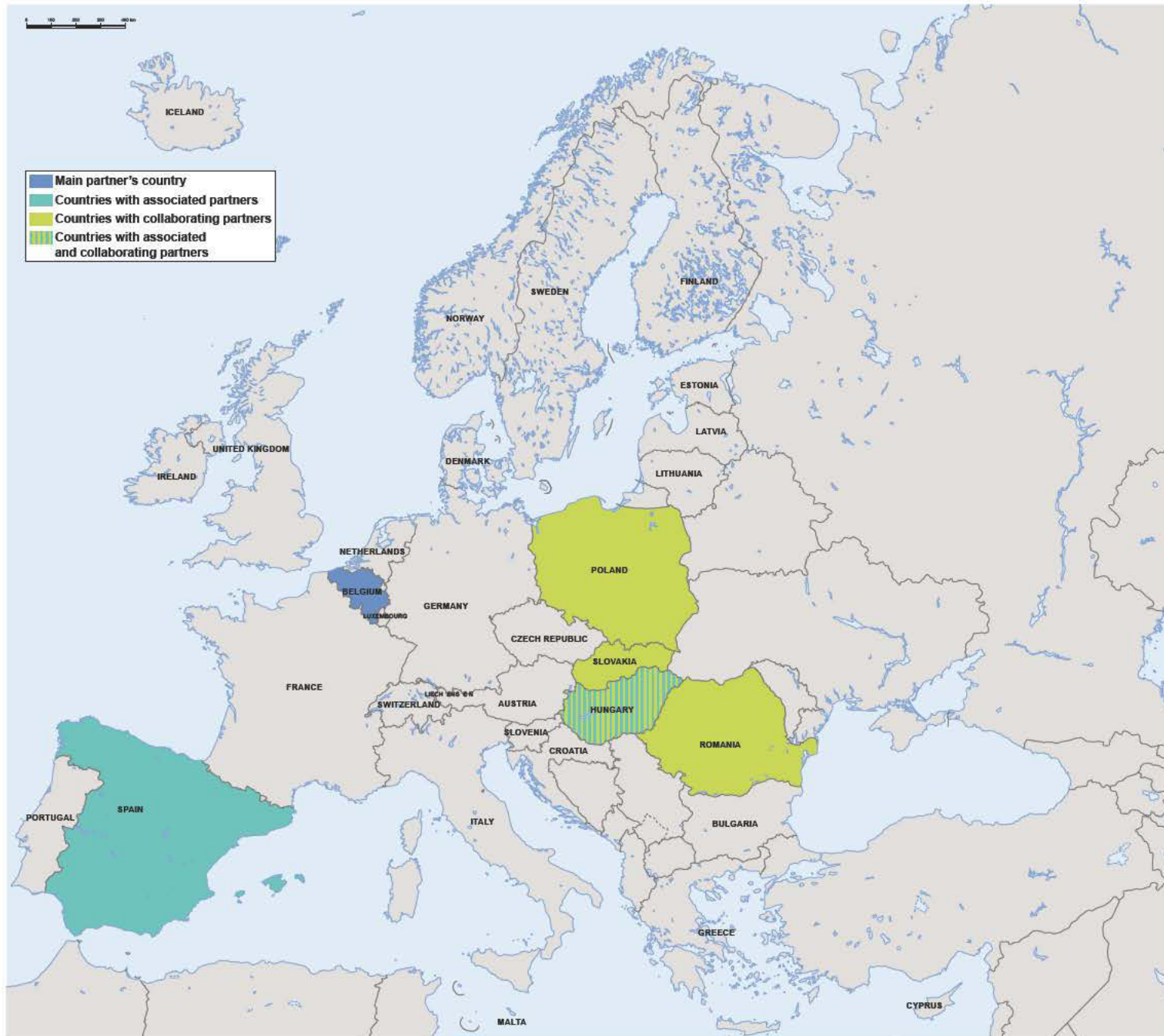
- Total budget: €782 727
- EC contribution: €469 409

Duration

- 05.06.2007 – 04.06.2010

Main beneficiary

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- Email: rpetrovabenedict@iom.int



Main partner:

International Organization for Migration, Brussels, Belgium, IOM

Associated partners:

- University of Pécs, Hungary
- Escuela Andaluza de Salud Pública, Spain

Collaborating partners:

- Border Guard HQ of the Polish Ministry of Interior, Warsaw, Poland
- Chief Sanitary Inspectorate of Polish Ministry of Health, Warsaw, Poland
- Slovakian Ministry of Health, Bratislava, Slovakia
- Alien Border Police HQ of the Slovakian Ministry of Interior, Bratislava, Slovakia
- Hungarian Ministry of Health, National Public Health and Medical Officer Service, Hungary
- Border Guard HQ of the Hungarian Ministry of Justice and Law Enforcement, Budapest, Hungary

- FRONTEX WHO EURO Romanian Ministry of Interior, Bucharest, Romania
- ECDC Center for Migration Research, Warsaw, Poland
- Voivodeship Sanitary-Epidemiological Station in Olsztyn, Bialystok, Poland
- School of Law Enforcement, Szeged, Hungary
- University of Trnava, Public Health Department, Trnava, Slovakia
- Slovak Foreign Policy Association, Bratislava, Slovakia

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project contributed to the COM(2009) 567 Solidarity in health Communication by addressing inequalities relating to access to health services. It did this by raising awareness, promoting and assisting exchange of information and knowledge and identifying and spreading good practice. It contributed to combatting poverty and social exclusion as indicated by the Europe 2020 initiative by facilitating knowledge exchange between researchers, policy makers, advocacy groups and health care providers, in order to improve the access to effective health care for UDMs.

Why was the public health problem(s) addressed important for Europe?

UDMs' poor health is a major public health problem in Europe; literature and case reports from support organisations suggest high infection rates, poor disease prevention, and delays in health care provision for this vulnerable group, reflecting both increased health risk and barriers to health care access. This problem is exacerbated by differing national public health policies and service provision models.

Objectives

The project aimed to improve the health protection of UDMs by supporting health policy decision makers and health care providers; when eligibility for health care and insurance issues arise that compromise the basic human right to health. The objectives were:

- to collect policies and regulations in force in the EU-27 and to draw a European landscape of the legal and financial frameworks under which health care services operate;
- to collect data on health care practices for UDMs — and enable governmental organisations (GOs) and non-governmental organisations (NGOs) to make this available — and to identify transferable models of good practice;
- to gain an overview about the needs and strategies of UDM in getting access to health care services and to compile experiences from NGOs and other advocacy groups that work with UDMs.

Methods

To achieve these objectives quantitative and qualitative methods were used. This involved desk research and expert interviews for policy compilation, web-based database collection, staff and client interviews, plus phone interviews for compiling the perspectives of advocacy groups.

The project produced a number of documents in different languages that are now available on two project websites (www.nowhereland.info and www.c-hm.com). These include:

- an executive summary and recommendations addressing the policy frameworks and health care provision, as well as ideas for further research;
- 27 country reports describing national policies and regulations on health care for UDMs;
- a fact sheet clustering the EU countries according to legal regulations governing UDM access to health care;
- an online database on health care provision in 11 EU countries and Switzerland;
- information on four selected practice models representing different types of provision: mainstream services, dedicated public health services and NGOs;
- 17 country reports on UDM health needs and strategies, focusing on the main health concerns and obstacles to accessing health care;

- a fact sheet containing information and experiences of barriers facing UDM in accessing health care, and recommendations to solve these problems;
- a book containing the overall findings titled 'Migration and Health in Nowhereland' published by the Danube University of Krems.

Achievements

The project contributed to raising awareness among policy stakeholders, health care providers and the public of UDMs' health needs. This was done by making visible the different public health policy and health care provision approaches in EU Member States, and representing the perspective of UDMs themselves.

Collecting data on health care provision was a challenge, and in many cases this provision seemed as invisible as the UDMs. The outcome of the research — using different channels such as international experts, hospitals and NGO networks — was a collection of 71 practice models, involving 24 GOs and 47 NGOs.

What effect have the results had on the policies and programmes of Member States and the EU?

The project supports EU legislation and best practice promotion by drawing an EU landscape of the legal and financial frameworks under which health care services/providers act. It also does this by gaining an overview about problems, experiences and strategies of UDMs in accessing health care, and by collecting good quality service provision models that could be used in other countries. The project impacted directly on Sweden, where partial access to health care for UDMs was introduced in 2012.

Some preliminary recommendations from the project might impact on future policies and programmes of Member States and the EU itself. One such recommendation is raising awareness of UDM rights to health care. Other recommendations cover the need for evidence-based health policies, the connection of UDM health issues to labour market policies, the separation of migration control from health care provision and the promotion of effective collaboration between NGOs and public health services in providing health care for UDMs.

What were the benefits of working jointly at EU level?

Project partners represented research organisations, policy makers, international organisations, health care associations and NGOs. This made it possible to develop and provide knowledge through approaching and integrating health care organisations, advocacy organisations and UDMs. In turn this ensured discussion at policy level. Individual partners had opportunities to share expertise and discuss findings in an interdisciplinary team with partners from different backgrounds.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

Many stakeholders are not well informed about regulations in place that create uncertainty and health inequality for people in vulnerable situations. A priority is investment to widen access to health care through better information and communication (interpreting and intercultural mediation services). Other priorities are to ensure sufficient support for NGOs, economic evaluation of existing policies and practices, and the establishment of a framework for sustainable data collection as a precursor for informed decision making for new policies.

Project website

- www.nowhereland.info

Budget

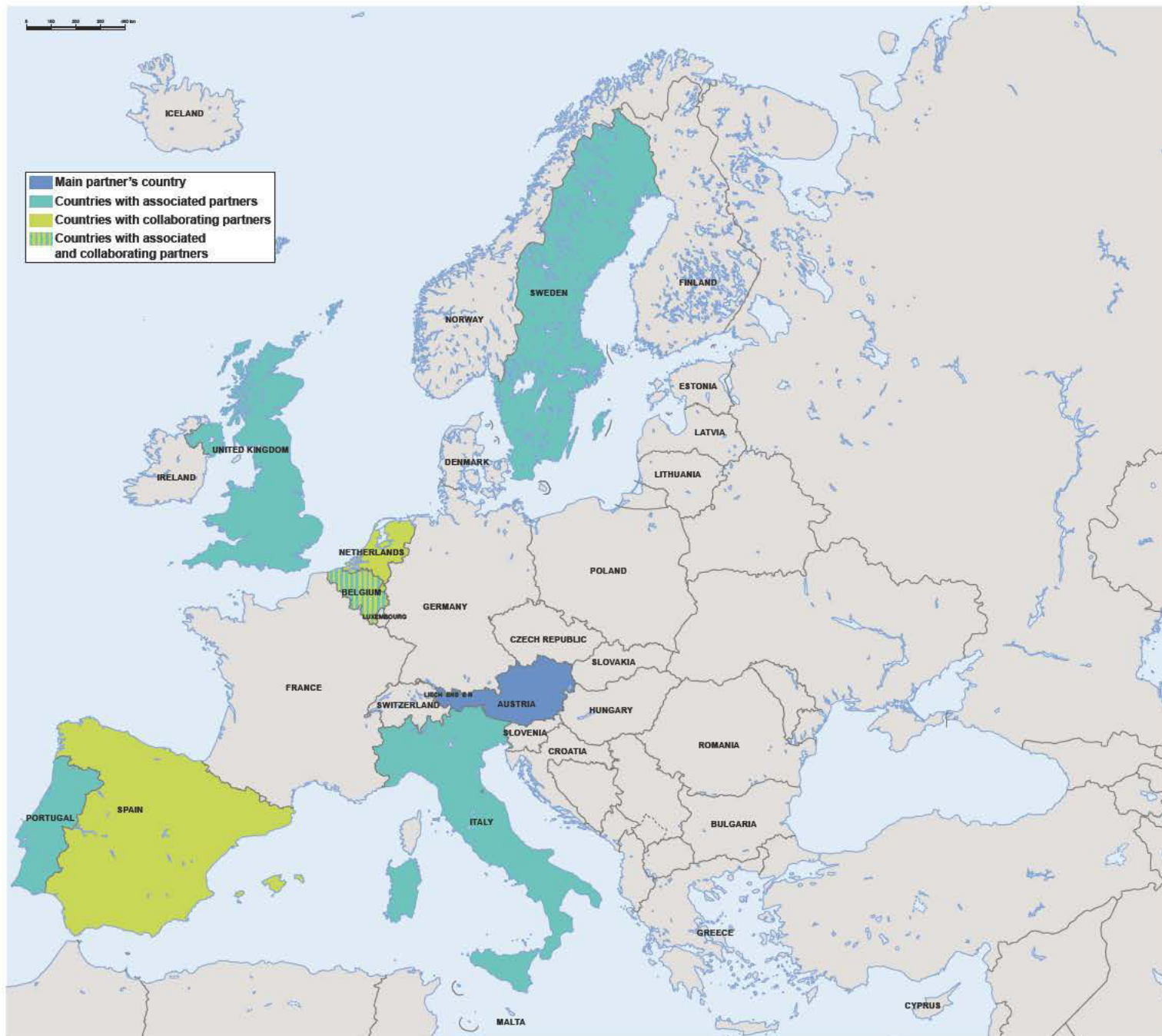
- Total budget: €834 899
- EC contribution: €499 949

Duration

- 01.01.2008 – 31.12.2010 (36 months)

Main beneficiary

- Danube University Krems DUK, Strasse 30, 3500 Krems, Austria.
- Contact person: Ursula Karl-Trummer, Project Leader.
- Tel.: +43 1 4277 48 296
- E-mail: uschi.trummer@univie.ac.at



Main partner:

Danube University Krems DUK; Strasse 30,
3500 KREMS Austria

Associated partners:

- AUSL Azienda Unità Sanitaria Locale di Reggio Emilia, Italy
- CIES Centro de Investigacao e Estudos de Sociologia, Lisbon, Portugal
- MIM — Malmö Institute for Studies of Migration, Malmö, Sweden
- PICUM — Platform for International Cooperation on Undocumented Migrants, Brussels, Belgium
- University of Brighton, Faculty of Health and Social Science, Brighton, UK

Collaborating partners:

- HOPE European Hospital and Healthcare Federation, Brussels, Belgium
- ICMPD International Centre for Migration Policy Development, Vienna, Austria
- IOM International Organization for Migration, Brussels, Belgium
- UNITED for Intercultural Action, Amsterdam, The Netherlands
- University of Vienna, Institute for Nursing Science, Vienna, Austria
- WHO European Office for Integrated Health Care Services, Barcelona, Spain

*Best practice in Access, Quality and Appropriateness
of Health Services for Immigrants in Europe:*

EUGATE

Keywords: health services organisation, health services utilisation, migrant health, irregular migrants, capacity building

The aim of the EUGATE project was to assess the restrictions and obstacles migrants experience when accessing health services, and to identify good practice in the delivery of health care to migrant populations. The project reviewed legislation and policies, and assessed good practices relating to migrant access to different types of health services. The study was conducted in 16 EU countries: Austria, Belgium,

Denmark, Finland, France, Germany, Greece, Hungary, Italy, Lithuania, the Netherlands, Poland, Portugal, Spain, Sweden and the United Kingdom.

