

# HealthBox

## Healthy Lifestyle through Education

Background information for adult educators  
implementing the Health Box

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Human Concern

**Healthbox**  
**Healthy Lifestyle through Education**

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<b>1. Introduction</b> .....	<b>2</b>	3.5.1 Alcohol misuse.....	7	5.1.1.2 Consequences for the Health Box project.....	25
<b>2. The Health Box with its vision of a “Healthy Europe”</b> .....	<b>2</b>	3.5.2 Unhealthy nutrition .....	8	5.2 The role of the trainer and the decision for the Health Box implementation.....	26
2.1 The idea of a “Healthy Europe” and the consequence for the labour market .....	3	3.5.3 Physical inactivity.....	9	5.2.1 The flexibility of the Health Box and its possible impact of employability.....	26
<b>3. Lifestyle and lifestyle diseases</b> ...	<b>3</b>	3.5.4 Smoking .....	12	5.2.2 Accessibility to socio-economically disadvantaged persons in the adult education field.....	27
3.1 Definition of lifestyle.....	3	3.5.5 Stress .....	15	5.2.3 Social responsibility of the trainer	27
3.1.1 Influence factors on lifestyle.....	4	3.5.6 Substance misuse .....	17	5.2.4 Knowledge transfer of health issues .....	27
3.2 Healthy life: What constitutes a healthy life in Europe? .....	4	<b>4. Social economically disadvantaged people</b> .....	<b>19</b>	5.2.5 Possible obstacles for the Health Box implementation out of the trainer’s point of view.....	28
3.2.1 Distinction between healthy and unhealthy .....	4	4.1 General definition of disadvantaged people in Europe .....	19	5.3 Expected outcomes of the Health Box implementation.....	28
3.3 Definition of lifestyle diseases.....	5	4.2 Barriers to behaviour change.....	20	5.3.1 Short term changes on individual and interpersonal level.....	29
3.3.1 Influence factors on lifestyle diseases.....	5	<b>5. Education as means to reduce lifestyle diseases among socio-economically disadvantaged learners..</b>	<b>21</b>	5.3.2 Long term consequences on individual and interpersonal level .....	29
3.4 Main needs regarding lifestyle diseases in the Health Box project’s partner countries .....	5	5.1 Different learning settings with special consideration of the Health Box’s learning context.....	23		
3.5 Behaviour patterns leading to lifestyle diseases .....	6	5.1.1 Place and space for exchange – learning from each other .....	24		
		5.1.1.1 A theoretical excursion to Formal, Non-Formal and Informal Education ...	24		

## 1. Introduction

„Though health is not everything –  
but without health everything is nothing.“  
Arthur Schopenhauer (1788–1860)

It is a matter of common knowledge that a healthy lifestyle has many positive impacts on a person's life that leads in the end to a higher personal feeling of wellbeing and an increased expectation of life. Hence health is an important topic which concerns everybody – depending on the importance given – more or less intense.

Scientific studies show that one's healthy or less healthy lifestyle depends on different factors such as the influence of one's social environment (role models in family and peers), level of education, occupational status, income or media. Based on this it is not surprising that socio-economically disadvantaged people, meaning for example those with a low level of education or a migrant background, belong to the group with the highest risk to live unhealthy.

When it comes to the question of improving the population's health the aforementioned influence factors have to be taken into account and activities have to be set here. This is why many existing health campaigns or other activities dealing with the health topic try to reach the individuals through different channels and in different settings.

From this point of view the approach of using education as a method aiming at improving the health behavior of the learners does not seem to be new but the specialty of the Health Box strategy is that the target group – socio-economically disadvantaged people – will directly be targeted in learning settings where they are with the utmost probability (e.g. in labour market oriented trainings).

This brochure – as a part of the Health Box developed for adult educators working with this target group, training providers, decision makers and multipliers in adult education, government, social and labour market organisations, umbrella associations and networks in adult education as well as the public in large – gives a short presentation of the Health Box project and its vision of a “healthy Europe” (chapter 2) as well as information on the concept of lifestyle and lifestyle diseases (chapter 3). In the same section typical behaviour patterns leading to some lifestyle diseases in Europe are also presented.

The term “socio-economically disadvantaged persons” which represents the main target group of the Health Box is discussed in the following chapter (4). The last part of this information brochure (chapter 5) deals with the theme “Education as a means to reduce lifestyle diseases”. The role of the trainer as well as expected outcomes of the Health Box implementation is described.

## 2. The Health Box with its vision of a “Healthy Europe”

The Health Box which was developed in the European funded project called Health Box ([www.healthbox.eu](http://www.healthbox.eu)) consists of different training materials such as handouts, short presentations, self reflecting tools, small games, role plays, simulations and guided discussions dealing with the topics alcohol misuse, (un)healthy nutrition, physical (in)activity, smoking, stress and substance misuse. Furthermore small practical exercises for the seminar room and visual material can be found in the Health Box. It is accompanied by this brochure which gives the trainer basic information about lifestyle diseases in general and those caused by the aforementioned misbehaviours.

The Health Box project team is aware that the knowledge about unhealthy behaviour patterns such as smoking, alcohol drinking, usage of drugs or other topics from the Health Box is wide spread. Nevertheless often many small additional hints (in regard to knowledge and/or acting) can give the push that is needed to release the motivation necessary for a positive development.

The Health Box is adequate for a general approach and promises to have considerable application and transfer potential which means that the small learning units can be easily integrated into existing courses and training programmes on issues other than health.

The Health Box follows not only the vision of a “Healthy Europe” but also supports and promotes positive changes to peoples’ health situation wherever possible:

### 2.1 The idea of a “Healthy Europe” and the consequence for the labour market

The overall aim of the Health Box project – the implementation of health issues into adult education – is to facilitate a Healthy Europe including the reduction of so called lifestyle diseases among the European habitants – especially among the most afflicted group – socio-economical disadvantaged persons with a low education and/or migration background. The more trainers and adult educators become aware of the necessity of such kind of support the easier the start of the changing process will be. Although it will take time to reach this aim Health Box can be understood as an important step towards it.

Out of the labour market perspective the need for people with on the one hand professional competence and skills in relation to jobs and on the other hand physical and mental strength that make them viable in the job is high.

A number of European studies show that people who are overweight, smoke or for other reasons are seen as not taking care of

their own health, are picked when companies cut jobs. It is commonly known that this is happening in countries where it is not legal to choose from or dismiss on these grounds. The challenge for a lot of ‘socially weak’ employees is therefore not only lack of professional qualifications and abilities but also what their general state of health is like. This means that employers prefer to employ and hold on to employees with the lowest sick leave and those who are able to be most productive, with the lowest margin of error throughout the day.

Health Box aims at supporting socio-economically disadvantaged persons in different training settings which target to improve the persons’ employability to convince them of pursuing healthy life habits. So the Health Box follows the understanding that not only a professional qualification is crucial for returning to or staying in working life, but employers also set an eye on basic physical and mental skills which are required for the fulfillment of job-related tasks. This means that people will not only be encouraged to live a healthier life but also to become, from the health perspective, “job-fit” again.

## 3. Lifestyle and lifestyle diseases

### 3.1 Definition of lifestyle

**Lifestyle** is a term to describe the way a person lives. It describes a stable and regular pattern in the daily life. A set of behaviors and the senses of self and belonging which these behaviors represent, are collectively used to define a given lifestyle (Geißler 2002)<sup>1</sup>.

1 Geißler, R. (2002), Die Sozialstruktur Deutschlands. die gesellschaftliche Entwicklung vor und nach der Wiedervereinigung, 3. Aufl. Wiesbaden: Westdeutscher Verlag, S 126ff. [http://en.wikipedia.org/wiki/Lifestyle\\_\(sociology\)](http://en.wikipedia.org/wiki/Lifestyle_(sociology)) 19.9.2010

A lifestyle is a characteristic bundle of behaviours that makes sense to both others and oneself in a given time and place, including social relations, consumption, entertainment, and dress. The behaviours and practices within lifestyles are a mixture of habits, conventional ways of doing things, and reasoned actions.

