

**Information and communication network  
concerning health-related prevention projects  
for young people in the European Union**

**F I N A L R E P O R T**

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## 1. Introduction

Since the Treaty of Amsterdam (1991), health protection and disease prevention have been expanded in the EU and offer many starting points for improvements to the European health system. In this context, the EU Commission has recently developed various strategies to counter negative health trends in Europe through preventive measures and place the lifestyles of EU citizens on a better basis, e.g. the EU conference in Milan "*Healthy Lifestyles – Education, Information and Communication*" (held on 3-4 September 2003, on the occasion of Italy's EU presidency).

This strategy applies equally to children, young people and adults in Europe, with a special focus being placed on children and young people who are particularly vulnerable due to their developmental status. Children and young people in Europe are increasingly exposed to health related risks, e.g. (traffic) accidents, overweight, smoking, alcohol and drug consumption, and need support in the form of supra-regional measures to safeguard their health related development in the Europe of tomorrow.<sup>1</sup>

Projects, programmes and activities targeted at disease prevention and health promotion in childhood and youth are important steps towards the goals of the European Commission defined in the new health strategy.<sup>2</sup> The contents described in this strategy are grouped round three general goals:<sup>3</sup>

- improvement of the level of information and knowledge on the further development of the public health system;
- improvement of the ability to respond quickly and in a coordinated manner to health risks;
- health promotion and disease prevention through consideration of health related factors in all policies and activities.

With these goals in mind and within the scope of various EU action programmes (in line with Article 129 of the Treaty of Maastricht), the EU Commission has developed a number of

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<sup>1</sup> European Commission: Report on the state of young people's health in the European Union, Luxembourg 2000.

<sup>2</sup> European Commission (2000) 285 final of 16.5.2000.

<sup>3</sup> Official Journal of the European Commission (2003), C 62/21, 15 March 2003.

measures targeted at young people e.g. the European Network of Health Promoting Schools, the European Network on Young People and Tobacco, measures to combat AIDS and addiction, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), "Feel free to say No" etc.

Against the background of this European trend towards health system improvements, the German Youth Institute filed an application for an EU project entitled "*Information and Communication Network on Health Related Prevention Projects for Young People in the European Union*", aimed at investigating the wide variety of health promoting and disease preventing strategies targeted at young people in the EU Member States and finding "Good Practice" projects and programmes. This overview is intended to help improve and institutionalise practical approaches to reducing health problems and risks faced by young people.

Responsibility for overall project coordination and preparation of the reports for Germany and the entire EU rests with the German Youth Institute, Munich. The project was conducted in 15 EU Member States, which selected experts to represent them in the 'Information and Communication Network' set up to carry out the project tasks. The national sub-reports (by 12 national experts) and a compendium, including all projects, programmes and activities, are annexed hereto.

## **2. Summary**

### **3. Goals, context and purpose of the project**

Current reports on surveys concerning the health situation of young people in the EU (European Commission 2000<sup>4</sup>, Hackauf/Winzen 1999<sup>5</sup>) show that this section of the population is subject to considerable health risks (e.g. traffic accidents and injuries linked to alcohol and drugs, emotional disturbances, danger of suicide, malnutrition, overweight, lack of exercise, tobacco, alcohol and drug consumption). Therefore, in view of the findings of the

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<sup>4</sup> European Commission: Report on the state of young people's health in the European Union. A Commission Services Working Paper, European Commission, DG Health and Consumer Protection Unit F3, L-2920 Luxembourg, 2002.

<sup>5</sup> Hackauf, H./Winzen, G.: On the state of young people's health in the European Union. German Youth Institute, Munich, 1999. 171 pages (available upon request from The European Commission, DG Health and Consumer Protection Unit F3, L-2920 Luxembourg – English language version only).

reports presented above, the question arises what possibilities are suitable for health prevention or health promotion to influence and reduce the risk potential of young people. Structural changes, on the one hand, and measures to provide information and change behaviour, on the other hand, are central issues.

The aim of the project was to carry out an empirical survey of preventive projects for young people in the 15 EU Member States and to have experts gather information on the status, orientation and quality of offering.<sup>6</sup> A European network of selected specialists was established in support of this work and to exchange experiences.<sup>7</sup> One of the things the empirical survey thus implemented was supposed to find out was what programmes there were that could be classified as "best practice" models. The project coordinator, jointly with the European specialists and members of the body of consultants,<sup>8</sup> organised two workshops where topics and methods were discussed in detail.

The *first workshop* (Bernried, March 15 and 16, 2003) coordinated the work programme of the EU network. The following tasks were realised step by step in the next project phase:

- successively building up a network of experts from the various EU Member States;
- developing the concept and control process of the project and establishing cooperation terms;
- defining, jointly with the experts, what criteria should be applied to choose the object and field of the survey;
- developing a questionnaire, semi-standardised, that characterises the selected health prevention projects; translating the questionnaire and pre-test in individual Member States;

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<sup>6</sup> In the text the term "offering" is used as a synonym for the terms project/programme/activity.

<sup>7</sup> This EU-Network bears the name "Information network concerning health related prevention programmes for young people in the European Union."

<sup>8</sup> The advisory board consists of seven scientists from the German Youth Institute, Munich, some of whom have participated in the advisory board of a previous EU project (Hackauf/Winzen 1999).

- implementing the survey, narrowing down the sample, contacting the projects, making use of the questionnaire (and supplementing it with oral interviews, if required), controlling completed questionnaires, evaluating data, assuring the quality of survey procedures, drafting descriptive per-country reports in English (including additional information), supplying the project coordinator with data.

In the *second workshop* (Freising, December 5 and 6, 2003), results were presented and discussed in an exemplary way. The main issue was to find a common strategy for dealing with "best practice" criteria. The result was that no standard solutions for health promotion at the EU level could be found. Rather, an overview of all projects shows a large variety of possible approaches in different activity fields. Projects/programmes/activities try to find solutions using very different modules of offering. Individual modules can be combined and adapted. The implementation of any method depends on country-specific contexts. The following aspects, in particular, must be included:

- Questions concerning definitions of health promotion;
- The country-specific perception of health problems;
- The subjective perception of young people and their parents concerning their own health problems;
- The country-specific nature of vocational training systems involved in health promotion;
- Political strategies for reacting to young people's health problems;
- The results of the second workshop made clear that the elaborated European database is a kind of "modular system" which can be offered to interested parties inquiring about youth-related projects/programmes/activities of health promotion because of its many innovative ideas and creative approaches.

The following points were also decided on during the second workshop:

- Structure of the final report

- Correction of the final report by expert review
- Health policy strategies and proposals for the further development of youth-related health promotion in EU Member States
- Structure of the country reports
- Strategies for consolidating and developing the EU network
- Dissemination of the results EU-wide or nationwide.

#### **4. The health situation of young people in the European Union**

In the following, the health situation of young people in Europe will be outlined briefly to show in what areas health policy problems related to children and adolescents exist. Areas that the survey can put in a European context will be given particular attention. Country reports will render the topics more accurately, presenting the situation in individual EU countries in detail and describing the central issues of national health promotion measures with the help of selected projects, programmes and activities.

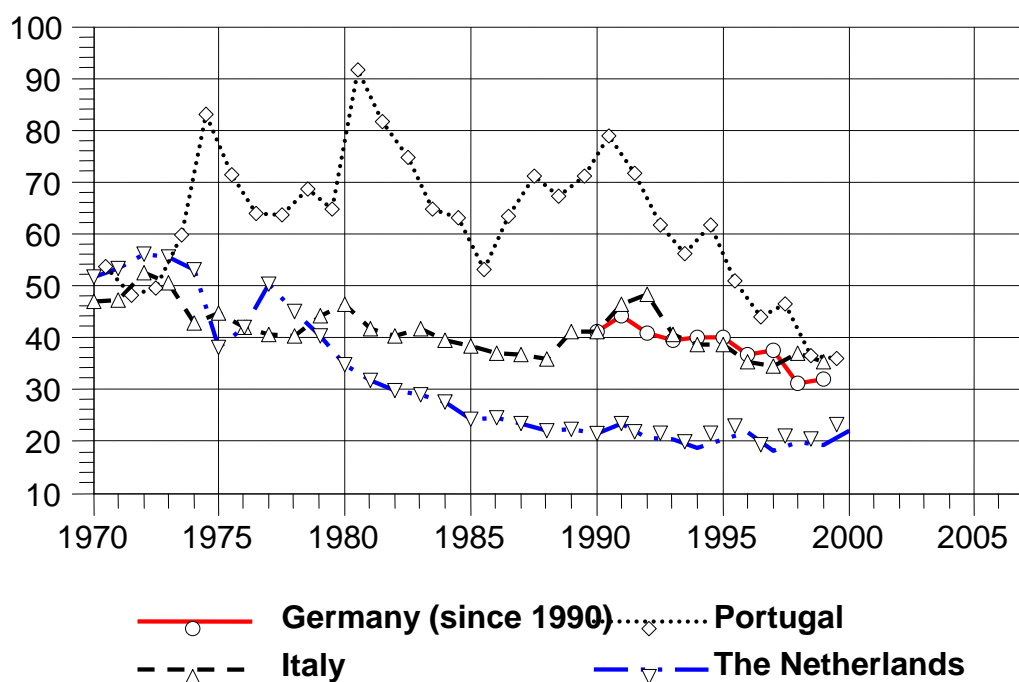
The survey done by the EU network serves the purpose of collecting data about projects, programmes and activities geared to preventive, health-promotional and therapeutic measures for children and adolescents. Imparting knowledge and changing behaviour are important aspects in this context, whereas changes in the social conditions of growing up can only be dealt with in a micro-social context. As for the reports on European trends mentioned above and similar European sources, the following health policy problem areas have been classified as areas of high risk by network experts.

##### **4.1 Public traffic risks**

Children and adolescents must learn to cope actively with the risks of traffic in everyday situations. There are many initiatives for a safe way to school, and both parents and qualified

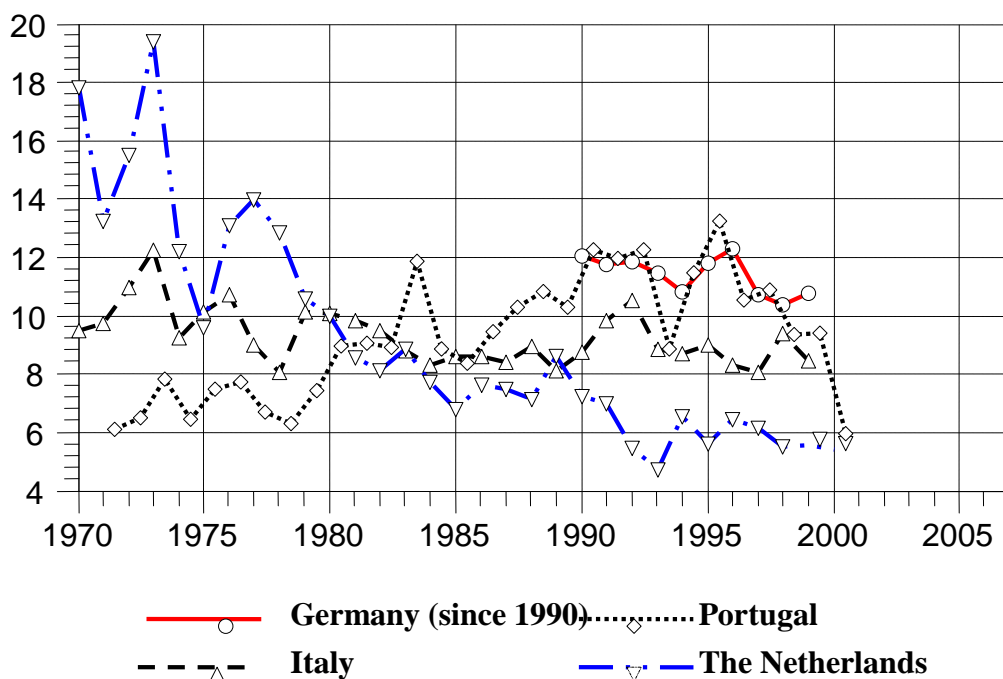
youth workers endeavour to protect children and adolescents from the many dangers and risks of a motorised and electrified society. Moreover, there are driving school programmes for obtaining the automobile and motorcycle licence etc. They are necessary to make young beginners' participation in traffic safer and, at the same time, to increase the safety of all road users. Nevertheless, accidents with serious injuries and traffic-related fatalities are the order of the day among children and adolescents in all EU Member States, i.e. they are a challenge for European societies. The risks arising from road traffic in selected EU Member States are demonstrated by the line graph of young people killed in road traffic (see diagram 1 and diagram 2).

**Diagram 1: Causes of death – motor vehicle traffic accidents, number of deaths, 15-24-year-old males, per 100.000**



Source: European health for all database, WHO Regional Office for Europe, Copenhagen, Denmark.

**Diagram 2: Causes of death – motor vehicle traffic accidents, number of deaths, 15-24-year-old females, per 100.000**



Source: European health for all database, WHO Regional Office for Europe, Copenhagen, Denmark

Young men, aged 15 to 24 in particular, are at considerable risk because of their dangerous driving style (under the influence of alcohol). Relevant statistics from individual Member States show that in car accidents involving 15 to 18 year olds in which people were injured, approximately every third person involved in the accident was under the influence of alcohol (see WiSta 1999, p.637). However, comparative data on accidents under the influence of alcohol are not reliable enough. Still, drinking and driving is recognised as a public health risk, for instance, in Belgium, France and Portugal.<sup>9</sup>

As a relevant study (Raithel 2000) shows, reasons for the risk of accidents among young motorcyclists, in particular, but also among some young car drivers, are their insufficient self-protection and their readiness to take risks, which often results in near accidents. The social resources provided by schools, jobs, family, peers and in leisure time do not help them sufficiently reduce psycho-social pressures that lead to risky behaviour (such as consumption of alcohol, tobacco, medicine and drugs).

There is wide-spread agreement that young people at risk should be offered special preventive programmes capable of doing better than just to impart knowledge and/or act as a deterrent. Most of the time, risky traffic behaviour promises young people a subjective gain in competence and an improvement of their status within the group (Jessor/Jessor 1977, Jessor/Donovan/Costa 1991). That is why training courses are offered to young people to strengthen their self-esteem and competence by means of less risky behaviour.

## **4.2 Mental health**

The report of the European Commission (2000, p.29) mentioned above indicates that emotional and psycho-social problems during youth are often not recognised and not treated sufficiently. The report also points out that the incidence of many illnesses (depressions, drug addiction, suicidal behaviour, eating disorders and psychotic disorders) increases from childhood to adolescence and prevalence increases right into adulthood owing to relapses. The report is based on sparse information from Member States, but according to estimates, the general prevalence of emotional illnesses during youth is about 15 - 20%. Among young people coming from sections of the population with social disadvantages and a low level of integration (such as migrants) the percentages tend to be even higher.

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<sup>9</sup> European Commission: The health situation in the EU, European Statistical Office, Luxemburg, 2003, p. 17.

Suicide is the second most frequent cause of death among young people (aged 15 to 24) after death in traffic accidents and, together with suicide *attempts*, burdens their families and the social network considerably.

For the last twenty years, the *suicide rate* among young people (aged 15 to 24) has been at a high level and has only recently declined a little. For EU Member States it is a dramatic, but often underestimated problem of public health. Suicide occurs more frequently among young men than young women and rather in lower than higher socio-economic status groups (Acheson 1998).

Suicidal tendencies are associated with social stress factors (such as family and partnership problems, unemployment), on the one hand, and alcohol or substance abuse (as cause and/or effect of emotional disorders), on the other hand. There are clear indications that the family background has a strong influence on the suicidal behaviour of young people. In particular, experiences with sexual abuse and severe physical and emotional acts of violence in childhood and youth play an important part. Factors of a family's influence may be the breakdown of personal relationships, parents' suicide or suicide attempts (or those of close relatives), a tendency in the family towards depressive disorders, and abuse of or dependence on alcohol and drugs (Crepet 1996, p. 53 et seq).

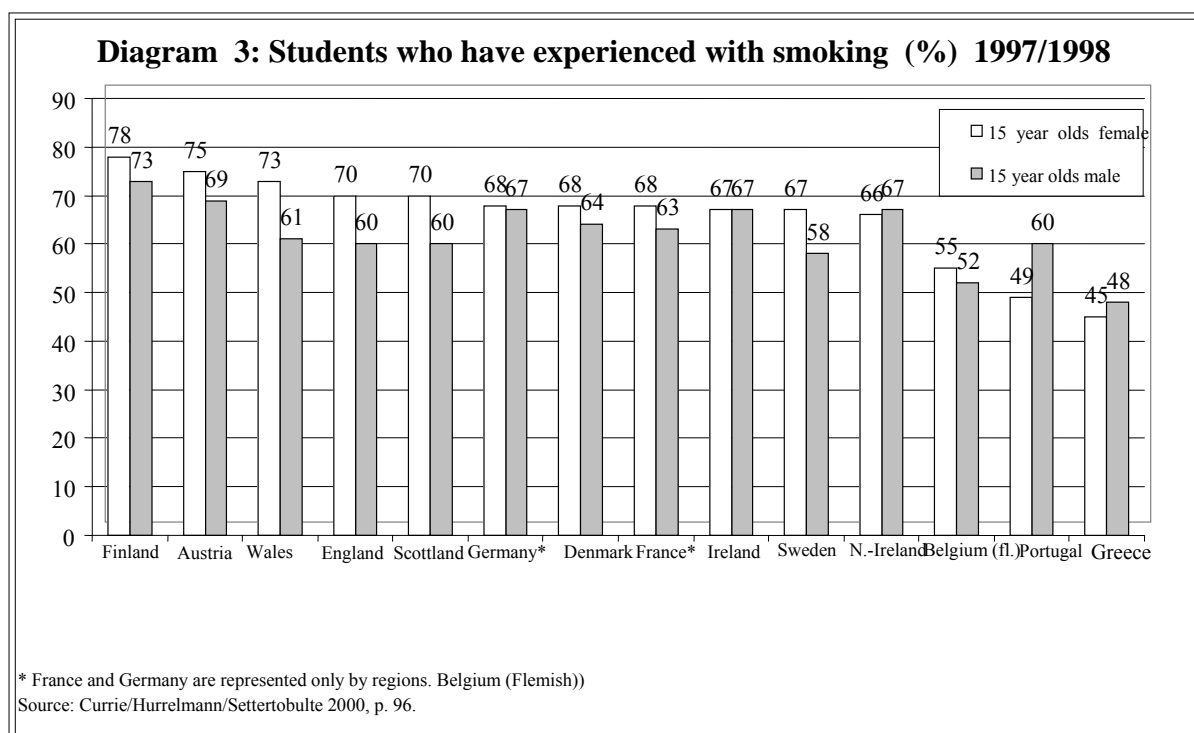
Emotional and psychosocial problems of children and adolescents are an urgent topic that health policy in the EU has to address. Promoting emotional health, psychosocial care and psychotherapeutic services for young people and young adults means providing new programmes, projects and initiatives.

### **4.3 Risky lifestyles: smoking, alcohol and drug consumption**

#### **Smoking**

Studies on the health of young people pay special attention to the *moment* when health-damaging behaviour starts. Health prevention assumes that young people's smoking, for instance, if it is started at all, should be started as late as possible to minimise its damaging effects. Health-related behaviour leading to alcohol and drug consumption, but also unbalanced diets and chronic lack of exercise, is the topic of a large variety of studies.

The WHO-Study HBSC (1996, 2000) points out a rapidly rising quota of young people in Europe who, between 11 and 15 years of age, begin smoking. The frequency of smoking, however, differs noticeably from one EU country to another, which indicates the varying degrees of cultural acceptance of smoking. Conspicuously, there are more girls than boys, and increasingly so in nearly all European countries or regions, who have admitted to have started smoking (e.g. Austria, Finland, Northern Ireland, Scotland, Wales, Denmark, England, Germany and France).



### Alcohol consumption

Indisputably, regular and excessive alcohol consumption raises the risk of illness generally, and in the long term, depression, cancer, strokes, high blood pressure and cirrhosis of the liver can be the consequence. Alcohol abuse and dependence affects many levels of individual action, e.g. in road accidents, risky sexual behaviour, violence within and outside the home, criminal offences, absence from the workplace, reduced performance.

According to recent EU-reports (EU-network Megapoles 2003)<sup>10</sup>, group-specific drinking behaviour of young people in Europe is very alarming. Consumption mainly of "alcopops" and beer is increasing among younger age groups in many EU countries, girls and young women being a growing consumer group, as well. This trend (with regard to "alcopops") can be traced back to new products of the alcoholic beverage industry for young consumers, offering mixed drinks, i.e. lemonade with a shot of alcohol. Moreover, young people increasingly show the tendency to deliberately practice "binge drinking" on weekends. This trend has not yet attracted a great deal of public attention.

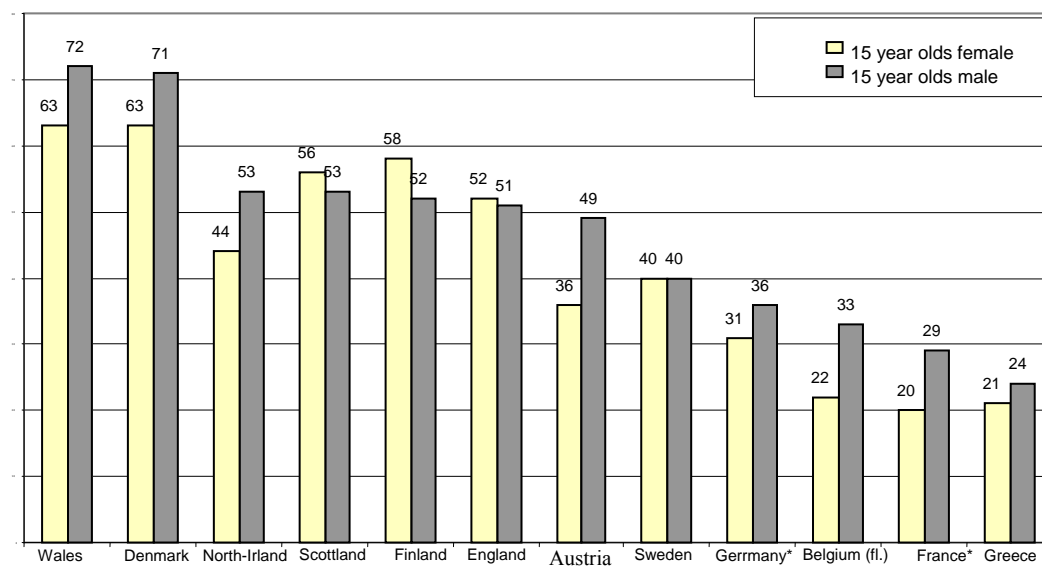
Growing up in a family with alcoholic parents and/or siblings as well as beginning to consume alcohol regularly at an early age are basic risk factors (Eurocare 1998). Even before children are born, their constitution is often damaged by their mothers' alcohol and drug consumption (embryopathy).