EUGATE created a multilingual, searchable website for disseminating its results, including models of good practice and recommendations for appropriate, more equitable service delivery to migrants.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

Equity in health is recognised as a fundamental value by EU bodies. The Commission Communication *Solidarity in health: reducing health inequalities in the EU* admits that 'Vulnerable and socially excluded groups such as people from some migrant or ethnic minority backgrounds, [] experience particularly poor average levels of health'.

Moreover, better levels of health across all population groups are critical for increasing productivity and reducing poverty in the context of an ageing EU population, in line with the Europe 2020 initiative.

Why was the public health problem(s) addressed important for Europe?

Although Europe has been home to tens of millions of migrants over decades, health care systems in the EU Member States are still challenged by the need to develop accessible, appropriate and quality services for migrant groups. One of the challenges is to ensure reliable data is available on the access to and delivery of health care to migrants. Several studies suggest migrants, in particular migrants with irregular status, experience unequal access to health care. In the majority of EU Member States migrants with irregular status — estimated at between 4.5 and 8 million — are not entitled to receive medical care from public health care services with the exception of medical emergencies. Besides legal barriers, migrants face other specific difficulties in accessing health care, such as language and cultural obstacles.

Objectives

The EUGATE project aimed to consolidate the fragmented knowledge relating to migrants' access to and use of health care services, and to identify good practice in health care provision for different migrant populations. More specifically, the project aimed to:

- Develop a common definition of migrant groups which could be introduced in health care services' data collection systems;
- Collect, assess and present in a compendium concepts, legislation, policies and practices with regards to the use of health care services by migrant groups;

- Identify models of good practice and assess the potential for transferring them to other countries;
- Develop a compendium with good practices in the field of capacity building;
- Identify the professional standards and competencies of practitioners;
- Create a multilingual, searchable website to widely disseminate the project's products and support the exchange of information.

Methods

Information was collected through desk review and interviews with experts and practitioners at national and European levels. A review of legislation and policies concerning migrants' access to health care was conducted in each of the participating countries using a standardised questionnaire. In addition, a total of 128 experts from academia, NGOs, policy making bodies and the health care sector participated in a four-step Delphi process to reach a consensus regarding good practices in the provision of health care to migrants. Interviews were also conducted with 240 health professionals and administrators/managers experienced in the provision of care to migrants. Participants were recruited from three urban areas with high concentrations of migrants, within three different services per country: an emergency department, mental illness long-term care, and primary care services.

The Delphi method was used to identify common definitions of migrant groups and relevant indicators, such as country of birth, language use, etc. In addition the project attempted to assess data on health care use by migrants.

Achievements

EUGATE contributed to the improvement of health care services for migrants by defining measures of quality and by facilitating a discussion on the issue at both national and European level. The project identified and disseminated models of good practice and supported the operation of an experts' network among the participating EU countries.

Best practice recommendations include: improving access to health care, developing culturally sensitive health services, improving patient-health care provider communication, networking in and outside of health services, and more outreach activities. Likewise, the interviews with health care professionals identified similar components of good practice including organisational flexibility, good interpreting services and training on care entitlements for immigrants.

The project produced a database which serves as a tool for comparing existing legislation and policies regulating delivery of health care to migrants. A compendium of best practices in service delivery to migrant groups is also available on the project's website.

What effect have the results had on the policies and programmes of Member States and the EU?

The project contributed to increasing awareness among policy makers at EU and national level on the need to improve the access of migrant groups to health care, and on the challenges health care systems should meet to achieve more equitable service delivery.

What were the benefits of working jointly at EU level?

Interestingly the results from the assessment of local practices showed that although national legislation and policies presented discrepancies, the experience of delivering health care to migrants (regardless of migration status) was to a large extent very similar between countries. The project was therefore able to present common recommendations for good practice across the 16 participating countries.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

Migrants with irregular status and victims of human trafficking are vulnerable to health inequalities and experience poor access to health care services. In that respect the restrictive legislative framework of most EU countries regarding irregular migrants' access to the public health care system is of major concern as it creates and reinforces health inequalities. The project also highlighted the need for more organisational flexibility and increased awareness of migrant entitlements.

Project website

- www.eugate.org.uk

Budget

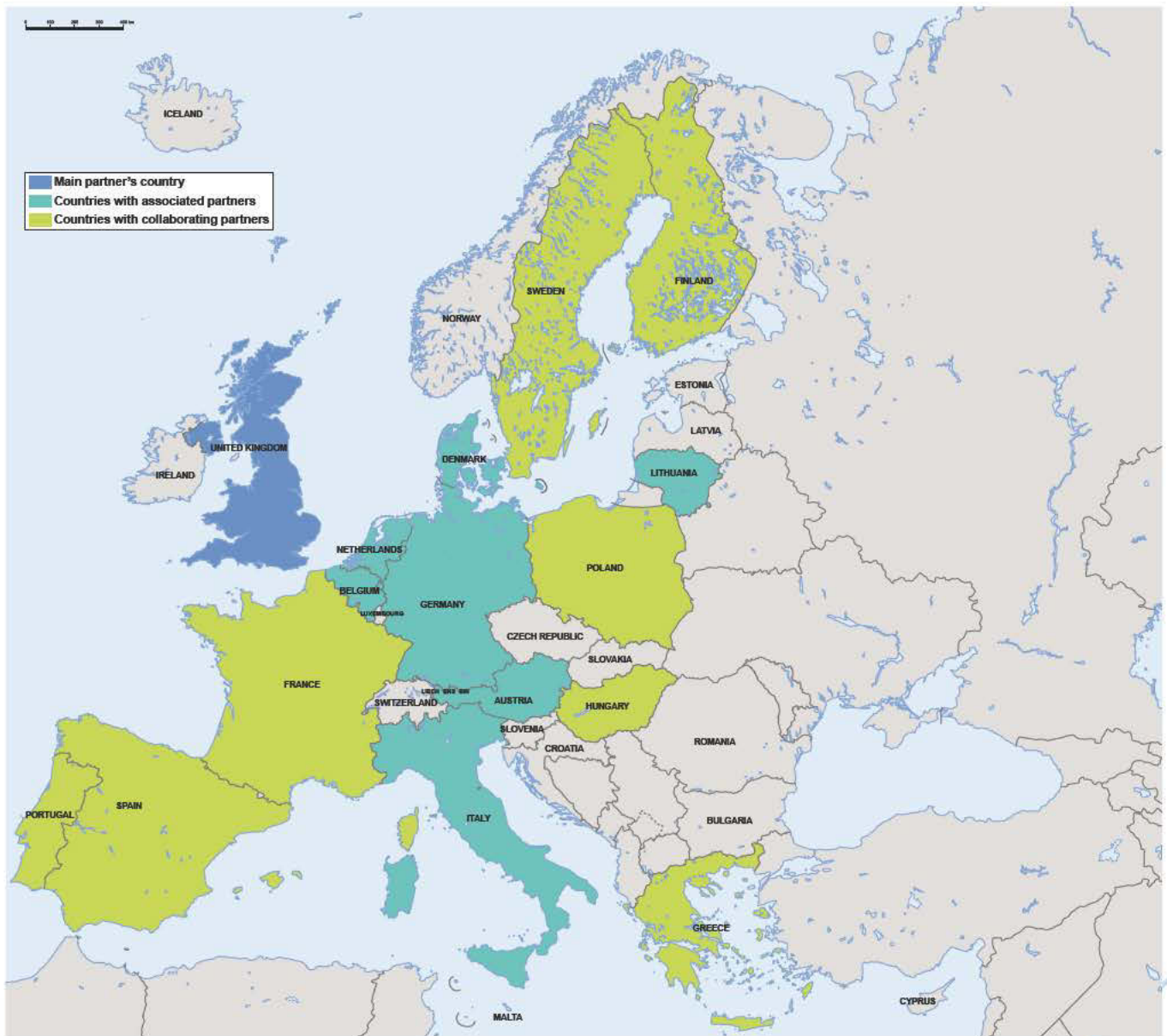
- Total budget: €1 166 627
- EC contribution: €699 968

Duration

- 01.01.2008 – 31.12.2010

Main beneficiary

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Main partner:

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- Agency of Public Health of Barcelona, Pça. Lesseps, 1, 08023 Barcelona, Pça. Lesseps, 1, 08023 Barcelona, Spain
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Good Practice in Mental Health Care for Socially Marginalised People in Europe

PROMO

Keywords: mental health, vulnerable groups, migrants, Roma, sex workers, access and quality of health care

The PROMO project aimed to improve mental health services provided to groups experiencing social marginalisation, in particular the long-term unemployed, the homeless, street sex workers, migrants and travelling communities.

The project consortium assessed services providing mental health and social care to socially excluded groups across 14 European countries, as well as the quality of the mental health and social care system as a whole.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

Meeting the needs of marginalised groups is a priority for European policies on public health, poverty and cohesion. The PROMO project is aligned with the goal of reducing health inequalities set by the Europe 2020 initiative and the strategy for Solidarity in Health: Reducing health inequalities in the EU (COM(2009) 567).

PROMO addressed the provision of mental health care for vulnerable and marginalised groups in highly disadvantaged urban areas across the European Union (EU). It identified the barriers to accessing care, ways to overcome them and good practices in mental health care for these groups. The findings and relevant policy recommendations were disseminated widely to stakeholders, including health departments in all EU countries, the European Commission and WHO Europe.

Why was the public health problem addressed important for Europe?

Socially marginalised groups are more likely to experience mental health problems than the rest of the population. In addition, the burden of mental illness among the homeless, the long-term unemployed, minorities and other marginalised groups makes it difficult to reduce inequalities and promote cohesion in European society. Individuals who are socially marginalised have restricted lifestyle choices, along with fewer and less effective means of coping with psychological distress. It has been recognised that factors such as lack of money, discrimination, social exclusion, lack of education and poor housing standards have a major impact on their mental health. It is not clear whether EU countries have adequate policies and services in place to lessen the risk of socially marginalised people developing mental illness, or to ensure their access to appropriate care.

Objectives

PROMO's main objectives included:

- Reviewing legislation and policies relevant to mental health care for socially marginalised groups.
- Assessing mental health and social care services targeting in particular the long-term unemployed, homeless, street sex workers, migrants and travelling communities.

- Identifying good practices for the provision of mental health care to socially marginalised groups, assessing barriers to accessing and receiving care — and suggesting ways to overcome them.
- Developing and disseminating policy recommendations based on the identified good practices.

Methods

The main activity of the project was the identification of good practices and the drafting of recommendations in the field of mental health provision for socially excluded groups. This was achieved through: the critical review of legislation and policies; the assessment of services providing mental health and social care to marginalised groups; and a survey with the participation of health and social care experts.

PROMO's assessment of services included 617 cases and was focused on the two most deprived areas in the capitals of each of the 14 participating countries. The services identified for assessment included all mental health, social care and general health services that potentially serve individuals with mental health problems who belong to marginalised groups. The assessment tools were developed using the Delphi technique and evaluated a variety of the services' organisational characteristics. Data was also collected via semi-structured interviews with 154 experts experienced in providing care to the target groups in different EU countries. Qualitative and

quantitative findings were combined to identify barriers to care, ways to overcome them and the components of good practice which could be translated into policy recommendations.

Achievements

The project brought together a multidisciplinary consortium of experts from 14 EU countries and developed information material for practitioners and policy makers so they could share good practices and recommendations on the provision of mental health and social care to marginalised groups. The information packages were distributed to 768 stakeholders and are available on the project's website for further dissemination. Project findings were also shared with the scientific community (six papers were published in peer reviewed journals).

Moreover, the project developed assessment tools for the quality evaluation of mental health services provided to socially marginalised groups. It also developed a 'Quality Index of Service Organisation' designed to assess organisational good practice in the provision of mental health care for disadvantaged patients.

What effect have the results had on the policies and programmes of Member States and the EU?

PROMO provided significant evidence that may be used to reduce health inequalities in the area of mental health care. The project recommendations were shared with the health departments of the 27 Member States, representatives of EU bodies and WHO Europe. The recommendations may guide future policies to improve marginalised groups' access to appropriate mental health care. PROMO's findings were also included in the WHO Mental Health Action Plan background paper.

What were the benefits of working jointly at EU level?

The participation of 14 European countries in the project's consortium promoted the exchange of information and knowledge between countries with different mental health and social care traditions and available resources. Despite the differences in systems and approaches, it is telling that the experts from the different countries reached a broad consensus on the barriers marginalised groups face in accessing health care, as well as on what constitutes good practice. As a result the policy recommendations developed by the project apply across health and social care systems in Europe.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

Practice in mental health care for marginalised groups varies substantially across Europe. Despite these differences, there are some common barriers to providing appropriate care for patients facing social exclusion. PROMO identified as a priority the provision of services that will better meet the needs of these vulnerable groups and to this end it recommends that health and social care systems devote sufficient resources, coordinate different services, provide adequate information to potential users, and invest in the training of practitioners.