A lifestyle also typically reflects an individual's attitudes, values or worldview. Therefore, a lifestyle is a means of forging a sense of self and to create cultural symbols that resonate with personal identity. Not all aspects of a lifestyle are entirely voluntary. Surrounding social and technical systems can constrain the lifestyle choices available to the individual and the symbols she/he is able to project to others and the self.

### 3.1.1 Influence factors on lifestyle

Studies during the 90s show that the "free choice" of one's lifestyle is more and more limited by objective living conditions, such as age, educational level, position in professional life, income and gender (Geißler, 2002). Apart from this the lifestyle is highly determined by external living conditions and the culture a person is confronted with. Empirical results show that most lifestyles are concentrated in each social class.

The Health Box is based on the idea that people who are socially disadvantaged for several reasons (migrants, unemployed, low level of education, etc) develop a certain lifestyle. The type of lifestyle can be influenced by available resources (income, education, information, social contacts etc.).

## 3.2 Healthy life: What constitutes a healthy life in Europe?

Very similar to the influencing factors on lifestyle are also determinants which influence the health-lifestyle, such as:

- Age
- Education
- Gender
- Income
- Family status and number of children
- Position in professional hierarchy

From the sociological point of view an attitude to healthy living does not constitute one's lifestyle but it is an important component on the, so called "health-lifestyle".<sup>2</sup>

### 3.2.1 Distinction between healthy and unhealthy

According to the World Health Organization (WHO), **health** is a state of complete physical, mental, and social well-being. Interestingly health is not simply defined as just the absence of disease. The actual **definition of Healthy Living** is the steps, actions and strategies one puts in place to achieve optimum health. Healthy Living is about taking responsibility and making smart health choices for today and for the future.<sup>3</sup>

A healthy lifestyle is based on:

- **Healthy and balanced nutrition**
- **Physical activity**
- **Emotional and spiritual wellness**
- **Prevention of health risks**

Neglecting these basic rules in combination with following habits like smoking, regular alcohol consumption or drug misuse could be called an **unhealthy lifestyle**.

2 Hradil, S. (2009) in: Gesundheitliche Ungleichheit: Grundlagen, Probleme Perspektiven. Richter Matthias, Hurrelmann, Klaus (Hrsg.) 2. Auflage

3 <http://www.healthy-holistic-living.com/Definition-of-HealthyLiving.html#ixzz13egfy400>

### 3.3 Definition of lifestyle diseases

**Lifestyle diseases** (also sometimes called **diseases of longevity** or **diseases of civilization interchangeably**) are diseases that appear to increase in frequency as countries become more industrialised and people live longer. It is a disease associated with the way a person or group of people lives. Lifestyle diseases include atherosclerosis, heart disease, and stroke; obesity, type 2 diabetes, depression, and diseases associated with smoking, alcohol and drug abuse.

The basic evidence that supports the existence of lifestyle diseases is the different incidences of diseases and causes of death in various nations and cultures, as evidenced in compiled statistics.<sup>4</sup>

#### 3.3.1 Influence factors on lifestyle diseases

Diet and lifestyle are major factors thought to influence susceptibility to many diseases. Drug abuse, tobacco smoking, and alcohol drinking, as well as a lack of exercise may also increase the risk of developing certain diseases, especially in later life. Regular physical activity helps to prevent obesity, heart disease, hypertension, diabetes, colon cancer, and premature mortality.

In some alternative health interpretations, such lifestyle diseases are a result of an inappropriate relationship between people and their environment. The onset of degenerative diseases is insidious, they take years to develop, and once encountered are not readily cured.<sup>5</sup>

4 <http://www.medterms.com/script/main/art.asp?articlekey=38316>  
[http://en.wikipedia.org/wiki/Lifestyle\\_diseases](http://en.wikipedia.org/wiki/Lifestyle_diseases), 27.10.2010

5 [http://www.wordiq.com/definition/Lifestyle\\_diseases](http://www.wordiq.com/definition/Lifestyle_diseases)

### 3.4 Main needs regarding lifestyle diseases in the Health Box project's partner countries

Lifestyle diseases are acknowledged in all partner countries involved in the Health Box project: Italy, Austria, Denmark, Finland, United Kingdom, Romania and Germany.<sup>6</sup>

The most frequent lifestyle diseases are: **cardiovascular diseases** (mentioned by all partners: Italy, Austria, Denmark, Finland, United Kingdom, Romania and Germany); **alcoholism** (Italy, United Kingdom, Germany, Austria and Romania); **depression** (Italy, Austria, United Kingdom, Germany and Romania) and **diabetes** (Austria, Finland, Denmark and United Kingdom).

Countries not mentioning alcoholism as a lifestyle disease indicate that alcohol could be one of the causes of cardiac diseases. Despite the fact that Denmark and Finland do not specifically mention depression as a lifestyle disease, they indicate psychiatric disorders (Denmark) and an increase of mental stress (Finland).

**Unhealthy diets, smoking and a lack of exercise seem to play a key role in developing lifestyle diseases** as already mentioned.

Romania's situation needs to be taken into consideration: since 1989, mortality due to the above mentioned causes appears to be related to an explosive rise in social stress, a condition which arises when individuals have difficulty in responding to new and unexpected situations.

As a matter of fact, people in general suffer from lifestyle diseases, but disadvantaged groups are more likely to be affected: elderly, unemployed, homeless, migrants. Education, financial situation, employment, age and access to information are crucial factors for the development of the diseases (for more information see chapter 4.2 Barriers to behaviour change).

6 Needs analysis/Research „Health Box“

The main needs within the identified target groups in relation to lifestyles diseases are:

- Raising awareness and providing information
- Individual and group support
- A sensitive approach
- Creating incentives for taking part in health promotion activities
- Considering environmental aspects

All these needs have been taken into consideration while developing the Health Box exercises. To follow the main needs of our target group in the project, the information is given in a way that encourages learners to take ownership of their habits and lifestyle – reflecting positive and negative aspects of living.

### 3.5 Behaviour patterns leading to lifestyle diseases

Europe today has a high prevalence of diseases such as cancer, diabetes, cardiovascular diseases, obesity disorders, musculo-skeletal disorders which can be **attributable** to the interaction of various genetic, **environmental and especially lifestyle factors, including smoking, alcohol abuse, unhealthy diets and physical inactivity.**

**A cardiovascular disease (CVD)** is a typical lifestyle disease because it highly related to a person’s lifestyle. It affects the heart and surrounding blood vessels and can take many forms, such as high blood pressure, coronary artery disease, heart disease and stroke. CVD is the largest cause of death in the EU and accounts for approximately 40% of deaths or 2 million deaths per year.<sup>7</sup>

The following figure shows the most common health risk factors connected with the ten leading diseases and injuries in Europe.

