Summary Report on the Workshop of the Central and East European Network on Essential National Health Research

Balatonlelle 9-14 November 1997

Jointly organised

STAKES National Research and Development Centre for Welfare and Health (Helsinki)

National Institute for Health Promotion (Budapest)
The International Forum of Social Sciences in Health (IFSSH)

PROGRAMME FOR THE ADVANCED SEMINAR ON EQUITY AND HEALTH: FROM RESEARCH TO ACTION

BALATONLELLE (Hungary) 9-14 NOVEMBER 1997

Monday

9.00 -> Chaired by Peter Makara<

ABOUT OF THE WORKSHOP
Peter Makara, Erio Ziglio, Anneli Milen

IN-DEPTH INTRODUCTION OF THE PARTICIPANTS AND THEIR INTERESTS
Technique of introduction to be introduced

INEQUITY, DEPRIVATION, MORTALITY
Andrea Cornia

14.30 - 18.00 Chaired by Simo Kokko

INTRODUCTION OF THE RELEVANT KEY CONCEPTS
- DISCUSSION IN WORKING GROUPS

Tuesday

9.00 - 13.00 Chairperson: Pauliina Aarva

RAISING THE QUESTIONS ON THE TABLE NEEDS-ASSESSMENT THROUGH GROUP WORK

14.30 - 18.00 Chaired By Peter Makara

CHALLENGES FOR HEALTH POLICY: THE CASE OF ROMANY POPULATION IN HUNGARY

Maria Nemeni: Romany women and health services
Martha Váci, Zoltán Mohai: Health Promotion by NGOs
Eszter Harsanyi: Education and ethnic minorities
György Lakatos: Co-operating with Roma organisations for health

Discussion

20.00 Gypsy folklore programme

Wednesday

9.00 - 13.00 Chaired by Anneli Milen

FROM PROBLEMS TO ACTION

Erio Ziglio: Situation analysis and policy planning for health

Yvo Nuyens: From research to action: The concept of Essential National Health Research

Discussion in working groups

14.30 - 17.00 Chaired by Erio Ziglio

Pjotr Mierzewsky: Ethics and public policy: the perspective of the Council of Europe

Discussion

18.00 -19.00 Round table discussion with the counsellor of the Minister of Welfare of Hungary, Dr. Piroska Varga

Thursday

9.00 - 13.00 Chaired by Minna Sinkkonen

CHALLENGES FOR HEALTH POLICY:MIGRATION

Judit Juhasz: Migration in CEE
Per Spenning: Migration and health

Discussion

Simo Kokko: The possibilities of Primary Care in enhancing equity in health

Discussion

14.30 - 17.00 Field visit to a traditional Hungarian settlement / outdoor museum

17.00 - 19.00 Chaired by Pauliina Aarva

Bela Buda: Deprivation and mental health

Discussion: Empowering individuals and communities

Friday

9.00 - 12.00 Chaired by Peter Makara

9.00 Proposal for conclusions for CEE presented

Discussion in working groups on the proposal

11.30 - 12.00 Bringing it together

INTRODUCTION

The IFSSH Workshop on "Equity and Health: From Research to Policies" was organised by The National Institute for Health Promotion, Budapest, Hungary and STAKES (National Research and Development Centre for Welfare and Health), Helsinki, Finland. The workshop had 19 participants from 9 countries (Croatia, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia) as well as lecturers from the WHO Regional Office for Europe, Copenhagen, The Council of Europe, Strasbourg, UN World institute for Development Economics Research (UNU/WIDER), Helsinki. Finland, Council on Health Research for Development (COHRED), Geneva and International Organisation for Migration (IOM), Budapest. This report is a summary of the written and oral contributions to the workshop. Discussions and group work formed and integral part of the workshop but they are not included in this report.