Project website

- www.promostudy.org/project/index.html

Budget

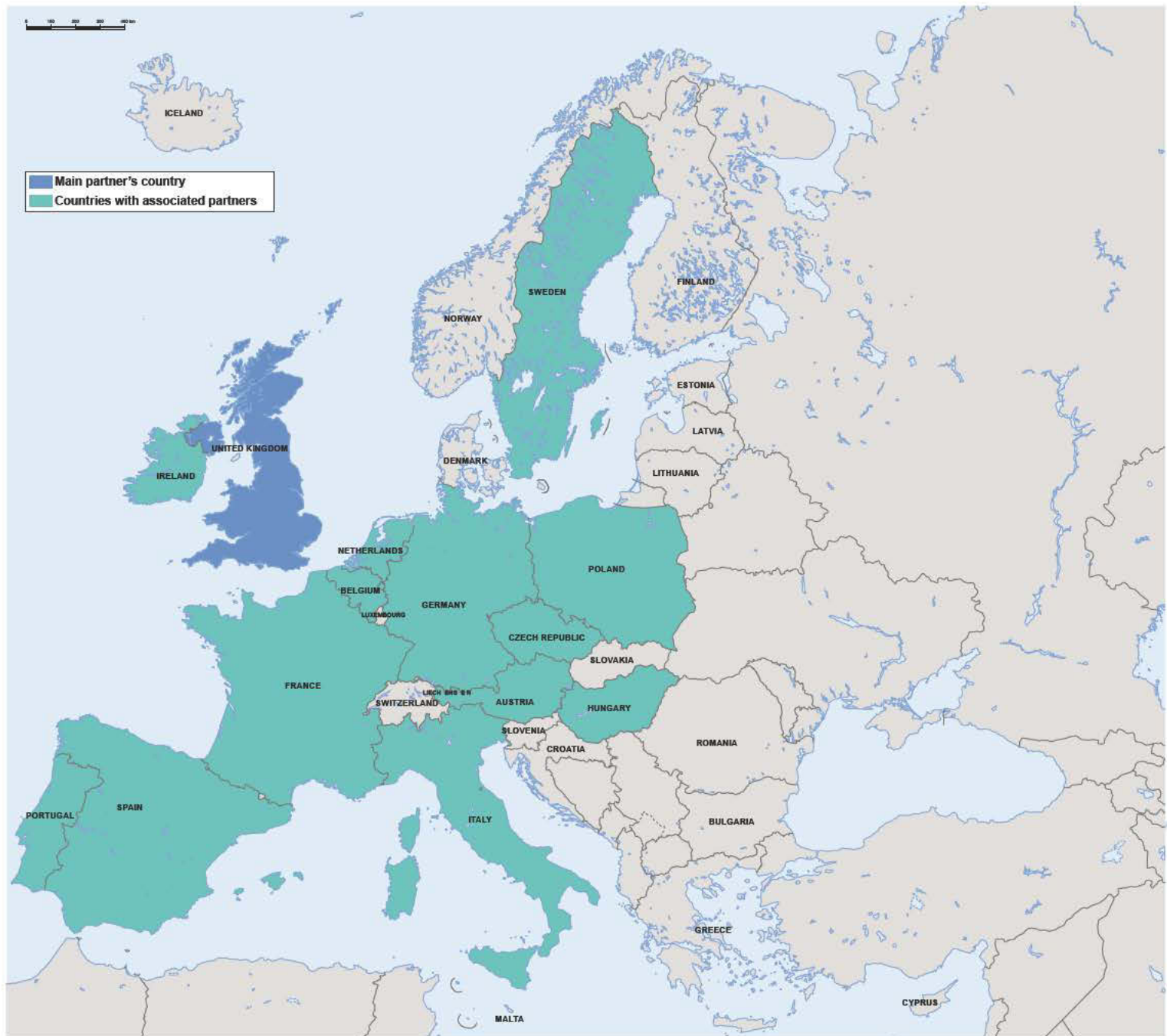
- Total budget: €1 499 543
- EC contribution: €875 664

Duration

- 01.09.2007 – 31.12.2010

Main beneficiary

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Main partner:

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- Universita Karlova v Praze, Prague, Czech Republic
- Etablissement Public de Sante Maison Blanche, Paris, France (EPSMB)
- Hungarian National Institute for Health Development, Budapest, Hungary (NIHD)
- Institute Psychiatrii Neurologii, Warsaw, Poland (IPIN)
- University of Porto Medical School, Porto, Lisbon (FMUP PORTO)
- Madrid Salud, Madrid, Spain (MADRID SALUD)
- Karolinska Institute, Stockholm, Sweden (KI)

- Universitätsmedizin Charite, Campus Mitte, Berlin, Germany (CHARITE)
- National University of Ireland, Galway, Ireland (NUI GALWAY)
- Agency for Public Health, Lazio Region, Rome, Italy (ASP Lazio)
- Academic Medical Centre Amsterdam, The Netherlands (AMC)

Collaborating partners:

- None

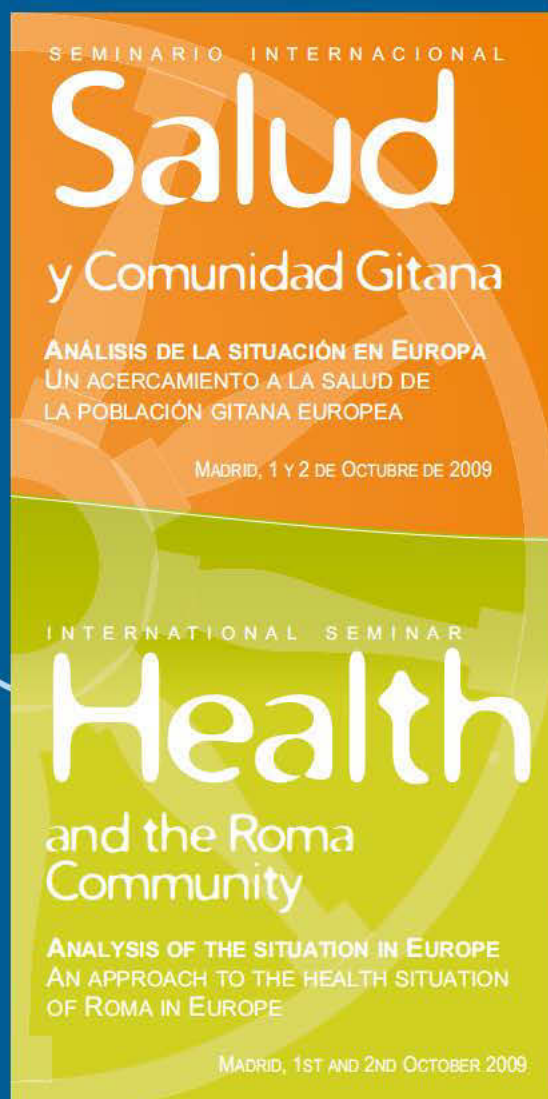


Health and the Roma Community

Keywords: data collection, Romany, social determinants of health, health status, health services needs and demand

Efforts to improve the health of Roma have been hampered by a serious shortage of data on their health status and use of health services. This project set out to address this shortcoming by collecting data in seven European countries (Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain). The results were analysed and compared. Recommendations were made for improving the health situation of Roma, at national and European level. Awareness was increased by disseminating the project's results among health workers, Roma representatives, policy makers and the public.

This pioneering project set out to promote evidence-based responses to the serious health inequalities between Roma communities and the non-Roma population. It has played a major role in raising awareness of these issues and its findings have had an important influence on policies addressing the health of Roma.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

This project has made a significant contribution to Roma health policies. Along with education, employment and housing, health was highlighted as a priority area in the Decade of Roma Inclusion 2005–15. The EC Roma Task Force (2010) and the EU Framework for National Roma Integration Strategies up to 2020 (2011) took over and strengthened this emphasis on health issues. Since their publication, the results of this project have been widely cited in policy documents.

The project's contribution to reducing health inequalities can be found at both national and European levels. It has increased awareness of the health problems of the Roma community and promoted strategies for solving them. Data from the project have strengthened the evidence base for policy initiatives in this area, and it has promoted cooperation between agencies working to combat the health disadvantages of Roma. Exchange of information and knowledge between Member States has been furthered in relation to both health problems and good practice for tackling them.

Why was the public health problem(s) addressed important for Europe?

The Roma community is one of Europe's longest standing, largest, most marginalised, and least well studied ethnic minority communities. It is characterised by social exclusion and discrimination, including serious inequalities in access to health care and health services. Until now, data on the Roma community's access to health care and use of services has been sparse, and the project attempts to address this.

Objectives

The project's main aims were:

- To gather and analyse data on the socio-demographic characteristics, health status, access to health and social care provisions, and health behaviour of Roma, using the health interview survey (HIS) methods.
- To promote the implementation of effective strategies to reduce the health disadvantages of Roma.
- To raise the awareness among stakeholders (policy makers, health workers, representatives of the Roma community and the public) regarding the need for action to tackle health inequalities.

Methods

- First-hand survey and interview information was collected from about 800–1 000 members of Roma populations in each country. This information concerned socio-demographic variables, illnesses, accidents, limitations on daily activities, consumption of medicine, medical consultations, hospitalisation, smoking, alcohol consumption, lifestyle and nutrition. Samples were matched for sex, age, Roma cultural group, social status and residence. Results were compared with data from the general national population and between the participating countries.
- A group of experts was formed in each country to monitor the project, give methodological advice, and supervise the analyses. Individual country reports and a general report were produced and disseminated.
- Forums were set up to exchange and debate results from the project and make recommendations, with the principal players in each country, including representing governmental and non-governmental organisations, and representatives of the Roma community. A final seminar to present results and recommendations was organised in each country, as was a joint transnational meeting of the whole project.

Achievements

The survey documented the social exclusion and disadvantage of the Roma communities studied. It showed that the health status of Roma children and adults is characterised by chronic, yet largely curable, illnesses and complaints. Migraines, headaches, hypertension, asthma, chronic bronchitis, high cholesterol, cavities, and some form of hearing and/or vision impairment were the most common problems reported. However, use of health care services and medication tended to be sporadic. Maternal and child care was particularly lacking. Whereas the overwhelming majority did not have alcohol and/or drug-related problems, almost half over the age of 15 smoke daily, while about one third are overweight or obese.

The project produced and disseminated recommendations and proposals for action at both national and European level. The project's main recommendations concerned tackling the social determinants of Roma health, improvement of access to health care and preventive services, as well as health education and health promotion among Roma communities. The involvement of Roma communities themselves was crucial.

What effect have the results had on the policies and programmes of Member States and the EU?

The project was undertaken during a period of increasing concern among policy makers about the situation of Roma in Europe, including their health status. It provided a much needed source of data to back up policy initiatives. At national level, responses to its recommendations were uneven. The economic crisis has undermined both the social position of Roma and the willingness of governments to finance initiatives. At European level the project's influence has been more diffuse than specific, the final report having been widely cited as a source of data on the health needs of Roma.

What were the benefits of working jointly at EU level?

International cooperation is especially important for identifying and tackling the problems of Roma, since this population is dispersed over many different European countries. This project strengthened links between the main Roma and non-Roma NGOs in different countries, and between them and governmental and intergovernmental agencies. Comparative data from different countries yielded additional insights into the health situation of Roma.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The conclusions were broadly consistent with the ten common basic principles on Roma inclusion adopted by the EU's Integrated Platform for Roma Inclusion. The highest priority was given to tackling the social determinants of Roma health, in particular education, employment and housing. The second priority concerned the need for interventions to be carried out 'with' the Roma community rather than 'on' them. Further, health programmes should be explicitly but not exclusively targeted at Roma; they should be strengthened and mainstreamed. Particular attention should be paid to the gender perspective, the involvement of young people, and continuing collection and analysis of data.

Project website

- www.gitanos.org/european_programmes/health/index.html

Budget

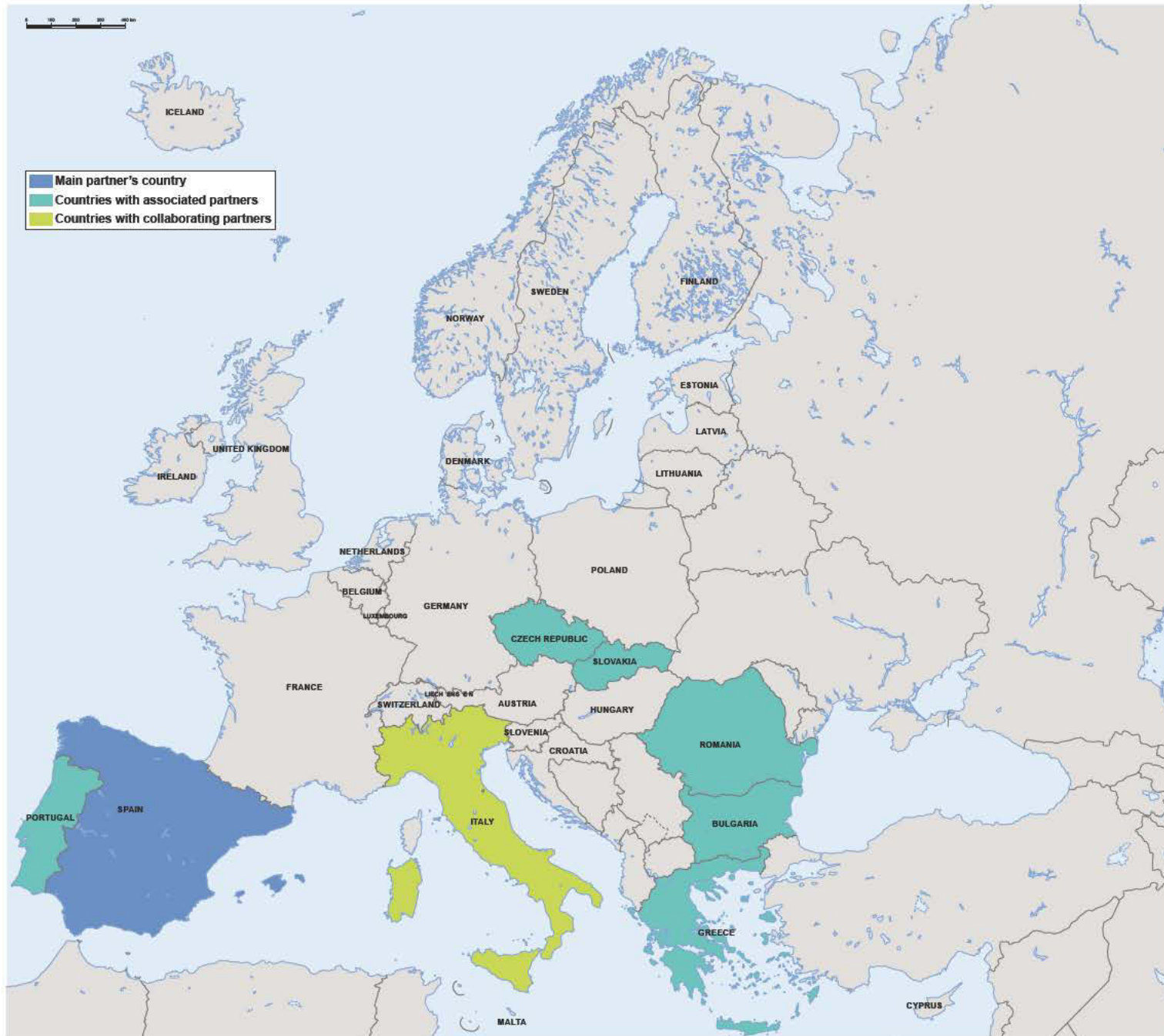
- Total budget: €611 775
- EC contribution: €367 056

Duration

- 1/11/2007 – 31/10/2009 (24 months)

Main beneficiary

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Main partner:

Fundación Secretariado Gitano
C/Ahijones s/n . 28018 Madrid, Spain

Associated partners:

- Bulgaria: The Health of Romany People Foundation (THRPF)
- Czech Republic: Office for the Council for Roma Community Affairs
- Greece: Local Authorities for Social, Cultural, Tourist, Environmental and Cultural Development (EFXINI POLI)
- Portugal: Rede Europeia Anti-Pobreza (REAPN)
- Romania: Roma Center for Social Interventions and Studies (ROMANI CRISS)
- Slovakia: Partners for Democratic Change Slovakia (PDCS)
- Spain: Fundación Secretariado Gitano (FSG)

Collaborating partners:

- National, regional and local administrations involved in health and Roma issues (Ministries of Health, Social Affairs, Council Offices for Roma Affairs, etc.)
- Health and Social departments of regions and municipalities
- Roma advisors, coordinators on local / municipal government level
- Health workers' organisations from Hospitals, Primary Care Health Services
- Universities (researchers, health sciences professionals, professors...)
- Roma and non-Roma NGOs involved in health and the Roma community
- Institutes / Centres for Drug addiction
- Social Workers, Field Workers, Mediators
- Decade Representatives



Addiction Prevention within
Roma and Sinti communities

Addiction Prevention within Roma and Sinti Communities: **SRAP**

Keywords: substance addiction, prevention, health promotion, Roma, youth

The SRAP project focused on preventing drug abuse among Roma aged 11–25 by investigating the use and abuse of illegal and legal substances amongst this vulnerable population. It also sought to help health care workers adopt an intercultural approach when tackling this issue. Building a transnational network and promoting cooperation in a bid to increase the impact of local interventions were additional project objectives.