7 [http://ec.europa.eu/health-eu/health\\_problems/index\\_en.htm](http://ec.europa.eu/health-eu/health_problems/index_en.htm)

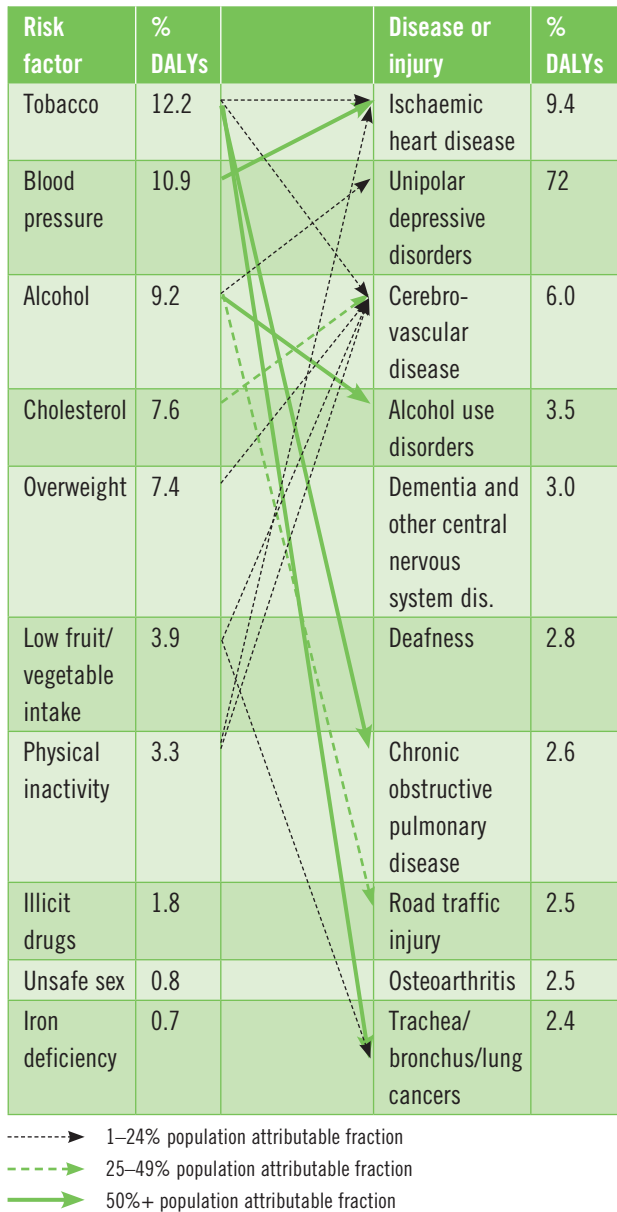


Figure 1 : Major burden of disease – 10 selected risk factors and 10 leading diseases and injuries, 2000 (WHO, 2002d)



The first step of the Health Box project was to carry out desk research of the most common lifestyle diseases in the project partner countries, where the Health Box training material should focus on. The main topics were summarised under the following categories:

- Alcohol misuse
- Unhealthy nutrition
- Physical inactivity
- Smoking
- Stress
- Substance misuse

### 3.5.1 Alcohol misuse

**Alcohol** is a key public health and social concern across the European Community. Europe has the highest proportion of drinkers in the world, the highest levels of alcohol consumption per capita and a high level of alcohol-related harm.

Most Europeans drink alcohol, but 55 million adults (15%) abstain. Taking this and unrecorded consumption into account, the consumption per drinker reaches 15 liters per year. **Around half of alcohol consumers in the EU drink 1 to 3 times a week.**

In every culture ever studied, men are more likely than women to drink at all and to drink more when they do, with the gap greater for riskier behaviour. Although many women give up alcohol when pregnant, a significant number (25% to 50%) continue to drink, and some continue to drink to harmful levels. Patterns in drinking behaviour can also be seen for socio-economic status (SES), where those with low SES are more likely to drink alcohol at all. Despite a complex picture for some aspects of drinking (with some measures showing opposite trends for men and women), getting drunk and becoming dependent on alcohol are both more likely among drinkers of lower SES.

Nearly all 15 to 16 years old students (>90%) have drunk alcohol at some point in their life, on average beginning to drink at 12 years of age, and getting drunk for the first time at 14 years.

Partner Country	Several times a week/once a week
Austria	36 %
Denmark	22 %
Finland	22 %
Germany	36 %
Italy	30 %
Romania	39 %
UK	34 %
European average	29 %

*Table 1: How often in the past twelve months have you had five or more drinks on one occasion? Results for Health Box partner countries based on data of the Eurobarometer 331, Attitudes towards alcohol, 2010)<sup>8</sup>*

**Harmful and hazardous alcohol consumption is the third largest risk factor for ill health responsible for 195.000 deaths each year and accounting for 12% of male and 2% of female premature mortality.<sup>9</sup>**

The consequences of harmful and hazardous alcohol consumption also includes a considerable number of fatalities on EU roads, a broad social impact such as violence, hooliganism, crime, family problems and social exclusion, as well as low productivity at work.

<sup>8</sup> Regarding to all this statistical data which is presented on the following pages, it has to be taken into consideration that different kind of questions can lead to different statistical results – which do not necessarily reflect the real situation in a country.

<sup>9</sup> Eurobarometer Special 331, 2010: [http://ec.europa.eu/health/alcohol/docs/ebs\\_331\\_en.pdf](http://ec.europa.eu/health/alcohol/docs/ebs_331_en.pdf)

Apart from being a drug of dependence, **alcohol is a cause of some 60 different types of diseases and conditions**, including injuries, mental and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, lung diseases, skeletal and muscular diseases, reproductive disorders and pre-natal harm, including an increased risk of prematurity and low birth weight. For most conditions, alcohol increases the risk in a dose dependent manner, with the higher the alcohol consumption, the greater the risk.

The frequency and volume of episodic heavy drinking is of particular importance for increasing the risk of injuries and certain cardiovascular diseases (coronary heart disease and stroke). A small dose of alcohol consumption reduces the risk of heart disease, although the exact size of the reduction in risk and the level of alcohol consumption at which the greatest reduction occurs are still debated. Better quality studies that account for other influences find less of a risk and find that the reduced risk occurs at a lower level of alcohol consumption. Most of the reduction in risk can be achieved by an average of 10g of alcohol (one drink) every other day.

The effect on health through alcohol consumption is very well known among the EU citizens: **97 % of the respondents included in the Eurobarometer 331/2010 recognise that alcohol can have detrimental effects on health**. Nearly all respondents believe that alcohol can contribute to liver disease but only two in a three are aware about the risks of cancers (67 %).

But these studies also show that this high level of risk awareness does not necessarily indicate full knowledge and understanding of the association between drinking and liver diseases. There is still a gap in the general public's understanding, for instance regarding levels and patterns of drinking, that increase risk or regarding the nature and treatability of liver disease.

#### Activities and exercises in Health Box related to the topic "Alcohol misuse"

All activities and exercises provided in the Health Box aim at guiding learners to handle their consumption of alcohol in a responsible and moderate way. The learning activities

- encourage learners to reflect on their consumption of alcohol and their motivation to drink alcohol regularly
- raise awareness of the physical and also social effects of alcohol consumption
- provide information on health effects of alcohol combined with information on the financial charge of alcoholic beverages
- and stimulate learners to think of healthy alternatives.

#### 3.5.2 Unhealthy nutrition

In Europe today, six of the seven biggest risk factors for premature death – blood pressure, cholesterol, high BMI (Body Mass Index), inadequate fruit and vegetable intake, physical inactivity and alcohol abuse – relate to how we eat, drink and move.<sup>10</sup> European Union citizens are moving too little and consuming too much: too much energy, too many calories, too much fat, sugar and salt.

The last three decades have seen the levels of overweight and obesity in the EU population rise dramatically, particularly among children where the estimated prevalence of overweight was 30 % in 2006. This is indicative of a worsening trend of poor diets and low physical activity levels across the EU-population which can be expected to increase future levels of a number of chronic

<sup>10</sup> [http://ec.europa.eu/health/nutrition\\_physical\\_activity/policy/index\\_en.htm](http://ec.europa.eu/health/nutrition_physical_activity/policy/index_en.htm)

conditions such as cardiovascular disease, hypertension, type 2 diabetes, stroke, certain cancers, musculo-skeletal disorders, and even a range of mental health conditions.<sup>11</sup>

The rise in obesity runs parallel to the growing proportion of overweight people. It is estimated that half of the EU adult population is overweight and a quarter of schoolchildren.