Alcohol consumption of young people seems to be a trend in the EU that, according to the WHO-HBSC-Study (2000), is developing in two directions. On the one hand, more than half of all 15-year-olds in Denmark, Wales, Scotland, Finland and England had been intoxicated more than twice (see Diagram 4). On the other hand, less than 30% of boys and girls in France and Greece had ever been intoxicated. Data are inconsistent, as in Greece, for instance, according to the statements of 15-year-olds, they have the second highest regular alcohol consumption per week. A comparison of surveys done in 1993/94 and 1997/98 shows that alcohol abuse has increased: the percentage of 15-year-old boys and girls who had been intoxicated two or more times in their lives increased between these two survey periods in the region investigated (see WHO-HBSC-Study 1996, 2000, p. 110).

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<sup>10</sup> Ranzetta, L., Fitzpatrick, J., Seljmani, F.: Megapoles: Young People and Alcohol. Greater London Authority, London 2003.

**Diagram 4: Percentages of 15-year-old students who report having been drunk twice or more often in their lifetime (by gender), (%), 1997/98**



Belgium (fl.): Flemish

\* France and Germany are represented only by regions.

Source: King et al. 1996, p. 23; Currie/Hurrelmann/Settortobulte et al. 2000, p. 110.

One of the promising approaches to the prevention of drug abuse is to confront the normative, stimulating influence of peer groups and to support social competencies. There are special training programmes for dealing with social influencing attempts and for teaching social competencies (see Botvin/Tortu 1988; Evans 1988; Tobler/Stratton 1997). Their aim is to make children and adolescents understand how to recognise social influences and to develop attitudes that make them resistant and autonomous.

### **Risky Lifestyles Drugs**

Since 1995, the European Observation Office for Drugs and Drug Addiction (E.B.D.D.) has been dealing with the topic of drugs and collecting data on drug fatalities, population surveys, infectious diseases among drug consumers and other aspects. The E.B.D.D. noticed an increase in the drug consumption of EU populations during the nineties.<sup>11</sup> The E.B.D.D. report published annually since 1995 gives information about an increase in the distribution of

<sup>11</sup> E.B.D.D. 2003, p. 16.

cannabis products such as marijuana and hashish within the EU. Between 20 and 25% of the adult European population have tried these drugs once in their life.

Nevertheless, the figures of the E.B.D.D. report make clear that the consumption of cannabis products, mainly among young people, is wide-spread in Europe, and the number of first users has risen, i.e. 25% in the age group of 15- to 26-year-olds and already 40% of 18-year-olds.<sup>12</sup>

In the area of illegal drugs, as the E.B.D.D. annual report has determined, cannabis is the most frequent one, but new drugs are gaining ground, though at a far lower level. Consumption of cannabis among 15- to 34-year-olds ranges from 1% in Sweden to about 17 to 19% in France, Spain, Ireland and Great Britain.<sup>13</sup> Likewise the consumption of amphetamines, cocaine and ecstasy is also increasing. Ireland, Great Britain, the Netherlands and Spain rank highest; between 2 and 5% of 15- to 34-year-olds consumed amphetamines during the last 12 months. Cocaine consumption clearly increased among 15- to 34-year-olds in Spain and Great Britain (Ireland also experiences high consumption rates). The values in the countries mentioned (excluding Ireland) have risen from 1 to 5% since 1996.

The risks of "designer-" or "disco-drug" consumption in form of ecstasy, amphetamine-derivatives and LSD are often discussed in public. These drugs are wide-spread in the context of youth culture and are consumed by certain groups of young people in clubs and at rave- or house-parties. The data from the E.B.D.D. annual report show that almost 5% of 15- to 34-year-olds experiment with ecstasy<sup>14</sup>

According to data of the E.B.D.D. report<sup>15</sup>, which will repeatedly be quoted below, the spreading of ecstasy and amphetamine consumption in EU member states, compared to that of cannabis, is not as high as sometimes expected. As for the party drug ecstasy, there seems to be a downward trend. Since the rave culture appeared at the end of the eighties, there has been an increase in the number of young people who have tried out synthetic drugs. Still, they

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<sup>12</sup> E.B.D.D. 2000, p. 7.

<sup>13</sup> E.B.D.D. 2003, p. 18.

<sup>14</sup> Since 1970, a youth rather than a school survey has been done among 12- to 25-year-olds in Germany recording data about drug consumption every three to four years. Accordingly, lifetime prevalence for all illegal drugs is 11% in West Germany and 10% in East Germany (cf. Central Federal Office for Health Education (BzgA) 1997).

<sup>15</sup> European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 1997, p. 13.

remain a relatively small group including less than 10% of youths, according to estimates, and regular consumption is not often observed. With reference to the EU population as a whole, fewer people have tried out ecstasy than LSD or amphetamines. Recently, however, ecstasy consumption has started rising in comparison to other synthetic drugs. The group of people who consume ecstasy, doing so frequently on weekends, does not belong to the socially weak groups, but rather to a financially well-off middle class, sometimes composed of college students. Previously, reports on fatalities and health defects owing to amphetamine, ecstasy or LSD consumption have been relatively few. The drug monitoring centre in Lisbon has received information about a small number of deaths only. The physical side effects of ecstasy and amphetamines show in that they put a strain on blood circulation and other systems because of their stimulating effect. Consumption during an exhausting long night of dancing in overheated rooms can lead to heat-strokes. The physical effects of LSD are considered to be relatively mild.

A more thorough analysis cannot be done with the available data of the EBDD report (2003), because these are limited to only a few epidemiological indicators of drug consumption within the European population. Moreover, the data used are full of methodological problems. Frequently, they come from national surveys differing from one another in design, methods applied and age groups. Long-term data on trends and comparable data are not sufficiently available.<sup>16</sup>

The risks of drug consumption often begin in childhood and youth when legal drugs like alcohol and tobacco are consumed for the first time. At the beginning, many young people limit their drug consumption to these addictive drugs. A varying number of youths experiment with soft illegal drugs like cannabis. There are good reasons to believe that those young people who move on to hard illegal drugs like heroin emerge from the group of cannabis consumers. During youth, a typical sequence of consumption is assumed for various drugs. Legal drugs are considered as the precursors of illegal drugs. As a rule, people's first experience is with nicotine, followed by alcohol, cannabis, sniffing substances, hallucinogens, amphetamines, opiates, sedatives and cocaine.

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<sup>16</sup> The indicators the EU uses for data capture or the comparison of data among various EU member states are not co-ordinated. That is one of the problems the European Monitoring Centre for Drugs and Drug Addiction (E.B.D.D.) is dealing with (cf. E.B.D.D. 2000).

It should be kept in mind that young people who have experienced drugs are not equivalent to regular consumers. Many young people simply try out soft drugs without becoming regular consumers.<sup>17</sup>

Consumption of illegal (and legal) drugs is considered as a great challenge in all countries of the European community. The importance of the problem is often illustrated, as in the EBDD report, by looking at the amount of confiscated illegal drugs. Between 1987 and 1995, the amount of heroin found by authorities more than doubled, and the amount of cocaine increased more than sevenfold. Although the confiscated amounts within the EU have, meanwhile, dropped a little, there is still a high demand in the illegal drug market. A large part of the dealing is done in the Netherlands, where one third of the heroin trafficked in the EU market was seized.<sup>18</sup>

Drug addiction or addictive illness put a lot of social and economic pressure on society. Drug addiction damages the physical and emotional health of consumers and usually leads to social decline. The extent to which health is at risk because of drugs depends on the kind of drug, the way it is consumed and the amount consumed. The intravenous use of heroin together with the intake of other narcotics (drugs, medicine, alcohol) is considered to be especially risky. Dangerous situations may arise. The circumstances of hard drug consumption (lack of hygiene, lack of medical care, an insufficient or wrong diet, frequent drug abuse) damage the health of drug addicts through illnesses and lead to a bad state of health. Problems of drug-related crime are another factor, in addition to the problems of addiction.<sup>19</sup>

As previously mentioned in regards to legal tobacco and alcohol consumption, the age when young people begin to take drugs is a crucial threshold with regard to their behaviour as consumers later on. Therefore, the aim of prevention must be to raise the age when alcohol and drug consumption begin. This aim can also be considered as a protective factor where the complex issue of illegal drugs is concerned.<sup>20</sup>

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<sup>17</sup> Cf. Hurrelmann 1994, p.43. Even though these assumptions have been made based on addictive illnesses in Germany, similar developments in European countries are considered to apply, taking cultural patterns into account.

<sup>18</sup> The amount of confiscated heroin rose from 2.3 tons in 1987 to 5.2 tons in 1995. The amount of cocaine seized in the same period of time rose from 2.8 tons to 20.6 tons. From: European Monitoring Centre for Drugs and Drug Addiction (E.B.D.D.) 1997, pp.36 - 37; E.B.D.D. 2000, p. 26.

<sup>19</sup> Federal Statistical Office 1998, pp. 99 - 100.

<sup>20</sup> Federal Statistical Office 1998, pp. 99 - 100.

Unmistakably, there have been new developments in drug consumption during the nineties having to do, for instance, with designer drugs like ecstasy or amphetamines. Experience with illegal drugs shows that more young people than before are in contact with them and that research and prevention are running a race against the new trends in consumption. To the extent that hard drugs are spreading, aspects of national cultural peculiarities are also at issue. They can be found in drug statistics, but cannot really be measured.

Drug addicts have a mortality risk which is 20 to 30 times higher than among young people of the same age who are not addicted. The type of drug used affects the mortality risk. Many EU member states observed a sharp rise in drug fatalities during the second half of the eighties which continued into the early nineties. Since then, the trend has been downward.<sup>21</sup> Hence, the attempt should be made to prevent or limit the consumption of illegal drugs even more consistently. For drug consumers, the main way that HIV or hepatitis is passed on is the common use of contaminated injection needles. Specific precautions against infection risks seem to have influenced the HIV transmission path, but not that of hepatitis B and C. Generally, the rate of new AIDS cases is decreasing (see Chapter 6.6 Hepatitis B and Chapter 8.6 Sexual behaviour, HIV and AIDS). Hepatitis C is 50 to 100 times more infectious than HIV and can lead to extensive liver damage and to cancer of the liver. The group at risk is comparable to that of HIV-infected people. There are probably half a million drug consumers in the EU who are infected by hepatitis C. High hepatitis-C-infection rates indicate that the risky practice which transmits the HIV-virus and other viruses continues at a lower level.

## **Prevention**

Many local associations and, to a lesser extent, national services have recognized the importance of harm-reduction-strategies. Voluntary/non-government organizations rather than official drug services are in overall charge of these strategies. Drug substitution programmes can be pointed out here, provision of disposable syringes free of charge and sanitary facilities as well as social and medical support services. Beyond that, many efforts are being made to urge or even force club owners and promoters to introduce safety measures such as sufficient ventilation, provision of drinking water and first-aid-services. Clubs volunteer more and more often to take responsibility for such measures themselves. In prevention, the language and symbolism of the rave culture are often employed to promote drug-free events or "safer use".

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<sup>21</sup> European Monitoring Centre for Drugs and Drug Addiction 1997, p. 11 and p. 71.

Peer education and peer projects initiated by members of the dancing scene also contribute to prevention. Wide-spread drug consumption at dancing events, even though it is prohibited, indicates the hesitant attitude of the authorities who, on the one hand, speak up for restrictive measures, but on the other hand, have come to the sober realization that such measures may do more harm than good, e.g. by inducing young people to arrange illegal events in remote locations.

In contrast to the consumption of opiates and to intravenous consumption, the consumption of synthetic drugs has not been researched to a great extent. Studies of consumption patterns are required, as are investigations of the consequences of consumption, e.g. a doctor's examination of consumers to determine potential health-damaging effects.

#### **4.4 Contraception, protection against AIDS, protection against STDs (sexually transmitted diseases)**

Preventive measures during the age of youth are a difficult matter if they are to reach young people in different social contexts. It also takes a very long time for changes in health-related behaviour to take place. Knowledge about contraception and the risk of HIV-infection is widespread and at a high level among young people, but they know relatively little about sexually transmitted diseases. In the last ten years, behavioural changes among young people have taken place hesitantly, with a moderately positive tendency. That is partly due to a carefree attitude of many young people, judging their individual risk to be slight and considering themselves to be relatively "invulnerable" (Slonim-Nevo/Ozawa/Auslander 1991).

Young people tend to underestimate individual risks with regard to HIV-infection. Current epidemiological prevalence rates substantiate that the risk of HIV-infection in Europe is slight for young people. However, one must keep in mind that, because of the long incubation period, the illness does not break out until much later. Possibly, these long phases (from HIV-infection to the full-blown form of the disease) have distorted public perception of AIDS. That is why young people often underestimate their individual risk of HIV-infection as it relates to their immediate life situation (Lohaus 1993, p. 111).

In view of the AIDS threat, the willingness to change one's own behaviour is stronger among 15- to 24-year-olds than among older sections of the population. The latter seem to be less willing to change their practical behaviour than young people who are quite open to comprehensive precautionary measures of HIV-prevention. Three out of four young people declare themselves in favour of precautionary measures in sexual relationships because of AIDS. It remains unclear, however, if young people really take these precautionary measures (European Commission 1996, p.22). These uncertainties and inconsistent results of the Eurobarometer-Study (1996) lead to the assumption that young people's knowledge base about HIV-infections does not serve well to predict their preventive behaviour. In comparison with other areas of prevention, it can be concluded that an elaborated knowledge base alone does not guarantee suitable behavioural adjustments (Segest/Mygind/Jorgensen/Bechgaard/Fallov 1990, Slonim-Nevo/Ozawa/Auslander 1991).

#### 4.5 Teenage pregnancies

The increasing number of abortions that young women and girls have who are still minors are a growing problem in some EU countries. Pregnancies and abortions among teenagers occur mainly in socially vulnerable groups. Teenage mothers are considered to be early starters<sup>22</sup>, i.e. young girls who, at an exceptionally young age (15 to 19), give birth to their first child.

**Table 1: Fertility rates, age 15-19 (live births per 1000 females)**

	B	DK	G <sup>1)</sup>	GR	SP	F	IRL	I	L	NL	A	P	FIN	SW	UK
<b>1970</b>	23,2	32,4	35,8	36,0	14,3	26,9	16,3	27,0	27,7	17,0	58,2	29,8	32,2	33,9	49,1
<b>1980</b>	14,9	16,8	15,2	53,1	25,8	17,8	23,0	20,9	16,7	6,8	34,5	41,0	18,9	15,8	30,5
<b>1990</b>	11,3	9,1	12,4	21,6	11,9	9,2	16,8	9,0	14,1	6,4	21,2	24,1	12,4	14,1	33,1
<b>1995</b>	9,1	8,3	10,0	13,0	8,2	7,0	15,0	7,3	10,3	4,2	17,5	20,5	9,8	8,6	28,3
<b>1998</b>	8,9	9,1	13,1	11,8	7,9	8,3	19,7	5,6	9,7	6,2	18,4	21,2	9,2	6,5	30,8

<sup>1)</sup> Germany (West)

Source: Council of Europe 1997, Innocenti Report Card No. 3, July 2001 Innocenti Research Centre, Florence.

Teenage pregnancies were far more frequent in the fifties and seventies of the 20<sup>th</sup> century, i.e. the tendency is for the number of pregnancies to decline - with deviations in some countries. Reasons for instance in Sweden are that preventive measures for young people are

<sup>22</sup> Höpflinger 1987, p. 126.

implemented by health system facilities or youth social welfare institutions.<sup>23</sup> However, there are still countries with a high number of teenage pregnancies. Table 1 shows that the United Kingdom, Portugal, Ireland and Austria had high values at the end of the nineties. An improvement of young people's overall information level make counselling centres for family planning possible. They exist in all EU countries, although they sometimes differ considerably in the age groups they address and in counselling fees. Some countries (Finland, Italy and the United Kingdom) give contraceptives to all youths free of charge, whereas other countries give them only to youths from low-income families.<sup>24</sup>

#### **4.6 Nutritional behaviour**

A healthy diet is an important contribution to disease prevention and health promotion. A poor and unbalanced diet entails long-term risks, since health impairments such as circulatory disorders, diabetes and cancer might develop.<sup>25</sup> European culture shows a large variety of nutritional styles that can be roughly divided into a northern and a southern (Mediterranean) nutritional culture, the latter being clearly advantageous.

In EU Member States, systematic survey findings do not yet exist for the eating habits of 15- to 25-year-old young people. The DAFNE project gives some information, having collected nutritional data in the households of selected EU Member States.<sup>26</sup> It was only the WHO-HBSC-Studies that asked 11- to 15-year-olds some questions about their eating habits. The studies focused on the consumption of fruit, vegetables, sweets, chocolate, potato chips and French fries as well as soft drinks and milk. These foods are a selection of indicators for a "healthy" or "unhealthy" diet. A diet rich in fibres as well as one with a low fat content (without much sugar) can promote health. Mineral substances such as calcium can lower the risk of illnesses such as, for instance, osteoporosis. The survey among 11-, 13- and 15-year-olds about their consumption of selected foods led to the following results:<sup>27</sup>

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<sup>23</sup> Sweden's Public Health Report 1998, p. 184.

<sup>24</sup> European Commission 1997, p. 118.

<sup>25</sup> European Commission: The Health Situation in the EU, Eurostat Luxemburg, 2003, p.41.

<sup>26</sup> The data are accessible in the FAO statistical database: <http://apps.fao.org/cgi-bin/nph-dp.pl> Vgl. DAFNE 1997.

<sup>27</sup> Currie/Hurrelmann/Settertobulte et al. 2000, p. 83.

- *Fruit and vegetables*

Consumption of fruit and vegetables depends on age and decreases between the 11<sup>th</sup>, 13<sup>th</sup> and 15<sup>th</sup> year of life. More than 70% of 15-year-old boys and girls in Portugal and Greece eat fruit and vegetables, whereas only 39% of 15-year-old boys and girls in Finland and Belgium (Flemish language area) do so. Generally speaking, girls eat more fruit and vegetables than boys.

- *Potato chips and French fries*

This everyday food is well-liked among students in Anglo-Saxon countries. Thus, 45 to 78% of students (more boys than girls) eat potato chips and French fries every day. Between ages 11 and 15, consumption of this type of food often decreases.

- *Sweets and chocolate*

Sweets and chocolate are in high demand among students in Anglo-Saxon countries. They are consumed by more than 60% of 15-year-old girls in Northern Ireland, Ireland, Scotland and England every day. In France, Germany and Austria, male and female students are somewhat more restrained, although even so, about 40% consume products containing sugar every day, whereas less than 31% of students in Scandinavian countries (Sweden, Denmark and Finland) do so, and the others can often do without. In most countries, there is no big difference between girls and boys.

- *Soft drinks*

In all countries it can be observed that boys drink more every day than girls. There is a clear age-related increase in the consumption of soft drinks among boys.

- *Milk*

More than 65% of male and female students in Finland, Denmark, Northern Ireland and England drink low-fat milk every day. Germany, Greece, Ireland and Austria are on the

lower part of the scale: only 30% of students prefer low-fat to high-fat milk. Although boys drink more milk than girls every day, consumption in both groups decreases between the ages of 11 and 15.

As the WHO-HBSC-Study (2000) found out, the socio-economic status of parents is a factor that clearly influences the more or less healthy nutrition of 11- to 15-year-old students of both sexes. Students from a parental home with a low social status eat less fruit and raw or cooked vegetables; instead, they eat more fatty foods and foods with sugar content (French fries and sweets).<sup>28</sup> a finding that indicates the significance of socio-economic factors, fruit and vegetables often being more expensive.

A comparison of eating and drinking habits in the EU is difficult because of structural and cultural differences in Member States that an empirical survey cannot easily access. Studies previously done on several northern and southern EU Member States show relatively consistent and clear differences in the eating habits of all sections of the population.<sup>29</sup>

A EU-report found out that if traditional Mediterranean diets, as they are common in Southern Europe, are combined with regular physical exercise, there is a connection to longer life expectancy.<sup>30</sup> Nutrition and the ecological quality of groceries are becoming increasingly important in Europe. Economic and political factors, as well, have a strong influence on people's nutritional behaviour.<sup>31</sup>

All diet-specific details cannot be dealt with exhaustively at this point, as eating habits are culturally determined and exposed to various risk factors. For clarification, the findings of the WHO-HBSC-Studies (1996, 2000) can be looked at; they document that unhealthy eating habits are practised mainly in the youth phase. The WHO-HBSC-Study verifies that significant groups of young people in all EU countries investigated do not make much use of recommendations for a healthy diet.<sup>32</sup> These findings are not surprising if one considers that

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<sup>28</sup> *Ib.*, p. 87.

<sup>29</sup> European Commission 1995, p. 24.

<sup>30</sup> *Ib.*, p. 24.

<sup>31</sup> Cf. Robertson/Brunner/Sheiham 1999.

<sup>32</sup> *Ib.*, p. 83 et seq.

knowledge about nutrition is not communicated to school children very effectively, as various studies show. In the future, families and schools can reinforce their crucial roles in this area.<sup>33</sup>

#### 4.7 Weight

Since the mid-nineties, the percentage of young people who are strongly overweight (adipositas) has risen noticeably in some EU countries (as, for instance, in Germany).<sup>34</sup> Being strongly overweight is a risk factor for a number of diseases caused by today's lifestyle. Among these are circulation disorders, diabetes, high blood pressure, cardio-vascular diseases and cancer. Frequently, overweight people also have psychological disturbances. In the last few decades, there has been an increasing trend towards overweight and adipositas, affecting adults as well as young people in the EU.<sup>35</sup> In the year 2000, not quite 5% of male and female youths in Germany were adipose, i.e. these young people should reduce their weight to avoid further health risks and resultant diseases. For both sexes, the percentage of adipose young people has increased between 1995 and 2000, for boys by one third, for girls even by one half.<sup>36</sup>

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<sup>33</sup> MAL I Dezernat für Gesundheitsplanung Wien 2000, p. 287.

<sup>34</sup> Ministerium für Arbeit, Soziales, Gesundheit und Frauen des Landes Brandenburg 2001, p. 76.

<sup>35</sup> Bergmann/Mensink 1999.

<sup>36</sup> Bericht des Ministerium für Arbeit, Soziales, Gesundheit und Frauen des Landes Brandenburg 2001, p. 76.