In addition, the action responds to specific EC policies: EC Communication COM (2010) The European Platform against Poverty and Social Exclusion: A European framework for social and territorial cohesion, and EC Communication COM (2010) The social and economic integration of the Roma in Europe.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

This project aims to address health inequalities affecting migrants and vulnerable ethnic minorities, in particular drug use amongst young Roma, thus supporting the aims of the Commission Communication COM(2009) 567 Solidarity in health: reducing health inequalities in the EU and the Europe 2020 health programme. The action supported awareness raising, exchange of information and knowledge, the identification and dissemination of good practices, the design of tailor-made policies, as well as monitoring and evaluating progress in applying health inequalities policies. It will also promote data collection on health issues affecting Roma.

Why was the public health problem(s) addressed important for Europe?

Substance abuse among young people can be a serious burden for Roma communities. It can undermine health and hamper integration with the majority community as well as social cohesion within the family and group. Specially targeted programmes for health promotion, prevention of addiction and treatment are needed, based on inside knowledge of these communities, and with their cooperation.

Objectives

The general aim of the project was to advance efforts to prevent and reduce substance abuse among young Roma. To this end, the following objectives were pursued:

- To better understand young Roma people's attitudes and behaviour towards legal and illegal substances and analyse factors triggering abuse. Barriers to access to health services were also studied.
- To transfer this research and knowledge across Europe.
- To strengthen the prevention skills of young Roma and improve the intercultural approach of health care workers.

- To raise awareness among public health decision-makers and civil society about the specific needs of Roma youth, and to promote health and prevention policies and actions tailored to those needs.
- To promote the inclusion of this issue in the public health research agenda and the adoption of evidence-based approaches in mainstream policies.

Methods

To fulfil the first objective SRAP carried out qualitative action research in six countries, targeting young Roma aged 11–25.

Insights were then applied in a selective prevention approach, focusing not only on prevention of substance abuse, but on the broader social, environmental and behavioural factors that may lead to abuse. SRAP developed and tested an integrated and transferable methodology of addiction prevention. In particular, two methodologies that have proved effective and empowering in prevention in the general population were applied: Life Skills Training and Motivational Interviewing. This was complemented by capacity building among health care and social workers. Barriers limiting the access of Roma to services were also tackled.

The results were disseminated among study participants and stakeholders through events in partner countries, a newsletter, website and distribution of a publication.

Achievements

- A better understanding of addiction, what triggers consumption and how young Roma use drugs.
- A transferable intervention methodology tailored to the needs of young Roma, available to health and social workers in Europe.
- Training methods for health and social workers in relating to young Roma and providing Roma communities with information on health and addiction services.
- Enrolment of young Roma in prevention actions; empowerment and awareness raising on substance abuse.
- A European network dedicated to addiction prevention and harm reduction among young Roma.
- Improved awareness among researchers, policy makers and practitioners about substance abuse among young Roma.

What effect have the results had on the policies and programmes of Member States and the EU?

The immediate impact of the project is mostly at local and regional level. In most countries the local public authorities participated, and the results were disseminated to them. In the same countries there was a working relationship between project partners and public authorities in charge of policies for substance abuse, youth or Roma.

Results were also disseminated among national, local and regional public authorities in charge of health policies and Roma policies, local associations and NGOs representing Roma, European networks concerned with Roma, NGOs working in the field of addiction and health, universities and research centres, and European networks and associations. SRAP was also presented at a European conference and debated at the European Parliament (16 October 2012). The final publication has been translated into four languages. SRAP has been presented to approximately 1 500 participants attending 42 events, and some 1 500 leaflets have been distributed in eight languages.

What were the benefits of working jointly at EU level?

In terms of European Added Value, the project promoted best practice for health promotion, prevention and treatment in substance abuse among young Roma. It also strengthened networking in the EU. Because the Roma community is dispersed over several Member States, economies of scale can be realised by sharing insights and methods.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The project confirmed the value of regarding substance abuse as a public health issue rather than merely a matter of security or law enforcement. It demonstrated the value of a broad approach focusing not simply on substance abuse, but also on the context in which it occurs. Interventions concerning prevention and health should be linked with housing, employment and education. Cooperation between different organisations and individuals such as local health authorities, NGOs, employment agencies, families and teachers is important. In keeping with the EU approach, health promotion and preventive programmes should not be delivered ad hoc for specific groups, but included in mainstream services and policies. This is necessary to avoid stigmatisation and ensure sustainability.

Project website

- www.srap-project.eu/

Budget

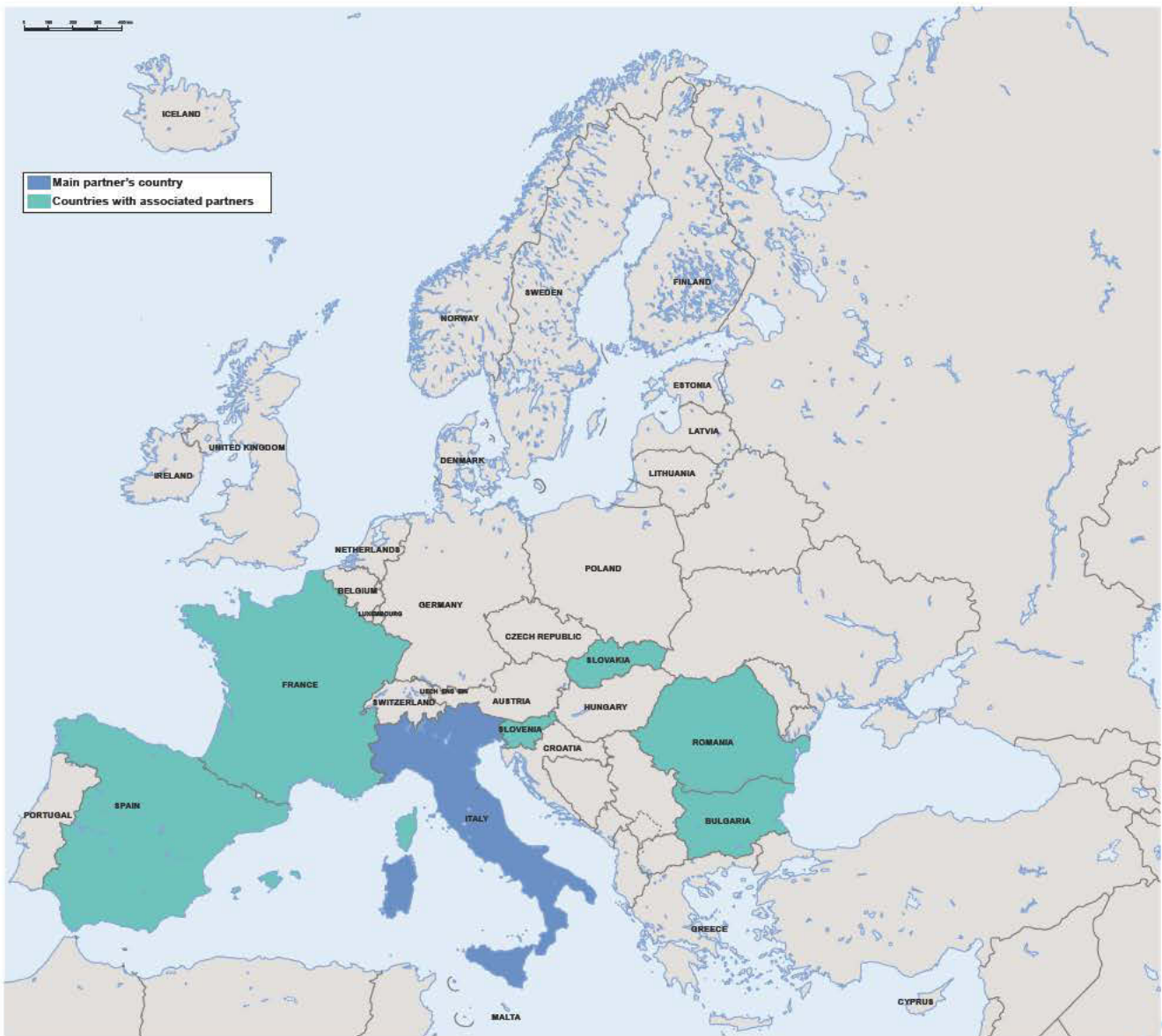
- Total budget: €1 102 309
- EC contribution: €661 385

Duration

- 06.07.2010 – 05.07.2013
(36 months)

Main beneficiary

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- Email: patrizia.marani@comune.bologna.it



Main partner:

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 Piazza Liber Paradisus 6, Bologna 40129, Italy

Associated partners:

- Social cooperative Società Dolce — Bologna (IT)
- Health and Social Development Foundation, HESED — Sofia (BG)
- Fundatia Parada — Bucharest (RO)
- Fundación Secretariado Gitano — Madrid (ES)
- Hors la Rue — Paris (FR)
- City of Venice — Venice (IT)
- European Forum for Urban Safety — EFUS
- Roma Public Council Kupate — Sofia (BG)
- Development and Education Centre RIC Novo Mesto — Novo mesto (SI)
- Faculty of Health Sciences and Social Work, University of Trnava — Trnava (SK)

Collaborating partners:

Italy

- Provincial and Regional authorities
- Local public health authority, Bologna
- Regional Healthcare, Service for addiction
- University of Bologna, Faculty of social and public communication

- Association Naufragi; Association Rom-Kalderash
- GEA social cooperative

Bulgaria

- Ministry of Education, Youth and Science; Municipality of Sofia

Romania

- Youth for Youth Foundation NT
- University of Bucharest, Faculties of Sociology
- SASTIPEN Association
- Carusel Association

Spain

- Government Delegation for the National Plan on Drugs
- Ministry of Health, Social Services and Equality
- Health + Madrid (Madrid City Council)
- Health Centre 'El Espinillo' (Region of Madrid)
- Foundation Ayuda contra la Drogadicción
- Centre of Comprehensive Care for Drug Addicts South

France

- Seine-Saint-Denis department: Care Centre for Accompaniment and Addiction Prevention, House for adolescents, Risk behaviour prevention mission, Agency for Regional Health; Educational Service, the Court, Ministry of Justice
- Médecins du Monde

The Network for the Control of Public Health Threats and other bio-security risks in the Mediterranean Region and Balkans:

EpiSouth Plus project

Network for Communicable Disease Control in Southern Europe and Mediterranean Countries: EPISOUTH Project

Keywords: cross-border health threats, Vector Borne Diseases, vaccine preventable diseases, immunisations, risk assessment

The EpiSouth Plus project aims to increase public health security in the Mediterranean region by enhancing preparedness to respond to public health threats at national and regional levels. It builds on the achievements of the original EpiSouth project, which developed a network for communicable disease control in the region. EpiSouth Plus aimed to address regional gaps and needs through increased cooperation and capacity building at the regional level.

Based on the framework of collaboration achieved by the original EpiSouth project, the latter project established a Regional Laboratories Network to support the detection of common health threats and other bio-security risks. In addition, capacity building activities — such as training sessions, workshops and simulation exercises — were organised to promote common procedures for generic preparedness and risk management planning. All the actions were organised within the IHR-WHO framework, and specific activities directly supported the implementation of International Health Regulations (IHR) in the region.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

By enhancing regional epidemiologic surveillance and response capacity in the southern Mediterranean, EpiSouth and EpiSouth Plus contribute directly to European policies promoting public health safety, such as the European Early Warning System (European Parliament and Council Decision 2119/98/EC).

EpiSouth activities also support the European Commission's strategy Solidarity in Health: Reducing Health Inequalities in the EU (COM(2009) 567), providing concrete recommendations for improving the access of underserved populations to immunisations, especially migrant and Roma populations.

Why was the public health problem addressed important for Europe?

While Europe is open to the increased circulation of goods and people, there is a downside to consider in the realm of public health security. This takes the form of an increased risk posed by global bio-security threats.

In addition, southern European and Mediterranean countries have common sea borders, experience significant migration movements and share common health concerns. It therefore makes sense to build interoperability in public health preparedness and responsiveness in the region as a way of handling global and trans-regional threats which could have an impact on public health.

Objectives

The main objective of the EpiSouth project was to facilitate collaboration between southern European and Mediterranean countries in the field of epidemiologic surveillance and response, including preparedness for cross-border emerging zoonotic infections. This was achieved by setting up an experts' network and by promoting capacity building. In the framework of prevention and surveillance measures in the Mediterranean region, the project also aimed at formulating recommendations to enhance access to immunisations for migrant and nomadic populations.

EpiSouth Plus sought to further enhance the capacity of authorities and epidemiologic surveillance networks to respond to public health threats and other bio-security risks. More specifically, it aimed to create a Mediterranean Network Lab Directory and to enhance the capacity of participating countries to revise their preparedness plans and risk management procedures. This was done in accordance with the requirements of International Health Regulations (IHR). In addition, project activities aimed to improve and complement local early warning systems.