A common measure of an obese person is the Body Mass Index (BMI). A BMI above 30 measures an obese person, while anyone with a BMI over 25 is classified as overweight.

$$\text{Body Mass Index} = \frac{\text{weight in kilograms}}{\text{height in meters squared}}$$

There are three principal factors leading to obesity:

1. **Poor nutrition:** across the EU, individuals are consuming around 500 calories per day more than they did 40 years ago.
2. **Lack of exercise:** more than one in three EU citizens do no exercises in their leisure time and the average European spends over 5 hours a day sitting down.
3. **Genetic reasons:** For example the absence of the hormone Leptin, secreted by fatty tissue to inform the brain of the amount of fat stored can provoke severe obesity.

The Eurobarometer 64.3 on Health and Food found out that the **lifestyle of EU citizens seems to be the main obstacle to healthy eating**. In the European Union, time (31 %) and a lack of control over what they eat (27 %) are the two main reasons given by people to explain the difficulty in eating a healthy diet. Other reasons stated are:

- Healthy food is bland and unappetizing (23 %)

- Lack of information about the food I eat (16%)
- Information about healthy eating is contradictory and confusing (15 %)
- Lack of information about what constitutes a healthy diet (12 %)

#### Activities and exercises in Health Box related to the topic “Unhealthy nutrition”

Based on these reasons, stated as obstacles to following a healthy diet, the exercises and activities in Health Box aim on the one hand to provide information on healthy nutrition. On the other hand a lot of practical exercises show learners how they can change their nutrition habits without investing a lot of time and money.

The activities aim at:

- reflections and discussions about nutrition issues
- awareness raising on nutrition habits, consequences
- promoting self analysis regarding the connections between lifestyle and nutrition
- stimulating positive attitudes towards healthy lifestyles
- promoting healthy alternatives and options

#### 3.5.3 Physical inactivity

**Physical activity is an important determinant of health.** The lack of it is associated with the development of many of the major non-communicable diseases. It has become increasingly clear that physical inactivity is a global health issue.

Physical activity is defined as any bodily movement produced by skeletal muscles that result in energy expenditure above resting

<sup>11</sup> [http://ec.europa.eu/health/archive/ph\\_determinants/life\\_style/nutrition/documents/nutrition\\_wp\\_en.pdf](http://ec.europa.eu/health/archive/ph_determinants/life_style/nutrition/documents/nutrition_wp_en.pdf): White paper on a strategy for Europe on nutrition, overweight and obesity related health issues (2007, Commission of the European Communities)

level. Health Enhancing Physical Activity is defined as any form of physical activity that benefits health and fitness without undue harm or risk.

For EU Member States, the results of the **Eurobarometer 2009** indicate that a clear **majority of EU citizens (65 %) get some form of physical exercises at least once a week**. Far more people get “informal” physical exercise (in such forms as cycling, walking, dancing or gardening) than play organised sports. On the one hand the **positive aspect is that 27 % of the respondents say that they engage in physical activity regularly (at least 5 times a week)**. On the other hand there is a worrying statistic from a public health perspective telling that **14 % of EU citizens are physically inactive**, saying that they “never” do any physical activity, while 20 % say they are active only seldom.<sup>12</sup>

Partner Country	No physical activity
Austria	5 %
Denmark	4 %
Finland	4 %
Germany	6 %
Italy	33 %
Romania	27 %
UK	12 %
European average	14 %

*Table 2: Percentage of EU citizens in who never engage in physical activities. Results for Health Box partner countries based on data of the Eurobarometer 334, Sports and physical activity, 2010)*

<sup>12</sup> SPECIAL Eurobarometer 334 “Sport and Physical Activity”, 2009: [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_334\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_334_en.pdf)

### Physical activity and its consequences on individual and society:

- **Physical activity has beneficial effects on onset and progression of several chronic diseases and conditions.** Among others, it reduces the risk of heart disease, stroke, overweight and obesity, type 2 diabetes, colon cancer, breast cancer and depression. It promotes musculoskeletal health and psychological well-being.
- **A physically active lifestyle exerts positive effects on communities and societies.** Next to health benefits, there are positive effects to communities and societies associated with an active lifestyle, such as:
  - opportunity to interact with others, the community and the environment;
  - chance to develop new skills and meet new people;
  - may help to reduce levels of crime and antisocial behavior;
- Most importantly, **physical activity is associated with other positive health behavior** (e. g. healthy eating and non-smoking), and mediates other behavioral change as well.

Health enhancing physical activity is any form of physical activity that benefits health and fitness without undue harm or risk. This can be all daily activities and can, but does not necessarily, include sports.

As mentioned above the majority of EU citizens prefer to do physical activity in a more informal setting than play organised sports. So those respondents in the Eurobarometer 2009 who say that they do sport or physical exercise use parks or other outdoor environments (48 % exercise here) or simply the journey to and from work, school or the shops.

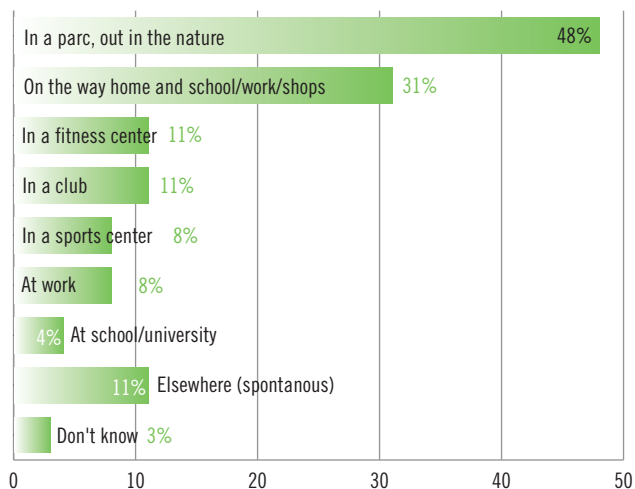


Figure 2: Where do EU citizens engage in sport or physical activity?

**The urban environment** is a very important **factor influencing physical activity**. The urban built environment and daily transport are among the most important barriers or promoters of daily physical activity. Possible traffic accidents can be a powerful reason for parents to not allow children to walk or cycle to school or play outdoors, especially in urban settings. Prevention strategies should focus on safe urban environments, to enable citizens to gain the positive effects of physically active living (Cavill et al., 2006).

Promoters	Barriers
availability of cycle tracks or walking paths	
close access to nature or green open space	
shopping centres and amenities in close vicinity to housing areas	shopping centres and amenities that need to be driven to by car
availability of stairs in public buildings	availability of escalators and lifts in public buildings
availability of leisure time facilities, sport facilities	

Table 3: Promoters and barriers of physical activity in urban areas<sup>13</sup>

**Workplace conditions influence the amount of physical activity** people have during work. Adults spend a great part of their waking time per day at the workplace, but perform in general very little physical activity during this time.

Although they are less influential than environmental factors, **personal and psychological factors** play a role in a physical active life as well.

13 [http://www.euphix.org/object\\_document/o5430n27422.html](http://www.euphix.org/object_document/o5430n27422.html)

Promoters	Barriers
self-efficacy (belief in one's own ability to be active)	perception of lack of time
intention and enjoyment of exercise	perception that one is not "the sporty type" (particularly for women)
level of perceived health or fitness	concerns about personal safety
self-motivation	feeling too tired or preferring to rest and relax in spare time
social support	self-perceptions (for example, assuming that one is already active enough)
expectation of benefits from exercise	
perceived benefits	

Table 4: Promoters and barriers of physical activity from personal and psychological factors<sup>14</sup>

To improve one's health or fitness is one of the main motivations for people to engage in physical activities or sports, followed from motivating factors like "relax", "having fun" but also to improve the physical performance and appearance.<sup>15</sup>

<sup>14</sup> [http://www.euphix.org/object\\_document/o5430n27422.html](http://www.euphix.org/object_document/o5430n27422.html)

<sup>15</sup> Special Eurobarometer 334 Physical activities and sports 2009, p. 29

### Activities and exercises in Health Box related to the topic "Physical inactivity"

Exercises and discussions on physical activity in Health Box aim at encouraging learners to discuss and reflect on their habits regarding physical activity. The exercises want to

- raise awareness on the importance of physical activities related to one's health
- show possibilities for learners to use the facilities and surroundings for activity
- sensitise learners for what happens with their body when they are more active
- activate learners by encouraging them of training together/enforcing group activities
- show low-cost solutions for the most interesting physical activities

### 3.5.4 Smoking

Tobacco is the largest single cause of avoidable death in the EU. With awareness of its harmful effects increasing, the EU is working to prevent people from taking up smoking, help smokers to quit, protect people from exposure to tobacco smoke and restrict tobacco advertising and marketing.