**Table 2: Percent Over- and Underweight, Women 15-25 years, EU 15, 1996**

	severe underweight (BMI<18)	underweight (18<BMI<20)	normal weight (20<BMI<27)	overweight (27<BMI<30)	severe overweight (BMI>30)
<b>The Netherlands</b>	5,2	19,5	63,6	3,9	7,8
<b>United Kingdom</b>	5,0	16,7	59,2	11,7	7,4
<b>Denmark</b>	5,4	23,0	63,5	4,1	4,0
<b>Ireland</b>	4,4	20,4	69,9	1,8	3,5
<b>Finland</b>	4,2	21,1	67,4	4,2	3,1
<b>Italy</b>	8,5	31,1	54,7	2,8	2,9
<b>EU 15</b>	6,4	24,9	61,6	4,4	2,7
<b>Belgium</b>	10,5	20,9	62,8	3,5	2,3
<b>Greece</b>	4,3	33,7	50,0	9,8	2,2
<b>Spain</b>	8,5	27,4	62,3	0,0	1,8
<b>Germany (West)</b>	3,1	23,1	67,7	4,6	1,5
<b>Germany (East)</b>	7,6	16,7	69,7	4,5	1,5
<b>Austria</b>	7,0	22,1	68,6	1,1	1,2
<b>Sweden</b>	6,2	27,2	60,5	4,9	1,2
<b>France</b>	9,2	36,8	49,4	3,4	1,2
<b>Portugal</b>	5,7	24,5	65,1	3,8	0,9
<b>Luxembourg</b>	7,5	39,6	49,1	3,8	0,0

Source: Eurobarometer 44.3/1996

An analysis of the Eurobarometer reveals that, on average, 7.1% of young women aged 15 to 25 in the EU are overweight or strongly overweight (see Table 2). The distribution of (more or less strongly) under- or overweight women in the EU is determined by using the Body-Measurement-Index (BMI).<sup>37</sup> WHO classifies women as underweight when the BMI is between 18 and 20. Women are defined as overweight when the BMI lies between 27 and 30, and as strongly overweight with a BMI of 30 or more. Women are considered as normal weight with a BMI between 20 and 27. When the BMI is greater than 27, the health risks mentioned above increase.<sup>38</sup> The readings of the Eurobarometer must be seen as a trend, since

<sup>37</sup> Body Mass Index (BMI) is defined as body weight in kilograms divided by height in meters squared (thus, BMI = kg/m<sup>2</sup> (ib., p. 89).

<sup>38</sup> Kommission der Europäischen Gemeinschaften 1997, p. 91.

the WHO-definition of under- and overweight refers to adults and, for young people under 18 years of age, would actually have to be adapted.<sup>39</sup>

Within the EU, there are considerable differences: the percentage of overweight or strongly overweight young women in the United Kingdom and the Netherlands is the highest (19.1% and 12.0%), whereas the values for underweight or strongly underweight young women are the highest in Luxembourg, France, Italy, Greece and Spain (47.1%, 46%, 39.5%, 38.0% and 35.9%).

	<b>Date of survey</b>	<b>Overweight + Obese</b>
<b>Czech Republic</b>	1991	10%
	2000	13%
<b>France</b>	1963	3%
	1977	6%
	1990	10%
	1995	13%
	2000	16%
<b>Germany</b>	1975	11%
	1985	12%
	1995	18%
<b>The Netherlands</b>	1980	10%
	1997	18%
<b>Poland</b>	1994	8%
	2000	18%
<b>Spain</b>	1980	12%
	1995	19%
<b>Switzerland</b>	1965	4%
	1975	8%
<b>UK</b>	1974	8%
	1984	8%
	1994	17%
<b>Yugoslavia</b>	1989	12%
	1998	16%
Source: IOTF – International Obesity TaskForce - Childhood Obesity Project, <a href="mailto:childhood@iotf.org">childhood@iotf.org</a> ; ECOG – European Childhood Obesity Group, <a href="mailto:frelut@club-internet.fr">frelut@club-internet.fr</a>		

<sup>39</sup> An alternative for measuring underweight and overweight in children and adolescents is the Broca Index (height in centimetres minus 100 = ideal body weight) and the use of growth standard percentiles for body weight and height (cf. MAL I Dezernat für Gesundheitsplanung Wien 2000, p. 287).

As seen in Table 3, an increase in children who are overweight in many European countries over various time periods has been established. The International Obesity Task Force<sup>40</sup> compiled data from different surveys. The country samples in Table 3 are not comparable however one can observe similar trends in the rise of overweight over several decades. The data show that an increase in weight among children is a common public health problem which needs immediate public attention and preventive action.

The eating habits in Northern and Southern Europe are entirely different because of different cultural traditions, the state of agriculture and foods offered. Thus, it is well-known that more animal protein and fats are consumed in Northern Europe, whereas diets in Southern Europe consist of a high percentage of natural fibres derived from the frequent consumption of vegetables, fruit and cereals as well as unsaturated fatty acids. Occasionally, eating habits change in Northern Europe, as can be observed, for instance, in Sweden, where Mediterranean kinds of food are on the increase.<sup>41</sup>

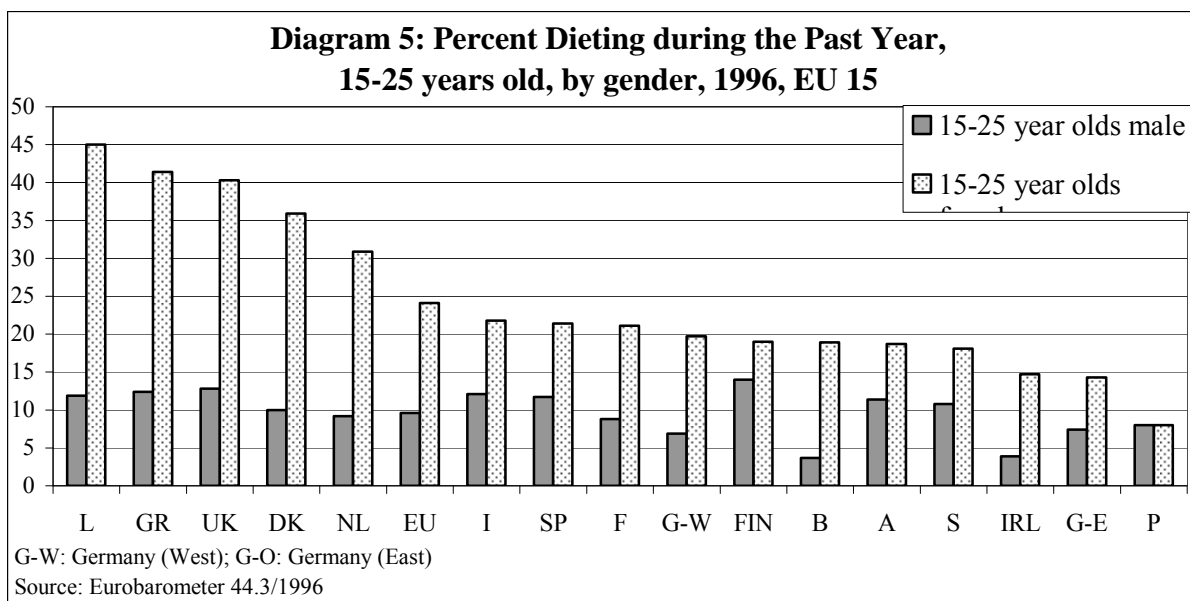
The Eurobarometer data include information about whether young people, during the last twelve months, have been on a diet. The data show that many young women in Luxembourg, Greece and the United Kingdom have attempted to change their eating behaviour (see Diagram 5). Regional differences between countries are obvious, but cultural and gender-specific differences are also remarkable. It seems that young women submit to the pressure of an ideal of a slim body much more strongly than young men. But observing a diet can involve health risks, as is indicated more and more often by the fact that young women develop anorexia. Hence, girls' eating disorders are among the most urgent age-specific problems, because they can have anorexic-bulimic consequences.<sup>42</sup>

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<sup>40</sup> IOTF – International Obesity TaskForce - Childhood Obesity Project, [childhood@iotf.org](mailto:childhood@iotf.org) ; ECOG – European Childhood Obesity Group, [frelut@club-internet.fr](mailto:frelut@club-internet.fr)

<sup>41</sup> Kommission der Europäischen Gemeinschaften 1997, p. 92

<sup>42</sup> Fend 2000, p. 242.



#### 4.8 Sports activities and leisure time behaviour

Regular physical exercise is a decisive factor that influences the health and quality of life in all age groups. Physical activities in childhood and youth are, therefore, an important contribution to the prevention of health risks in later life. Most children and adolescents do sports regularly at school and in sports clubs, but after the age of 14, club memberships rapidly decrease. Boys do more sports than girls. The type of school is part of the reason: children and adolescents in elementary schools doing less sports than students in higher educational institutions.

According to experts, regular sports activities and exercise in the fresh air belong to the central elements of a healthy lifestyle. This opinion is not very strongly reflected in the behaviour of Europeans at large. About 15% of the adult population do sports regularly, whereas for 88% the most frequent leisure time activity is watching television. People who do sports in moderation have positive views about its effects on health. More than three quarters of all leisure time athletes (88%) assume that sports contributes to their health in a positive way.<sup>43</sup>

<sup>43</sup> European Year of Education Through Sport 2004. Cf. [www.eyes-2004](http://www.eyes-2004), [www.media-conulta.com](http://www.media-conulta.com).

Goals of a balanced sports agenda conform to the following goals for physical, emotional and social wellbeing: fun, balancing out work, being in the fresh air, switching off, improving resilience, doing things together with others, keeping a good figure, testing one's upper limits of achievement.<sup>44</sup> But one should keep in mind that individual age groups do sports for different reasons. Among 16- to 30-year-olds, fun, fitness and a good figure take precedence, whereas for older people it's resilience and robustness.<sup>45</sup>

Sport is considered "a benefit for one's entire life", as the authors of a current European study on sports argue.<sup>46</sup> The study gives an overview of connections between sports, youth and government as well as non-government institutions that prevail in EU member states. It analyses to what extent public opinion makers are interested in sports and physical exercise. It also describes the methods employed by joint programmes such as "Youth for Europe" and "European Volunteer Services" with regards to the organization of sports activities.<sup>47</sup>

To get actively involved in sports, you usually enrol in a sports club - which is typical for Finland, Sweden and Denmark<sup>48</sup> - (at the bottom of the scale are Italy, France and Greece<sup>49</sup>) - and people feel stimulated to do so by the example that peer groups set, by the search for social contacts, by an interest in physical attractiveness and by physical self-esteem (looks, performance).<sup>50</sup> As body and health develop during the age of youth, sports activities are important factors for keeping fit - if they are not used excessively.

Along with the EU study on sports mentioned above<sup>51</sup>, the WHO-HBSC-Studies (1996, 2000) are one of the few data sources providing comparative international data about sports activities. The WHO-HBSC-Study shows that, among all male and female students aged 11 to 15, sports activities outside school are on the decline. This general trend is stronger among

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<sup>44</sup> Ib. 2004.

<sup>45</sup> Federal Office of Statistics 1998, p. 83.

<sup>46</sup> Le Magazine, Nr. 13/2000, p.3. Cf. Becker/Brandes/Kilb et al 2000.

<sup>47</sup> Ib., p. 2.

<sup>48</sup> Kurz/Sack/Brinkhoff 1996.

<sup>49</sup> European Year of Education Through Sport 2004. Siehe [www.eyes-2004](http://www.eyes-2004), [www.media-conulta.com](http://www.media-conulta.com)

<sup>50</sup> Sygusch 1999, p. 41.

<sup>51</sup> Becker/Brandes/Kilb et al. 2000.

girls than boys. In all countries, two thirds of boys aged 15 do sports outside school two times or more per week. This level of activity is attained by girls the same age in only four EU countries (Austria, Denmark, Finland and Germany). In Spain, the involvement of girls in sports is at a low level. They also get less involved in leisure time activities such as watching TV and videos and playing computer games; these are more likely to be the domain of boys.<sup>52</sup> There is no scientific proof as yet of how much sport is necessary for young people to maintain a way of life conducive to their health. Medical research gives different recommendations which should be linked more strongly to the criteria for a healthy way of life.

The EU white paper "New momentum for young people in Europe"<sup>53</sup> also presents important ideas concerning sports as part of a youth policy to be implemented in the future. Thus, it is emphasized how well young people in Europe are organized in sports clubs, these having the highest approval rating (28%) among youth organizations. The white paper wants to challenge the distance that young people keep towards traditional forms of participation in community life and has probed for possibilities to support coordination between member states and to ensure that young people are considered more appropriately in departmental policies. Sports is an important bridge for this purpose.

#### **4.9 Socially disadvantaged young people**

Socially disadvantaged young people often suffer more than other youths from behavioural disorders, aggressions and contact/alcohol/drug problems. One way of helping them is to change those factors in their social surroundings that influence their situation in a negative way or that have aggravated the position they started from. These social factors are an autonomous starting point for preventive measures established at the level of social, educational and local government policy and should be treated as an independent topic.

Special competence trainings belong to a preventive approach that wants to improve the personal situation of young people. Well-structured behavioural trainings can help young people control their pessimistic attitude with regard to their past and future. The aim is to use

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<sup>52</sup> King/Wold/Tudor-Smith/Harel 1996, p. 20.

<sup>53</sup> EU Commission 2001.

these training programmes to teach young people social skills (competencies) which they need to improve their social and professional behaviour. These trainings are selectively offered in various areas (e.g. for young people in residential care, see Petermann 2000) and can help young people stabilize their personal situation and cope more successfully with pressure.

#### **4.10 Migration and intercultural networks**

The social integration of migrants is a special social problem in EU countries. Traditional health and prevention services are usually not prepared to deal with migrants, and the use that migrants make of preventive provision and health services is, therefore, below average. Language barriers as well as cultural and financial barriers seem to be part of the problem.<sup>54</sup> These barriers affect young people, as well, and they are a target group particularly at risk and in need of stronger integration support. To prevent that migration leads to social discrimination, it is useful to build intercultural networks as one way of making integrative measures that already exist more effective. There already are institutions for foreign children and adolescents that offer counselling at a local level. Often, these institutions do their work where schools and youth welfare services intersect. Local integration concepts of this kind provide possibilities to reach out more successfully to foreign youths and their families (Wollnik 2000).

The problem areas of health policy mentioned above are only a fraction of the problems that should be dealt with in preventive ways. In this context, violence prevention measures for children and adolescents play a particularly important role, since they belong to the overall concept of health promotion for Europe's young generation.

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<sup>54</sup> The Flemish Institute for Health Promotion (VIG) in Collaboration with the European Network of Health Promotion Agencies (ENHPA): Tackling Social Inequalities in Health. The Role of Health Promotion. Research Report, September 2001, Brussels.

## 5. Methodical Problems

### 5.1 How to identify "Best Practice" projects?

The first workshop defined, discussed and documented criteria for identifying "Best Practice" projects. This workshop resulted in the drawing up of "Project Guidelines" intended to support the search strategies of individual experts looking for suitable "Best Practice" projects/programmes/activities. The Project Guidelines can be characterised as follows:

1. Experts should first identify youth-related health problems and risks in their respective countries. Subsequently, they should ascertain which of these youth-related health problems and risks can be remedied through projects, programmes and activities.
2. Next, experts should investigate the extent to which youth-related health problems and risks are subjectively or objectively perceived in their countries. Does subjective or objective perception match the way these health problems and risks of children and young people are handled in practice?
3. Apart from the above, a behavioural model was discussed that explains the types of behaviour on the part of young people to be expected on an individual level, each of which can represent a specific target group for health promotion and prevention measures.

Points 1 and 2 were discussed during the workshop and it became evident that subjective and objective perceptions of young people's health-related problems and risks differ on a national level. It also became clear that national policies and strategies aimed at reducing and monitoring health problems differ greatly. To some extent this fact can be attributed to a lack of systematic information and differences in cultural interpretations of the problems. Tackling these aspects from a European perspective is an important step. These aspects were therefore included in the national reports. Discussing specific national health trends among children and young people in a European context and presenting successful national projects, programmes and activities was also considered important.

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Regarding point 3, case studies were developed to characterise different types of behaviour among children and young people. The subsequent discussion led to the following models:

1. A young person may feel well, although he/she displays high-risk behaviour and is exposed to adverse influences connected with his/her social environment (e.g. family-related problems, unfavourable socio-economic class).
2. A young person may feel unwell despite displaying health-aware behaviour or being exposed to favourable influences in his/her social environment.
3. A young person may feel unwell and display high-risk behaviour or be exposed to unfavourable influences connected with his/her social environment (e.g. family-related problems, unfavourable socio-economic class).

In schemes involving health-promoting measures, identifying the correct target group and applying appropriate measures play a significant role. In case 1, strengthening the young person and also reducing unfavourable influences in the young person's social environment would be helpful. In case 2, involving the young person actively in direct health-supporting measures may prove expedient. In case 3, a double strategy, involving both of the above approaches, would most certainly be meaningful, since, in this case, there is a danger of cumulative risk-oriented behaviour that is almost impossible to manage with costly health-promoting measures.

The question that must be answered when addressing the health problems is: which preventive strategy should be pursued. Can the problems be reduced by individual health-promoting actions, e.g. by encouraging physical exercise, or is a holistic approach called for. The answer to this question depends on the analysis of the respective health problem or risk and the objectives of health-promoting projects/programmes/activities. The more detailed the target-group definition, the more accurately requirements can be described and potential sub-groups integrated.

The discussion also addressed the question of whether to pursue a generalized "preventive strategy" or an individualized "protective strategy". How should a preventive strategy be designed, should it be in the form of a collective overall strategy, for example, aimed at

empowering children or should it pursue an individualized protective strategy? This also depends, however, on the social problem-solving strategies or social policies of the individual Member States. Finally, the question of the role played by individual activities on a national, regional or local level was discussed. This aspect was included as a question in the empirical survey.

Some questions discussed within the scope of "Best Practice" remained unanswered, since they call for a more in-depth scientific approach. A brief overview, examples from the literature and experiences gained in other projects will be presented elsewhere to this end.

The "Project Guidelines" were approved by all experts, with implementation thereof in their search strategies being left to the experts' discretion, however. The discussions were also brought to a successful end in terms of the instrument used, viz. the project questionnaire.

## **5.2 Evaluation, Effectiveness and Best Practice**

One aim of the empirical survey is to analyse the quality of projects, programmes and activities to determine, among other things, whether an evaluation was done or not. The attempt is made to provide data about quality aspects, so that the quality of projects, programmes and activities can be more accurately classified (see Chapter 5.1 "Best Practice").

First, the importance of evaluations relevant to the implementation of prevention and intervention programmes will have to be clarified. Evaluations depend on the evaluating agency who analyses the quality, the practical implementation and the effectiveness of provision. Thus, Scriven (1967, 1991) considers "evaluation" to be a term that "fixes the value of a thing in whatever way".<sup>55</sup> In that sense, evaluation covers a wide spectrum which, in literature, includes people, products, techniques and methods, projects and programmes etc. Furthermore, one has to keep in mind that "evaluation" can be understood in the sense of a "goal- and purpose-oriented process for the evaluation of an object" and that this process takes place with regard to health-related measures and programmes.<sup>56</sup> However, this does not

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<sup>55</sup> Scriven, M: The methodology of evaluation, in: R.W. Tyler/R.M. Gagne and M.Scriven (Eds.): Perspectives of curriculum evaluation, pp. 39 - 83, 1967 Chicago; Scriven, M: Evaluation thesaurus (4<sup>th</sup> ed.), 1991 Newbury Park.

<sup>56</sup> Mittag, W: Quality control and evaluation, in: M: Jerusalem/H. Weber (Eds.): Psychological Health Promotion, pp. 121-137, Göttingen, 2003, p. 122.

mean that all "evaluation" reports give evidence of the quality of the material. One has to take care that scientific methods and instruments were employed.

Our information and communication network does not do evaluations of its own with regard to projects, programmes and activities, but uses existing information collected via the questionnaire. Consequently, social science methods in the sense of evaluation research are done without. Rather, data on projects, programmes and activities are evaluated which are structured similarly to "best practice"-criteria. Data are used and documented which examine the effectiveness of projects, programmes and activities.

In the empirical survey, this topic was considered where types of evaluation were at issue, e.g. internal or external evaluation. This distinction is useful, both types of evaluation being done in practice. An "internal" self-evaluation has the purpose of contributing to the optimization of a project, programme or activity, identifying errors and organizing beneficial processes and conditions.<sup>57</sup> An "external" evaluation is preferred for advanced projects, programmes and activities as well as for those that might be continued. The aim of an "external" evaluation is to process questions about the effectiveness and usefulness of projects, programmes and activities.<sup>58</sup> It is the operators of a project, programme or activity who benefit most from the results of an evaluation because of the legitimacy they get vis-a-vis the public and the bodies responsible for an activity, e.g. financial backers, authorities, target groups and interested project providers.

Another function, that of decision-making, is facilitated. Evaluation results can help decide whether a project should be expanded and what ranking it receives. However, evaluating the effectiveness of a programme is not the same as an "outcome evaluation", i.e. the evaluation of success or results.

Another aspect is the time axis along which projects, programmes and activities can be evaluated. Internal evaluations might be done at the beginning of a development or test phase or during the fine-tuning phase of implementation. On the other hand, external evaluations

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<sup>57</sup> *Ib.*, p. 126

<sup>58</sup> *Ib.*, p. 127

might rather be done at the end of a programme.<sup>59</sup> It would be meaningful for evaluations to examine the course a programme takes, i.e. from development through to possible effects. For that purpose, more research on time lapse analysis similar to longitudinal investigations is required as well as the development of respective indicators.

The issue of evaluation allows instructive insights into the quality criteria of projects, programmes and activities. Moreover, information about reports and publications gives further insights into health-promoting measures.

Project-related publications in specialist journals in EU member states, discussed during the second workshop as being a quality criterion, showed that in smaller member states the appropriate infrastructure often did not exist. Therefore, publications proved to be an unsuitable quality criterion.

Various "best practice" concepts<sup>60</sup> have been noted, but the approach chosen in the empirical survey differs from them all. The questionnaire used contains questions about evaluation which focus on information about already existing projects, programmes and activities, i.e. data are gathered later about quality criteria which have already been developed.

In conclusion, we can say that it would be an advantage to do project evaluations over greater periods of time to prove their effectiveness, e.g. in the case of smoking prevention among students. Previously, one could assume that long-term evaluations did not take place for financial reasons. A solution would be to do school surveys in places where a health-promoting measure already occurred, thus being able to examine its long-term effects on smoking behaviour. Long-term effects of health promotion measures could be proved on the same occasion.