Methods

The EpiSouth projects have achieved their objectives by establishing a robust regional network for cooperation and exchange of information. To achieve this, governance models were used to promote inclusion, sense of ownership and participation among the partner countries. In addition, participatory methodology was used to set priorities according to each country's needs.

Capacity building has also been central to EpiSouth activities and was achieved through vigorous training programmes and several expert workshops. Literature reviews and surveys were the methods used for the mapping and assessment of existing resources of epidemiologic surveillance systems in the region.

Achievements

The EpiSouth projects succeeded in setting up and maintaining a regional network of cooperation on epidemiologic surveillance and response.

An Epidemiological Bulletin (e-WEB) that reports on health events and threats relevant to the Mediterranean region is released weekly. Alerts about events of potential concern for the Mediterranean countries are shared through a secure platform, which has been transferred to the ECDC/EpiS environment to ensure sustainability.

A Mediterranean Regional Laboratories network has been set up, and many experts have participated in training sessions and workshops for capacity building in areas such as early warnings and field epidemiology, and laboratory diagnosis of Dengue and West Nile.

The projects have produced recommendations on: epidemic intelligence and cross-border issues; improving the access to immunisations for migrant and nomadic populations; exchanging data on vaccine-preventable diseases; epidemiology and preparedness for cross-border emerging zoonoses in the Mediterranean countries and the Balkans; and public health preparedness and response capacities.

What effect have the results had on the policies and programmes of Member States and the EU?

Presently the EpiSouth Network involves the Institutes of Public Health or the Ministries of Health from 27 countries, including 10 EU Member States and 17 non-EU neighbour countries. The project has consolidated a network of national authorities and has greatly contributed in increasing trust and cooperation between them. One of the main targets of EpiSouth Plus is to enhance the capacity of national authorities to implement the International Health Regulations (IHR) 2005 — a legally binding commitment for all EpiSouth partners.

What were the benefits of working jointly at EU level?

The EpiSouth Network is the biggest inter-country collaborative effort in the Mediterranean region representing a unique collaborative experience. The

EpiSouth Network is a novel way of sharing the burden of disease control that focuses on common environmental and epidemiological concerns. It has gone well beyond political tensions, language and cultural barriers and has developed a common and competent technical platform of communication, which allows individual countries to benefit from European collaboration.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

EpiSouth has highlighted the issue of unequal access to immunisations and has offered concrete recommendations for improving the access of underserved populations, in particular migrant and Roma populations.

Project website

- www.episouthnetwork.org

Phase I

Budget

- Total budget: €2 308 722
- EC contribution: €1 719 032

Duration

- 01.10.2006 – 30.09.2007

Phase II

Budget

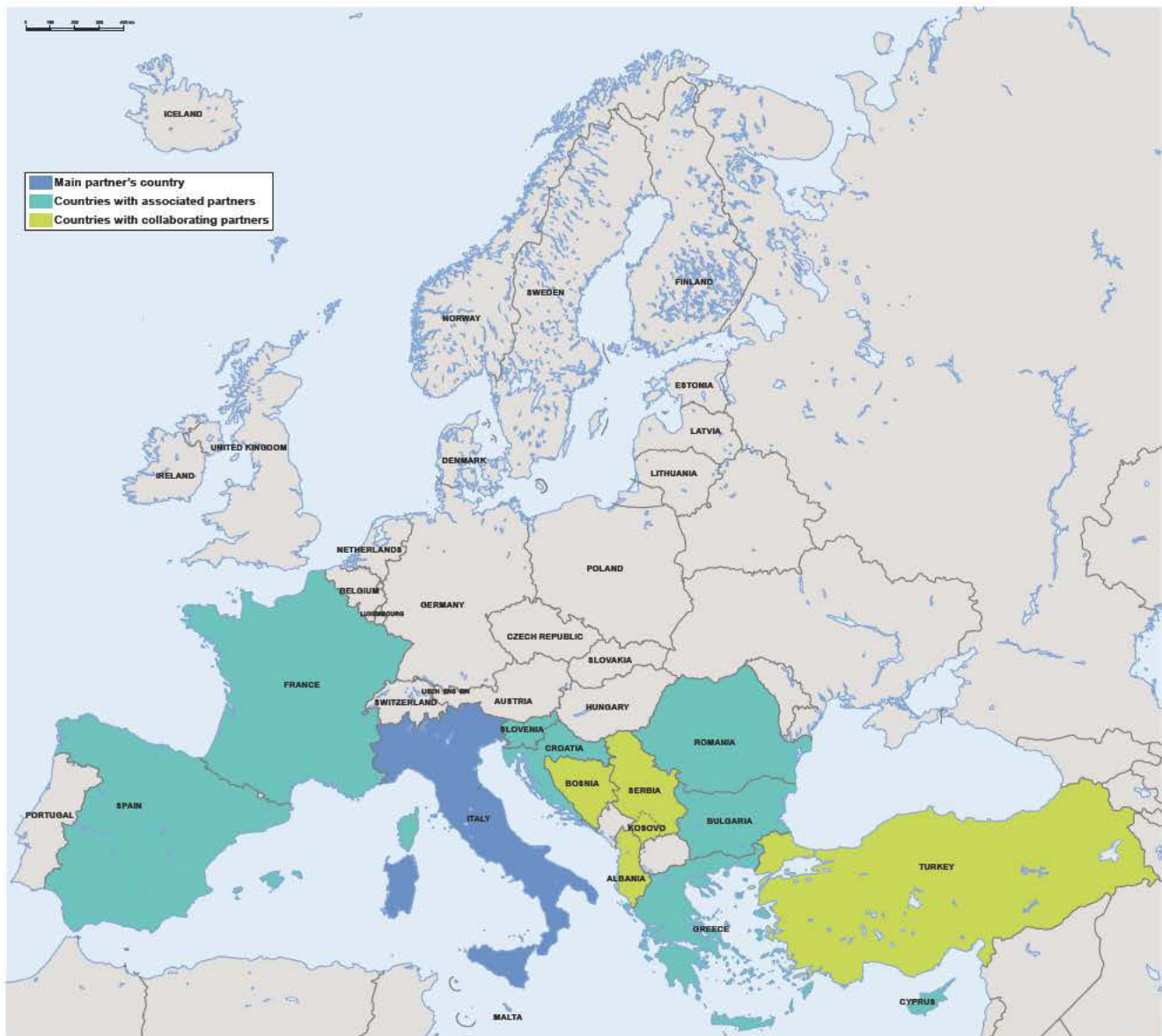
- Total budget: €1 680 000
- EC contribution: €900 000

Duration

- 15.10.2010 – 31.12.2013

Main beneficiary

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Main partner:

ISS — Istituto Superiore di Sanità (Italy)
00161 Roma
Italy

Associated partners:

- Institut de Veille Sanitaire (InVS), France
- Instituto de Salud Carlos III (ISCIII), Spain
- Institut Pasteur (IP), France
- Azienda Sanitaria Locale di Torino (ASLTO1), Italy
- National Center of Infectious & Parasitic Diseases (NCIPD), Bulgaria
- Hellenic Center for Infectious Diseases Control (HCDCP), Greece
- Ministry of Health (MoH-CY), Cyprus
- Ministry of Health (MOH-MT), Malta
- Institute of Public Health (IPHB), Romania
- Institute of Public Health (NIPH-IVZ-RS), Slovenia
- Azienda Ospedaliera di Padova (Padua GH), Veneto Region, Italy
- Istituto Nazionale Lazzaro Spallanzani (INMI), Italy
- Cineca Consorzio Interuniversitario (CINECA), Italy
- Croatian Institute of Public Health (NIPH-HR), Croatia

Collaborating partners:

- PHI - Tirana - Albania
- Institut National de Santé Publique — Alger

- Ministry of Civil Affairs — Sarajevo - Federation of Bosnia and Herzegovina
- PHI of Republika Srpska - Banja Luka — Federation of Bosnia and Herzegovina
- MoH of Federation of B & H Mostar, Federation of Bosnia and Herzegovina
- MoH and Population - Cairo - Egypt
- Institute for Health Protection and Clinic for Infectious Diseases - Skopje - Macedonia
- MoH and Israel Center for Diseases Control - Tel Hashomer - Israel
- MoH Amman - Jordan
- IPH of Kosova - Prishtina - Kosovo
- MoPH - Beirut - Lebanon
- National center for infectious disease prevention and control - Tripoli - Libya
- PHI - Podgorica - Montenegro
- MoH - Rabat - Morocco
- Public Health Central Laboratory - MoH Ramallah
- PHI - Belgrade - Serbia
- MoH - Damascus - Syria
- Ministère de la Santé Publique - Tunis - Tunisia
- MoH-Ankara - Turkey
- MECIDS - ISRAEL, JORDAN and PALESTINE
- WHO-LYON/HQ - Lyon; WHO EURO, WHO EMRO, WHO AFRO, ECDC

Promote Vaccinations among Migrant Populations in Europe

PROMOVAX

Keywords: migrants, immunisation, vaccination, access to health care, cultural diversity

The aim of the PROMOVAX project was to promote vaccinations among migrant populations in Europe. The project primarily addressed health care professionals. It provided a toolkit with best practices and educational material that can be used to design and implement interventions to promote immunisation among hard-to-reach populations, such as recent migrants. An evaluation of migrants' access to primary health care and immunisations in Europe was also conducted, recording the available migrant immunisation policies, legislation and practices in eight EU Member States.

The project concluded that immunisation coverage data relating to migrant groups is hard to find and that national immunisation policies and practices do not address the needs of migrant populations. Moreover, obstacles were recorded regarding the availability of immunisation services, such as the limited availability of interpretation services at regular immunisation sites and the limited knowledge of PROMOVAX among recent migrants.

To address the identified gaps, the project developed an index of best practices and recommendations which targets both health care professionals and policy makers and is complementary to the produced educational material.

Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

PROMOVAX addresses a key determinant of health and social inequality — the differential access to preventive care and health promotion for vulnerable groups. The action therefore contributes to the Europe 2020 initiative and the strategy set by the Commission's Communication: Solidarity in Health: Reducing health inequalities in the EU, COM(2009) 567.

The project addresses the lack of adequate access to vaccination services for migrant populations, a particularly sensitive issue in terms of both persisting health inequalities and public health.

Why was the public health problem addressed important for Europe?

The average immunisation coverage for childhood diseases is higher than 90% in the WHO European region. However, full protection can only be achieved by coverage rates of 95% or more. In addition, regional country averages mask inequities both within and between countries. Most people who are not immunised belong to hard-to-reach groups — like recent migrants — that lack access to immunisation services and information about the importance of being vaccinated. Reaching migrant populations is particularly important in order to eliminate measles and congenital rubella infection, maintain Europe's polio-free status, and assume control of other vaccine-preventable diseases.

Objectives

The action aimed to promote vaccinations among migrant populations in Europe. More specifically it sought to:

- Identify and record the immunisation needs of migrant populations, in particular groups of newly established migrants.
- Evaluate migrants' access to immunisation in EU countries by reviewing national legislation and practices on immunisation.
- Identify, evaluate and disseminate good practices for promoting immunisation among migrant groups.

- Add to the knowledge of health care professionals about the immunisation needs of migrants.
- Make available information to improve the knowledge of migrant populations.

Methods

Extensive desk research was undertaken to assess legislation, policies and practices regarding immunisation, along with the immunisation status of migrants in Europe. Another priority was to identify good practices for the promotion of immunisation among migrant groups. Relevant material was also collected through direct contact with national and regional authorities, NGOs and international organisations.

The Delphi process was used in combination with mathematical/statistical analysis to evaluate the identified good practices (33 in total).

The toolkit for health care practitioners and the educational material for migrants were developed during workshops with the participation of consortium members and external experts. Both products were reviewed at an EU-wide workshop, with the participation of stakeholders from the health care and migrant communities. The toolkit for the health care professionals was then pilot-tested in each of the consortium countries by at least ten health care practitioners who provided feedback which was incorporated in the final version.

Achievements

PROMOVAX published a report on the immunisation status of migrants in the EU, which included information on demographics, immunisation rates, cultures and attitudes towards vaccines.

Priorities for future action were also identified and recorded in EU-level recommendations for the promotion of immunisation among migrant groups.

The project delivered useful tools for policy makers, health care practitioners and migrant communities — including a set of the indexed best practices for migrant immunisation, a Health Worker Toolkit (available in eight languages), and Educational Material for Migrants (available in 12 languages, most common for migrant communities in Europe).

What effect have the results had on the policies and programmes of Member States and the EU?

The project highlighted the need for routinely available and comparable data on the immunisation access and coverage of migrant groups at EU level. It also informed policy makers at national and EU level about the need to improve the access and appropriateness of health promotion and preventive care — especially vaccination services — for migrants and other vulnerable groups. Moreover, it recommended good practices to facilitate the design of activities to promote immunisation among hard-to-reach populations.

However to ensure the sustainability of the project's results, follow-up actions will be recommended in partnership with organisations such as WHO Europe and the European Centre for Disease Prevention and Control.

What were the benefits of working jointly at EU level?

The PROMOVAX consortium brought together public health and migrant health institutions and organisations from eight Member States. A network of experts and cooperating institutions was established in a field that remains under-researched in Europe and which should be addressed in a coordinated manner. Efforts to promote immunisations among excluded groups at national level directly benefit European public health security and should therefore be encouraged and supported at EU level.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

Achieving equity in access to preventive care and health promotion for all population groups is paramount for reducing health inequalities. Actions to promote immunisation among hard-to-reach populations, like migrants, can also be used as an entry point for improving the use of other health care services.