Despite considerable progress, the number of smokers in the EU is still high – around one third of the population – and the associated health problems include some 650.000 smoking-related deaths each year. Almost half of those dying are aged between 35 and 69 – well below average life expectancy. The Eurobarometer 332 (2009)<sup>16</sup> states that a third of citizens in the European Union

<sup>16</sup> [http://ec.europa.eu/health/tobacco/docs/ebs332\\_en.pdf](http://ec.europa.eu/health/tobacco/docs/ebs332_en.pdf)

Cancers	Respiratory diseases and adverse health effects
<ul style="list-style-type: none"> <li>■ Lung</li> <li>■ Mouth and throat: oral cavity, pharynx, larynx</li> <li>■ Oesophagus (squamous cell and adenocarcinoma)</li> <li>■ Stomach</li> <li>■ Pancreas</li> <li>■ Urinary bladder</li> <li>■ Kidney (renal pelvis and renal cell carcinoma)</li> <li>■ Uterine cervix</li> <li>■ Breast cancer</li> <li>■ Bone marrow (myeloid leukaemia)</li> <li>■ Nasal cavities</li> <li>■ Nasal sinuses</li> <li>■ Liver</li> </ul>	<ul style="list-style-type: none"> <li>■ Chronic obstructive pulmonary disease (COPD)</li> <li>■ Acute respiratory illnesses, incl. bronchitis and pneumonia</li> <li>■ Exacerbation of and poor control of asthma</li> <li>■ Impaired lung growth and increased risk of respiratory diseases in children and young people exposed to cigarette</li> </ul>
Cardiovascular diseases and adverse health effects	Effects on Maternal and Child Health
<ul style="list-style-type: none"> <li>■ Coronary heart disease</li> <li>■ Cerebrovascular disease</li> <li>■ Aortic aneurysm</li> <li>■ Peripheral arterial disease</li> </ul>	<p>Smoking in pregnancy</p> <ul style="list-style-type: none"> <li>■ Pregnancy complications</li> <li>■ Preterm delivery</li> <li>■ Foetal growth restrictions and low birth weight</li> <li>■ Increased likelihood of developing childhood asthma</li> </ul> <p>Passive smoking and children</p> <ul style="list-style-type: none"> <li>■ Sudden infant death syndrome (SIDS)</li> <li>■ Increased rate of respiratory infections</li> </ul>
Other diseases and adverse health effects	
<ul style="list-style-type: none"> <li>■ Gastric ulcer</li> <li>■ Cataract</li> <li>■ Periodontitis</li> <li>■ Duodenal ulcer</li> <li>■ Poor wound healing</li> <li>■ Risk factor for diabetes and aggravation of its symptoms</li> <li>■ Reduced fertility in males and females</li> <li>■ Earlier onset of menopause</li> <li>■ Chron's disease</li> <li>■ Osteoporosis</li> <li>■ Impotence</li> <li>■ Premature skin ageing</li> </ul>	

Table 5: Diseases and adverse health effects caused by smoking. Adapted from „Tobacco or health in the European Union“ (sources: ASPECT, 2004 and ASH)<sup>17</sup>

17 [http://www.euphix.org/object\\_document/o4758n27423.html](http://www.euphix.org/object_document/o4758n27423.html)

(29%) currently smoke cigarettes, pipe or cigars. Almost half of the participants of this research claim that they have never smoked, while the remainders have given up smoking (22%).

Smoking harms virtually every organ in the human body causing a wide range of diseases and a massive burden of chronic illness.

Not only active smoking, but also passive inhalation of environmental tobacco smoke (ETS) causes adverse health effects, including lung cancer, Chronic Obstructive Pulmonary Disease (COPD) and Cardiovascular disease (CVD). It is estimated that 79,500 people die each year in the EU as a result of passive smoking.

**Smoking plays an important role in early death.** In the EU premature mortality represents one third of the total mortality, with death rates twice as high for men as for women. Smokers live ten years less than their non-smoking peers according to a study conducted over a period of 50 years (Doll et al., 2004)<sup>18</sup>.

**Tobacco is the leading cause for disease burden in the EU.** The term burden of disease denotes the gap between the current health status and an ideal situation in which everyone lives into old age free of disease and disability. Tobacco is strongly linked to both Chronic Obstructive Pulmonary Disease and lung cancer, and is known to combine with other risk factors to cause ischemic heart disease and cerebrovascular disease.

**The impact of tobacco morbidity and mortality on society** can be expressed in:

- direct costs, associated with health care (hospitalisation, ambulatory care, prescription drugs, home health care and nursing home services) for smoking related diseases among smokers and second-hand smoke (SHS) victims; and
- indirect costs, associated with the loss of human capital due to tobacco attributable premature deaths, productivity losses,

<sup>18</sup> Doll R, Peto R, Boreham J, Sutherland I: Mortality in relation to smoking: 50 years' observation on male British doctors. *BMJ*, 2004; 328 (7455): 1519.

unpaid income taxes and contributions to social security from smokers, patient-second hand smoke victims and cares who would otherwise be in paid employment (informal care).<sup>19</sup>

Socio demographically smokers are more likely to be male than female, under 54 years of age and from lower social groups (Special Eurobarometer 332, Tobacco). In terms of occupation, smoking is more prevalent among the unemployed (52%) than those in work, whereas amongst the employed manual workers are the most prevalent smokers with almost four in ten being smokers.

On average EU smokers are smoking 14,4 cigarettes per day.

Partner Country	Cigarettes per day
Austria	17,7
Denmark	14,6
Finland	12,8
Germany	14,7
Italy	13,0
Romania	15,0
UK	14,6

*Table 6: The average daily consumption of tobacco amongst the Health Box partner countries (based on data of the Eurobarometer 3332, Tobacco, 2009)*

On average **almost three out of ten smokers across the EU countries have tried to quit smoking** at least once in the past 12 months (28%). Almost half of those who have tried to give up smoking have tried to do so more than one occasion. The main motivator to quit smoking is personal health.

<sup>19</sup> <http://www.euphix.org/>



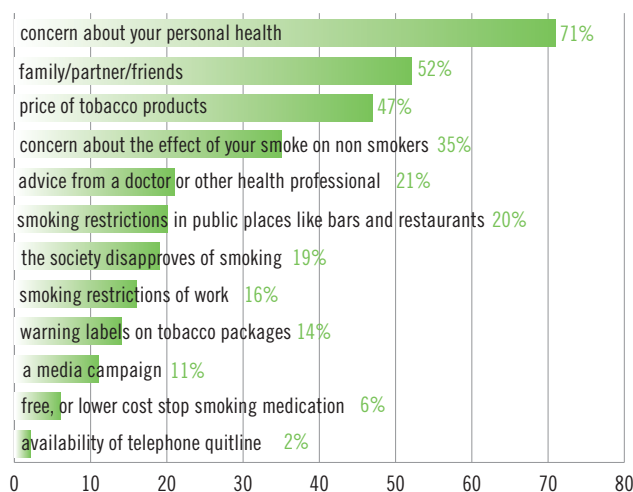


Figure 3: Motivating factors to think about quitting smoking during the last 12 months amongst EU citizens (Eurobarometer 332 on tobacco 2009)

The primary motivation factor, the concern for health is most prevalent among 25 to 54 years old, those who are well educated. Although also concerned with health, advice from a doctor or other health professional is more motivational to a different subgroup, being more frequent among those over 55 years of age, the retired and those from lower social groups.