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<sup>59</sup> *Ib.*, p. 128

<sup>60</sup> The Megapoles project uses the criteria effectiveness (the extent to which aims and objectives are met), appropriateness (relevance to need), acceptability (to the people concerned and society at large), efficiency (ratio of costs to benefits) and equity (equal provision for equal needs). Cf. Megapoles 2003, p.36

## **6. Survey methods**

### **6.1 Search strategies**

To take stock of health-related prevention projects for young people in the EU, the project coordinator, project staff and network partners set themselves the following goals to be reached between October 2002 and June 2003:

1. To conduct a computer-assisted database search (Medline, international and national databases) for periodicals up to June 2003; Scanning of relevant abstracts and systematic reading of original reports and review articles;
2. To conduct an Internet search for relevant health prevention institutions as well as specific literature on prevention projects;
3. To make use of research contacts for obtaining relevant grey literature from selected international and national research centres;
4. To conduct expert discussions with a large variety of expert groups and institutions involved in the survey;
5. To take part in relevant European conferences and workshops  
(The project coordinator has contacted various European networks such as the European Network of Health Promoting Schools (ENHPS), Health Behaviour in School-Aged Children (HBSC) belonging to WHO, Mental Health Europe and Megapoles. For instance, a cooperation was agreed with Sue Atkinson, head of the EU network Megapoles, to exchange experiences, and survey staff participated in two Megapoles workshops.<sup>61</sup>)

### **6.2 Organizing a network of international experts**

Immediately after the project began, a network of international experts was initiated. It turned out to be a long-term task, because national experts in the field of health promotion and

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<sup>61</sup> Megapoles is a network of 15 European capitals founded in 1997. Its aim is to improve health and reduce social inequality by exchanging information, making comparisons and cooperating among European capitals.

disease prevention had to be identified first, and then contacts had to be established, which in some cases was a difficult process. The reason for that may have been that funds available to the project coordinator at the German Youth Institute for paying fees were rather limited.

A first European network meeting took place on March 15/16, 2003, in Munich (Bernried) with national experts from Belgium, Denmark, Finland, France, Italy, Ireland, Luxemburg, the Netherlands, Austria, Sweden and Spain. National experts from Portugal and Greece had withdrawn at short notice, and the United Kingdom could not participate on a short term basis, although contacts had been made.

The most important result of the first European network meeting in Munich (Bernried) was that the national experts who participated were very supportive of the project. The suggested procedures for the project were accepted. A matrix with selected topics about health promotion, binding for each country, was determined (**see matrix of topics, Appendix No. 1**).

The empirical survey agreed upon with the EU network was a survey of youth-related projects, programmes and activities based on semi-standardized interviews. A questionnaire with 28 questions was developed and used (**see questionnaire, Appendix No. 3**). This questionnaire was prepared by the project coordination team and revised at the first workshop jointly with the experts. Questions were adapted to specific conditions in individual EU Member States. The questionnaire was translated by the experts into their respective native languages. The pre-test was executed with small random samples. The volume of sampling was not to exceed three to five selected topics per country (**see project guidelines in Appendix No. 2**). Where necessary, the survey could be combined with other methods. The assumption was that the questionnaire alone would not provide sufficient information. Therefore, it was suggested that other written material on the projects should be included. It was also useful to look for contacts who might be available for telephone interviews on special aspects of provision.

### 6.2.1 The empirical study

Interviews were begun in March 2003 after the workshop in Munich (Bernried). All experts received the questionnaire and translated it into their native languages. During the empirical field work, they used the project guidelines along with other search strategies to find suitable interview partners. The empirical field work ended in August 2003. After that, national reports were provided by the experts within two months, no later than the end of October 2003 (see 6.2.7 National Reports and Appendix No. 4).

### 6.2.2 Contents of the questionnaire

The questionnaire<sup>62</sup> asked questions about the topic of a programme, project or activity, its kind of funding, the data it was based on, activity providers, target group, project goals and activity fields, the qualifications of project staff, the network, the social setting, internal or external evaluation, publications and more. The following information was taken into account:

- *Project providers*

What type of funding is available? What financial sources are being used to support the project? Which regional levels contribute to project promotion?

- *Activity organizers*

What professional groups implement the activities? Are volunteers etc. involved?

- *Data or information base*

What kind of database does each project build up on? Is goal-oriented planning intended? What data sources are used for that purpose?

- *Goals and activity fields*

What selection criteria, goals, activity fields and methods are the projects or methods related to?

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<sup>62</sup> The questionnaire was adapted from a survey done by Siegrist, J. Joksimovic, L.: Tackling Inequalities in Health - a project of the "European Network of Health Promoting Agencies" (ENHPA) for promoting health among the socially disadvantaged. Düsseldorf. No year mentioned. (Cf. BZgA 1999). It was reworked and adapted during the first workshop.

- *Level and networking*

At what level (national, regional, local) is the project or measure established? What networks are being set up?

- *Social setting*

Do projects follow the setting approach? What settings are there?

- *Evaluation*

Is an evaluation of the project, programme or activity being done? How is the effectiveness of the project, programme or activity going to be proved? Is there an external evaluation?

- *Public relations, publications*

What ongoing project documentation is being carried out? What publications are available?

### **6.2.3 Sample of projects, programmes and activities**

The sample consists of institutions that implement projects, programmes and activities to promote the health of young people. These can be local facilities, schools, educational institutions, health promotional institutes and organizations, youth centres and social work provision, psychological counselling services, local social networks, sports clubs, government or private health insurance companies, medical counselling centres, medical aid, specialist societies and self-help groups. What institutions are selected depends on the search strategy of the experts in respective EU member states (see data matrix, Appendix Nr.3). Some of the institutions mentioned above were picked and written to and asked to provide information about their projects. It was not always easy to find such projects, because a successful search also depends on how well the projects make themselves known to the public.

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#### **6.2.4 Targets of the empirical study**

The survey targets were projects, programmes and activities in the area of health promotion for children and adolescents implemented at a national, regional or local level. The target group of provision was to consist of young people aged 6 to 25.

#### **6.2.5 Data evaluation**

The respondents were controlled, i.e. all questionnaires were checked and errors corrected. For instance, it was necessary to write again to "non-response" organizations. As far as possible, project data were fed into electronic storage media and processed according to standardized and non-standardized categories. Additional information gained through written material was included in the project presentation. Data were evaluated by respective project partners, described and interpreted, and recorded in a brief English-language country report. English-language project descriptions were handed over to the coordinator for statistical purposes. Survey results were presented and discussed in a second workshop in Munich (Freising) in December 2003. Country reports were integrated in the overall report. They are shown in the attachments (**country reports, see below and in Appendix Nr. 4**). The aim is to publish the survey results in specialist literature after the second workshop.

#### **6.2.6 Country Reports**

The experts prepared country reports based on the survey done. Important results of national surveys were recorded. Reports are structured according to the following sections:

- Introduction
- The health of young people in relation to the health situation in the EU
- Selection of projects, programmes and activities
- Data survey
- Description of selected projects, programmes and activities

(Project profile: description, duration, activity organizers, target group, social setting, project goal, methods, evaluation results, publications, contacts)

- Conclusions
- Consequences and proposals for health policy
- List of literature

This pattern was implemented in country reports as far as possible. However, the length of reports depended on the number of projects, programmes and activities documented. Country reports from Belgium, Denmark, Germany, Finland, France, Ireland, Luxemburg, the Netherlands, Austria, Sweden, Spain and the United Kingdom are available.

Networking was a success, as EU member states participated with great interest and did a lot of extra work. There are many national results in the country reports that could not be fully considered in the final report. Therefore, the country reports in the attachments are referred to at this point. They give a more thorough description, from a national perspective, of the situation that youth related health promotion is in and present a detailed selection of projects in the sense of Best Practice (see **appendix country reports No. 4**).

#### **6.2.7 Presentation of results at the second workshop**

At the second workshop in Freising (Munich) the initial results of the empirical study were presented. The project co-ordinator presented an initial data analysis of the projects surveyed in the EU. In preparation for the workshop, the experts sent their edited project data to the project co-ordinator. A compendium was compiled by the project co-ordinator for the documentation of the projects which included detailed descriptions of the 113 projects surveyed up until then in English. In addition, six experts reported on selected projects during a “project-market of possibilities” and discussed these projects in an European context. These projects were also discussed in terms of their transferability. In further sessions network strategies, political recommendations, EU network options, dissemination strategies as well as the final report outline were discussed.

## 7. An overview of the results of the data survey in EU Member States

### 7.1 Data survey of programmes involved

The following account gives an overview of 121 health promotion programmes for children and adolescents in EU Member States. These include projects/programmes/activities investigated by our network partners in their own countries. The data survey carried out for this purpose began in March 2003 and ended in December 2003.<sup>63</sup> The following account shows a selection from the total number of documented results. Descriptive data are presented with regard to structure, quality, social networks and fields of activity.

**Table 1: Offering distribution**

No.	Country	Country report	Offerings
1	<b>Germany</b>	Yes	24
2	<b>France</b>	Yes	13
3	<b>United Kingdom</b>	Yes	12
4	<b>Ireland</b>	Yes	11
5	<b>Finland</b>	Yes	11
7	<b>Spain</b>	Yes	10
6	<b>Belgium (Flanders)</b>	Yes	9
8	<b>Denmark</b>	Yes	6
9	<b>Luxembourg</b>	Yes	5
10	<b>Austria</b>	Yes	5
11	<b>Sweden</b>	Yes	5
12	<b>Italy<sup>1)</sup></b>	-	3
13	<b>The Netherlands</b>	In preparation	-
14	<b>Greece</b>	In preparation	-
15	<b>Portugal</b>	In preparation	-
	<b>Total</b>		<b>114</b>

\* country report is not available instead of this please refer to the compendium.

<sup>63</sup> In some exceptional cases, the project coordinators accepted data up to March 2004.

In cooperation with experts from the various countries, it was decided that each EU member state would work on about 3-5 special topics. The topics were chosen by individual experts and put together by the project coordinator in an overall European sample survey (n = 121).

A programme may sum up a large number of schools, such as Health Promoting Schools which involves some hundred schools. However, a programme can also consist of a very small project, for example a small counselling centre with few people. This point will be discussed later in regards to the target groups. First, the implementation of the empirical survey was planned and implemented. The realisation of the country specific samples were thereby dependent on the following factors:

1. The search strategy applied in individual EU Member States,
2. The structure of existing programmes in each country,
3. The different information systems used.

Therefore the survey follows a specific search strategy which differs from country to country. In the composition of the entire survey sample, an overview of possible projects, programmes and activities arises which contains various building blocks. These building blocks can be combined by experts in each country to create future projects, programmes and activities.

## **7.2 Programme funding**

Sources of programme funding mentioned below give insight into the different procedures that governments in EU Member States use to allocate budgetary funds.<sup>63</sup> The data collected do not evaluate quantitative amounts, but distinguish between individual ways of funding. Clearly, there are only a few programmes funded from a single source. As a rule, funding depends on local, regional and national procedures for allocating budgetary funds. A programme is rarely funded from one source only. Most of the programmes are based on a mix of local, regional and national funding procedures (see Table 2).

Government funds are most frequently allocated at the regional level (n = 60). Funding at the national level follows in second place (n = 45). Funds from higher public institutions that belong neither to the local nor the national level take third place (n = 36). It is only in the fourth position that funding through local budgets can be found (n = 35). Other financial

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<sup>63</sup> Further quantitative information about the finances in each category would only have been possible in a more extensive survey which was not taken into consideration in the project plans.

sources - such as non-governmental organizations (n = 23) and private institutions (n = 13) follow in fifth and sixth place. "Other organizations" include private sponsoring, health

**Table 2: Offering funding\***

	Total	G	B	FIN	F	IRL	I	L	A	UK	DK	SW	SP
<b>Regional government level</b>	60	17	6	3	10	8	3	-	4	2	2	-	5
<b>National government level</b>	45	5	1	6	1	5	1	4	3	8	5	5	1
<b>Public institutions</b>	36	9	2	-	2	5	1	1	3	5	1	-	7
<b>Local level</b>	35	6	3	1	9	1	1	3	-	3	3	2	3
<b>Private institutions</b>	13	5	2	-	1	-	-	2	-	2	-	-	1
<b>Volunteer organisations</b>	8	-	2	-	-	1	-	1	2	1	-	-	1
<b>Religious organisations</b>	5	3	-	-	-	-	-	-	-	2	-	-	-
<b>Other organisations</b>	23	16	1	-	1	-	-	-	4	1	1	-	-
<b>Which ones?</b>													
<b>Private sponsors</b>	3	2							1				
<b>Health insurance companies</b>	5	5			1								
<b>Health insurance for students</b>	2								1				
<b>Institutions e.g. IFT, OPUS</b>	4	4								1			
<b>Commercial sponsors</b>	4	3									1		
<b>Foundations e.g. Österreichischer Fond Gesundheit</b>	3	2							1		1		
<b>Membership fees</b>													
<b>Total</b>	226	61	17	10	24	20	6	11	16	24	13	7	18
* Multiple answers possible													

insurance companies, academic institutions, commercial sponsors and money from foundations.

The data table shows clearly that health promotion for young people is hardly possible without government support. Local funding does not seem to be sufficient, as the extensive need for mixed financing through local and national sources exemplifies. However, the kind of promotion that depends on organizational structures of government (centralism vs. federalism) plays a major role. Government funding is more significant than private funding (private institutions, private sponsors, commercial sponsors, foundations). Nevertheless, in some EU Member States private sources of funding show strong commitment. There are examples of private donations for, say, drug prevention programmes in the area of "health promoting schools". This reflects the willingness of citizens to take their share of responsibility for young people's wellbeing. Voluntary organizations (n = 8) and Christian churches (n = 5), on the other hand, are in our sample survey not so important for the funding of programmes.

### 7.3 Status of completion

The data of Table 3 show that about three quarters of the programmes (n = 69) were still in

**Table 3: Offerings' status of completion\***

	<b>Total</b>	<b>G</b>	<b>B</b>	<b>FIN</b>	<b>F</b>	<b>IRL</b>	<b>I</b>	<b>L</b>	<b>A</b>	<b>UK</b>	<b>DK</b>	<b>SP</b>
<b>Ongoing</b>	69	19	4	9	8	12	3	5	3	6	5	6
<b>Completed</b>	17	3	2	1	4	-	-	-	2	5	1	1
<b>Planned</b>	2	-	-	-	1	-	-	-	-	-	-	1
<b>Interrupted</b>	-	-	-	-	-	-	-	-	-	-	-	-
<b>Without interruption</b>	44	11	5	4	6	9	2	4	1	2	-	5
<b>Total</b>	130	33	11	14	19	21	5	9	6	13	6	13
* multiple answers possible.												

progress at the time of the survey. More than a third of the programmes (n = 44) are running for an indefinite period. This indicates that measures are kept up over longer stretches of time, which has positive effects on the continuity of health promotion. Only a few programmes have already been completed (n = 17). This overview shows clearly that the permanence of

youth-related health promotion is becoming increasingly important in many EU Member States.

#### **7.4 Data sources**

In order to carry out a promotion programme, it is important to define the main target group, since, to the extent that measures are developed, there should be certainty about actually having identified and reached the selected target group. The programmes that were examined use quite different data sources to provide an information base for adequately analysing the situation and defining goals. This initial work is crucial to the effectiveness of measures taken: a data analysis of the target group can help define and quantify the need for intervention and provide evidence of a measure's effectiveness. (When, for example, students, male and female, begin smoking ever more early in their lives, it would be helpful to know the variables that cause such behaviour. They might be found, for instance, in the atmosphere of a school or classroom or in problems within the family. Without taking stock of a student's situation, it is difficult to report reliably on the effectiveness of particular intervention measures.)

**Table 4: Data sources** <sup>1) 2)</sup>

	<b>Total</b>	<b>B</b>	<b>FIN</b>	<b>F</b>	<b>D</b>	<b>IRL</b>	<b>I</b>	<b>L</b>	<b>A</b>	<b>UK</b>	<b>DK</b>	<b>E</b>
<b>Subjective survey data</b>	55	6	4	10	9	8	1	5	3	6	2	3
<b>Data concerning the health situation</b>	52	5	6	3	10	9	2	5	3	6	-	3
<b>Representative survey data</b>	49	5	8	1	8	7	3	2	1	6	1	5
<b>Expert interviews</b>	41	5	5	3	9	5	-	4	3	4	5	3
<b>Official data</b>	40	5	3	3	7	4	1	2	2	8	-	5
<b>Regional data</b>	36	1	3	4	8	6	2	2	-	6	-	4
<b>Analysis of media reports</b>	26	5	3	-	7	3	-	1	1	1	-	2
<b>Data concerning the health care situation</b>	17	2	2	-	4	2	-	-	-	2	-	3
<b>Individual biomedical data</b>	15	1	1	1	3	3	-	-	-	4	-	2
<b>Others:</b>	14	-	-	-	7	-	1	-	3	1	-	2
<b>Aggregate data</b>	1											
<b>Observational data</b>	1				1							
<b>Institute</b>	2						1		1			
<b>Scientific literature</b>	7				1							1
<b>Technical data</b>	2				5				1			
<b>Schools</b>	1								1	1		1

<sup>1)</sup> Multiple answers possible <sup>2)</sup> Sweden is missing because the raw data are not available.

Evaluating the data and information base for programmes, Table 4 shows that subjective survey data concerning young people (n = 55) are most frequently used. Data on the (objectively measured) health situation of young people come second. Data on young people gleaned from representative surveys (n = 49) take third place. Expert interviews (n = 41) also rank high, as do official data (n = 40), regional data (n = 36) and the analysis of media reports (n = 26). Some programmes obviously had problems getting any data at all about specific target groups. (In one case, project management had to do a survey of their own, since young people admitted to hospital with alcohol poisoning were an entirely new phenomenon.)

The demand for relevant data about young people emphasizes the importance of data information systems where health support programmes are to be implemented. For this kind of work to be successful, suitable systems keeping topical data about the situation of young people available must be maintained. Without doubt, a regional structuring of data (e.g. according to school districts, school entry examinations, school surveys) is very useful here.

### 7.5 Employees grouped according to professions

It is useful to distinguish between project employees according to professional groups.

Table 5 shows that, on average, 2.4 employees are involved in the programmes. Many highly

**Table 5: Employees grouped according to professions\***

	<b>G</b>	<b>B</b>	<b>FIN</b>	<b>F</b>	<b>IRL</b>	<b>I</b>	<b>L</b>	<b>A</b>	<b>UK</b>	<b>SP</b>	<b>Total</b>
<b>Profession</b>											
<b>Physicians</b>	8	4	3	2	2	1	1	-	4	4	29
<b>Social workers</b>	16	6	2	6	1	1	2	1	-	5	40
<b>Child care workers</b>	4	3	2	-	-	-	-	2	-	1	12
<b>Teachers</b>	12	5	4	2	6	3	2	1	6	4	45
<b>Psychologists</b>	9	3	1	2	1	3	2	3	5	3	32
<b>Sociologists</b>	1	1	2	-	-	1	1	2	4	1	13
<b>Church employees</b>	-	-	1	-	1	-	-	-	1	-	3
<b>Nurses</b>	1	2	3	1	-	-	-	-	1	1	9
<b>Volunteers</b>	6	3	-	5	1	-	2	3	3	3	26
<b>Other professional groups*</b>	15	8	9	9	11	3	5	5	11	3	79
*Multipliers were not taken into consideration											288

qualified professions requiring a university degree are represented. The most frequently represented qualified professions include teachers, social workers, psychologists and physicians. Among physicians and nurses, health promotion is part of professional training, whereas in some professions, such as teacher and social worker, this is not very likely. "Volunteers" and "other professional groups" come as a surprise, making up a third of all employees. Under the heading of "other professional groups", we can find special health-related jobs such as health educator, health economist, coordinator, administrator, health promoter and safety representative. Other jobs come from the field of sports (sports instructor,

sports scientist, sports therapist) as well as nutritional science. All these groups do highly professional jobs.

## **7.6 Networking and cooperation**

Health promotion and prevention programmes whose conception is tailored to the needs of children and adolescents have been run in certain settings, such as schools and doctor's practices, for a long time. Their disadvantage is that they serve as a kind of catchment area for certain target groups such as students, patients etc.<sup>64</sup> When the concept of "settings" was introduced as a new principle of organizational development, new forces were released for the planning and implementing of health promotion activities. This means that, thanks to additional possibilities of cooperation, programmes can access more resources and know-how that benefit the implementation of project goals.

Settings related to the social environment of children and adolescents and taking a holistic approach to health promotion are especially suitable. Thus, some health promotion organizations, e.g. the "Health Promoting Schools", follow WHO's understanding of the term health and the results of the "Ottawa Charta" (1986). The health promotion and prevention programme of WHO refers to the integrated concept of the "healthy school" including factors that can strengthen and promote students' health. A large number of the school programmes investigated refer to WHO's setting approach, which has to be viewed in a broader sense, as the survey on hand also focuses on day-care-centre programmes, vocational training programmes, leisure time programmes (youth centres, discos, socio-educational provision for young people, child and youth services), health service counselling programmes (e.g. registered doctors, therapists, psychologists, school nurses) at the local level.

Many of the EU-member-state programmes examined approve of WHO's goals entirely. For about two thirds of all programmes (see Table 6), networking is an important objective. The fact that qualified professional groups work in the programmes and cooperate with suitable health promotion institutions indicates high professional standards. The introduction of the

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<sup>64</sup> Barić, L./Conrad, G: Health promotion in settings, Gamburg 1999, p. 14.

**Table 6: Is forming a network a goal of the project?**

	<b>G</b>	<b>B</b>	<b>FIN</b>	<b>F</b>	<b>IRL</b>	<b>I</b>	<b>L</b>	<b>A</b>	<b>UK</b>	<b>SP</b>	<b>Total</b>
<b>Yes</b>	14	8	9	6	12	3	4	4	4	2	66
<b>No</b>	9	2	2	4	-		2	1	8	6	34
<b>Total</b>	23	10	11	10	12	3	2	5	12	8	100

"setting"- concept as a new organizational system was accompanied by certain innovations in the planning process of (youth-related) health promotion projects. Among them were changing the atmosphere at work, determining organizational goals and applying participative management techniques.<sup>65</sup> All in all, the new organizational system has positive effects on contexts in which health promotion and educational programmes are realized.<sup>66</sup> New opportunities that people find in the "settings" affect their roles as actors in a community committed to health promotion in a positive way. Organizational improvements led to changes within the projects and to external cooperation with "networks" and "alliances." "Networks" are similar "settings", such as networks among schools of the same type, and "alliances" are formal relations among "settings" of different kinds (e.g. between a school and a sports club) [see example below].<sup>67</sup>

<b>Examples of networks and alliances</b>				
	<b>Alliances</b>	<b>Networks</b>		
	School 1	School 2	School 3	School 4
	Community 1	Community 2	Community 3	Community 4
	Sports club 1	Sports club 2	Sports club 3	Sports club 4
	etc.	etc.	etc.	etc.

Source: Barić, L./Conrad, G.: Gesundheitsförderung in Settings, Gamburg 1999, p. 14.