OPENING OF THE WORKSHOP

The workshop was opened by the Director of the National Institute for Health Promotion, Hungary Dr. Peter Makara who welcomed the participants to the workshop. The key issue in the future is to organise a functioning network and a regular workshop for Central European Health Promotion. Maybe the problems will not be solved during the workshop but the participants will learn and have a better understanding of each other through participatory working methods and discussions. Dr. Erio Ziglio from WHO Euro pointed out that inequity is increasing and that it is very important to arrange workshops like this.

Dr. Anneli Milén, Director, STAKES/Hedec, Finland presented the working methods of the workshop in detail. She emphasised that the presentations of the workshop are not lectures but introductions to the subject and serve as a basis for discussions Mr. Peter Makara continued about the context of the workshop; the relationship between health and social factors and how to move from research to policies.

INEQUITY, DEPRIVATION, MORTALITY

Director of UNU World Institute for Development Economics Research, Dr. Giovanni Andrea Cornia presented the relationships between inequity and deprivation and mortality rates in countries in transition. Over the last seven years, most countries of central and Eastern Europe and the former Soviet Union have been affected by an unprecedented fall in output and incomes, a rapid impoverishment of large sections of the population, increasing uncertainty and exceptional mortality crisis.

The transition's mortality crisis remains largely unexplained.
Dr. Cornia argues that the transition's mortality crisis has been mainly caused by the growing psycho-social stress resulting from acute, transition related, dislocations in the labour market, family structure and geographical distribution of the population, and by inadequate policy action of which he presented empirical evidence. Psycho-social stress reflects three components: anxiety caused by the inability to cope with unexpected situations; the apathy, rage and depression caused by changes in social hierarchies and the frustration due to relative social deprivation.

A successful testing of the psycho-social stress hypothesis will have massive policy and political implications. Supporters of the "big bang" tend to minimise its mortality impact, to ascribe it to problems inherited from the socialist era to the "unavoidable chaos" brought about by the transition, and to suggest that there are no quick fixes for its solution. In turn conservative forces argue that the mortality crisis has been caused by sheer impoverishment brought about by shock-therapy and that - therefor - many market reforms should be repealed or sharply amended. The policy implications of psycho-social stress analysis are substantially different from either views: vigorous market reforms are needed, but need to be characterised by a realistic pace of industrial restructuring, strong active labour market and social sector policies, maintenance of law and order, the strengthening of specific health interventions, and - to finance all this in a non-inflationary manner - by adequate revenue generation.

The close connection established between economic events, public policies and health outcomes implies that the current health crisis will not be overturned rapidly if public policy remains aloof or continues to be focused on few sectoral responses with limited impact. An active industrial policy focusing on a properly paced restructuring process, accompanied by an adequate mix of active-passive labour market policies to support employment, training, public works, time bound wage subsidies, as well as o public health measures for the control of the sources and manifestations of social stress is needed.
It will require also more comprehensive policy initiatives to contain and excessive surge of income inequality by means better regulation of minimum and social sector wages and social transfers, as well as by an enhanced tax collection policy to finance the necessary interventions in a non-inflationary manner. The overall situation in Eastern Europe requires rapid and more vigorous responses.

After Dr. Cornia's presentation Dr. Simo Kokko from STAKES argued that the social gradient is true for most (common) health problems (low income, low education, unstable life, powerlessness, unemployment). The existence of the gradient is a sign of inequity: the disadvantaged people are not getting g fair share - not to mention fairness in relation to need. The workshop continued with a two part discussion and exploration in working groups on concepts defining the social reality: poverty, deprivation, marginalisation, social exclusion, disadvantaged/vulnerable groups, social class, social stratification, social stability and ethical structure.

FROM PROBLEMS TO ACTION

Situation analysis and policy planning for health

Dr. Erio Ziglio from the WHO Regional Office for Europe introduced his subject by addressing the following questions: can the promotion of health become central stage in the debate about health policy in European countries?, Can health promotion become the new and much needed paradigm for policy planning for health ?, In which way can we bridge the emerging new literature of research findings on health determinants with coherent policy action ? and Which kind of strategic, managerial and organisational features should a country, region or local area have in order to implement an investment for health strategy?