Project website

- www.promovax.eu

Budget

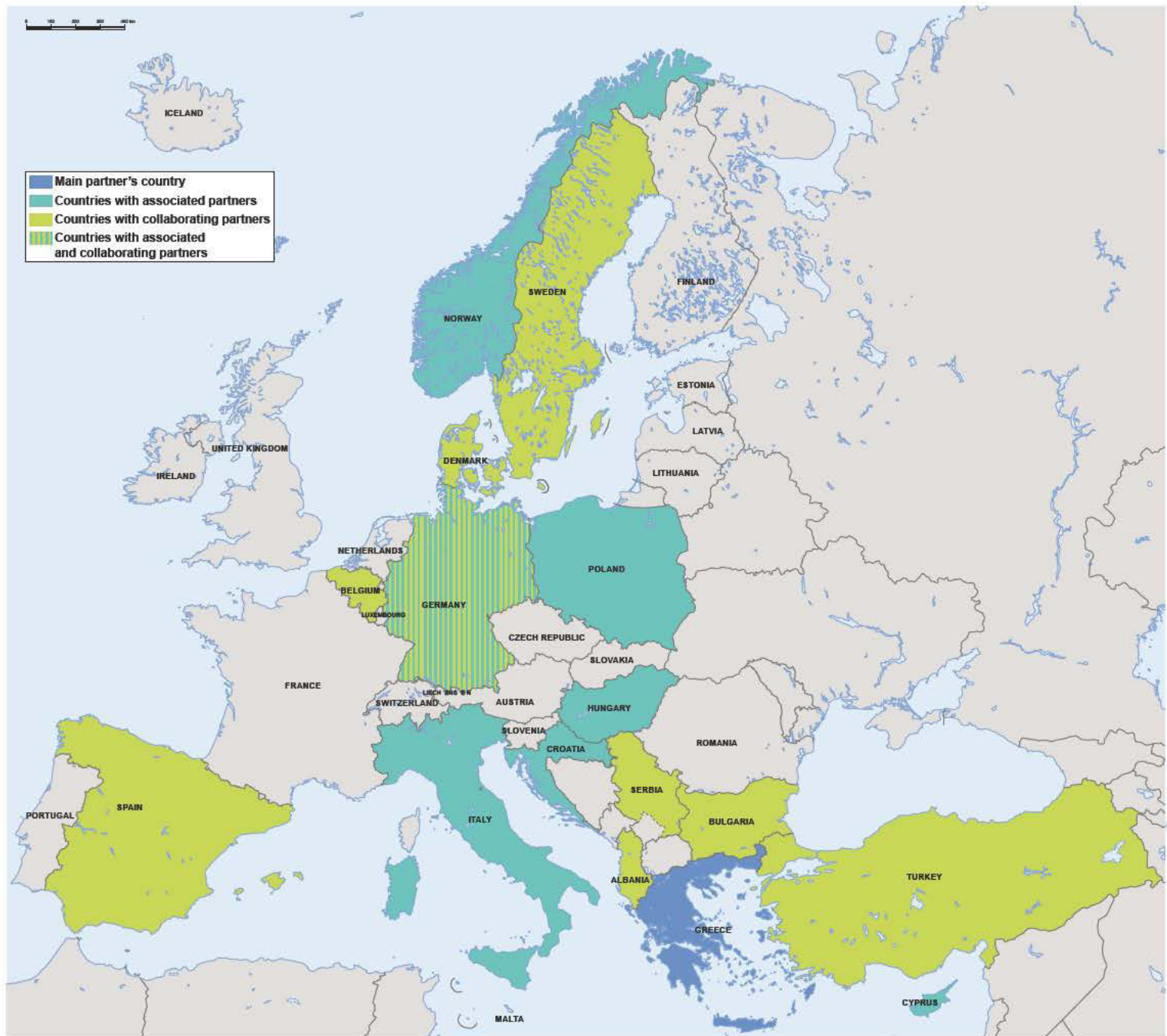
- Total budget: €864 448
- EC contribution: €498 908

Duration

- 22.05.2010 – 21.05.2013

Main beneficiary

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Main partner:

Institute of Preventive Medicine, Environmental and Occupational Health, Prolepsis - Greece

Associated partners:

- Technische Universität Dresden - Germany
- Università degli Studi di Sassari - Italy
- The SINTEF Foundation - Norway
- Nofer Institute of Occupational Medicine - Poland
- University of Zagreb, Medical School - Croatia
- RUBSI—Research Unit in Behaviour and Social Issues - Cyprus
- University of Pécs - Hungary
- Università degli Studi di Milano - Italy
- Istituto Superiore di Sanità - Italy
- Cyprus University of Technology - Cyprus

Collaborating partners:

- Public Health Institute - Albania
- Baskent University - Turkey

- Hospital de Sabadell. Consorci Hospitalari Parc Taulí. Universitat Autònoma de Barcelona - Spain
- Institute of Occupational Health - Serbia
- WHO/Europe Occupational Health, Bonn - Germany
- WHO/Europe Communicable Disease Units, Copenhagen - Denmark
- Alpert Medical School of Brown University - USA
- International Organization for Migration (IOM), Migration Health Division (MHD), Brussels - Belgium
- Institute of Epidemiology, Preventive Medicine and Public Health - Greece
- National School of Health. Instituto de Salud Carlos III. Ministry of Science and Innovation - Spain
- European Centre for Disease Prevention and Control (ECDC) - Sweden
- National Centre of Infectious and Parasitic Diseases (NCIPD) - Bulgaria



A European network on cervical cancer surveillance and control in the new Member States:

AURORA

Keywords: cervical cancer screening, vulnerable populations, training, advocacy, pilot action

The AURORA project aimed to promote cervical cancer prevention in Europe, especially in the new EU Member States of Bulgaria, Czech Republic, Cyprus, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia. Project goals were established in accordance with the Council Recommendation on cancer screening (2003/878/EC), and the second edition of the European guidelines for quality assurance in cervical cancer screening.

The project promoted the implementation of evidence-based prevention for cervical cancer through the exchange of information and expertise at European level. AURORA has contributed to the dissemination of good practices and to capacity building in Italy and the new Member States through the training of health care professionals and advocacy leaders. In addition, the project's methodology was pilot tested by a network of centres that were already performing cervical cancer prevention activities.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

The project objectives were consistent with the European Commission's Communication Solidarity in Health: Reducing health inequalities in the EU (COM(2009) 567) and the Europe 2020 initiative. In particular, the project considered the challenges in reaching hard-to-reach groups, such as young people, rural communities, ethnic groups and minorities. AURORA identified ways to communicate and engage with disadvantaged population groups to increase their participation in cervical cancer prevention programmes.

Why was the public health problem addressed important for Europe?

Cervical cancer is responsible for 16 000 deaths every year across the EU. Those affected are predominantly women between the ages of 35 and 50. However, it is worth noting that cervical cancer screening is one of the most effective cancer prevention techniques. In fact, incidences of cervical cancer and mortality rates have decreased significantly in Europe since the introduction of cervical cancer screening in the 1970s. Nevertheless, inequalities between countries and population groups remain wide.

Countries that have recently joined the EU, with the exception of Malta, record higher — in some cases almost double — rates of cervical cancer incidence and mortality than those recorded in the EU-15. To reduce the burden of the disease and persisting health inequalities, newer Member States need to be encouraged and supported to adopt population cervical prevention programmes.

Objectives

The project aimed to identify appropriate and transferable strategies for the promotion of cervical cancer prevention in the newer Member States and to help national stakeholders implement evidence-based population screening and vaccination campaigns.

More specifically, the project focused on strengthening the expertise of health care professionals and advocacy leaders, and on increasing cervical cancer prevention activities through the dissemination of good practices.

Methods

AURORA's activities focused on the transfer of know-how and skills development by identifying, sharing and testing good practices — and through training stakeholders.

To compile good practices the project carried out an extensive literature review, along with a survey to identify and assess local cervical cancer prevention experiences.

A 'train-the-trainers' approach was used to ensure wider dissemination and sustainability of the capacity building results. The courses were adapted to local contexts and targeted health professionals and advocacy leaders. Moreover, the network of pilot centres was established to perform cervical prevention activities.

Achievements

The project contributed to the training of health care professionals and advocacy leaders at European level by developing and disseminating a specific training model for high-quality cervical cancer prevention. More than 200 health care workers and 68 advocacy leaders undertook the training.

The in-depth analysis of local contexts in 11 Member States provided a thorough picture regarding the implementation of cervical cancer prevention programmes and highlighted the gaps in addressing hard-to-reach populations.

22 pilot centres are now part of the Aurora network. It is expected that the trained health care professionals will improve the quality and number of cervical screening tests performed in the pilot centres.

In addition, the project was able to engage medical associations and universities which endorsed the AURORA methodology and included it in their training programmes and educational curriculums.

What effect have the results had on the policies and programmes of Member States and the EU?

The project highlighted the need for strong engagement by policy makers in those countries where cervical screening programmes are absent or not fully implemented. It also offered concrete information on the strengths and weaknesses of previous experiences with cervical cancer prevention programmes and recommended improvements in the cost effectiveness of prevention activities.

It is expected that the project results will be used for the development of public health training programmes and the implementation of new policies for cervical cancer prevention. It is further anticipated that trained advocacy leaders will build a long-term advocacy strategy into prevention programme activities to ensure ongoing support at national and European level.

What were the benefits of working jointly at EU level?

It has been very useful to share experiences about the use of various models of prevention and advocacy activities, and to build a network of exchange and cooperation between old and new Member States. This should help the new Member States to adopt strategies that have already proven successful and cost effective.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The project recognised the need to reduce access inequalities relating to cervical cancer prevention. For this to happen it is vital to target the specific hard-to-reach populations and to achieve effective implementation of population-based screening programmes. It is also important to develop health promotion and prevention activities to reach hard-to-reach groups. This can be achieved through the increased participation of community health educators and promoters.

Project website

- www.aurora-project.eu

Budget

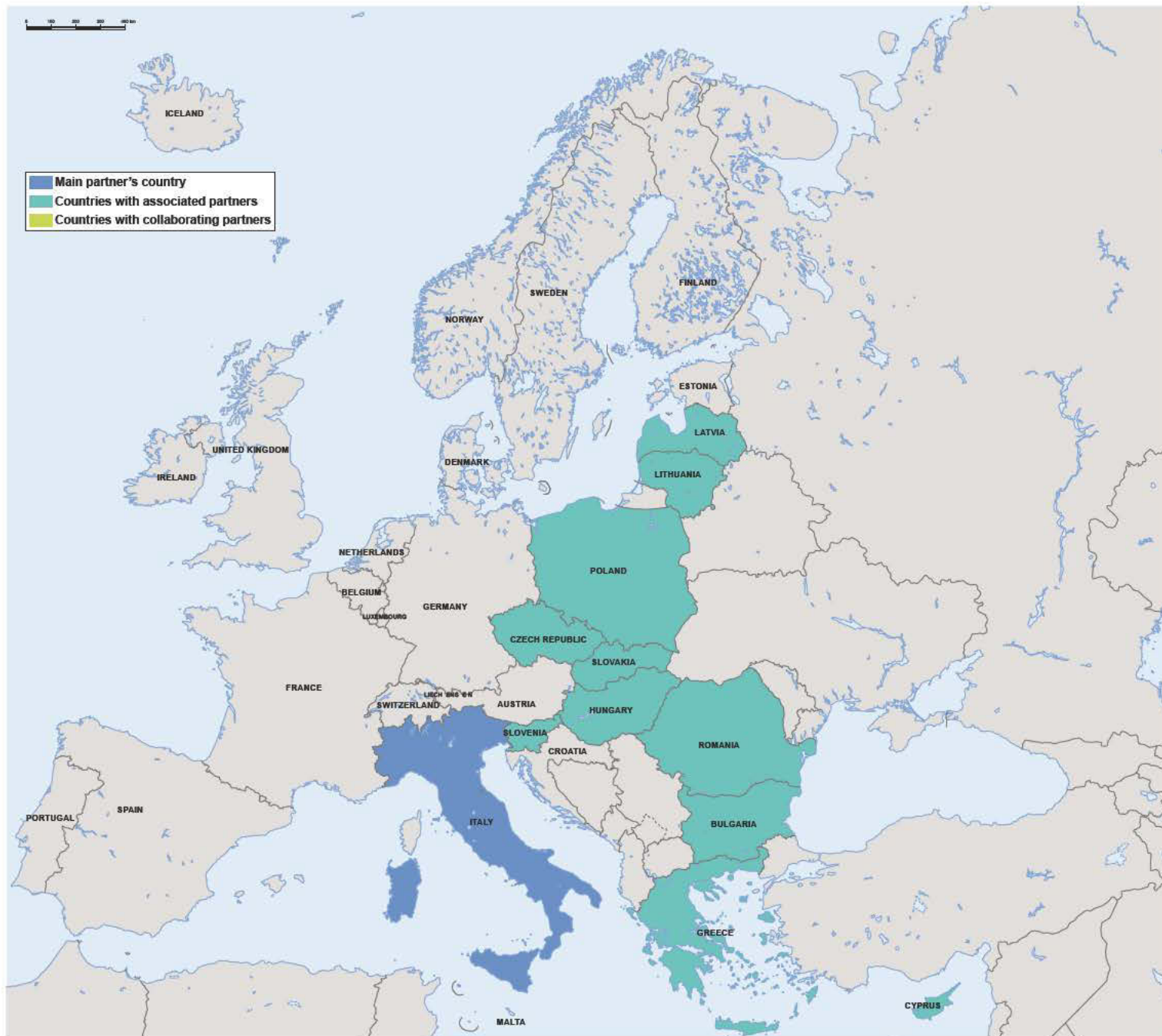
- Total budget: €1 152 043
- EC contribution: €615 077

Duration

- 01.12.2010 – 30.11.2013

Main beneficiary

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Main partner:

Osservatorio Nazionale sulla salute della Donna
20121 Milan
Italy

Associated partners:

- Bulgarian Family Planning and Sexual Health Association, Bulgaria
- Centrul PROFILAXIA, Romania
- DEKUT Debreceni Kutatásfejlesztési Kht (until 04/04/2012), Hungary
- DRUŠTVO ŠKUC, Slovenia
- Institute of Experimental Pathology and Parasitology at Bulgarian Academy of Science, Bulgaria
- ISTITUTO EUROPEO PER LO SVILUPPO SOCIO ECONOMICO, Italy
- Jessenius Faculty of Medicine Comenius University in Martin, Slovakia

- Regional Institute of Public Health based in Usti nad Labem Zdravotní ústav se sídlem v Ústí nad Labem (ZÚ Ústí n. L.), Czech Republic
- RESEARCH UNIT IN BEHAVIOUR & SOCIAL ISSUES, Cyprus
- Socialinių iniciatyvų jaunimui draugija (Fellowship of social initiatives for youth), Lithuania
- Society for Oncology Patients 'Dzīvības koks', Latvia
- The Institute of Preventive Medicine, Environmental and Occupational Health, Greece
- Uniwersytet Łódzki, Poland
- 'Stefan S Nicolau' Institute of Virology, Romania
- DEKUT Nonprofit Kft. (since 05/04/2012), Hungary

Collaborating partners:

- European Partnership for Action Against Cancer Joint Action
- International Agency for Research on Cancer

*Screening for Hepatitis B and C among migrants
in the European Union:*

EU-HEP-SCREEN

Keywords: Hepatitis B, Hepatitis C, chronic liver diseases, screening, early diagnosis, migrants

EU-HEP-SCREEN aims to enhance the capacity of health care professionals to implement successful hepatitis B and C screening programmes, targeting migrant populations in the European Union. The project will produce a toolkit for public health professionals and policy makers, while providing information, materials and recommendations on the implementation of screening programmes for hepatitis B and C.