The examined programmes adopted "alliances" and "networks", as Table 7 shows, and made use of diverse cooperative relations with different institutions. The most frequent among them are schools and educational institutions (n = 76). They are followed by municipal institutions (n = 57), health promotion institutions (n = 49) and youth centres/social work (n = 43). Sports clubs (n = 28) and local social networks (n = 30) take fifth place. The increasing number of

<sup>65</sup> Ib., p. 15.

<sup>66</sup> Barić, L.: Health Promotion and Health Education in practice - The organizational model, module 2, Hale Barns, Cheshire 1994.

<sup>67</sup> Ib., p.15

local institutions emphasizes the role of local authorities in youth-related health promotion. Cooperative relations show clearly how beneficial it is for health promotion programmes to work together with important services run by local authorities. In concrete cases, this means

**Table 7: Cooperative relationships with institutions\***

	<b>G</b>	<b>B</b>	<b>FIN</b>	<b>F</b>	<b>IRL</b>	<b>I</b>	<b>L</b>	<b>A</b>	<b>UK</b>	<b>SP</b>	<b>Total</b>
<b>Municipal institutions</b>	13	4	6	8	3	2	5	3	5	8	57
<b>Schools, educational institutions</b>	13	9	9	6	10	3	5	4	11	6	76
<b>Businesses</b>	4	5	2	2	1	-	1	2	2	2	21
<b>Health insurance companies</b>	3	1	1	-	-	-	-	1	1	-	7
<b>Sport clubs</b>	9	2	2	1	3		4	3	-	4	28
<b>Health promotion institutions</b>	13	3	4	6	10	1	1	3	7	1	49
<b>Professional societies</b>	6	2	4	-	5	1	1	-	2	1	22
<b>Neighbourhood watches/support services</b>	1	2	1	4	1	-	1	-	1	-	11
<b>City district assistance**</b>	3	-	-	-	1	-	1	-	-	-	5
<b>Environmental organisations</b>	-	-	1	-	3	-	1	-	1	-	6
<b>Local social networks</b>	8	2	4	2	8	1	3	-	2	-	30
<b>Youth centres, Social work</b>	12	6	6	6	5	-	3	-	2	3	43
<b>Centres of psychological care</b>	8	2	2	3	4	1	1	2	-	2	25
<b>Medical practices</b>	6	3	1	3	3	-	1	1	2	3	23
<b>Medical care facilities</b>	6	3	2	2	4	-	1	-	2	-	20
<b>Others</b>	6	5	2	6	5	3	2	3	3	1	36

\* Multiple answers possible \*\*Data was not collected in every country.

that, for instance, schools cooperate with sports clubs to offer students new sports activity programmes. Sometimes, when such programmes are implemented (e.g. in Denmark), several partners work together (sports associations, universities, schools) and are funded by the partners as well as ministries. The goal is to create the best environment possible for implementing sports promotion measures at all levels. (The concrete project, established in day care centres for children and young people, aims to enhance children's self-awareness and self-confidence and, consequently, to strengthen their competencies in sports and exercise.)

## 7.7 Programmes in different setting categories

What is meant by a setting is a small system, well-definable in terms of social space, that makes visible the various influences of the social environment which a particular group of people is exposed to. In a setting of this kind, conditions are discussed that cause illnesses or health and can actively be changed. Day care centres for children and young people are considered to be settings, as are schools, universities, local authorities, leisure centres, health services, training and vocational training facilities and counselling services. In order to classify the examined programmes more accurately, they were grouped in seven setting categories (see Table 8).

**Table 8: Offerings grouped according to settings (in a narrower sense)**

Setting	Total	G	DK	B	FIN	F	IRL	I	L	A	SP	SW	UK
<b>1. Child care centres</b>	3	2	-	-	-	-	-	-	1	-	-	-	-
<b>2. School</b>	59	11	3	1	11	1	10	2	1	2	1	4	12
<b>3. University</b>	3	-	-	-	-	1	1	1	-	-	-	-	-
<b>4. Training/ Vocational training</b>	2	1	-	-	-	-	-	-	1	-	-	-	-
<b>5. Leisure centres (Youth centres, dance clubs, social work)</b>	18	2	1	5	-	3	-	-	1	3	3	-	-
<b>6. Health services- counselling (e.g. physicians, psychologists, therapists, school nurses)</b>	5	3	-	1	-	1	-	-	-	-	-	-	-
<b>7. Local authorities</b>	24	5	2	2	-	7	-	-	1	-	6	1	-
<b>Total</b>	114	24	6	9	11	13	11	3	5	5	10	5	12

Table 8 identifies provision for each setting only once to facilitate a basic count. (The significance of activity fields that a programme might be involved in is shown in Table 9.)

The largest setting category is school (n = 59). It is followed by local authorities (n = 24) and leisure centres (n = 18) simultaneously. Health services (counselling) (n = 5), day care centres for children (n = 3) and young people, universities (n = 3) and training/vocational training (n = 2) come after that.

The fact that schools are clearly over-represented is due to the extent that WHO's "Health Promoting School"-approach has been consolidated. The attempt was made to record every programme only once, but then definition problems came into play (some programmes report

two or more settings). For reasons of accuracy, additional information given by the programmes was used.

A glance at Table 8 reveals that half of some countries' programmes come from the school setting and the other half from other settings (e.g. Germany, Denmark, Belgium, Luxemburg, Austria and Spain). In some countries (e.g. Finland, Ireland, Italy, Sweden and the United Kingdom), nearly all programmes consist of "Health Promoting School"-projects. The local level (including leisure time provision) shows clearly how important a concrete location is for working with young people in health promotion (n = 30). Naturally, the social environment of children and adolescents unfolds here, and consequently, local actors are closer to the grass-roots and can deal with problems more adequately.

### **7.8 Activity fields in the school setting**

According to Table 9, programmes in the school setting show the following activity fields: the "healthy school", smoking and drug prevention, stress prevention, nutritional counselling and many more. In many programmes, there is a common approach to smoking and drug prevention, and they are combined in one activity field (just like stress prevention and general social competencies). As a rule, programmes take place in additional teaching units during regular school hours, e.g. counselling with the help of facilitators, provision of drama education and outdoor pursuits. The activity field "healthy school" takes a holistic approach to various health objectives: e.g. improving the school atmosphere. The lifeskill approach is also a holistic offering (see Box 1) integrating a large number of programmes. In contrast to didactic teaching, the lifeskill approach uses specific psychological programmes to strengthen students' self-esteem and social competencies. Perseverance and lifeskill trainings are among these psychosocial strategies that are used frequently in the school curricula of several countries examined.

**Table 9: Offering activity fields\* in the school setting**

	<b>Total</b>	<b>B</b>	<b>FIN</b>	<b>F</b>	<b>G</b>	<b>IRL</b>	<b>I</b>	<b>L</b>	<b>A</b>	<b>UK</b>	<b>DK</b>	<b>SW</b>	<b>SP</b>
<b>Healthy child care centres/schools and surroundings</b>	17	-	5	-	2	2	1	1	-	3	1	2	-
<b>Promotion of body perception, emotional health</b>	5	-	-	-	2	2	-	1	-	-	-	-	-
<b>Alcohol prevention</b>	15	-	2	2	5	3	-	-	-	-	-	3	-
<b>Drug prevention</b>	13	-	1	-	5	3	1	-	1	-	-	2	-
<b>Sex education offerings</b>	7	-	-	-	-	1	-	-	1	4	-	-	1
<b>Smoking prevention</b>	10	-	-	-	5	3	-	-	-	-	1	1	-
<b>Health promoting way of life, therapy with art</b>	14	-	5	1	3	2	-	-	-	-	-	2	1
<b>Nutritional counselling/weight reduction</b>	8	-	-	-	2	1	-	-	-	5	-	-	-
<b>Fortification of self-esteem, life skills and coping strategies</b>	19	-	2	1	8	6	-	-	-	1	1	-	-
<b>Social behaviour promotion, group work, discussions</b>	18	1	4	2	2	3	1	1	1	-	1	-	2
<b>Exercise offerings, acquisition of relaxation techniques</b>	10	-	-	-	1	3	-	1	1	-	1	2	1
<b>Enhancement of media skills</b>	4	-	-	-	1	-	-	-	-	-	-	-	3
<b>Mental health promotion/ bullying prevention</b>	13	1	4	1	-	6	-	-	-	-	-	1	-
<b>Promotion of a sense of responsibility</b>	4	-	1	-	-	2	-	-	-	-	-	1	-
<b>Peer education</b>	1	-	-	-	-	-	-	-	-	1	-	-	-
<b>Accident prevention</b>	2	-	1	-	-	-	-	-	-	1	-	-	-
<b>Violence prevention</b>	2	1	-	-	1	-	-	-	-	-	-	-	-
<b>Prevention of risky behaviour</b>	4	-	1	2	-	-	-	-	-	1	-	-	-
<b>Media campaigns, videos, student magazines</b>	2	-	2	-	-	-	-	-	-	-	-	-	-
<b>Information systems</b>	3	-	3	-	-	-	-	-	-	-	-	-	-
<b>Creation of networks</b>	8	-	3	-	-	3	1	-	-	-	-	1	-
<b>Quality assurance</b>	1	-	1	-	-	-	-	-	-	-	-	-	-
<b>Health services</b>	1	-	1	-	-	-	-	-	-	-	-	-	-
<b>School nurses</b>	1	-	1	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	131	3	37	9	37	41	4	4	4	16	5	15	8
*Multiple answers possible													

**Box 1****Social influence resistance (“Saying No”-programs)**

“Saying No” programs are often used for smoking prevention in schools and other institutions. This kind of training originates in the works of Bandura (1986) on social learning and expectations of social acceptance. One aim of the training is to restrain the influence of friends and young people of the same age who already are smoking. Trainees are expected to learn how to resist the group pressure coming from those quarters (social immunization). Furthermore, misdirected notions about having to smoke in order to be accepted are challenged. That the training is effective has been proved empirically; young people begin to smoke or drink alcohol a few years later. However, the training has practically no effect on those who already smoke when the training starts (Jerusalem 2003, p. 464).

**Life skill training**

This training is adapted to the promotion of general life skill and coping competencies. It is not specifically linked to health or substances, since it wants to improve skills that can be applied to other areas of life. It goes back to the work of Botvin (1998). The approach is factually interested in changing concrete behaviour. Role plays are tried out and group discussions held to develop coping strategies. They are repeatedly practiced and internalized. The training wants to promote individual competencies for coping with stress and conflict, making decisions, communicating, taking responsibility and gaining self-confidence and self-esteem (Jerusalem 2003, p. 464).

See: Bandura, A: Social foundations of thought and action. Englewood Cliffs 1986. Botvin, G.J.: Preventing adolescent drug abuse through life skills training. Theory, methods and effectiveness. In: J. Crane (ed.): Social programs that really work. New York 1998, pp. 225 - 257. Jerusalem, M: Prevention in schools, in: Jerusalem, M./Weber, H. (eds.): Psychological health promotion. Göttingen 2003, pp. 461 – 477.

**7.9 Duration of programmes and size of target groups**

Table 10 is a double-reference table recording programme duration and the size of target groups according to setting categories. We can see that a large number of school programmes involves target groups of more than a hundred students (up to 10,000 students). Some of the programmes have been running for more than five years. In the area of leisure time provision,

some programmes also have long running times with special activity fields including alcohol and drug prevention. Counselling provision in health services is partly geared to smaller target

**Table 10: Number of projects grouped according to duration and size of target group within setting offerings**

**Child care centres (n = 3)**

Years	Size of target group (persons)					
	1-20	21-49	50-99	100-999	1,000-9,999	10,000+
0 – 1						
1 – 2	1*					
2 – 3						
3 – 4				1*		
4 – 5						
Above 5				1*		

\*target group reached \*\*desired target group

**Schools (n = 44\*\*\*)**

Years	Size of target group (persons)					
	1-20	21-49	50-99	100-999	1,000-9,999	10,000+
0 – 1				1*	1*	1**
1 – 2	1*		1*		2*	3*
2 – 3			1*	4*	2*	3*
3 – 4				5*	1*	3*
4 – 5					2*	4*
Above 5					3*	5*, 1**

\*target group reached \*\*desired target group

\*\*\* 15 projects with missing data excluded.

**University (n = 2\*)**

Years	Size of target group (persons)					
	1-20	21-49	50-99	100-999	1,000-9,999	10,000+
0 – 1						
1 – 2						
2 – 3						1**
3 – 4						2*
4 – 5						
Above 5						

**Training/ Vocational training (n = 2)**

	Size of target group (persons)					
Years	1-20	21-49	50-99	100-999	1,000-9,999	10,000+
0 – 1						
1 – 2						
2 – 3						
3 – 4						
4 – 5					1*	
Above 5				1*		

**Leisure (Youth centres, dance clubs, social work, Internet)  
(n = 18)**

	Size of target group (persons)					
Years	1-20	21-49	50-99	100-999	1,000-9,999	10,000+
0 – 1						1**
1 – 2				2*	1*	1*, 1**
2 – 3					1*	
3 – 4						1*, 1**
4 – 5				1*		1*
Above 5					2*	2*, 3**

**Health services - counselling (e.g. Doctors, therapists, psychologists, school nurses) (n = 5)**

	Size of target group (persons)					
Years	1-20	21-49	50-99	100-999	1,000-9,999	10,000+
0 – 1						
1 – 2				1*	1*	
2 – 3						
3 – 4						
4 – 5				1*		
Above 5			1*			1*

**Local authorities (n = 11\*)**

Years	Size of target group (persons)					
	1-20	21-49	50-99	100-999	1,000-9,999	10,000+
0 – 1				1*		
1 – 2	1*					
2 – 3				2*		
3 – 4			1*		1*	
4 – 5				1*		
Above 5				2*	2*	1**

\*13 projects with missing data excluded

Size of the target group was not defined in the following projects: Germany (Project 3, 7, 9, 19, 23), Denmark (Project 4), Finland (Project 7, 8), France (Project 1, 8, 9), Italy (Project 3), Ireland (Project 2, 4, 5, 9, 12), Sweden (Project 5).

groups. It includes counselling centres (e.g. for suicide prevention) with very long running times. Most programmes with a running time of two to three years and target groups of 100 to 9,999 young people can be found at the local level. There is a correlation between the duration of programmes and the size of target groups involved: the longer a programme runs, the larger the target group is.

**7.10 Programme evaluation**

Programmes can follow three strategies to prove the effectiveness of their measures: an internal evaluation, an external evaluation or both evaluations at the same time. As Table 11

**Table 11: Evaluation of offerings**

	Total	B	FIN	F	D	IRL	I	L	A	UK	DK	SE	E
<b>Evaluation*</b>	97	7	8	11	21	11	3	3	5	9	7	5	7
Internal*	81	7	4	7	14	9	2	4	5	7	5	2	5
External*	43	4	3	4	11	4	1	-	4	7	2	3 <sup>1</sup>	2
*Multiple answers possible													

shows, more than two thirds of programmes (n = 81) produce an internal evaluation which consists of certain procedures that verify the effectiveness of measures. The number of

external evaluations is only half as big (n = 43). As a rule, external evaluations are done by an expert or an institute, which usually involves relatively high costs. In some cases, programmes are subject to both an internal and an external evaluation.

Presumably, the number of evaluations for the selected programmes will still increase, because many programmes are not evaluated until they have come to an end.

An important aspect is to prove the effectiveness of health promotion offerings. Where schools are concerned, programmes are often subject to an evaluation. Some of the existing programmes in Germany and Finland demonstrate primary preventive effects. Proof is related to short-term effects, because the long-term effectiveness of youth-related health promotion measures has not been sufficiently examined yet. There is a demand for standardized instruments to record success criteria, so that the results of diverse projects can be compared.<sup>68</sup>

## **8. Settings and Important Subjects**

### **8.1 School Setting**

It is never too early to commence preventive measures addressing children and young people. Besides the home, school is the most important setting for preventive and health-promoting measures. Schools designed as health-promoting institutions offer manifold intervention opportunities within their social systems. At school

- access to an important target group covering various age groups is relatively simple;
- children and young people can acquire health-related knowledge and implement this knowledge in their behaviour;
- the psychological and social development of children and young people can be influenced in the long term;
- children and young people acquire social behaviour and a social value system which enable them to respond to rapid changes in life with the help of social skills and a broad knowledge base.

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<sup>68</sup> Jerusalem, M: Prevention in schools, in: Jerusalem, M., Weber, H: (publishers): Psychological health promotion, Göttingen, 2003, p. 469

Knowledge acquisition and school performance also depend on the creation of health-promoting structures for pupils to prevent health-related risk behaviour. If pupils' well-being is poor and if they tend towards increased health-related risk behaviour, their learning ability is reduced and their success at school more endangered. Health-promotion measures in line with the Ottawa Charter (1986) can counter trends towards health-related risk behaviour among pupils, as a positive approach to health is taught at a very young age at school, thus delaying or preventing deleterious health-risk-related lifestyles.

Preventive and health-promoting offerings in the school setting furnish immensely varied and creative project ideas, fields of action and techniques which can be used in different ways. They include, but are not limited to:

- strengthening of individual competencies (self-esteem, life skills, coping strategies),
- holistic approaches (healthy school and healthy environment),
- alcohol prevention,
- drug prevention,
- promoting of a healthy lifestyle, art therapy,
- promoting mental health,
- prevention of bullying,
- prevention of smoking,
- promoting social behaviour/team work/ discussions,
- physical exercise (sports, exercise, games, learning relaxation techniques (cf. Table 8.7)).

The health-promotion offers surveyed show two different lines of approach that have proved significant, viz. *resistance-* and *life-skills training* programmes.<sup>69</sup>

*Resistance-skills training* has proved its worth in smoking prevention as demonstrated by the EU-wide project "Be smart – Don't start" (Germany, Project 8) and "Class 2000" (Germany, Project 1). In "Class 2000", pupils at elementary schools familiarize themselves with breathing techniques, body awareness and relaxation exercises as early as in 1<sup>st</sup> grade. In 2<sup>nd</sup> grade, pupils acquire knowledge about a healthy diet, environmentally-aware conduct and physical exercise. In grades 3 and 4, social behaviour and social skills are taught. This promotes self-awareness and strengthens self-esteem, thus assisting personality development.

Subsequently, "resistance" is trained, the aim being to enable pupils to recognize the deleterious effects on health caused by smoking and alcohol consumption, assess advertising messages more critically, learn how to handle tobacco and alcohol in a responsible manner and reject concrete offers. At the same time, pupils also learn how to resist peer-group pressure.

The "OPUS" network pursues similar goals to those of "Class 2000", but "OPUS" (Germany, Project 14) also specifically addresses schools wishing to participate in a health-promoting network. Lesson and workplace design as well as services addressing teachers are therefore integrated in health promotion. To establish a health-promoting network, appropriate measures, such as noise reduction, improved lighting conditions, ergonomic, ecological and aesthetic room and workplace design, and school-yard improvements are initiated at schools. Teachers' health should also be promoted by offering measures addressing stress and time management, teamwork among the teaching staff and supervision.

*Life skills training* ("life-skills" approach) imparts general life and coping skills and uses a scheme that is neither substance- nor health-specific. The scheme does not focus on a single aspect, such as drug prevention, but attempts to strengthen comprehensive psychological aspects. One characteristic example of the life-skills approach is the "ALF – Allgemeine Lebenskompetenzen und Fertigkeiten" (General life skills and proficiencies) project (Germany, Project 12) outlined below.

For "ALF" the best protection against substance abuse (tobacco, alcohol, illegal drugs) is early strengthening of the personality. The "life-skills approach" pursued by teachers is most suitable for pupils in grades 5 and 6. The approach is implemented through interactive teaching techniques such as role play, teamwork with a partner or in small groups, group discussions, relaxation exercises, feedback rounds etc. Teacher-centred teaching is mostly waived to increase active participation by pupils. The teaching units of the life-skills approach in grade 5 and, to some extent, also in grade 6, involve information about addictive substances and techniques to improve self-awareness and communication skills. Learning how to resist group pressure, express one's feelings, resist messages in media and advertising, make decisions, solve problems, work on improving the way one sees oneself and become self-assured is considered important.

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<sup>69</sup> Jerusalem: Prävention in Schulen, in: Jerusalem, M., Weber, H. (eds.): Psychologische Gesundheitsförderung.

The "ALF" project imparts knowledge to pupils in all types of school and is well accepted by them. In classes characterized by a poor class climate and lack of trust between teachers and pupils, however, implementation of ALF has proved very difficult.

The "ALF" life-skills training approach is rated relatively effective in the battle against tobacco and alcohol: in the classes included in the "ALF" project, the share of smokers dropped from 8.5% to 4.5% after the 5<sup>th</sup> grade, while in control classes this share doubled from 5.5% to 11.4 %. After grade 6, the share of pupils who already experienced intoxication was significantly lower in "ALF" classes than in the control classes.

In Finland, a different health-promoting-school scheme is implemented. There, the government has introduced a "Health Curriculum in Finnish Schools" project (Finland, Project 1), an independent and voluntary measure that promotes health in comprehensive and secondary schools. Parallel to the project, investments are made to further teacher training at universities. The objectives of the new curriculum are to

- teach pupils the physical, mental and social significance of health;
- induce pupils to assume responsibility for their own health and the health of others;
- help pupils gain an understanding of the impact of their own actions on community health;
- enhance pupils' knowledge and competencies with respect to the topics of health and illness.

Finland has developed a unique health-promotion tool, the "School Health Promotion Survey" (Finland, Project 3), which allows targeted investigation of pupils' health in small regions. This tool is intended to make planning and implementation of health-promoting measures on the municipality and school level more effective, thus providing selective access to high-quality data which can be used to assess health trends among pupils and review the effectiveness of interventions.

The "Healthy Kainuu Project: 'Limits are for love'" programme (Finland, Project 4) can be seen as a good example of successful implementation. The aim of this project, executed in a north-eastern region of Finland, is to reduce increased tobacco and alcohol consumption

among pupils. For this project, the "School Health Promotion Survey" first carried out a data survey. The results of this survey led to the decision to establish a regional health-promotion programme at the schools most seriously affected by the above problems. To achieve the above goal, a setting involving schools, health services and municipalities was established; social workers interested in cooperating and teachers from the local municipalities participated in the project. An internal and external evaluation was conducted. The "School Health Promotion Survey" (2003) demonstrated that young people's tobacco and alcohol consumption was clearly reduced in this region between 2001 and 2003. The project was selected for participation in the 2<sup>nd</sup> European Health Promotion Awards 2000.

The described projects and programmes furnish impressive evidence of what has also been demonstrated by various studies over the last few years, viz. that health-promotion programmes at schools can be successful.<sup>70</sup> They are effective when it comes to imparting knowledge about health, promoting life skills and healthy lifestyles among pupils. On the basis of relevant studies, the "International Union for Health Promotion and Education" has developed pertinent criteria to characterize the success of such programmes:

1. The programme aims at achieving changes in behaviour patterns and orientation to social and individual psychological outcomes.
2. The programme gives preference to a social-setting approach that involves networking schools with teachers, parents and persons from other institutions.
3. The programme is designed to run for a number of years and is of relevance for changes in social and individual psychological development.
4. The programme has also discovered teachers as a target group. They are offered follow-up education to strengthen their professional technical knowledge.