Almost all member states of the WHO/Europe have been (or still are) heavily involved in health care reform processes. The current processes share a number of common elements. In several instances the reform processes stem from cost-containment pressures. Quality assurance and access to health care are also issues that are increasingly finding their way onto the agenda. In the light of the trend in health care reforms, what are the challenges for those working in health promotion? When analysed from a health promotion perspective, the processes of reforms have three major weaknesses: a short-sighted vision of the future, a chronic incapacity to seriously focus on health and its determinants (rather than merely on the finance and delivery of medical and health care services); and a lack of managerial and strategic planning for a strong intersectorial approach to address health determinants (which are in most cases linked to social, economic and human development factors).

From a health promotion perspective, the analysis of the health care reforms introduced in the last decade leave us perplexed as to their real capacity to address the tremendous challenges facing the promotion of health of the eight-hundred and fifty million people living in the European region of WHO.

Health promotion is defined as the process of enabling people to increase control over, and to improve, their health. In the light of the changes occurring in Europe this definition can be enriched as follows:"Health promotion is the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health". The perquisites and potential for the promotion of health of the population are not limited only to the health sector. A sound and credible strategy for health promotion implies synergy of efforts among a variety of players including: all levels of government; sectors such as health care, the social services and education; environmental policy, the country development sectors, the media, NGOs and all other institutional arrangements crucial to social cohesiveness, social justice and human rights. Unfortunately the current debate around health care reforms is far too narrow and does not place health at the centre of the debate. The five action domains identified in the Ottawa charter for health promotion (building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; reorienting health services) are barely at the margin of health care reforms.

Health is an investment and is a crucial social and individual resource.
Health promotion has to be pursued, and increasingly perceived, as an innovative modern strategy which in addition to health benefits in the population brings about "healthy" social and economic returns for a nation. There are at least three key questions which are important for developing and maintaining a strong and credible health promotion strategy:

– where is health promoted and maintained in a given population?

- which investment and strategies produce the largest population health gains?
- which investment and strategies help reduce health inequities and are in line with human rights?

These are the questions where the link between research and policies must break new ground and progress. Only a very few reforms underway are trying to put these questions on the table. The Health Promotion and Investment Programme of the European Office of the WHO has started a number of innovative projects and set up new services which aim at addressing the above-listed questions by testing policy means and managerial, financial and organisational development tools. The first results show that there is ample possibility for innovation and change at various levels of decision-making.

Grasping the health promotion paradigm rests on two lines of analysis: first, a reassessment of the major health assets and challenges facing Europe together with their root causes, and second, an examination of how best the root causes might be influenced. In this process there is a need to focus "upstream" to the wider determinants of health in the social and economic policy environment. More emphasis should be put on the notion of health being an investment. The economic and social development of European countries will depend to a significant extent upon effective measures to promote and sustain the health of the peoples of the continent. In grasping the new paradigm, the challenge is , therefore, to find ways of deploying investment for health to reinforce immediate priorities, such as economic development and fiscal soundness to enhance people's health - equitably and sustainable.

What characteristics should a country, region or local area have in order to implement an investment for health strategy? Listed below are major features that should be fostered in countries - at all levels of policy - making - in order to grasp the new paradigm both conceptually and operationally:

- political and managerial understanding of the determinants population health;
- more focus on "health" (not merely on medical care and on mechanisms to control the consumption of health care);
- accountability for population health (through appropriate channels and structures);
- review on investment potential (within the health sector as well as in key sectors of human, social and economic development, e.g. education, environment, transport, communications, housing, etc.);
- capacity for intersectoral action (at national, regional, local and international levels);
- incentives for bringing together all interests and stakeholdres (which are related directly or indirectly to the promotion and maintenance of population health and quality of life);
- positioning health promotion at the heart of social, economic and human development (and influencing such development to ensure that it is "healthy", equitable and sustainable);
- establishing an infrastructure enabling the above (both within and outside the health sector).