The project has already contributed to knowledge on screening and patient management practices for hepatitis B and C through an extensive literature review and experts' survey, which was conducted in six European countries. Pilot studies of different screening approaches targeting migrant groups have also been carried out in four regions. The results will be used to recommend good practices to both health practitioners and policy makers.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

Although people with a migrant background from countries where hepatitis B and C are endemic are at increased risk of chronic infection, few screening programmes addressing their needs have been implemented in EU countries. Recent advancements in the treatment of hepatitis B and C have made secondary prevention possible and there is an urgent need to identify patients who qualify for treatment.

EU-HEP-SCREEN aims to lay the foundations for the expansion of nationwide screening and prevention programmes for hepatitis B and C in order to include high-risk migrant populations, which will contribute to the reduction of health inequalities.

The project therefore contributes to the European Commission's strategy Solidarity in Health: Reducing health inequalities in the EU (COM(2009) 567), and the Europe 2020 initiative.

Why was the public health problem addressed important for Europe?

Chronic viral hepatitis B and C are leading causes of liver cancer and cirrhosis. Migrants, including European citizens with migrant background, from hepatitis B and C endemic areas are at particular risk. In migrant populations, hepatitis B is transmitted primarily from mother to child at birth or in early childhood, while hepatitis C is mainly transmitted through blood transfusions and unsafe injections. Both conditions are mostly asymptomatic and can remain undetected for many years.

Awareness among health professionals, those at risk and the general public is low, which makes case finding a challenge. Effective antiviral treatment can slow progression of these diseases and delay the onset of cirrhosis. It can also reduce the risk of liver cancer. Treatment of eligible patients can prevent a considerable part of the hepatitis-related burden of disease and death, and reduce inequalities in health.

Objectives

The project aims to raise awareness and enhance the capacity of health care professionals to implement successful screening programmes for hepatitis B and C that will target particularly high risk migrant groups.

EU-HEP-SCREEN will achieve this through the following specific objectives:

- Collecting, assessing and sharing the evidence on screening, counselling, treatment and patient management for hepatitis B and C;
- Collating information on effective communication strategies and materials aimed at migrant groups;
- Pilot testing diverse approaches for case finding screening programmes;
- Bringing together a broad range of stakeholders to enhance networking and gather consensus on best practice;
- Developing a toolkit for public health professionals and policy recommendations for public health organisations.

Methods

A systematic literature review was conducted to collect and assess hepatitis B and C related screening, counselling, referral and treatment practices and guidelines in the six consortium countries. Additional information was collected through an online survey that targeted six professional groups: public health experts, antenatal care providers, general practitioners, providers for asylum seekers, providers of sexual health services, and specialist gastroenterologists. The survey covered Germany, Hungary, Italy, the Netherlands, Spain and the UK.

Screening programmes were designed and pilot tested in England, Hungary, Scotland and Spain, using systematic, opportunistic and outreach approaches for case detection. The implementation of the pilot studies included the involvement of different partners: a university and work places (Aberdeen), GP practices (London), an antenatal screening programme and health visitors (Hungary), and community migrant health centres (Barcelona). A cost-effectiveness assessment tool is to be developed in collaboration with the ECDC.

Achievements

The project produced a report on the screening and patient management practices for hepatitis B and C in the six participating European countries which includes:

- A quantitative assessment of the burden of chronic hepatitis B and C in the five most affected migrant groups;
- A summary of published clinical practice guidelines about hepatitis B and C;
- A detailed overview of clinical management practices and available antiviral treatment options;
- A review of screening practices and policies; targeting a range of high-risk population groups;
- An evaluation of access to treatment for six population groups, including undocumented migrants and asylum seekers.

The results of this comparative research on different approaches to hepatitis screening for migrant populations, along with the other project findings, will be used to compile the toolkit for health professionals and to formulate policy recommendations.

What effect have the results had on the policies and programmes of Member States and the EU?

EU-HEP-SCREEN results are expected to stimulate and encourage investment, intervention and a range of activities relating to hepatitis B and C screening and treatment among migrants in the EU.

By the end of 2014 the project will have helped to raise awareness among health professionals, policy makers and other stakeholders about existing and recommended hepatitis B and C screening practices — and about the need to reach out to migrant populations from hepatitis endemic areas. Pilot screening activities have been successfully implemented and their methodology can be transferred and replicated.

What were the benefits of working jointly at EU level?

The cooperation at EU level offered the possibility to enlarge the scope of the reviewed screening practices and to assess diverse approaches for conducting comparative research in different countries with different migrant groups. Working jointly at the EU level also offered valuable insights into different health systems, policies and cultures.

What priorities did this action identify in relation to reducing health inequalities within the EU and meeting the needs of people in vulnerable situations?

The project clearly identifies the need for hepatitis B and C screening programmes to include migrant groups, which are at high risk and currently underserved. As the prevalence of hepatitis B and C can be up to ten times higher among migrant groups the identification of eligible patients for treatment can greatly reduce the burden of disease and reduce inequalities in health between migrant and non-migrant groups. To achieve this it is essential to improve culturally competent health care delivery and health literacy among culturally diverse populations.

Project website

- www.hepscreen.eu

Budget

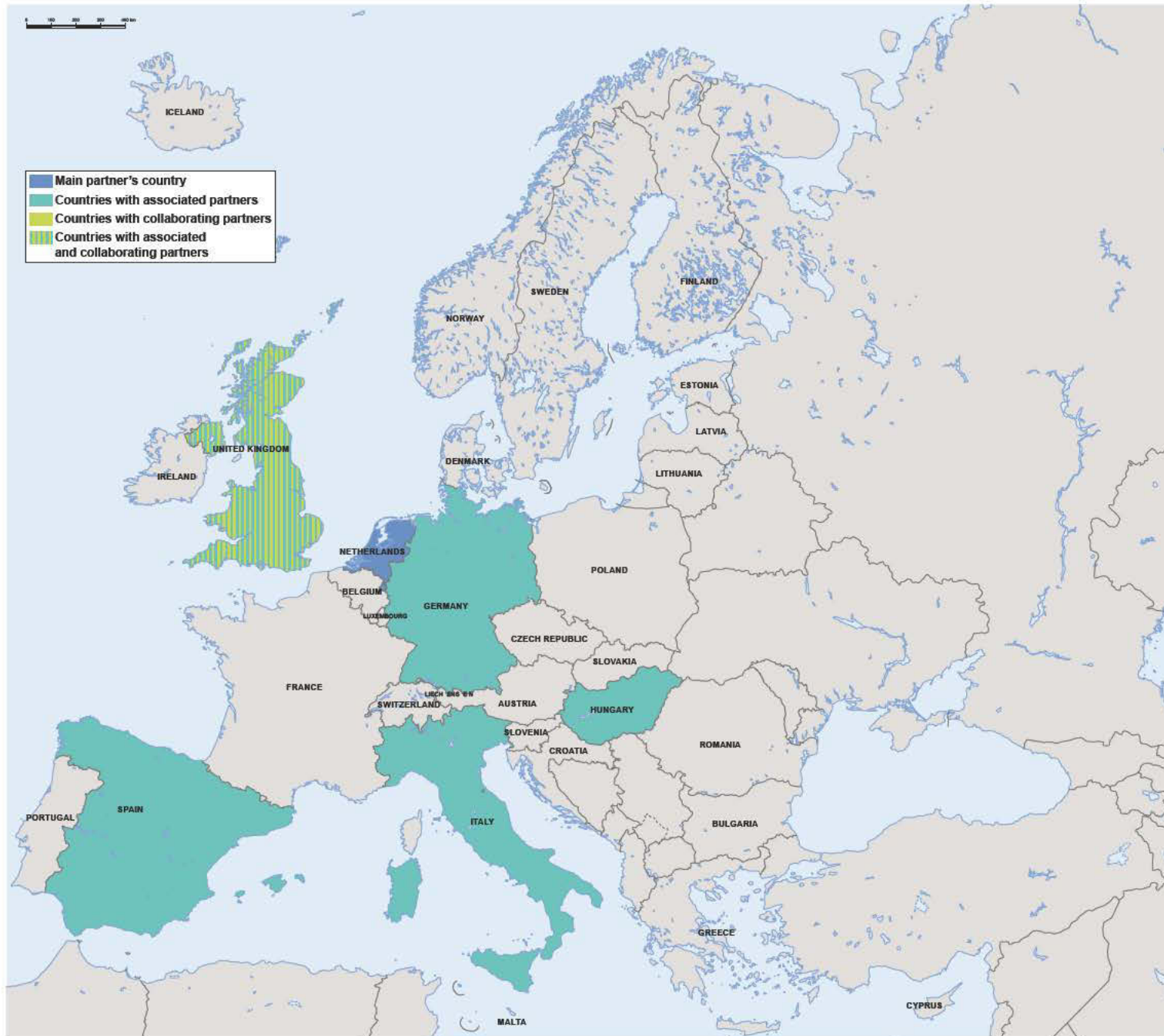
- Total budget: €1 321 360
- EC contribution: €792 816

Duration

- 01.10.2011 – 01.10.2013

Main beneficiary

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Main partner:

Erasmus MC University Medical Centre,
The Netherlands

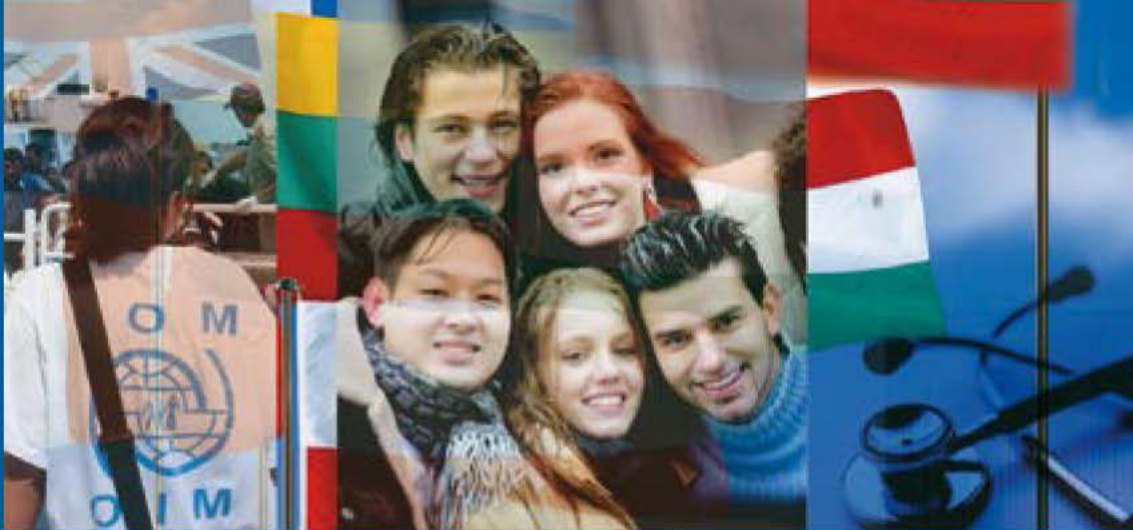
Associated partners:

- Municipal Public Health Service Rotterdam-Rijnmond, The Netherlands
- Hamburg University of Applied Sciences, Germany
- National Center for Public Health and the Environment, the Netherlands
- The National Center for Epidemiology, Hungary

- Queen Mary's University London, UK
- Public Health Agency of Barcelona, Spain
- National Health Service Grampian, UK
- University of Las Palmas Gran Canaria, Spain
- Hepatitis C Trust, UK
- University of Florence, Italy

Collaborating partners:

- Hepatitis Scotland, UK



Fostering health provision for migrants, the Roma, and other vulnerable groups:

EQUI-HEALTH

Keywords: Roma, vulnerable populations, irregular migrants, health care access and quality, border crossing

The main aim of EQUI-HEALTH is to improve the accessibility and appropriateness of health care services, health promotion and prevention to meet the needs of migrants, the Roma and other vulnerable ethnic minority groups, including irregular migrants. Work at the southern EU borders focuses on migrants, in particular those dealt with by border control authorities. Activities related to Roma health are

being carried out in eight EU countries with a high percentage of Roma nationals, as well as three countries with large numbers of Roma migrants. Work related to migrant health, to be carried out in all EU/EEA countries, will review policies on migrant health and analyse cost-effectiveness issues and make recommendations on health care for migrants in irregular situations.



Contribution to actions outlined in the 2009 Commission Communication to reduce health inequalities across the EU and to the Europe 2020 strategy for smart, sustainable and inclusive growth

Contributions to Solidarity in Health and Europe 2020: This action aims to reduce health inequalities affecting migrants and vulnerable ethnic minorities, in particular Roma. The action will support awareness-raising, exchange of information and knowledge, identification and dissemination of good practice and design of tailored policies, and will evaluate progress in applying health inequalities policies. It will also promote data collection on health issues affecting vulnerable target populations. In addition, the EQUI-HEALTH action responds to specific EC policies relating to migrants, asylum seekers and the Roma.

Why was the public health problem(s) addressed important for Europe?

EQUI-HEALTH targets several groups with known health vulnerabilities. It will strengthen the health component of the National Roma Integration Strategies being implemented by Member States. Furthermore, migrant health policies in the EU/EEA area will be reviewed and strategies for public health management at Europe's southern borders will be improved. Special attention will be paid to migrants in irregular situations, including those in detention.

Objectives

1. The first sub-action focuses on the health needs of migrants apprehended at the EU's southern borders, including those residing in closed and/or open centres and border facilities. The occupational health of staff working with migrants will also be considered. This sub-action aims to foster comprehensive multisectoral approaches, and to enhance the capacity of law enforcement and health services to ensure accessible and appropriate health care provision.
2. The sub-action on Roma health supports the implementation of national plans to enable Member States to better monitor, share and strengthen their respective national approaches. It will promote dialogue among key governmental and non-governmental stakeholders on Roma health issues.
3. The sub-action on migrant health will collect data on policies in the EU/EEA relating to migrant health, which will be incorporated into the Migrant Integration Policy Index (MIPEX). It will also analyse issues concerning cost-effectiveness and good practice in health service provision for migrants in irregular situations.