The second most motivating factor family/partner/friends is most prevalent among 25 to 54 years old, managers and lower social groups.

The price of tobacco is most motivational among 40 to 54 years old, those who are self-employed, manual workers and students. Whereas those who are most concerned about the effect of their smoke on non-smokers are more likely to be women, self-employed, house persons and those in lower social groups.

More detailed information and statistical data on countries is given in the Eurobarometer Special 332 on Tobacco, 2009: [http://ec.europa.eu/health/tobacco/docs/ebs332\\_en.pdf](http://ec.europa.eu/health/tobacco/docs/ebs332_en.pdf)

### Activities and exercises in Health Box related to the topic “Smoking”

#### The activities on the topic smoking in the Health Box

- encourage learners to discuss their different attitudes towards smoking, their smoking habits and the meaning of smoking on our society
- provide information on how tobacco influences the health status
- make people think about the possible benefits of changing their smoking habits and let them reflect on the consequences

### 3.5.5 Stress

Stress can be positive or negative. In this understanding a distinction is made between the eustress and the distress. Eustress can be understood as stress that is healthy, or gives one a feeling of fulfillment or other positive feelings whereas distress is the most commonly-referred to type of stress, having negative implications. Eustress is a positive form of stress, usually related to desirable events in a person’s life. Both can be equally taxing on the body, and are cumulative in nature, depending on a person’s way of adapting to a change that has caused it. The body itself cannot physically discern between distress and eustress<sup>20</sup>.

<sup>20</sup> <http://en.wikipedia.org/wiki/Eustress>

Talking about stress in the Health Box always refers to the negative, the distress which can be created by influences such as work, school, peers or co-workers, family and death. Other influences vary upon age. People under constant distress are more likely to become sick, mentally or physically. Stress caused by working conditions – which for the most people is the main stress influence factor includes lack of control over work, unsuitable demands being made of workers, and lack of support from colleagues and management. But not only circumstances related to work can cause stress.

**People experience stress** when they perceive that there is **an imbalance between the demands made of them and the resources they have available to cope with those demands.** Although the experience of stress is psychological, stress also affects people's physical health.<sup>21</sup>

Reactions to the same circumstances vary between individuals. Some people can cope better with high demands, than others. It is the individual's subjective evaluation of their situation that is important. It is not possible to determine from the situation alone the amount of stress it may cause.

The experience of stress can alter the way a person feels, thinks and behaves. Symptoms on the individual level include:

- emotional reactions (irritability, anxiety, sleep problems, depression, hypochondria, alienation, burnout, family relationship problems);
- cognitive reactions (difficulty in concentrating, remembering, learning new things, making decisions);
- behavioral reactions (abuse of drugs, alcohol and tobacco; destructive behavior), and
- physiological reactions (back problems, weakened immunity, peptic ulcers, heart problems, hypertension).

<sup>21</sup> <http://osha.europa.eu/en/topics/stress>

### Stress related illness

Stress is potential of exerting unwanted influence on a person's susceptibility of various illnesses. It can also speedup the progress of diseases – ranging from cold to cancer. There is a link to our evolutionary process and our body's reaction to stress. In primitive times, human beings were constantly threatened by their environment and faced physical threats from animals and nature. Human beings have learnt with time to cope with physical stresses. The heart pumps blood faster and our body is all set to face the forthcoming challenges. The fight or escape response triggered by the release of adrenaline, is also a part of our evolutionary process.

The problem, however, arises when the body is prepared yet incapable of facing its perils.

There are various determinants to stress related illnesses. Scientific researches came to the result of classifying people in two different types:

1. **People who are highly competitive and have a certain drive.** They are ambitious people who are ready to give it their heart and soul. Such people are goal oriented, highly focused and often known as workaholics. They are always subjected to stress.
2. On the other hand, there are **people who have hardly any focus in life who may be unemployed or just plain complacent.** They too can be equally prone to stress. It is actually a matter of resilience.

Stress related order is very subjective as various people have different levels of tolerating stress. When the stress overpowers the tolerance level, stress related disorder is imminent.<sup>22</sup>

People often find ways of dealing with stress, in both negative and positive ways. Examples of positive ways are listening to music, calming exercises, sports and similar healthy distractions. Negative

<sup>22</sup> <http://www.stressrelatedillness.com/stress-related-illness-and-disorder.html>

ways are often drugs, alcohol and anger, which lead to addictions and, later, more stress. The Health Box focuses on supporting learners to detect their personal stress prevention strategy.

#### Activities and exercises in Health Box related to the topic “Stress”

Apart from providing information about the most characteristic symptoms of stress and the effect on the personal health situation, the Health Box activities focus on developing new strategies to learn to relax. To reach this aim, the exercises include:

- raising awareness on concrete situations which cause stress/relaxation
- discussions how to avoid stress situations
- raising awareness on one’s actual reactions and behaviours related to stress
- introducing a humorous aspect into the group

#### 3.5.6 Substance misuse

The European monitoring centre for drugs and drug addiction (EMCDDA) estimates that drug abuse in the EU accounts for 6500 to 9000 deaths (by overdose) a year. Injecting is also a major vehicle for blood-borne infections such as HIV/AIDS and hepatitis B and C. The incidence of HIV among injectors fell between 2001 and 2005, but still accounted for some 3 500 new cases in 2005<sup>23</sup>.

This is to give a short overview on the most common illicit drugs in the EU:

#### ***Cannabis***

The use of cannabis in Europe has evolved considerably over the last decade, as has the debate on how to respond appropriately to the widespread use of this drug. In most countries, cannabis use increased during the 1990s and early 2000s. Moreover, the last few years have seen a growing understanding of the public health implications of the long-term and widespread use of this drug, and rising reported levels of treatment demand for cannabis related problems.

#### ***Amphetamines, ecstasy and hallucinogenic substances***

Amphetamines (a generic term that includes both amphetamine and methamphetamine) and ecstasy are among the most commonly used illicit drugs in Europe. In terms of the absolute numbers, cocaine use may be higher, but its geographic concentration means that in many countries, after cannabis, the second most commonly used illicit substance is either ecstasy or amphetamines.

#### ***Cocaine and crack cocaine***

An overall increase in cocaine use and cocaine seizures has been observed in the European Union during the last decade, although this has been largely confined to Western Member States, and major differences exist between countries. The data available also indicate considerable diversity among cocaine users, both in terms of patterns of use and in terms of socio-demographics. Those who only experiment with the substance on one or a few occasions make up the largest group. Another group includes socially integrated regular users who, in some countries, account for a relatively large number of young people. Some of them will intensify their use of cocaine, or use it over a long period. A third set of users includes members of socially excluded groups, including current and former opioid users. Because of the diversity of profiles among cocaine users, assessing the prevalence of the drug’s use, its health and social consequences and the necessary responses presents a unique set of challenges.

23 [http://ec.europa.eu/health-eu/my\\_lifestyle/index\\_en.htm](http://ec.europa.eu/health-eu/my_lifestyle/index_en.htm)

### ***Opioid use and drug injection***

Heroin use, particularly injecting the drug, has been closely associated with problem drug use in Europe since the 1970s. Today, this drug still accounts for the greatest share of morbidity and mortality related to drug use in the European Union. A decline in heroin use and associated problems has been observed in the last ten years.

### **Drug-related infectious diseases and deaths**

Infectious diseases such as **HIV** and **hepatitis B and C** are among the most serious health consequences of drug use. Even in countries where HIV prevalence in injecting drug users is low, **other infectious diseases** including **hepatitis A, B and C, sexually transmitted diseases, tuberculosis, tetanus, botulism and human T-lymphotropic virus** may disproportionately affect drug users.

Drug use is one of the major causes of health problems and death among young people in Europe. This can be illustrated by an international study supported by the EMCDDA, which found that, in seven European urban areas, between 10 % and 23 % of mortality among those aged 15 to 49 could be attributed to opioid use.