In the reality of the changes occurring in Europe, we must consider what adjustments in public policies can best maintain and advance the health of all citizens, east and west,

north and south. We must jointly begin the search for health investments in social, economic and environmental policies as well as health policies.
From research to action; The concept of Essential National Research

This presentation was health by Dr. Yvo Nuyens form the Council on Health Research for Development (COHRED). Discussion was initiated about how research can be put to action. The participants were asked to evaluate how and in which context research has come up previously in the workshop. What is bothering people? The comments were:research reports are too complicated for politicians and decision-makers; decision-makers are not ready to listen; research is not relevant; timeframe of research and politics is different; information bias and excellence and reliability of research Then the participants evaluated whom are we doing research for: clients, decisionmakers, community, third parties, researchers, donors and providers of health care. Research seems to be locked in capital, cabinet and campus.

The knowledge driven model of decision-making presumes that data collecting leads to information, knowledge, understanding, judgement and in the end decision. This is not reality, in the real world decisions are made according to the stakeholders model where research is only one input to the decision making process and different stakesholders (professional groups, industry, church, politicians, government, media and NGOs) play a very strong role. The strategies that can be chosen to put research into action are:

1. educational strategies for stakeholders
2. institutional strategies: academic subordination without freedom to choose orientation, politically decided; segregation, decision makers do not want to health the results of academic institutions; integration, a way between, a joint venture between the groups.

Essential national Health Research (ENHR) is an integrated strategy for organising and managing research, whose special characteristics include its goal, focus, content, and mode of operation.

The goal is to promote health and development on the basis of equity and social justice.

The focus is national and country specific. A country may choose to apply the ENHR strategy at the sub-national or the district level in its efforts to use resources most effectively. The goal of equity and effective allocation of limited resources makes the ENHR strategy just as relevant to developed as to developing countries.

The content includes many types or research such as epidemiological, human behavioural, clinical and biomedical, health systems, policy analysis, operational, management, and communications research. However, the research disciplines and methodologies used evolve from the problems and research questions identified through the process. Usually the research requires the involvement of a number of disciplines.

The mode of operation of process is characterised by inclusiveness. It involves scientists, policy and decision makers (including health care providers) and representatives from the community. All three constituencies are crucial for setting priorities and for planning, promoting and implementing research and action

programmes. Effective linkages must be established among the constituencies to enable each to participate as an equal partner in the decisions and actions leading to Equity in Health. In this way, the process ensures that the results of research are translated into action.

The ENHR loop:ENHR establishes a dynamic relationship among the policy, action and research sectors and spurs researchers, division makers and community representatives to use scientific methods to analyse health situations, identify problems and solve them. ENHR aims to improve health and equity, and this makes it an essential component of both primary health care and human development.

Piotr Mierzewski made his presentation on Ethics and Public Policy: the Perspective of the Council of Europe. It is important to integrate human rights and ethical considerations in health care and public policy. Medicine is a social science and politics is nothing but a medicine on a grand scale. Sound policy making starts with principles, leading to policy, politics and practice. The value of the Council of Europe is that is states its values: democracy, rule of law and human rights. In his opinion equity in health means equal chance to use one's health potential. The Council of Europe has worked with vulnerable groups for a long period of time bringing up the ethical aspects of health: equity, patients rights and bioethics by international conventions.
At the end of the day participants had a chance for discussion with the representative of the Ministry of Welfare, Hungary: Ms.Piroska Varga, chief Advisor to the Minister.

CHALLENGES FOR HEALTH POLICY: THE CASE OF ROMANY POPULATION IN HUNGARY

The national Institute for Health Promotion, Hungary has a programme for people with social handicap. In the along-term principles of the National Health Promotion Programme there is special attention to people with poor or worsening background. among them the problem of gypsy people having badhealth characteristics is especially important and urgent, so it needs special coordinated social activity for improving their health and health care.