Many of the surveyed Health Promoting School projects come very close to the above criteria defined by the "International Union for Health Promotion and Education". The mode of

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<sup>70</sup> International Union for Health Promotion and Education: The Evidence of Health Promotion Effectiveness, 2000, p. 112

operation of these health-promoting programmes requires incorporation of the curriculum, the school's social environment, health services, partnerships and a supportive school policy.<sup>71</sup>

*School-related interventions* play an important role in health promotion.<sup>72</sup> Their effects are perceived in a relatively differentiated manner. Pertinent *school-related interventions* concerning smoking, for example, are likely to change pupils' behaviour. For this reason, integration of school-related intervention in Health Promoting School programmes is recommended. The programme developed within the scope of the European Competition "Be smart – Don't start" (Germany, Project 8) encourages pupils to refrain from smoking for six months. In this programme, school classes compete with each other and successful participants may win attractive cash and other prizes in a draw. In Germany alone, 8402 year 6-8 classes, i.e. 220,000 pupils, have participated in the programme so far. Of the above 8402 classes, 5190 classes, viz. 61.8%, completed the programme successfully. The programme was rated successful and obtained various awards.<sup>73</sup>

One of the prioritised goals is to create a health-promoting environment. Children's healthy development and their social living conditions are accorded as much importance as their own behaviour. To address these aspects, pupils, teachers, parents, health promoters and multipliers for a child-friendly and health-promoting environment are brought together to discuss these aspects.

### **Transferability**

The extent to which the project ideas, fields of action and techniques from the surveyed sample can be transferred to other Member States can be assessed as relatively good, in view of the fact that the following prerequisites are fulfilled:

1. Health Promoting School projects can be found throughout all EU Member States. Ministries, school authorities, schools and teachers have access to relevant programmes.

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<sup>71</sup> op. cit., p. 112

<sup>72</sup> op. cit., p. 74

<sup>73</sup> Institut für Therapie- und Gesundheitsforschung (IFT-Nord) Kiel. Press release [www.besmart.info](http://www.besmart.info). Cf. Hanewinkel, R., Wiborg, G.: Diffusion of the Non-Smoking Campaign « Be Smart – Don't Start » between 1997 and 2003 in Germany, in: *Gesundheitswesen*, 2003, 65, pp. 250-254

Approximately 500 pilot schools are registered members of the European Network of Health Promoting Schools (ENHPS) and another 2000 schools are affiliated via national or regional initiatives.<sup>74</sup>

2. The offerings we collected for the school setting can be broken down into many fields of action and provide a broad range of approaches that have proved effective in practice. The first important group of action fields includes strengthening of self-confidence, life skills and coping strategies, while another important group focuses on the promotion of social behaviour, team work and discussions.
3. Action fields consist of modules in the form of successful offerings that can be interlinked. These offerings may be used in a specific or non-specific way. Implementation in the school system is relatively simple and effort-free.
4. For this purpose we have also developed project profiles in English that can be used as an information basis because they include detailed descriptions of the key aspects of the offerings, including contacts.

Empirical data from the European Network of Health Promoting Schools demonstrate national differences on the basis of different cultures and strategies. In some countries, for instance, statutory school authorities focus on a strategy of "health education", while other countries focus on "health promotion". It therefore proved impossible to implement Health Promoting School schemes in an identical fashion in all Member States, as they did not conform with key strategies. Discrepancies and differences in strategy continue to exist in those Member States that have not equated "health education" with "health promotion". It is planned to address and reduce these problems by means of an international information campaign.<sup>75</sup>

### **8.1.2 Promoting mental health**

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<sup>74</sup> The European Network of Health Promoting Schools: The alliance of education and health. By Mary Stewart Burgher, Vivian Barnekow Rasmussen, David Rivett, ENHPS, WHO Regional Office for Europe, Copenhagen, 1999.

<sup>75</sup> Piette, D./Roberts, C./Prevost, M. et al.: Tracking down ENHPS, successes for sustainable, development and dissemination. The EVA2 project. Final report, nd, np

Mental health is on the EU's political agenda and is attracting increasing attention worldwide. Supported by the European Union, the Finnish National Research and Development Centre for Welfare and Health (STAKES) and the Finnish Ministry of Social Affairs and Health have developed a "Public Health Action Framework on Mental Health".<sup>76</sup> In 2000, within the scope of Finland's EU presidency, these two institutions organized an international seminar<sup>77</sup> at which closing discussions were held on the two projects "Putting Mental Health on the European Agenda" and "Establishment of Indicators for Mental Health Monitoring in Europe". At the seminar it was ascertained that a broad range of activities aiming at increasing the importance attached to mental health and awareness of this topic in the European context had taken place since initiation of the Mental Health Agenda in 1995. Some of the topics are now taken for granted in European cultures. The attitude that mental health should be treated as a broad concept that includes a wide variety of aspects, for example, can be found throughout the EU. The slogan "There Is No Health Without Mental Health" meanwhile has become known all over Europe.<sup>78</sup>

The activities of the STAKES Institute and the European Network on Mental Health Policy (ENMHPO) have led to clearly increased interest in the important subject "Mental Health" in Europe. Conceptual research strategies, e.g. regarding mental-health reporting or mental-health agendas for various age groups, have not yet been developed, however.

So far, the WHO's general definition of health is still applicable, according to which mental health is not only defined by the absence of psychological disorders and diseases but also by a state of mental well-being: "It is a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."<sup>79</sup>

According to various studies (e.g. WHO-HBSC 1996, 2000), psychological strains and problems in childhood and youth have increased drastically in Europe and this trend will

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<sup>76</sup> National Research and Development Centre for Welfare and Health, STAKES/Ministry of Social Affairs and Health: Public Health Action Framework on Mental Health, Saarijärvi 2000

<sup>77</sup> Lavikainen, J./Lathinen, E./Lethinen, V. (Eds.): European Mental Health Agenda: Future Perspectives. Seminar Report. Helsinki 2001

<sup>78</sup> *Ib.*, p. 6

<sup>79</sup> WHO: Fact sheet N° 220, Revised November 2001, p. 1.

continue. Estimates assume that 15 to 20% of all children and young people suffer from psychological problems, many of which are undiagnosed and inadequately treated.<sup>80</sup>

School plays an important role in the cognitive, social and psychological development of children and young people. For this reason, schools should also increasingly work towards favourable social and emotional development. The WHO describes a "child-friendly" school as follows:

"A child-friendly school encourages tolerance and equality between boys and girls and different ethnic, religious and social groups. It promotes active involvement and cooperation, avoids the use of physical punishment, and does not tolerate bullying. It is also a supportive and nurturing environment, providing education which responds to the reality of the children's lives. Finally, it helps to establish connections between school and family life, encourage creativity as well as academic abilities, and promotes the self-esteem and self-confidence of children."<sup>81</sup>

School measures to promote mental health are frequently part of broader objectives. Examples of this are health promoting schools or general life-skills promoting programmes.

In addition to the above, however, there are also programmes undertaking targeted efforts to promote mental health. In this context, a broad range of objectives for school measures is conceivable, e.g. information, destigmatising mental disease, preventing marginalisation, understanding psychological impairments and activities ranging from case work to structural changes at schools.

Two selected projects are introduced below, whose key concerns are promoting mental health by changing school structures, informing about mental health, providing individual care, ensuring better understanding and extending the scope for action addressing mental health on the basis of information. Both projects actively involve children and young people in project

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<sup>80</sup> European Commission: Report on the state of young people's health in the European Union. A Commission Services Working Paper. 2000, p. 27.

<sup>81</sup> WHO: Fact sheet N° 220, Revised November 2001, p. 2.

work. They are based in Finland and Ireland. In the EU, Finland has the highest and Ireland a very high suicide rate among the age group of 15-24-year olds.<sup>82</sup>

### **Koulumiete: The Pirkanmaa Mental Health Promotion Project (Finland: Project 5)**

Central starting point for this project to promote mental health among school children are school structures. The project starts by determining the "well-being profile" of a school, which is subdivided into four categories: school structures, social relationships in school, avenues for self-fulfilment, and health. These profiles can be used to identify the most important areas for development. The entire school, pupils and teaching staff are involved in the development process.

A further basis for this project consists of systematic records of truancy and support for pupils who truant frequently.

In addition to turning school into an institution promoting favourable mental-health development and well-being, knowledge and understanding of mental-health matters are also enhanced through the new subject, health education.

This project is a promising approach involving a thorough, systematic survey of living conditions at school and to this extent having an especially motivating function. Truancy indicates school integration problems, the question of whether schools have other indicators for early identification of psychological impairments in pupils at their disposal remains unanswered, however. After all, were other indicators, e.g. a drastic decline in performance, lack of social integration within the class and of participation in lessons taken into account, truancy might, for example, be prevented completely or at least to some extent through appropriate and early intervention.

### **The School Journal (Ireland: Project 3)**

The aim of the "School Journal" was to prepare adequate information about mental-health topics and services jointly with young people and make this information available to an estimated target group of approx. 20,000 young people. 41 young people were enlisted to plan

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<sup>82</sup> European Commission: Report on the state of young people's health in the European Union. A Commission

and design the Journal together with a doctor, social worker and mental health promotion officer. The young people were involved throughout the entire process of School-Journal preparation.

Evaluation of the use of the brochure showed that the Journal was accepted very positively. Young people considered the language used, viz. their own jargon, one of its strengths.

The process of Journal preparation was assessed positively by all parties involved. The product was also assessed positively by the young people to whom it was distributed – information in their own jargon written by their peers.

The aspired degree of distribution, however, could not be achieved. One of the reasons was that it was up to school principals and teachers to decide whether the Journal was to be distributed. Some of the schools were concerned about individual subjects contained in the Journal, i.e. homosexuality, and thought parents would share these concerns. These schools decided not to offer the Journal to their pupils. Initiatives wishing to take up this project idea should thus include considerations regarding a successful marketing strategy in their plans from the very beginning.

### **8.1.3 Prevention of violence**

Pupils are exposed to numerous risks of becoming a victim or perpetrator of violence inside and outside school. After all, violence, including structural violence, covers a broad range of mutually complementary behaviour patterns and acts. Violence may be of a physical, sexual, psychological and verbal nature.

Although mass media in some countries have reported a rise in violence in schools, there is no empirical evidence confirming these reports on an international level. Reports about violence, mobbing and bullying among pupils, however, raise the question of whether conditions that promote violence are increasingly established in schools and their environment. In spite of legal sanctioning, violent acts committed by adults and directed against children and young people occur regularly at schools and other educational institutions. While physical violence seems to be rather the exception, nowadays, verbal aggression and psychological violence still

play a major role. High pressure to perform and stringent selection processes, too, may be experienced as violence by some pupils.

Violence experienced outside school may also impair daily school life. It may impose considerable strain on children's and young-people's physical, emotional, social and cognitive development, thus having repercussions for school life.

In the school setting, aspects of violence prevention are frequently integrated in overarching objectives, as in health-promoting schools or life-skills promoting programmes.

By way of illustration, we have selected two examples from our collection of European projects/programmes/activities in which violence prevention is defined as an explicit objective and suggestions for new activities are included. These examples are outlined below.

### **Emancipatory Youth Work (Germany: Project 19)**

The "Emancipatory Youth Work" project (Germany: project 19) was developed by the adult education programme of the German district of Oberbergischer Kreis in cooperation with the police and with the support of the Ministry of the Interior of the German *Land* of North-Rhine Westphalia. The project pursues a gender-specific approach to violence prevention. It offers different training courses for boys and girls, self-confidence training for girls and conflict training for boys.

The self-confidence training for girls is aimed at enabling girls to protect themselves against sexual attacks. The conflict training for boys addresses the subject of violence, especially violence in partnerships, and stereotype male gender roles.

Both training programmes consist of various modules. They are offered in schools and youth facilities and conducted in cooperation with the prevention unit of the local police force.

An external evaluation showed the self-confidence training for girls to be adequate and effective; for financial reasons, an evaluation of the conflict training for boys had not been carried out by the time of this survey.

The training programmes were developed in a district of the German *Land* North-Rhine-Westphalia and are to be expanded throughout the whole of North-Rhine Westphalia. The self-confidence training for girls, offered since 1991, has been a uniform police strategy in North-Rhine-Westphalia since 1995 and has also met with national interest.

The training programmes have proved to be a useful strategy and can also be rated as transferable to other countries. As violence-prevention programmes should take social and cultural features into account, however, individual modules may have to be modified and adapted. The available manuals "Emancipatory Youth Work – Conflict Training" and "Self-Confidence Training For Girls And Women", with their individual modules, facilitate such modification and adaptation.

### **Tillsammans / Together (Sweden: Project 2)**

"Together", a project set up by the independent organization "The Foundation Friends – students against bullying" was designed to help schools actively combat bullying. "Together" coordinates approaches and procedures already employed in various areas and presents old and new instruments; it does not create a new approach, however.

Over the period of one year, almost 4,000 of Sweden's 5,300 nine-year compulsory schools were involved in the project in one way or the other. The independent organization continues to exist, even after official project completion.

The project was realized in all classes of the participating schools and included the entire teaching staff. As soon as bullying was observed, an anti-bullying team intervened. Preventive measures include initiation of group activities addressing subjects such as offensive and hurtful behaviour. A journal in which school children could write about their situation at school was used on a regular basis. Various activities were assigned to special subjects, mainly concerning rights and duties. Additionally, each class had a so-called "good friend", who encouraged classmates to behave correctly. Work at school was rounded off by parent-teacher meetings, at which school principals informed about the "Together" antibullying project.

#### **8.1.4 Teenage pregnancy and sexual education**

Generally, the number of teenage pregnancies in the EU is declining. In the 1990s, high teenage-pregnancy rates were observed in the United Kingdom, Portugal and Greece, with the United Kingdom having the highest rate in the EU. In Italy and in the Netherlands by contrast, teenage pregnancies are a relatively uncommon problem.

Even if teenage pregnancies tend to be an uncommon problem within the context of youth health status in some EU countries, the extreme differences between EU Member States demonstrate a major need for action in Europe. There are also indications that rates are rising again in some countries. In Germany, for example, although the number of teenage births and teenage birth rate have remained constant over the last 10 years, the absolute number of abortions and the abortion rate have almost doubled.<sup>83</sup> A glance at countries that have extensive experience with this problem could help develop programmes promoting positive sexual development and mainly addressing the target group of young women, but also the target group of young men, and may help avoid unwanted pregnancies.

Teenage pregnancies involve considerable medical and socio-economic risks for both individuals and society as a whole.

Worldwide, under 20-year old women run an at least twice as high risk of dying while giving birth than women over the age of 20. Teenage pregnancies are a serious problem that may involve grave health and social consequences for teenage mothers, their children and families and cause considerable public costs.<sup>84</sup> Teenage mothers and their families are frequently at a disadvantage in terms of education, employment and family income. In the EU, children of young mothers are more prone to lower birth weights and cot death than children of older mothers. Compared to mothers who gave birth at between 20 and 30 years of age, teenage mothers were constantly at a disadvantage. Compared to older mothers, a substantially larger share of teenage mothers was not gainfully employed and twice as many reached only a minimum level of education and lived in poverty.<sup>85</sup>

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<sup>83</sup> Bunge, Ch.: Babyboom unter Teenagern? In: Info\_Dienst für Gesundheitsförderung 1/04, p. 12.

<sup>84</sup> Kluge, N.: Schwangerschaftsabbrüche bei Teenagern im europäischen Vergleich. Forschungsstelle Sexualwissenschaft und Sexualpädagogik, Landau University 2002.

<sup>85</sup> Kontula, O.: Trends in teenage sexual behaviour: pregnancies, sexually transmitted infections and HIV infections in Europe. European Population Papers Series No. 14. Council of Europe, Strasbourg 2003.

The social and cultural background of a country is of fundamental importance for the prevention of unwanted and unplanned teenage pregnancies. Country-specific ideas on how to tackle this problem should however be bundled, reviewed for effectiveness and transferability to other countries and precisely described in a critical manner along with socio- and sexual-political recommendations.

Education, health-system, youth-work, municipal and socio-political measures, both independently and in combination, may assist in preventing unwanted teenage pregnancies and thus also help reduce the consequences associated therewith. Teenage pregnancies are a highly complex subject and preventive programs should thus be multi-faceted and address individual persons, while taking social and economic factors into account.

Among the European sexual-education projects included in our sample there are two from the UK. Our survey represents a model selection that is explained by the fact that the UK plays the role of trailblazer in the EU with respect to the problem of teenage pregnancies, as the UK is especially interested in eliminating or reducing this problem. The UK has installed special cross-government initiatives such as the Teenage Pregnancy Unit.

The projects outlined below both include peer-led education. Peer-led education has become very common in youth work, especially when working with more vulnerable or socially marginalised groups and in cases involving sensitive topics.

### **The Ripple Study – Randomised Trial of Peer-Led Sex Education in Schools in England (United Kingdom: Project 1)**

The Ripple study investigates the effectiveness of peer-led sex education aimed at preventing unprotected sexual intercourse and unintended pregnancies and improving the quality of sexual relationships.

29 schools were randomised either to a peer-led education group or a control group (usual teacher-led sex education). "Peer-led" intervention included training of Year 12 students (aged between 16 and 17 years), who then delivered to Year 9 students (aged between 13 and

14 years) three classroom sessions focusing on relationships, contraception and sexually transmitted infections (STIs).

Results with peer-led intervention were clearly superior to those achieved in the control group.

The study has been well documented in numerous publications. Since there are hardly any relevant studies addressing the benefits of peer effects, the results may help to involve peers in prevention to an increasing extent.

### **Added Power in Sex Education – A Pause (United Kingdom: Project 2)**

The "A Pause" project is intended to help young people to delay sexual intercourse until an age at which negative experiences are less likely, i.e. an age of approx. 16 years. Young people are also assisted in adopting a responsible approach to sexuality and partnership, using suitable contraceptives and find access to support services.

A Pause is a balanced programme involving several institutions, with various components being provided by teachers, health-service workers and slightly older peers.

External evaluation on the basis of action research has not yet been completed. According to criticism voiced by individual experts, standardized programmes are not adequate and every school should develop its own approach.

The project has been well documented in several publications. Even if it is most certainly true that standardized programmes, especially programmes in the sensitive area of sex education, must be adjusted to the respective social and cultural structures as well as students' interests and problems, the "A Pause" project nevertheless involves development work that can be used by other institutions. The interdisciplinary approach in which peer education is rooted, is also highly convincing.

### **8.2 Setting: Training/Vocational Training**

In the vocational training phase young people must cope with the developmental tasks of youth and, above all, learn their vocational roles. This comprises technical professional

knowledge, including practising the correct work posture. The social aspects of a vocational role, i.e. adherence to working hours, acceptance of the system of super- and subordination, development of teamwork skills, must also be acquired.

At the same time, given the continuing high level of youth unemployment in the EU, there is a group of young people who find neither a vocational-training position nor a job. Unemployed young people are exposed to special risks which may impair their self-image, their further psychosocial development, their social and economic existence and their health.

In the EU, unemployed young people are offered a wide variety of measures and projects aimed at vocational and social (re)integration. These measures are assessed positively if the goal of vocational re-integration is in fact achieved and the measures do not end up in (repeated) waiting loops, i.e. renewed training courses or unemployment.<sup>86</sup>

During the vocational training phase, young people must cope with specific developmental tasks, e.g. detachment from the parental home, establishment of independent relations with peers and development of gender identity. Health-related risk behaviour also accumulates during this phase in life, as demonstrated, for example, by the high number of traffic accidents in this age group. Additionally, decreasing participation in sports is often observed during this phase, more in girls than in boys.<sup>87</sup> The question therefore arises of whether vocational training institutions should not be included in health promotion measures, too, and take over special responsibility for the young people under their care.

### **8.2.1 Vocational integration measures**

Due to the shortage of vocational training places and workplaces, the manifold activities aimed at the vocational integration of young people have met with structural difficulties which, to some extent, are offset through the establishment of project-related, mostly small-scale companies,<sup>88</sup> as was also the case in the Luxembourg-based project described below. In the case of some of the untrained or unemployed young people, however, lack of qualifications, cognitive, social and emotional deficits or previous history also make it almost impossible to find vocational positions or jobs.

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<sup>86</sup> Cf. Lex, T.: *Berufswege Jugendlicher zwischen Integration und Ausgrenzung*. Munich 1997.

<sup>87</sup> WHO-HBSC 2000, p. 75.

The project below has taken care of such an especially difficult clientele.

**Atelier Schläifmillen Inter-Actions Asbl./Schläifmillen Workshop  
(Luxembourg: Project 2)**

This national programme assists unemployed young people in (re)gaining access to the labour market and also offers jobs and individual socio-psychological counselling. Three companies in which young people aged between 18 and 29 years can carry out simple tasks for a minimum wage were established. These measures are rounded off by the Schläifmillen Workshop, which offers disadvantaged young people vocational training.

This project is particularly remarkable since it addresses an extremely difficult target group. 72% of the young people participating in the project do not have any formal qualifications, approximately 50% are alcohol or drug dependent and/or have come into conflict with the law (25% are former prison inmates). In view of the difficult situation on the labour market, it is thus thoroughly remarkable that half of the project participants obtained a normal employment or vocational-training contract or recognized vocational training after having completed this project.

**8.2.2 Physical exercise and sports during vocational training**

The period of vocational training represents a phase of life in which young people, above all young women, have less physical exercise. At the same time, physical strain resulting from one-sided or false movements on the job may increase, with occupational safety aspects gaining in importance.

In light of the above, health-related prevention activities targeted at young people are of special significance in this context. The example below illustrates the connection between physical education at school and vocational training.

**State School Project "Innovation by Movement – Vocation Oriented Physical Education During the First Vocational Training Period" (Germany: Project 17)**

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<sup>88</sup> Schaub, G.: Ausbildung im Jugendhilfebetrieb. In: Braun, F./Lex, T./ Rademacker, H.: Jugend in Arbeit. Neue Wege des Übergangs Jugendlicher in die Arbeitswelt. Opladen 2001, pp. 86 – 91.

Vocational schools are the last opportunity for motivating adolescents to engage in health-promoting measures in the form of physical exercise in a school setting. The innovative aspect of this project lies in the fact that sports and physical education lessons serve the pedagogic goal of linking accident prevention, occupational health and safety, workplace, vocational school and leisure time. Various players offer young people manifold in- and out-of-school activities coordinated by vocational schools. Through their respective specialist competencies, all parties involved provide targeted contributions to realizing preventive health promotion by means of physical exercise, games and sports, also taking into account the requirements of the pertinent vocation. The intention is to motivate young people to do more sport in everyday life to compensate for bad posture and acquire health-promoting behaviour patterns on the job and in their spare time.