Methods

1. To increase the understanding of migrant, occupational and public health at the EU's southern borders, situational assessments and national/regional consultations will be carried out and discussions held about data collection mechanisms and referral systems. Priorities for capacity-building will be established and a training package for health care providers will be developed.
2. Progress in the development of national strategies on Roma health will be assessed, consultations between key stakeholders will be organised, and good practices will be identified.
3. An overview of migrant health policies will be carried out in collaboration with COST Action IS1103 ADAPT (Adapting European Health Systems to Diversity) and the Migration Policy Group, which produces MIPEX. This will be based on the 2011 Council of Europe Recommendations on mobility, migration and access to health care. Cost-benefit analysis will be used to examine the economic aspects of granting or denying access to health care. Consensus guidelines on health care for undocumented migrants will be developed.

Achievements

This action is still in its early stages, having started in February 2013. This section therefore mainly concerns planned outputs.

1. Health risks and priorities in different phases (apprehension or rescue at sea, reception, detention, transfer and return) will be analysed. Migrant health data collection and referral mechanisms will be enhanced. Training programmes for law enforcement officers and health professionals will be piloted in southern Member States.
2. Eight country progress reports on the health component of national Roma integration strategies will be produced, as well as four case studies of good practice. Recommendations will be made for future priority funding for Roma health under EU structural and social cohesion funds.
3. The results of the overview of migrant health policies will be incorporated into MIPEX to achieve widespread dissemination. Results of the cost-benefit analyses will be published separately.

What effect have the results had on the policies and programmes of Member States and the EU?

The action will be carried out in close collaboration with stakeholders including government ministries (Health and Interior) and other national partners, EU agencies (ECDC and FRONTEX), and other key stakeholders. Findings and recommendations will be disseminated among the stakeholders through consultations, regular meetings and conferences. Regular updates will be provided on the websites of EQUI-HEALTH and partner organisations.

What were the benefits of working jointly at EU level?

The problems tackled by EQUI-HEALTH are shared by many Member States. Seeking solutions to them together avoids duplication of effort and encourages the exchange of good practices (making due allowance for differing contexts between Member States). Specifically:

1. The health issues linked to irregular migration at the EU's southern borders have many elements in common and call for a coordinated response.
2. Action to improve the health of Roma needs to be encouraged in all Member States; the sharing of insights and effective solutions is crucial.
3. The addition of a health strand to MIPEX will make it possible to compare integration policies internationally as they relate to health. It will also provide a benchmark against which to measure future developments.

Project website

- equi-health.eea.iom.int/

Budget

- Total budget: €2 550 000
- EC contribution: €1 533 000

Duration

- 01.02.2013 – 31.07.2016

Beneficiary

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- This was a single beneficiary grant given to one organisation for this project.



Consortium Leader:

International Organization for Migration,
Migration Health Division, RO Brussels, Belgium

ABBREVIATIONS

AIDS - Acquired immunodeficiency syndrome
Chafea - Consumers, Health and Food Safety Executive Agency
CEE - Central East Europe
COM - Communication from the European Commission
COST - European cooperation in science and technology initiative
CVD - Cardiovascular diseases
DGA - Direct Grant Agreements
DU - Drug users
EASP - Andalusian School of Public Health
EC - European Commission
ECDC - European centre for disease prevention and control
EEA - European Economic Area countries (Iceland, Liechtenstein and Norway)
EFTA - European Free Trade Association countries are Iceland, Liechtenstein, Norway and Switzerland
EMCDDA - European Monitoring centre for drugs and drug addiction
ENP - European Neighbourhood Policy countries
EPIS - Epidemic intelligence information system
EU - European Union
EU-15 - European countries that joined the EU before 2004
EU-12 - European countries that joined the EU after 2004
EUPHA - European Public Health Association
GDP - Gross domestic product
HGG - Health gradients and gaps
HiAP - Health in All Policies
HIAef - Health impact assessments with an equity focus
HEA - Health equity audits
HIV - Human Immunodeficiency Virus
HLY - Healthy Life Years
HP 2 - Second Programme of community action in the field of health 2008–13
HUMA network - Improving access to health care for asylum seekers and undocumented migrants in the European Union
IDU - Intravenous drug users or People who inject drugs (PWID)
IHR - International health regulation
IOM - International Organisation for Migration
JA - Joint Actions
MIPEX - Migration Integration policy index
NEETs - Young people not in employment, education or training
NGOs - Non-governmental organisations
NRIs - National Roma Integration Strategies
OST - Opioid substitution treatment
PHP 1 - Community Programme in the field of public health 2003–08
PWID - People who inject drugs
SANCO - Directorate-General for Health and Consumers
SEE - South East Europe
SES - Socio-economic status
SEP - Socio-economic position
STI - Sexually transmissible infections
TB - Tuberculosis
UDM - Undocumented migrant
VG - Vulnerable groups, including at-risk groups and migrants and ethnic minorities
WHO - World Health Organisation

List of 64 actions addressing Health Inequalities funded under the Health Programme 2003–08 and 2008–13

ACTIONS DEVELOPING AND COLLECTING DATA AND HEALTH INEQUALITIES AND HEALTH STATUS INDICATORS

1. 2003125 - Tackling Health Inequalities In Europe: an integrated approach (Eurothine).
Website: www.erasmusmc.nl/MAGE/
2. 2003318 - Closing the Health Gap: Strategies for Action to tackle health inequalities in Europe (Closing the health gap). Website: www.bzga.de
3. 2004303 - Reduction of Health Inequalities in the Roma Community (Health Inequalities in the Roma).
Website: www.gitanos.org
4. 2005318 - Evidence Based Guidelines on Health Promotion for Elderly: social determinants, inequality and sustainability (HealthPROelderly). Website: www.healthproelderly.com
5. 2005118 - Impact assessments in improving population health and contributing to the objectives of the Lisbon Strategy (EU FOR HEALTH AND WEALTH). Website: www.stm.fi/etusivu
6. 2005300 - Tackling health inequalities: governing for health, United Kingdom European Presidency conference (THIGH). Website: www.health-inequalities.org; see also http://ec.europa.eu/health/ph_determinants/socio_economics/documents/ev_060302_rd05_en.pdf
7. 2006311 - EU Consortium for Action on Socio-Economic Determinants of Health (DETERMINE).
Website: www.szc.cz
8. 2006323 - The prevention of socio-economic inequalities in health behaviour in adolescents in Europe (TEENAGE). Website: www.teenageproject.eu (The website is no longer active); see also www.biomedcentral.com/1471-2458/9/125
9. 2006339 - Healthy Regions - When Well-being Creates Economic Growth (Healthy Regions).
Website: www.southdenmark.be
10. 2006WHO03 - Equity in Health: Inequalities in Health System Performance and their social determinants in Europe - Tools for Assessment and Information Sharing (Equity in Health).
Website: www.euro.who.int/en/data-and-evidence/equity-in-health-project
11. 2006302 - Health and migrations in the EU: Better health for all in an inclusive society, Portuguese European Presidency conference (H&M-EU). Website: www.insarj.pt
12. 2006109 - European Health and Life Expectancy Information System (EHLEIS I). Website: www.eurohex.eu
13. 2007114 - Better Statistics for Better Health for Pregnant Women and Their Babies: European Health Reports (EURO-PERISTAT III). Website: www.europeristat.com
14. 2007311 - Improving access to health care for asylum seekers and undocumented migrants in the EU (AVERROES). Website: www.averroes.fr
15. 20081306 - Inventory of good practices in Europe for promoting gender equity in health (ENGENDER).
Website: engender.eurohealth.ie/ad-minWP/
16. 20081309 - The potential for reduction of health inequalities in Europe (EURO-GBD-SE).
Website: www.euro-gbd-se.eu/
17. 20081213 - SOCIOECONOMIC INEQUALITIES IN MORTALITY: EVIDENCE AND POLICIES IN CITIES OF EUROPE (INEQ-CITIES). Website: www.ucl.ac.uk/ineqcities/
18. 20081215 - Addressing inequalities interventions in regions (AIR). Website: www.healthinequalities.eu/
19. 20091223 - Crossing Bridges; developing methodologies and building capacity to advance the implementation of HiAP and achieve health equity (CrossingBridges). Website: www.health-inequalities.eu/HEALTHYQUITY/EN/projects/crossing_bridges/
20. 20091212 - Health promotion for disadvantaged youth , health 2 you in 5 countries (health 25).
Website: www.health25.eu
21. 20101301 - Promoting better health for mothers and babies through routine European monitoring of perinatal health and health care (EURO-PERISTAT Action). Website: www.europeristat.com

22. 20102301 - European Health and Life Expectancy Information System (EHLEIS). Website: www.eurohex.eu
23. 20102203 - Joint Action on Health Inequalities (Equity Action). Website: www.equityaction-project.eu
24. 20106202 - Health inequalities in the EU (Marmot report).
Website: www.instituteofhealthequity.org/projects/eu-review
25. 20106303 - Impact of Structural Funds on Health Gains (Structural Funds on Health Gains).
Website: www.healthgain.eu
26. 20111203 - HEALTHEQUITY-2020 - Reducing health inequalities: preparation for action plans and Structural Funds projects. Website: www.healthequity2020.eu
27. 20111205 - ACTION-FOR-HEALTH - Reducing health inequalities: preparation for action plans and Structural Funds projects. Website: www.action-for-health.eu
28. 20115201 - European Review of Social Determinants and the Health Divide, WHO/Europe direct grant Agreement (RAHEE). Website: www.euro.who.int/en/data-and-evidence/equity-in-health-project
29. 20126322 - Tobacco and health inequalities (Tobacco and health inequalities).
Website: www.matrixknowledge.com/
30. 20126261 - Reports on health status of the Roma population in the EU and the monitoring of the data collection in the area of Roma health in Member States (Roma Health). Website: www.matrixknowledge.com/

ACTIONS ADDRESSING THE HEALTH NEEDS OF VULNERABLE GROUPS

31. 2003131 - A comprehensive health information and knowledge system for evaluating and monitoring perinatal health in Europe (Phase 2) (EURO-PERISTAT 2). Website: www.europeristat.com
32. 2003303 - European AIDS & Mobility A&M (A&M). Website: www.aidsmobility.org
33. 2004307 - European Network on Health and Social Inclusion (Correlation). Website: www.correlation-net.org
34. 2004320 - European Network for Transnational AIDS/STI Prevention among Migrant Prostitutes (TAMPEP 7) .
Website: www.tampep.eu
35. 2004327 - Innovative Care Against Social Exclusion (ICAASE).
Website: www.omega-graz.at/projekte/03-icaase.shtml
36. 2004107 - HIV/AIDS and STI-prevention, diagnostic and therapy in crossing border regions among the current and the new EC-outer borders (BORDERNET). Website: www.bordernet.eu
37. 2005122 - Monitoring the health status of migrants within Europe: development of indicators (MEHO).
Website: www.eupha.org
38. 2005206 - Network for communicable disease control in Southern Europe and Mediterranean countries, Vaccine-preventable diseases and migrant populations (Episouth). Website: www.episouthnetwork.org
39. 2006317 - Information network on good practice in health care for migrants and minorities in Europe (MIGHEALTHNET). Website: www.mighealth.net
40. 2006313 - Integrated responses to drugs and infections across European criminal justice systems (Connections). Website: www.connectionsproject.eu
41. 2006206 - Increasing Public Health Safety for the External Borders of an Enlarged EU (PHBLM).
Website: www.iom.int
42. 2006333 - Health Care in NowHereland - Improving Services for Undocumented migrants in Europe (Nowherecare). Website: www.nowhereland.info

43. 2006347 - Assisting Migrants and Communities: analysis of social determinants of Health and Health Inequalities (AMAC). Website: www.migrant-health-europe.org/
44. 2006129 - Best Practice in Access, Quality and Appropriateness of Health Services for Immigrants in Europe (EUGATE). Website: www.eugate.org.uk
45. 2006328 - Best Practice in Promoting Mental Health in Socially Marginalized People in Europe (PROMO). Website: www.promostudy.org/project/index.html
46. 2006344 - European Network for HIV/STI prevention and Health promotion among migrant sex workers (TAMPEP 8). Website: www.tampep.eu
47. 2006342 - HEALTH AND THE ROMA COMMUNITY, ANALYSIS OF THE SITUATION IN EUROPE (Roma health). Website: www.gitanos.org/european_programmes/health/index.html
48. 2007301 - Anti Stigma Programme: European Network (ASPEN). Website: <http://www.antistigma.eu/>
49. 2007321 - Development of Recommendations for Integrating Socio-Cultural Standards in Health Promoting Offers and Services (Healthy Inclusion). Website: www.rotekreuz.at/wien/forschungsinstitut-des-roten-kreuzes/projekte/laufende-forschungsprojekte/healthy-inclusion/
50. 2007323 - AIDS & Mobility Europe 2007 – 2010 (AIDS & MOBILITY). Website: www.aidsmobility.org
51. 20081204 - Developing a training and resource package for improving the sexual and reproductive health of people living with HIV/AIDS (EUROSUPPORT 6). Website: www.eurosupportstudy.net
52. 20081201 - European Network Social Inclusion and Health (Correlation II). Website: www.correlation-net.org
53. 20091201 - Improving Access to HIV/TB testing for marginalised groups (Impact). Website: www.projectimpact.eu
54. 20091202 - Highly active prevention: scale up HIV/AIDS/STI prevention, diagnostic and therapy across sectors and borders in CEE and SEE (Bordernet). Website: www.bordernet.eu
55. 20091218 - Addiction prevention within ROMA and SINTI communities (SRAP). Website: <http://srap-project.eu/>
56. 20091105 - EpiSouth+: a Network for the Control of Public Health Threats and other bio-security risks in the Mediterranean Region and Balkans (EpiSouth Plus). Website: www.episouthnetwork.org
57. 20091109 - Promote vaccinations among Migrant Populations in Europe (PROMOVAX). Website: www.promovax.eu
58. 20091102 - A European network on cervical cancer surveillance and control in the new Member States (AURORA). Website: www.aurora-project.eu
59. 20091212 - Health Promotion for Young Prisoners (HPYP). Website: www.hpyp.eu
60. 20101104 - Empowering civil society and public health system to fight tuberculosis epidemic among vulnerable groups (TUBIDU). Website: www.tai.ee/en/tubidu
61. 20101105 - Screening for Hepatitis B and C among migrants in the European Union (EU HEP SCREEN). Website: www.hepscreen.eu
62. 20125201 - Fostering health provision for migrants, the Roma, and other vulnerable groups (EQUI-HEALTH). Website: <http://equi-health.eea.iom.int/>
63. 20136209 - Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma (Training HP). Website: <http://www.easp.es>
64. 20134203 - Migrant and Ethnic Minority health and health care in the context of the current systemic crisis in Europe Conference (Migrant Health Conference). Website: <http://www.eupha-migranthealthconference.com/>

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