There is no national research about the health of the Hungarian gypsy population. Because of their life circumstances and social situation their life expectancy is about 10 years shorter than the non-gypsy population in Hungary. The premature birth (low birth weight <2500g) is more often, because their birth weight is lower than the others. The acute illnesses, mainly infections and chronic diseases are more common and longer.

The health promotion of gypsy people needs a special approach. The methods of health education, which are effective in the middle class, are ineffective in this population. According to the experience of the National Institute of Health Promotion, the effective way is to concentrate on the risk behaviours, work together with the gypsy population, and combine the health and social policy.

The team of the National Institute of Health Promotion elaborates special health tasks for the population with social handicap and its combination with socio-political activity. The team works according previous principles, plans new special health

promoting policy, starts pilot projects, and the successful models are transmitted to the local gypsy population across the gypsy governments, the gypsy communities and their educating institutions. Main standpoints of the prevention activities are: training for gypsy people; organisation of life-style clubs and camps for gypsy children, producing methodological films; employment of special streetworkers working among people who are at AIDS risk and/or homeless; cooperation with gypsy associations both in the capital and in the country-side and establishment and functioning of the gypsy association called Romano Glasso.

One example of successful projects is the first streetworker training in 1992 for gypsy people having no professional knowledge and formal education. There were around 20 participants at every 6 weeks long training programme. The programme of the training was planned and held by the professionals of the National Institute for Health Promotion. This project had a very good publicity in Hungary and in the foreign countries both in the written and the electronic media.

The presentation of the situation of the Romany population in Hungary was started by Maria Nemenyi from the Institute of Sociology, Hungarian Academy of Sciences. She presented her research on the relationship of the representatives of the health care system and young pregnant romany women and romany mothers with small children. According to the findings of the research the health care representatives have strong prejudice against romany women.

The Romanys themselves continued: Zoltan Mohai presenting the programme for street workers by the National Institute for Health Promotion and two other Romany representatives from National Institute for Health Promotion: Esther Harsanyi and György Lakatos. The prevailing strong prejudice in Hungary against the gypsy population is preventing positive developments. an example was given about a school in the country-side where gypsy children were separated from other children because they were believed to have lice.

Hungarians know very little about gypsy history and culture. The majority of the population expects the gypsies to solve their own problems. The amount of gypsy population in Hungary is estimated 500 000 - 600 000 (5-6 per cent of the total population). They are among the most hit in the worsening economical situation, housing and employment.

They have lower educational level. Poor social conditions and feeling of otherness bring them to the margin of the society. Analysis of the situation and special programmes are needed.

In the evening the participants of the workshop had a chance to enjoy gypsy music and learn gypsy dances with the musicians of Romano Glasso.

CHALLENGES FOR HEALTH POLICY: MIGRATION

Migration in CEE and Migration and Health were presented by
Dr. Judit Juhasz from the Central Office of Statistics, Budapest, Hungary and Dr. Per Spenning, Regional Medical Officer, the International Organisation for Migration.

Health of migrants is closely connected with major concerns resulting from the exploding globalization of tourism, displaced populations and person seeking a better life. This circus humans is threatening to overwhelm health care systems where they do exists, and create further problems in areas where previously well functioning health care systems are breaking down due to socio-economic and political changes.

"Old" infectious diseases are re-emerging; with the "twist" that many cannot any longer be treated with traditional drugs, due to development of drug-resistance or mutation of micro-organisms. New emerging diseases such as AIDS are causing major concerns all over the world.

Due to ignorance, poor tolerance and cultural factors, masses of migrants from all parts of the world intermingling and competing for scarce resources, we see these global travellers increasingly becoming focus for more violence an intolerance. This increases the difficulties of the most vulnerable in the migrant community: elderly, women, children and sick.