Drug-related mortality includes deaths that are directly caused by the pharmacological action of one or several substances (drug-induced deaths) and deaths that are indirectly caused by the use of drugs, often with other concurrent factors (e.g. accidents). Known causes of deaths include acute toxicity, traffic accidents in particular when combined with alcohol (EMCDDA, 2007), violence, suicide among already vulnerable people, or chronic conditions due to repeated use (e.g. cardiovascular problems in cocaine users).

**An analytical report (Flash Eurobarometer, European Commission, 2008) on young people and drugs shows that the majority of young people in the EU (15 to 24 years) are aware of the risk that drugs put on a person's health. Especially for heroin, cocaine and ecstasy the health risk is seen to be cer-**

tainty for almost all of the respondents: 98 %, 97 % and 96 % of them aware that using these substances might pose a *medium* or a *high risk* to a person's health.

A quite different picture is shown for young people's perceptions about the health risks associated with **cannabis**. Although 8 of 10 respondents (82 %) recognised the health risk (medium or high) of cannabis only half of them (40 %) thought it posed a high risk to their personal health.<sup>24</sup> This belief mirrors the wide spread thinking of one's immunity concerning specific illnesses or health problems which can be understood as a kind of self-security-system.

#### **Activities and exercises in Health Box related to the topic "Substance misuse"**

Since the topic of substance abuse is very sensitive most of the Health Box activities include games, quizzes and creative work to provide these issues in a fun and accessible way.

#### **The activities:**

- check understanding of drugs and drug use amongst the learners
- inform learners of some basic facts around substances
- raise awareness of type of drugs and their effects
- introduce the idea of positive and negative choices
- help learners to identify the consequences of choices
- raise awareness of the impact of substance misuse on people's lives

<sup>24</sup> [http://ec.europa.eu/public\\_opinion/flash/fl\\_233\\_en.pdf](http://ec.europa.eu/public_opinion/flash/fl_233_en.pdf)

## 4. Social economically disadvantaged people

### 4.1 General definition of disadvantaged people in Europe

Since the year 2010 is the European Year of Combating Poverty and Social Exclusion there are a lot of European publications and statistics dealing with the topic of social inequality also connected with health inequality. Even if Health Box does not deal with the topic poverty, there is a link to the definition of poverty because affected people experience a lot of **disadvantages** through

- unemployment,
- low income,
- poor housing,
- inadequate health care and
- barriers to lifelong learning, culture, sport and recreation.

They are often excluded from participating in activities due to economic, social and cultural reasons.

In the Health Box context the term “socio-economically disadvantaged learners” means that these people are disadvantaged in the meaning of their

- employment and occupational status
- income level
- educational attainment and
- because they are disadvantaged by different forms of **social exclusion**

In the Eurostat report “Combating Poverty and Social exclusion (2010)” the term **social exclusion** is defined as

*‘... a process whereby certain individuals are pushed to the edge of society and prevented from participating fully by virtue*

*of their poverty, or lack of basic competencies and lifelong learning opportunities, or as a result of discrimination. This distances them from job, income and education opportunities as well as social and community networks and activities. They have little access to power and decision-making bodies and thus often feeling powerless and unable to take control over the decisions that affect their day to day lives’.*

Social inequality encompasses a range of inequalities that mean that different groups in society do not have equal social status. Social inequality is closely linked to social exclusion in that it restricts people from participating fully and equally in society. Exclusion from the labor market is a key form of exclusion, most visible in the form of unemployment, which has a direct impact on income inequalities. However, exclusion covers a range of issues from gender and race, to citizenship and health status, to name but a few.<sup>25</sup>

**Scientific researches on Health inequalities in Europe show that almost all important health problems and major causes of premature death such as cardiovascular disease and cancer are more common among people with lower education, income and occupational status.**

**Health inequality** is seen as the systematic and avoidable differences in health outcomes between social groups such **that poorer and/or more disadvantaged people are more likely to have illnesses and disabilities and shorter lives than those who are more affluent.**

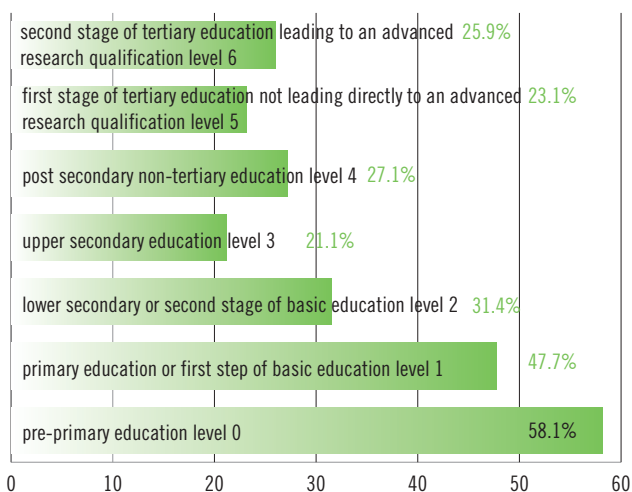
European statistical data also proves the fact that there is a correlation between the social and the health status of a person. The European Statistics of Income and Living Condition (EU-SILC) survey from **Eurostat** contains a small module on health, including a question on chronic (long-standing) illnesses or conditions. Data refer to the self-declaration by the respondents of whether

<sup>25</sup> [http://epp.eurostat.ec.europa.eu/cache/ITY\\_OFFPUB/KS-EP-09-001/EN/KS-EP-09-001-EN.PDF](http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-EP-09-001/EN/KS-EP-09-001-EN.PDF)

they have or do not have a chronic (longstanding) illness or condition. Data are broken down by sex, age group, activity status, educational level and income.<sup>26</sup>

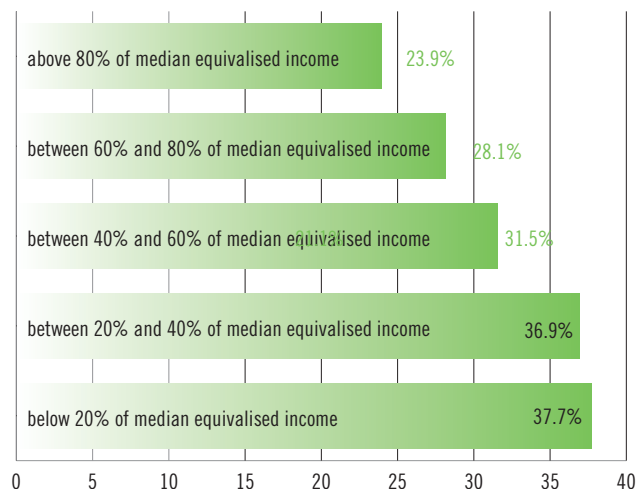
Related to the **factor education** the figures show that a long standing chronic disease does not necessarily decrease with the educational level. But it is quite clear that the **EU average percentage of people self-reporting to suffer from long standing diseases are overrepresented in the educational level 0 (58,1%) and 1 (47,7%)**.

Connected with income the statistical European data shows an **increasing percentage self reported chronic morbidity in lower income levels**.



*Figure 4: Self-reported chronic morbidity: People having a long-standing illness or health problem by educational level according to ISCED 1997 in 2008 (%) – EU27 European average*

<sup>26</sup> [http://ec.europa.eu/health/archive/ph\\_information/dissemination/echi/echi\\_43d\\_en.pdf](http://ec.europa.eu/health/archive/ph_information/dissemination/echi/echi_43d_en.pdf)



*Figure 5: Self-reported chronic morbidity: People having a long-standing illness or health problem by income in 2008 (%) – EU27 European average*

**More statistical information on Health status in European surveys:** [http://ec.europa.eu/health/indicators/echi/list/index\\_en.htm?echisub=24#echi3](http://ec.europa.eu/health/indicators/echi/list/index_en.htm?echisub=24#echi3)

## 4.2 Barriers to behaviour change

When it comes to improving our health it seems that the majority of people have a general understanding of what to do. Nevertheless there seem to be different influence factors that make the start of the change process difficult. Supporting (socio-economically) disadvantaged persons in changing their unhealthy lifestyle into a healthier one always has to go hand in hand with awareness raising about the impact of healthy behaviour (with the help of information). Furthermore individual help is important when the motivation gets less.