### **8.2.3 Accident prevention among vocational trainees**

Young people, above all male adolescents, are at greater risk than other age groups of dying in road accidents. Road-traffic accidents are the major cause of severe injuries and mortality in young people. At the same time, there are hardly any projects on offer that combat the risk via adequate preventive action. The case study below has been included because the project was designed in a systematically target-group-oriented manner.

#### **Christophorus Seminars (Germany: Project 23)**

Among trainees, metal workers and car mechanics lead the list of road-traffic accidents in the German *Land* Lower Saxony. This fact motivated the development of the "Christophorus Seminars", which are tailored especially to this target group.

Christophorus, the patron saint of traffic safety, was chosen as role model because his search for strength is in tune with young people's requirements.

At the three-day seminars, which are always held outside school and the workplace, "road-traffic safety" is discussed, demonstrated and practiced from various perspectives and with the participation of several experts. Using open-learning methods, the aim is not to teach traffic safety but to help the trainees to actively acquire it. The seminars address trainees'

professional competence and support the development of self-responsibility, not only in traffic but also in everyday life.

### **8.3 Leisure time setting**

The leisure time setting is difficult to define. It is wide-ranging and can include all kind of leisure time facilities, locations and activities.<sup>89</sup> The setting concept for leisure time is more than just a location where measures are implemented. In the sense of current health-promoting initiatives for children and adolescents, it must also be seen as a way of exerting influence on their social surroundings and individual life perspectives and encouraging them to take responsibility.<sup>90</sup> These efforts are undertaken by multipliers, cooperation partners and various institutions in charge of policy, administration and funding.

What leisure time provision was selected depended on what kind of search strategies the experts used. The evaluation of provision identified projects, programmes and activities in the area of alcohol prevention, drug prevention and sex education. Alcohol prevention, for instance, is implemented as a media campaign or as peer education. Locations were examined where young people spend their leisure time, such as discos, nightclubs etc. Drug prevention programmes are campaigns related to party drugs. The aim is to make young people, aged 14 to 25, with a strong interest in techno music and often to be found in discos and clubs, at parties and events, more sensitive for drug and addiction problems. Provision for sex and Aids education is provided in the form of mobile campaigns, e.g. at summer festivals. Other forms are workshops in sports and leisure time facilities (holiday sports centres) and projects initiated by young people themselves and managed by professional social workers (health-related prevention workers).

#### **8.3.1 Alcohol prevention (Belgium Project 2), (France Project 3)**

The Belgian "BOB Campaign" starts out from the fact that alcohol plays an increasingly important part in causing road accidents. Countermeasures have been enacted in Belgium, such as more traffic checks and the BOB campaign, with the aim of changing the mentality of

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<sup>89</sup> A German initiative, "Gesundheitsziele.de", defines the leisure time setting jointly with family. As family projects are not included in our study, we focus on leisure time only.

<sup>90</sup> Altgeld, T.: Work group "Health has a future": Goals for children and adolescents: nutrition, exercise, coping with stress. Interim results. "Gesundheitsziele.de", Cologne 2002, p.7. Available in English under ([www.health-targets.de](http://www.health-targets.de)).

young (and older) drivers so that the combination of alcohol and driving becomes socially discredited. The "BOB Campaign - Bewus Onbeschanken Bestvurder" means "consciously not drunken driver". The aim of the campaign is, firstly, to propagate that driving after alcohol consumption is unacceptable and, secondly, to require partygoers to decide beforehand who is not going to drink alcohol and can, therefore, drive everyone in the group home safely. Since the beginning of the campaign in 1995, the number of inebriated male and female drivers has decreased. Nevertheless, the number is higher on weekends than during the week. Hence, prevention and police inspections are being expanded.

A project from France (Project 3), "designated driver", is a peer education project. Young drivers deposit their car keys voluntarily at the entrance of a nightclub or discotheque. If they want the keys back later, they must prove that alcohol in their blood does not exceed 0.5g/l. This project has been very successful so far. The percentage of drivers who volunteer to turn in their keys has risen continually. The project has also been approved by nightclub and discotheque owners. Initially, the participation of drivers was at a rate of about 50%. Meanwhile, the rate has climbed to 80%. Both projects were presented at the second workshop of the EU network and considered to be transferable. One can assume that it would be no great problem to apply them in other countries.

### **8.3.2 Drug prevention (Belgium Project 1) (Germany Project 15)**

One project from Belgium (Project 1) is the sensitizing campaign "Deceived? I don't know!" This campaign addresses youngsters who are confronted with drugs in their immediate neighbourhood and who may or may not be drug consumers. The campaign was started in 2001 and, because of its tremendous success, repeated in the summer of 2002. It was broadcast on various TV channels to focus more people's attention on the target group when it is on the road at night. Information is also disseminated via a Web page, posters, flyers, magazines, T-shirts, videos etc. The following two strategies were selected to implement the campaign:

- **Push Strategy**

This method involves active communication through advertising, the distribution of advertising materials to make people familiar with the campaign.

- Pull Strategy

With this strategy, materials are taken to various intermediary locations such as youth work, media and bars and distributed there. The campaign is extended to other areas within clubs and discotheques such as First Aid, overheating, dehydration, training of club members, information about drug risks and permanent supervision.

Another peer education prevention project, "MindZone", comes from Germany (Project 15). This project has been working on addiction prevention since March, 1996, and addresses young partygoers aged 14 to 19 in Bavaria.

MindZone, the "zone of full awareness", uses the slogan "Clear your mind!" to give all interested young partygoers an opportunity to find out about topics such as party drugs, addiction, life planning, health etc. and wants to sensitize young people for these topics.

The project concentrates its efforts on discussing tendencies that promote addiction in the Bavarian party milieu, on looking for healthier alternatives, on sensitizing young people for a more responsible handling of addictive drugs, on preventing their even starting to use them and on indicating how they can get out of risky consumption patterns.

"MindZone takes a peer education approach. The social and educational work in the target group is passed on to the members of that very target group. During a party night, peers distribute parcels containing information material, jellybabies, condoms etc. and offer to help with questions and problems. Involving young people of the same age increases credibility, on the one hand, and raises the project's acceptance level in the target group, on the other.

"MindZone" programmes and activities:

- Training of young partygoers by "MindZone" staff and involving them in project tasks
- Carrying out preventive actions in the party scene
- Developing special information brochures for partygoers
- Offering alternative leisure time provision
- Giving initial counselling to individual consumers
- Involving potentially helpful third parties (friends, parents etc.)

- Distributing info-brochures all over Bavaria, not only in the party scene (e.g. in schools, businesses, counselling centres, youth work facilities etc.)
- Offering information events especially to parents, teachers, vocational trainers and trainees etc.

The project is widely networked. Bavaria-wide, it has five qualified youth workers and social workers, about 50 unpaid helpers, one administration employee and two people who help build up information stands at parties.

In 2002, 31 preventive actions were carried out at commercial and non-commercial parties in Bavaria. More than 28,000 young people and young adults were addressed.

According to the results of the external evaluation, MindZone is very well-known, MindZone brochures are read by 40% of those who receive them, and the acceptance of MindZone messages and materials is high. Especially younger partygoers find MindZone very effective.

Because the project is close to young people's social environment and the party scene, special requirements have to be coped with. Locally and regionally, there are different developments, and project implementation can, therefore, not be homogeneous. Moreover, the party scene changes very fast, and there are various sub-scenes. Concrete MindZone work must always adapt to new trends. A lot of persuasion is necessary, since the MindZone conception does not always come up to what cooperation partners expect (e.g. distributing condoms).

It is difficult to find suitable staff (qualified youth workers) who are connected to the milieu and commit themselves long-term. Moreover, only a few partygoers are willing to do voluntary work, so that peer group membership fluctuates strongly. At the beginning, it was difficult to convince club operators of the merits of MindZone efforts. Meanwhile, the project has been established nearly all over Bavaria.

As the party scene, technoclubs and the consumption of party drugs (e.g. ecstasy) are spread out in most EU member states, it is an important positive approach to use addiction-preventive methods in locations where consumption takes place. An important aspect is to be present on-site and to win over the youngest partygoers possible for education and counselling purposes. Young collaborators are familiar with young people's needs and the language they

use and can be very effective in drug prevention efforts by doing grass-roots work in the party scene and elsewhere. Internet media increasingly contribute to education in this field. A joint EU project, carried out in three large European cities (Amsterdam, Hamburg and Manchester) is an interesting venture. It is a European research project that, among other things, wants to inform young partygoers about health-related issues.<sup>91</sup>

Another drug prevention project, "Empower Kids through Sport" (Austria Project 4) can be considered to have a broader impact than the two projects described above. It promotes health by providing sports programmes to prevent drug consumption. Young people are offered alternative leisure time activities which sports trainers, parents and other helpers make available. The project addresses a broad target group of young people, offering them sports events and special training courses. So far, the number of drop-outs from sports clubs has decreased and new members have been won. More sports-oriented provision is introduced in the "school" setting.

### **8.3.3 Therapeutic help in the Internet /"Alcohol prevention" (Austria Project 2)**

A special project from Austria, "ONYSOS' CHAT" (Project 2), uses the Internet as a forum for alcohol prevention. This project is a low-threshold offering that allows children whose parents have alcohol problems to communicate with each other, anonymity guaranteed, or to receive therapeutic help. This project has been unique in Austria so far. Its aim is to encourage children whose parents have alcohol problems to reduce their anxieties and guilt feelings, build confidence and acquire new orientations. A chatroom was established to achieve this goal. The project is in high demand. According to the experience in Austria, counselling, in particular, can only be offered by specialists. There are similar projects in other EU member states, which indicates that the Internet is an important medium for promoting health among young people.<sup>92</sup> Especially those can be addressed who previously did not have the courage to take advantage of special counselling provision.

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<sup>91</sup> Cf. "Urban-Vibe" at <http://www.urban-vibe.net>. Information is available in English and Dutch.

<sup>92</sup> In Germany, the Federal Conference for Educational Counselling Inc. organizes "online-counselling" as an Internet service for young people and their parents. This service that sees itself as a "virtual setting" is available 24 hours a day under <http://www.bke.de>.

### 8.3.4 Sexual education and Aids prevention (Belgium Project 3, France Project 12)

In many EU member states, various campaigns are run to prevent Aids and sexually transmitted diseases (STDs). Programmes in the "leisure time" setting are quite different, e.g. in Belgium the "condomobile" (Belgium Project 3), addressing the target group of 13- to 25-year-olds and offering information at various summer festivals. The aim of the campaign is to break taboos about condoms and to give information about the sensible use of condoms. In the Belgian project, the campaign was run with a lot of imagination, i.e. unusual information material was generated. The campaign was evaluated, and what showed was that the taboo about condoms had clearly been reduced. Condoms are handed out at festivals, and an increasing number of non-profit-organizations is participating in the education of young people about safer sex. In another field, holiday sports centres for young people, a project in France (Project 12) called "Freedom Colours" is carried out. Workshops are organized about sexual education, the use of condoms, relationship issues (boy-girl relationships) etc.

Games and theatre want to prompt young people to talk about their sexuality, attempt communication and get help, so as to make confident decisions about love and partnerships.

These projects and campaigns can also reach boys who are more difficult to get through to than girls, where issues of sexual education are concerned. The workshops, in their special ways, can strengthen the competencies of young people in a relaxed manner in situations of personal experience. It is difficult to transfer projects in sexual education, because they run into many problems of different moral concepts in different cultures.

No project is available that deals with socially disadvantaged groups, particularly with migrants, where Aids prevention is at issue. It is being considered that information about different ways of getting infected and protecting oneself accordingly has to be translated into different languages. However, one project has been developed in Germany that does not belong to the sample.<sup>93</sup> This project uses pictograms to provide information about Aids prevention.

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<sup>93</sup> Central Federal Office for Health Education (BzgA): HIV-transmission, Aids-danger: situations, risks, recommendations, private publishing. Cologne 2000

## 8.4 Counselling

Counselling on health and well-being can be offered by various institutions. School nurses and especially trained counselling teachers are contacts for pupils at school; midwives, nurses and doctors are at their service within the health system. Apart from local self-help groups, a variety of local counselling centres exist, run by the municipality, church or independent organizations and providing, for example, health counselling, general life counselling and crisis intervention, partnership, marriage and family counselling etc. Within the individual areas there are various levels of counselling: resource counselling, lifestyle counselling and therapeutic counselling.<sup>94</sup>

Counselling centres are very common in many EU countries and heavily frequented, as demonstrated by the fact that people seeking help sometimes have to put up with long waiting times. For crises and emergencies requiring immediate attention, special crisis-intervention centres and telephone helplines have been installed.

Below, three projects are outlined by way of example. They are being realized in various areas, viz. in a family-planning centre, in doctors' surgeries and in a crisis-intervention centre. The goals, i.e. sexual health, smoking and suicide prevention, reflect significant developmental tasks or problems in youth.

### 8.4.1 Talking about Sex with Young People (France Project 11)

Generally, young people in Europe are well informed about their sexual development. Persistently high numbers of teenage pregnancies in some countries and an increasingly negligent approach to AIDS, however, show that some young people need special support for developing sexual health.

The project "Talking about Sex with Young People" targets a specific group of young people, viz. adolescents living in homes and young workers living in workers' hostels. For this group of young people, available initiatives were either non-existent or almost completely unsuitable. Given this lack, social workers from the family-planning centre, the young people's home and the workers' hostel developed a workshop consisting of three parts: first, a general discussion about sexuality within the scope of which anonymous questions can be

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<sup>94</sup> Cf. Köhnen, H.: Deutsch-englisches Glossar der Jugendhilfe. Ein vergleichendes Handbuch. German - English Glossary of Youth Services. A Comparative Handbook. Weinheim/Munich 1992

asked; second, information covering subjects of a more concrete or technical nature (body, contraception...); and, last but not least, an introduction to the family-planning centre where the events are held, including a visit to the centre's medical facilities. The events are carried out jointly by social workers and a general practitioner.

Beyond the narrow target of sexual health, the project seeks to assist young people in taking better care of their health and escort them on their way to more autonomy.

What is remarkable about this project is the fact that it selected a target group that is often much too easily ignored when health-promoting measures are planned. Given this particular target group, the question of whether the learning method, i.e. lessons and discussions, could be rounded off by other methods requiring more active participation by the young people, and the effects of peer education utilized is worth considering.

#### **8.4.2 Young Smokers (Germany Project 13)**

This model project was developed in response to the rising numbers of ever-younger smokers.

The IFT (Institute for Therapy Research) commissioned to develop and implement this model project, used available experience gathered in adult smoking cessation and compiled a brochure for young people, a checklist and discussion guide for physicians on the basis of this experience.

Doctors were selected as central players in the preventive measures, since short-term medical intervention had proved highly effective among adult smokers. Contacts between physicians and young smokers were also to be utilized.

The evaluation conducted among physicians showed that all physicians were interested in supporting young people in smoking cessation and that the materials developed were also assessed favourably. 98% of the physicians said they would like to continue using the brochure for young people in their surgeries. Evaluation among the target group of young smokers has not yet been completed.

### **8.4.3 Suicide prevention (Germany Project 20)**

"The Arch – Suicide Prevention and Crisis Intervention" has been in existence for more than thirty years and, as indicated by its name, is an institution dedicated to suicide prevention and crisis intervention. The Arch is not limited to young people but provides support to the entire adult population.

"The Arch" offers counselling in almost all problem areas in which people in need of help seek support. "The Arch" therefore employs an interdisciplinary team.

Psychologists trained in psychotherapy, physicians, social workers and a lawyer offer out-patient suicide prevention, crisis intervention and therapy for people in crises, people at risk of committing suicide and people who already attempted to commit suicide.

Additionally, extensive public-relations measures are taken to reduce public discrimination of suicidal people.

What is special about this institution is the strictly interdisciplinary makeup of its counselling and treatment team, which does justice to the fact that the reasons underlying suicides and suicide attempts are based on complex interactions.

## **8.5 Local Level**

Local preventive and health-promotion measures focus, above all, on interventions intended to influence underlying social conditions and improve the state of health and well-being of the local population. According to the setting approach initiated and developed by the WHO on the basis of the Ottawa Charter (1986), health promotion starts where people study, live and work, with primary-prevention strategies being chosen within this context.

"Primary prevention" is a collective term for strategies aimed at monitoring, reducing or eliminating health risks in environmental and living conditions (Waller 1995, quoted as per

Lehmann 1996<sup>95</sup>), reducing or eliminating disease or injury events in general living, working and environmental conditions<sup>96</sup>, or establishing healthy conditions.<sup>97</sup>

Community health promotion is based on cooperation between all relevant players (groups and initiatives, clubs and associations, health institutions, relevant municipal institutions etc.) and citizen participation. When such cooperation is achieved, direct improvements may be expected, especially in socially weak municipalities or urban districts. Apart from the above, initiation of continuous, long-term intervention is also preferable to short-term intervention because more sustained effects can be achieved.<sup>98</sup>

Thought must be given to the question of how health-promotion approaches which tend to be of a more general nature can be transferred to the needs of children and young people. Transferability depends, for example, on the extent to which youth associations, municipal youth-committees, youth offices etc. are involved or play an active role in the design of health-promotion measures.

Three projects, addressing different target groups, are outlined below by way of illustration.

### **8.5.1 Lille Youth Welfare Centre (France Project 4)**

The Lille Youth Welfare Centre caters to young people who have severed their ties with their social background or for young people with specific problems (unwanted pregnancies, social support programmes etc.). At the Lille Youth Welfare Centre, young people can obtain counselling on any social or health related problem. Counselling is voluntary and anonymous. To build up trust, nothing is recorded in writing. Young people are motivated to contact the available experts. A special feature of the institution is that it also offers short-term accommodation to young people with specific problems.

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<sup>95</sup> Waller, H.: Gesundheitswissenschaft. Stuttgart 1996; Lehmann, M.: Verhältnisprävention. In: BZgA: Leitbegriffe der Gesundheitsförderung. 1996, pp. 117 – 118.

<sup>96</sup> Bundestagsdrucksache 12/8238 of July 5, 1997 (reply of the Federal Government "Prävention in der Gesundheitspolitik" (Prevention in Health Policies) to the Major Question of SPD MPs and the parliamentary party).

<sup>97</sup> Cf. Lehmann, op. cit., p. 117.

Since records are waived for project-specific reasons, evaluation is impossible. Its long-standing existence - the facility has been in existence since 1983 -, and high degree of utilization - the offering is taken up by approx. 1,000 young people per year - signalise considerable demand and a high degree of acceptance.

### **8.5.2 Health Programme in Families (Spain Project 7)**

The objective of this project is mutual acceptance between Spanish women and female immigrants and joint participation of both groups in local activities. A health programme is intended to strengthen the social well-being of immigrant families.

The target group consists of approx. 200 children, young people and adults. The project is managed by teachers, social workers, a physician and a psychologist. Activities take place in schools, within the health system and the local community. The project cooperates with municipal institutions, schools and physicians' surgeries.

The project seems to be well networked on a local level and has a multidisciplinary team of employees. The combination of integration and health-promotion efforts appears innovative. Unfortunately, the project description does not give an answer to the question of how cultural differences between the individual immigrant groups and the Spanish population can be taken into account and utilized. When it comes to health-promoting measures for immigrants, cultural characteristics may also play a significant role in understanding and dealing with health. The project, which is still ongoing, may be able to offer interesting information and work aids addressing this subject at a later stage.

### **8.5.3 Nutrition and Exercise for Children and Youth (Germany Project 21)**

This project is based on a health insurance initiative in a socially disadvantaged urban district. A municipal administration task force in which all relevant players of the district participated had already been established in this urban district. A second task force, "Health in Neumühl",

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<sup>98</sup> Heckmann, W.: Präventionsforschung und kommunale Suchtprävention in der Bundesrepublik Deutschland – eine gelungene Allianz? In: Verein für Kommunalwissenschaften e.V. (eds.): Vorbildliche Strategien kommunaler Suchtprävention. Berlin 2003, pp. 12 - 17

was established, which addressed children's health, especially the health of socially disadvantaged children from the urban district.

Analysis of the situation showed that the majority of children attending the "Spielhaus", a municipal day-care centre for children under the age of 14, were overweight due to an unbalanced diet and lack of physical exercise. A small percentage of the children was constantly hungry and undernourished.

First, the objective was defined, i.e. to achieve a sustained change in nutrition and physical exercise behaviour. At the same time, however, better perception of health prevention and healthcare offers was also pursued. In the long-term, the project wishes to include addiction prevention.

The initial phase involved finding two mothers willing to prepare a healthy lunch to be offered to the children in the "Spielhaus". In order to encourage physical exercise on the part of the children, the pertinent housing company was persuaded to build a playground for the smaller children. The regional sports clubs were called upon to offer the older children opportunities for physical exercise and sport. In the second phase of the project, parents were informed and involved in the activities to a larger extent. A "parental weight-control group" has meanwhile led to a sustained change of diet in many families. A teachers' conference was held to design cooperation with the elementary school. The result showed that not only children but also their teachers may profit from health promoting measures. Various fields of action for joint involvement were identified.

Systematic networking of the project in the urban district has been successfully accomplished, as has cooperation with existing institutions and parents.

## **8.6 Gender**

Various recent surveys and studies demonstrate gender related differences not only in health disposition and stresses but also in health related social and behavioural dispositions.<sup>99</sup>

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<sup>99</sup> Commission of the European Community: Report from the Commission to the Council, the European Parliament, The Economic and Social Committee and the Committee of the Regions on the state of women's health in the European Community. Brussels 1997, COM(97) 224 final; European Agency for Safety and Health at Work: Gender issues in safety and health at work. Luxembourg 2003; Kurth, B.M.: Die Gesundheit von Frauen und Männern – Möglichkeiten und Grenzen einer geschlechtsspezifischen Gesundheitsberichterstattung. In: Bundesministerium für Familie, Senioren, Frauen und Jugend – BMFSFJ: FrauenGesundheit – FrauenLeben

Unfortunately, however, differentiation of the results of these surveys according to age groups is almost or even totally non-existent, so that statements on gender specific health conditions and health related risks with respect to young women and men are impossible. Although gender mainstreaming has become highly prioritised in the European Union, there are hardly any Europe-wide comparative data on the state of health of young people that are differentiated by gender.

Within the scope of sexual development during puberty and gender identity development during adolescence, these differences are indisputable and obvious. Additionally, there are also differences of a mainly social nature, i.e. shaped by social gender norms. The report on the state of young people's health and social situation in the European Union<sup>100</sup> includes relevant data on this aspect. According to this report, gender specific differences can mainly be seen in the following areas: legal and illegal drug consumption, road traffic accidents and injuries, where male adolescents are at a far higher risk, and eating disorders, problematic consumption of medical drugs and the experiencing of violence, where female adolescents are exposed to higher risks.