Dr Spenning defined positive and negative migration: Positive migration is regular and the migrants have regulated/mandatory interaction with the local host (temporary workers, students, immigrants, refugees, asylum seekers). Negative migration is irregular and the migrants are illegal, trafficked, unregistered/irregular workers. Each migrant or group of migrants carries with them specific health and medical characteristics reflecting their place of origin, journey to present destination and ability to integrate or access health care service on arrival. The medical characteristic cs include: genetic makeup, immunoligical sequlae of past infections, cultural preferences, customs and behavioural patterns. In addition: microbes, animals, other biological life which given the appropriate conditions; human behaviour patterns, vector, climatic conditions etc. can cause disease in host populations, its animal life or in other ways affect the ecosystem.

Massive movements of people and material sets the stage for mixing of diverse genetic pools at rates and in combinations previously unknown:

- In early 90's over 500 million persons cross international borders by air/year
- 70 million persons, mostly from developing world work in other countries legally of illegally
- 20 million refugees and 30 million displaced persons

The health impact of migration can broadly be seen as impact on individual migrant (uprooting, status of immunisation, education etc.), impact on host population and impact on ecosystem. Migrants from less developed areas of the world have had less intensive access to preventive and therapeutic health than individuals of similar age and sex born in Europe. This differential access to health services may result in migrants displaying different incidence and prevalence rates for certain illnesses, disease and ill health.

Specific areas of concern in migrant communities would include:
1. Limited access to aspects of maternal and child health care,
2. Nutritional deficiencies, 3. Limited or incomplete immunisation, 4. Higher background levels of certain infectious diseases, 5. Limited reproductive health information, 6. Limited or non-existent preventive health programs, 7. Limited

understanding of access to health care services at point of destination, 8. Higher incidence of trauma, torture, abuse in groups of refugees, asylum seekers and trafficked migrants, 9. Higher levels of psychosicial and mental illness in migrant communities, 10. Impact of poverty and limited resources, 11. Impact of limited or interrupted education, 12. Limited of infrequent access to health services or ability to pay for health services in absence of health insurance.

Some local Central and Eastern European concerns connected to migration:

1. Labor migration is a growing phenomenon from the countries of the east in to Central Europe, due to the economic differential. This labor migration is both regular and irregular seasonal and contract based, but there is today an absence of organised health screening for a large portion of these migrants and no available health insurance. E.g.: In the oblast of Uzhgorod with a population of 3 million 10 % are labor migrants, seek income for themselves and their families in the near republics to the east and west. Regularly there are reports of injuries; sickness requiring hospitalisation and deaths, where the host countries are not able to afford the added burden these migrants cost the health budgets. Additionally, these migrants are underpaid, often overworked and suffer nutritional deficiencies and poor housing with resulting poorer health after return to their homes.

2. Due to the health care differential between Hungary and its neighbours, there has over the past 7 years been a virtual health migration across the borders from Ukraine, Romania and former Yugoslavia for diagnostic and treatment purposes.

3. In Bosnia, there has, as we all know, been large population shifts over the last years due to the war. The population has been displaced internally and sought refuge in host countries. The health care system, which before war was reputed to be one of the best in the socialist countries have broken down due to direct destruction of facilities and death or departure of health care professionals (12 000). One of the consequences of this has been a significant increase in the incidence of tuberculosis, which in some areas has reached a staggering calculated 500 per 100 000.

In conclusion migratory patterns and flows have undergone a period of dramatic evolution during the past 25 years. Traditional patterns of population movements have given way to the consequences of a globalizing world in which several of the principles and historical limits and hindrances to travel have vanished. Those who design policy may not appreciate the size, characteristics, health parameters and distribution of migrant populations in Europe in sufficient detail.

Consequently, there is a need to a reassessment and quantification of the size demographically and health characteristics and location of migrant communities. This demographic analysis will facilitate the design and implementation of health policies that will work toward addressing some of the inequities and limitations experienced by migrants. Such demographic analysis and monitoring may need to become an integral part of health policy formulation in the region in order to be responsive to the shifting demographic nature of migrant populations.

In line with the organisations mandate, International Organisation for Migration has in cooperation with concerned member governments over the last year initiated projects

in the academic sector focusing on various aspects of migration. In line with this there is already a post-graduate course in migration in Argentina; another course on legal aspects of migration is under elaboration. Some courses are planned to start autumn 1998 in the Medical University of Pecs and Debrecen, Hungary.

THE POSSIBILITIES OF PRIMARY HEALTH CARE IN ENHANCING EQUITY IN HEALTH

Dr. Simo Kokko from Stakes, Finland initiated a discussion about the role of primary health care in enhancing equity in health. Some strong underlying beliefs were presented, such as: primary care is more equitable than secondary and tertiary care and that ambulatory care is more equitable than hospital care. The correctness of these beliefs was questioned and the question was put on the table: could health services be equitable - or promote equity - without being founded on strong Primary Care?

Special features of Primary health Care and their links to equity. primary Care:
1. is comprehensive; it does not usually exclude any health problems form its realm. It recognises co-morbidity and the social origind of illness.
2. is continuous instead of (only) episode based; it often has a family-focus
3. is - or should be multiprofessional
4. focuses on essential and common problems
5. includes prevention and health promotion and rehabilitation along curative actions
6. is locally rooted
7. has a coordinating role in the maze of health services - a role that is growing in importance
8. employs General Practitioners as key actors.

The Primary Health Care systems of Europe were discussed briefly and the case of Finland; Country with the widest use of health centres in Primary Care was presented in more detail. The typical array of services of health centres in Finland are:

- Curative services of the GP
- GP run hospitals
- Home nursing, nurse practitioners
- Public health nurses in maternity and child care
- Dentists
- Environment and work hygienists
- Physiotherapists
- Psychologists
- Psychiatric nurses
- Diagnostic facilities
- Ambulance services

Recently, in the 1990' the territory of specialism has grown in importance and the coordinating and gate-keeping roles of GP's have enhanced.

CHALLENGES FOR HEALTH POLICY: DEPRIVATION AND MENTAL HEALTH

Bela Buda from the Budapest Medical University gave his presentation on deprivation and mental health. marginalised people have had problems in their socialisation

process and are therefore more vulnerable to mental health problems. According to the latest study initiated by the WHO poverty and deprivation are the mainfactors in mental health in the world. Prevalence of schizophrenia and neurosis is five times more in lower social classes. This is due to deprived social conditions. Social decline is of course also die to the disease itself.

During the socialisation process lower class children get less attention and formal instructions from their parents. Their language code is less developed. Also the family life of the lower classes is more often disturbed and unstable. One example is the high prevalence of single gypsy mothers. Also hereditary factors and socio-cultural factors play a role in this process.

The whole life cycle of a poor, deprived person is full of negative factors affecting mental health: early smoking, alcohol and drugs abuse. Early sexuality for girls, no use of contraceptives and high prevalence of abortions and high infant mortality rate. Unemployment causing suicide, high alcohol consumption and homelessness. Coping in life is closely connected to the life experience of an individual.

After the presentation of Bela Buda, psychiatrist Wojciech Klosinski briefly presented the trends of mental health care in Poland.

CLOSING AND FUTURE PLANS

The seminar was closed by Director Peter Makara from the National Institute for Health Promotion Centre, Budapest, Hungary. He felt that the workshop was an important step towards European cooperation in health and a contribution to developing networks. The workshop can also be seen as a lesson for developing dialogue and democracy in the countries of Eastern Europe. A workshop around the same theme will be arranged next year, and he hopes that it will become a tradition.

The participants appreciated the participatory working methods of the workshop and found it very useful because people from different countries could meet and share there experience and opinions and find what is new in Europe in the field of equity and health.

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