In summary, one may say that young people's health biographies include clear gender specific differences. The subjective physical, psychological and social state of health of girls and boys is clearly different. This gender specific differentiation is absolutely essential therefore when it comes to the planning of prevention and health promotion measures.<sup>101</sup>

In spite of the clear differences between the genders, gender specific prevention approaches are still uncommon.<sup>102</sup> On the one hand, the explanation for what has so far tended to be

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– FrauenArbeit. Bericht zur gesundheitlichen Situation von Frauen in Deutschland. Bonn 2002, pp. 16 – 18; Thom, B.: Risk-taking behaviour in men. Substance use and gender. London 2003; Verbundprojekt zur gesundheitlichen Situation von Frauen in Deutschland: Untersuchung zur gesundheitlichen Situation von Frauen in Deutschland. Eine Bestandsaufnahme unter Berücksichtigung der unterschiedlichen Entwicklung in West- und Ostdeutschland. Berlin 1999.

<sup>100</sup> Hackauf, H./Winzen, G., 2004, in the press.

<sup>101</sup> Langness, A./Richter, M./Hurrelmann, K.: Zusammenfassung der Ergebnisse und Konsequenzen für eine jugendgerechte Prävention und Gesundheitsförderung. In: Hurrelmann, K./Klocke, A./Melzer, W./Ravens-Sieberer, U. (eds.): Youth health survey. International comparative study on behalf of the World Health Organization WHO. Weinheim, Munich, 2003.

<sup>102</sup> Vogt, I.: Frauen – Sucht – Hilfe. Anmerkungen zur geschlechtssensiblen Prävention und Versorgung. In: Bundesministerium für Familie, Senioren, Frauen und Jugend – BMFSFJ: FrauenGesundheit – FrauenLeben – FrauenArbeit. Bericht zur gesundheitlichen Situation von Frauen in Deutschland. Bonn 2002, pp. 50 – 51.

rather unsatisfactory implementation of gender mainstreaming, i.e. the consideration of gender specific aspects as a key cross sectional task - above all in prevention - may lie in a lack of human resources and time. On the other hand, however, the fact that the concept of "gender mainstreaming" is interpreted differently in theory and practice and does not include in itself specific target requirements for its implementation in practice is a major problem.<sup>103</sup> In a topical survey on "gender mainstreaming" in child and youth services conducted by the German Youth Institute,<sup>104</sup> for example, 50% of those interviewed stated that one of the problems of gender mainstreaming introduction was the fact that there are few concrete realization examples. Another 25% quoted the traditional resistance of persons occupying key positions of child-and youth-service institutions as an obstacle.

The necessity of a gender specific approach in prevention can be graphically illustrated by the high number of young people involved in road traffic accidents. Male adolescents aged between 15 and 25 years, above all, face a high risk of suffering serious or fatal injury in road traffic accidents. Developing gender specific programmes for young traffic participants offering both training in road traffic safety and male role behaviour and treating, above all, the risks involved in driving under the influence of drugs and alcohol would appear logical.

Another example is smoking. As demonstrated by various surveys (e.g. WHO-HBSC 2000), the number of girls starting to smoke cigarettes is increasing rapidly especially in the younger age groups. The rate of young female smokers is similar to and sometimes even exceeds that of young male smokers. Young women who now take up smoking, smoke much more than older women and are beginning to smoke more than young men of the same age. The need for gender specific prevention approaches is obvious.<sup>105</sup> Nevertheless such gender specific approaches are very rudimentary or very uncommon.

In the field of gender specific addiction prevention, too, hardly any gender specific projects are carried out in practice in Germany, for example, and those that do take place are

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<sup>103</sup> Bundesarbeitsgemeinschaft Kinder- und Jugendschutz/Landesstelle Jugendschutz Niedersachsen: Grenzen und Brücken. Arbeitsmaterialien zu Prävention und Geschlecht. Hanover 2003.

<sup>104</sup> Gender-Mainstreaming in der Jugendhilfe. Ongoing project (April 2002 – June 2006), German Youth Institute, Munich.

<sup>105</sup> Kurth, B.M.: Die Gesundheit von Frauen und Männern – Möglichkeiten und Grenzen einer geschlechtsspezifischen Gesundheitsberichterstattung. In: Bundesministerium für Familie, Senioren, Frauen und Jugend – BMFSFJ: FrauenGesundheit – FrauenLeben – FrauenArbeit. Bericht zur gesundheitlichen Situation von Frauen in Deutschland. Bonn 2002, p. 18.

implemented and communicated outside scientific communication and archiving channels. Extensive research found only 22 examples of projects for the whole of Germany. Gender specific addiction prevention is found only in isolated cases, mainly in out-of-school youth work.<sup>106</sup>

Within the preventive health related projects/programmes/activities addressing young people in the European Union we have compiled, gender specific or gender sensitive approaches are also far too uncommon. The few examples are restricted to those areas in which gender specific approaches are traditional, e.g. sex education and the prevention of teenage pregnancies, or areas in which the necessity of a gender sensitive approach is especially obvious, e.g. when it comes to the prevention of physical violence or other violence experiences.

Among the sex education projects included in our report, in which a gender specific approach may be assumed, such an approach is not explicitly mentioned – perhaps because it goes without saying. Exceptions from the above are two projects based in the Netherlands (Projects 1 and 6, cf. NL national report in the Annex), which include revision of teaching materials under gender aspects, among other things, and a gender specific approach, which is not explained in detail, however. The only project describing clear gender orientation is a project conducted in the school setting (Germany: Project 19), which has already been described in the pertinent chapter.

In summary, it can be said that explicit gender specific orientation is rare both in the relevant literature and in our collection of European prevention projects/programmes/activities. In our opinion, however, not only should existing gender specific programmes be publicised to a greater extent in order to generate stimuli but the gender issue should also become a routine element of future invitations to tender in the field of health prevention addressing children and young people.

## **8.7 Migration and health**

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<sup>106</sup> Cf. Franzkowiak, P./Helfferich, C./Weise, E.: Gender-related Drug Prevention for Youths: Practical Approaches And Theory Development. Cologne 1998, p. 17.

Population growth in the European Union can be attributed, above all, to the influx of international migrants. The net inflow of international migrants (immigration less emigration) into the EU increased to approx. 983,000 persons in 2003, a decline of approx. 280,000 compared with 2002, however.<sup>107</sup> Most migrants have a low socio-economic status. Their work in industry and service provision is characterized by low qualifications and payment as well as unfavourable working conditions.<sup>108</sup>

Young people make up the majority of migrants. They leave their countries of origin to find better economic conditions, study or join their families. They flee from persecution, human-right violations, war or extreme poverty. An unquantifiable number of migrants, including children, lured by unscrupulous human traffickers promising them a better life, become victims of abuse and exploitation. The members of the second generation may have never seen their country of origin; they are born as foreigners in a host country.<sup>109</sup>

This characterisation of the group of young migrants in Europe indicates that, in addition to their social integration, a wide variety of different activities and programmes is called for to protect their health. Expulsion, flight, resettlement and what are generally low qualifications and unfavourable working and living conditions mean that their physical and psychological health is at a higher risk than that of young nationals.<sup>110</sup> At the same time, health services in Europe face the problem of treating ethnic groups from various countries in a culture-conforming manner. In Europe, however, information about the effects of migration on health and health care according to age group and gender is non-existent. The reasons for ethnic differences in health status have not yet been sufficiently investigated and documented either.<sup>111</sup>

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<sup>107</sup> Eurostat: Statistik kurz gefaßt. Bevölkerung und soziale Bedingungen. Thema 3 – 1/2004, p. 1.

<sup>108</sup> Cf. Menke, R./Streich, W./Rössler, G.: Report on Socio-Economic Differences in Health Indicators in Europe. Health inequalities in Europe and the situation of disadvantaged groups. Institute of Public Health North Rhine Westphalia (loegd), Bielefeld n.d.

<sup>109</sup> Cf. Council of Europe, Parliamentary Assembly: Situation of young migrants in Europe. Doc. 9645, 13 January 2003.

<sup>110</sup> Cf. Council of Europe, Parliamentary Assembly: Health conditions of migrants and refugees in Europe. Doc. 8650, 9 February 2000.

<sup>111</sup> Cf. European Public Health Association (EUPHA): Section on Migrant health. [http://www.eupha.org/html/menu5\\_7.html](http://www.eupha.org/html/menu5_7.html).

The identifiable deficits with respect to the state of health of young migrants lead us to doubt their successful social integration in terms of health and well-being. They should therefore be given increased support throughout the EU and their involvement in preventive, health-related offerings should take place as early as in the planning stage, as a basic principle. Many municipalities now seem to be adjusting to isolated aspects of the situation of migrants. In sex education and AIDS prevention projects, for instance, an increasing number of staff well-versed in the languages in question is being employed to overcome language and cultural barriers.

Our collection of European projects/programmes/activities addressing health-related prevention for young people in the European Union may be an indication of the unsatisfactory situation of young migrants in this area. Only one national report, describes projects in this area, viz. the Spanish report, with two projects of this nature. One project addresses pregnant immigrants and assists them, also financially, in terminating an unwanted pregnancy (Spain: Project 6). The other project aims to achieve improved social integration of young immigrants via joint activities with young Spanish people (Spain: Project 5).

Admittedly, many municipalities and independent organisations in the EU offer further measures aimed at improving the integration of young migrants, but we found few health-related offerings. We do know, however, that Member States, such as Germany, are increasingly offering services in the field of drug prevention, for example, ethnic German emigrants from Russia, for instance, being very prone to drug abuse. Further examples are included in the report of the European Monitoring Centre for Drugs and Drug Addiction.<sup>112</sup>

## **Chapter 9: Conclusions**

### **9.1 Experiences with the EU network**

The declared goal of the project was to successfully implement agreed tasks with the help of a network of national experts. In a short time, the selected experts were prepared for the empirical survey required that was subsequently carried out in individual countries and led to country reports. The network proved to be a workable platform for the development of a European perspective, pushing for an exchange of experiences and establishing a common

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<sup>112</sup> European Monitoring Centre for Drugs and Drug Addiction: Annual Report 2003. Lisbon 2003, p. 65 et seq.

basis for action. In this manner, a common European "denominator" could be worked out, indispensable for executing the common tasks and developing common procedures.

The EU network ensures information exchange and helps to establish agreement on important goals and instruments. The network agreed on a common questionnaire and an empirical survey considered to be an appropriate procedure for recording health-promoting measures among children and adolescents. The questionnaire was translated into the languages of participating experts, and a common search strategy was elaborated, so that largely comparable data could be gained.

Experience with the functioning of the EU network shows that - if a common project on health promotion for young people is to be urged on in EU member states - a lot of time and space are necessary for the practical work. In spite of different scientific, political and cultural opinions, it was possible to develop a common sense of direction within the network and to create synergy effects that can lead to initiatives for new developments in the participating EU Member States. Thus, important insights into health risks for young people and health promoting measures related to those risks can be made known to the general public.

Moreover, the network has recognized the significance of its work for the EU enlargement due on May 1, 2004. It has offered to make its findings available to the new Member States, predicting a high demand for health promotion research and field work among children and adolescents in the Europe of the future.

Because of its positive experiences, our EU network has recommended to include the detailed results of the empirical survey in the final report and to give preferential treatment to the topic of transferability of projects, programmes and activities. Furthermore, all country reports handed in are to be made available in the appendix. The intention of the report is to stimulate the information exchange between Member States and to persuade other researchers, politicians and experts to include this know-how in their own actions. The final report offers an inventory of projects, programmes and activities in the health promotion of young people in Europe, indicating gaps conditional on health risks and presenting a range of possible actions and practical solutions in the form of projects, programmes and activities.

## **9.2 Health policy recommendations**

The following recommendations were discussed during the network's second workshop (in Munich, Freising, December 2003). They are meant for politicians in Member States and the European Parliament.

### **9.2.1 Organizing an information base**

One result of the two workshops was the observation that not enough data existed on health promotion for children and adolescents in the EU. That is why a systematic information system on projects, programmes and activities in health promotion has to be developed, structuring data according to standardized indicators and making them available to the public. A breakdown of data according to European, national, regional and local levels should be possible.

There is also a lack of data in the EU on the health status of children and adolescents. These data are required for health promotion. Existing EU reports (European Commission 2000, Hackauf/Winzen 1999) show sizeable gaps in European reporting on the health of children and adolescents in the EU. Available data should be presented at the European, national, regional and local levels in compatible ways.

There is also a lack of data on sub-groups like the socially disadvantaged, minorities, migrants and other groups that are not (cannot be) recorded in traditional statistics, e.g. children from deprived families, children from especially troubled families, homeless children and adolescents.

### **9.2.2 Promoting holistic prevention approaches**

The empirical survey identified a number of offerings using a holistic approach, e.g. "life-skill" techniques for the promotion of general life competencies. They are innovative programmes one of the aims of which is to influence risky behaviour of children and adolescents. Generally, children and adolescents should learn to acquire personal and social

competencies that prevent the emergence of permanent risky behaviour. It is important for adequate health promotion that networking is improved between the various "settings" where children and adolescents move about in their everyday lives (such as schools, leisure time facilities, local communities, health services) and other actors, groups and institutions.

### **9.2.3 Promoting effective projects for young people**

The EU network realizes that the effectiveness of projects, programmes and activities in health promotion must be proved and that this aspect must get particular attention. As the empirical survey we did shows, effectiveness can only be proved if the quality of projects is continually revised and documented on the basis of an evaluation.

Groups at risk who normally have no access to settings and cannot be reached easily by prevention programmes should be given special care. Children and adolescents who grow up in poverty and have few qualifications are more at risk healthwise than others and are often susceptible to risky behaviour. That is why socio-political as well as health policy measures are required to support disadvantaged children and adolescents and improve their chances in life.

The principle of "gender mainstreaming" is not very well-known or applied in projects, programmes and activities of health promotion for children and adolescents in the EU. If procedures are gender-sensitive, the effectiveness of health promotion can be increased. Therefore, people should be made familiar with, and encouraged to imitate, exemplary projects/programmes/activities applying the "gender mainstreaming" principle successfully.

### **9.2.4 Improving the quality of projects**

The quality of projects can be raised if competencies are improved consistently and funding is secured. For this purpose, efforts are necessary in the area of quality assurance which participants should work on in their professional fields. Professional training possibilities are desirable, as is the development of special quality control guidelines regarding prevention projects for children and adolescents.

### **9.2.5 Project funding**

It followed from discussions with experts of the EU network that project funding was sometimes insufficient with regard to methodology development, organization and evaluation. To ensure the best possible functioning of projects, adequate funding should be provided.

In particular, adequate funding should be ensured for the joint evaluation. Enquiries have shown that most countries have suitable institutes for doing an evaluation. Inadequate funding of projects weakens the infrastructure of relevant institutions and their specialized consulting services.

### **9.2.6 Disseminating information effectively**

It should be ensured that information on health promotion for children and adolescents gets to the proper information channels. They make health promoting measures well-known and contribute to their acceptance among EU citizens. Indirectly, they are a health promoting measure themselves. At national and regional levels, interested citizens and professional circles should be able to access information, thus prompting them to make health promoting efforts of their own.

### **9.2.7 Supporting comparative basic research**

The EU network recommends the support of research on the various personal and social determinants (illness, well-being) of health promotion. Research findings are required, so that effective prevention measures influencing the behaviour of young people can be developed at an early stage. Research that benefits the health promotion of children and adolescents should be expanded.

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## Appendixes

### Appendix 1 Topic Matrix

	F	NL	D	L	A	EL	B	FIN	P	IRL	I	S	E	UK	DK	
<b>Drugs (illegal)</b>			1			1				1	1					4
Tobacco	1		1		1	1		1							1	6
Alcohol	1	1	1			1		1				1	1		1	8
Consumerism						1										1
Health promoting schools			1			1										2
<b>Mental Health</b>	1			1	1		1	1		1	1	1			1	9
Suicide	1		1	1	1										1	5
Psycho-Somatic/Self Esteem										1		1				2
<b>Nutrition</b>	1				1	1					1	1				5
<b>Physical Activities</b>													1		1	2
<b>School Environment</b>					1					1	1	1				4
<b>Social Inequality</b>			1	1			1				1	1				5
Migrants		1		1	1							1	1			5
<b>Traffic Accidents</b>			1	1	1	1										4
<b>Risk Behavior</b>	1										1					2
<b>HIV STD Sexual Health</b>		1		1												2
<b>Relations &amp; Sexuality</b>						1										
<b>Gender related Health, Family Planning</b>												1				1
<b>Human rights</b>						1										
<b>Conflict Management, Bullying, Violence</b>				1								1				2
<b>Occupational Health</b>								1								1
<b>Participation</b>				1												1
<b>Leisure Activities</b>			1													1
<b>Vaccination</b>							1									1
	6	3	8	8	7	9	3	4	*	3	6	9	3	*	5	69

\* not available

## Appendix 2 Project Guidelines

Not every country has to present all thinkable activities. The aim is to create a broad view on European best practice activities more than to be representative of one country. This summary refers to session 1 and 3 of the Munich-Bernried conference. It provides practical suggestions for search strategies regarding the qualities that are important for “best practice” programmes, projects, and activities.

### 1. Search strategies for best practice activities

Looking around and finding the most appropriate activities are the most crucial parts of the project. Therefore, search strategies and suggestions for choosing projects are useful in making these parts of the project comparable for all countries.

The following key dimensions that resulted from the discussion in session 1 show the appropriate areas for the wanted sample. The projects, programmes, or activities in each country should be widespread over the dimensions being targeted.

If one chosen project is a combination of the realisations of several dimensions (e. g. current problem, mental health problem, feeling good and behaving bad, alcohol consumption, immigrants as a target group, focussed at a local level). Other chosen projects should describe other combinations.

#### *Country specific problems*

current real problem, problems should be changed

current problem highly discussed, but may not be real

former problems, yet solved or at least changed the relative position positive e.g. traffic problems in NL

#### *Perceived problems vs real problems*

physical problems

mental health problems

#### Interaction models

feeling good, behaving bad or bad situation

feeling bad, behaving good or good situation

feeling bad, behaving bad or bad situation

#### *General behaviour vs specific problem and holistic approaches to solving them*

bad socioeconomic conditions, e.g. better general education

alcohol consuming or teenage pregnancy, e.g. anti-alcohol campaign

#### *Representative subgroups for health promotion measures:*

young men

immigrants

and so on

#### *Prevention vs. Protection*

making children strong instead of protecting them

good self image, esteem instead feeling good by drugs or bad behaviour

#### *EU Country Region or Local activity*

## 2. “Best Practise” – suggestions

These suggestions were discussed during session 3 and serve as general tips for aiding in the empirical work. These are merely recommendations and should not be understood as strict guidelines.

If you are unsure as to what denotes “best practice”, please consult experts from your own country to get an idea for what is understood by the term on a national level.

Best Practise - Better than other activities  
scientific view  
useful for the target group  
cost efficiency

Common rating - National expert hearing

Relevancy for the topic

Well described

Broadly used

Efficiency

Usefulness for other countries  
(transferability)

## 3. Expert questions and project questionnaire

3.1. For all project activities there is a common questionnaire<sup>113</sup>. (attachment questionnaire)

3.2. Each questionnaire includes one part offering information about the selection of the project (A-C). This information should be filled out by the experts themselves (e. g. identification number and the project title).

3.3. The information about the project is to be acquired by the experts (1-29) through:

(phone) interviews with project coordinators  
completing the questionnaire by project coordinators  
other kinds of information, searches, or combinations of both.

3.4. The questionnaire is to serve as basic interview guideline, for example in some cases questions will need to be varied according to the situation. This is acceptable; however, such variations should be well documented.

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<sup>113</sup> Adapted from Siegrist, J./Joksimovic, L.(Federal Centre for Health Education: Social Inequalities and Health in Europe, 2001)

In addition to the questionnaire, other information should be gathered concerning the programmes, projects, and activities. These can be obtained through reports, articles, brochures etc.

3.5 For every programme, project, and activity, a profile should be created for the country report (see 6, profile example). This will include information from the questionnaire and other materials.

The additional information will consist of tips concerning the quality of the programmes, projects, and activities.

#### 4. Topic matrix

Please make sure that the information you have provided in the topic matrix (see attachment topics) is correct. Example: The Swedish expert suggested 9 topics. For 3-5 projects programmes, activities, this would mean that at least 27 such activities would need to be investigated.

Have you realised how many projects you will be investigating for your empirical study? In case of changes please inform us.

#### 5. Country specific report

The structure of the country specific reports should align with the requirements below. The report should not be longer than 20 pages.

Content for the country specific reports

Introduction (1 page)

Description of the project, goal setting, and contents of the country report  
(1 page)

Comparative part- specific country in relation to the EU (3 pages)

5.3.1. Compare your country with the given EU members, you will receive data from us\*.

Is the position of your country within the given tables relevant for the selection of your project or activity? If yes, please describe the given situation and the reasons for making your decision.

What specific problem areas arise in comparison with other EU countries?\*

5.4. Implementation of the study (1-2 pages)

5.5 Description of the investigated projects (10-12 pages) (sum of profiles)

5.6 Results stemming from the scientist's own empirical study (2-3 pages)

5.7 Consequences and suggestions for health policy (2 pages)

\*) To simplify this process, we will gladly send you appropriate data and tables on the following topics:

- welfare system, health expenditures
- health behaviour, e.g. HBSC-study
- **efficiency, life expectancy**

- socio economic dimensions.

Please contact us if you are interested in receiving these.

## 6. Profile example

After the expert has completed the questionnaire, he/she will use this example to organise the information in a proper way. Please follow the example below in structuring chapter 5 (description of investigated projects) of the country report.

Project title and identification number

Health promotion of apprentices

Short description of the intervention

The goal of the project is to use new teaching methods...

.....

.....

.....

Duration of the project: *December 1998-November 2001*

Project initiators:

Teachers...

Those carrying out the activities

Teachers, instructors...

Target group

Young apprentices...

Classification of the target group

*a class in their apprenticeship*

.....

Number of participants:

About 140 students

Project field

Traineeship program

Goal of the intervention

In addition to the goal of strengthening the overall health competence of the young people,...

Procedure in carrying out the intervention

*Definition of the project goals*

.....

Evaluation:

*University of XY*

Goal of Evaluation

- *Continuing improvement of the project model*

...

### Evaluation design

For the evaluation of the results, a standardised questionnaire will be used to...

### Intermediary results:

At this moment, no final results of the evaluation have been brought forward...

### Publications/reports of the project:

.....

### Contact information/person

Please note that it is not necessary to follow this example word for word; rather, it should serve as a general structural suggestion.

## **Appendix 3 Project questionnaire**

## **Appendix 4 Country reports**

## **Appendix 5 Compendium**