Also different psychological and social factors influencing people's behaviour have to be kept in mind as they can make a break with challenging unhealthy habits.

Even with the knowledge of the unhealthy aspects of smoking, drinking too much alcohol, consuming drugs etc. people continue to undertake these lifestyle risks.

Social, cultural and environmental factors enhance unhealthy habits.

Scientists carrying out researches in this field found inter alia the following reasons:<sup>27</sup>

- Innate human defiance
- Need for social acceptance. For one, when a behavior is socially accepted or even considered desirable people tend to reconcile the fact that it's bad for them with the idea that „everybody's doing it”
- Inability to truly understand the nature of risk
- Individualistic view of the world and the ability to rationalise unhealthy habits e. g. with individual experiences that support your action. “It hasn't hurt me yet,…”
- Genetic predisposition to addiction

People aren't changing their behaviors not because they miss the information that these are big risks but they tend to sort of live for now and into the limited future not the long term.

Most behavioural changes, such as losing weight or stopping smoking involve six stages<sup>28</sup>:

1. pre-contemplation: the person denies or fails to recognise the problem
2. contemplation: acknowledging the problem without being ready to change it
3. preparation: getting ready to change
4. action: changing behaviour
5. maintenance: not “falling off the wagon”
6. termination: the final stage, meaning the behaviour has been tamed and no longer poses a threat.

Behavioural change is a process and not an immediate action. The main focus of the Health Box activities will be to reach disadvantaged learners in the stages 1 and 2 with the aim to guide them into stage 3 and 4 – getting ready to change and act! The stages 5 and 6 ensure a sustainable “success” of behaviour changes – which is the overall (long term) aim of the Health Box project but depends more on the persons who want to change behaviour patterns than on the trainers. Therefore there can't be a guarantee that persons who with the help of the Health Box start their way to a healthier life will reach the last two stages within the training time.

## 5. Education as means to reduce lifestyle diseases among socio-economically disadvantaged learners

Different surveys indicate that people with low socio-economical statuses often live unhealthily, sicken more often and die earlier. This fact is also visible in so called developed countries with a good and accessible health system.

27 [http://www.livescience.com/health/061205\\_bad\\_habits.html](http://www.livescience.com/health/061205_bad_habits.html)

28 Prochaska, J. (2006): Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward, [http://lacrossetribune.com/lifestyles/health-med-fit/article\\_8c5f21ae-fa4b-11de-ad16-001cc4c002e0.html](http://lacrossetribune.com/lifestyles/health-med-fit/article_8c5f21ae-fa4b-11de-ad16-001cc4c002e0.html)

The level of one's education has an important impact of one's health: The higher the education the healthier the lifestyle. This means for example that the health situation of people who only graduated from compulsory school often is worse compared to the ones who graduated from university.

Anyhow, education in itself does not lead to a healthier lifestyle but to a larger awareness and to better opportunities. It will also lead to a better "disposition to learn" – in this case to adapt to healthier living.

This also may be seen as an explanation that never the less, independently from one's education health is subjective experienced and therefore subjective defined: One might judge his/her life as healthy whereby another person would value the same lifestyle as unhealthy.

The individual health behaviour depends on one's living and health conditions meaning the existing cultural, economical, social and ecological circumstances. They decide if a person has the necessary preconditions available to live a healthy life: financial means, nutrition, work, social security, acknowledgement, relaxing options and education (Hurrelmann, 2006)<sup>29</sup>.

Financial resources recognisable by the income of a person are especially interlinked with education and health: The higher the income the better the access to healthy lifestyle whereby the income also depends on one's education.

Hurrelmann (2006) describes three crucial factors that determine health:

- Personal factors such as genetic conditions, constitution of body and mind as well as ethnicity

<sup>29</sup> Hurrelmann, K. (2006), Gesundheitssoziologie. Eine Einführung in sozialwissenschaftliche Theorien von Krankheitsprävention und Gesundheitsförderung, Juventa Verlag, Weinheim und München

- Behaviour factors such as nutrition, physical activity and relaxing
- Other factors such as socio-economical status, education, economic situation, health care

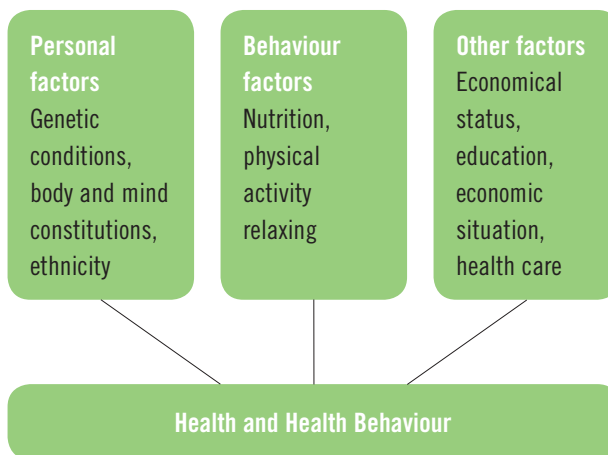


Figure 6: Three factors that determine health

Obviously the level of education has an important impact on one's health. Unfortunately the access to education in Europe is different, meaning not everybody has the chance to experience a long education time due to different reasons such as financial, cultural or other restrictions. Hence, poor and uneducated groups are more vulnerable for unhealthy life habits.

Providing basic health education to the people with the biggest need – socio-economically disadvantaged persons – aims at counteracting the spreading of lifestyle diseases among this person's group as education does not only include a knowledge transfer but also promotes self reflection regarding one's behaviour.

Especially socio-economically disadvantaged people with a low education and/or migration background either don't have access to (further and adult) education or don't participate in classic health care campaigns or health education. Reasons might be



financial limitations, cultural and/or social influences or lack of interest. Thus, these people should receive specific training to improve their healthy living. This is why the Health Box is especially targeting those groups in the non-formal or informal Adult Education sector as in settings like labour-market oriented training programmes, vocational training seminars, or classes on subjects other than health.

Adult educators who work with the target groups in such contexts need to be made aware of health issues and be provided with ready-to use training materials for health promotion which they can easily integrate in classes on subjects other than health.

The project Health Box promotes knowledge, attitudes and skills related to prevent lifestyle diseases and enhance healthy life habits among socio-economically disadvantaged adults, migrants and adults with a low level of education.

### 5.1 Different learning settings with special consideration of the Health Box's learning context

The following table shows some learning settings in which socio-economically disadvantaged persons are more likely to be reached and target groups that can be understood as typically learning contexts in which the Health Box could be used by the trainers:

Language, ICT and wellbeing courses for women over 40 with social and educational restricted background
Language and ICT courses for men over 50 with low education level and low access to education and social participation
Speaking and listening groups, drama workshops and peer mentoring training for young adults living in socially deprived areas
Speaking and listening groups, drama workshops and peer mentoring training for adults for whom English is a second language
Language courses for immigrants, to be integrated to the society and working life
Vocational and/or supporting courses for unemployed people
Training course with empowerment and job orientation elements for unemployed people with low qualifications
Training course with empowerment and job orientation elements for unemployed women with migration background
Special training initiatives/courses (qualification for skills, coaching, job orientation) for long-term unemployed
Special training initiatives/courses (qualification for skills, coaching, job orientation) for older unemployed people
Qualification courses (in constructions and general services) for unemployed men living in rural areas
Cooking courses for elderly and unemployed, mostly women
Courses for people who have suffered from a disease for a long period (up to one year) and now have to return to the labour market. The reasons why the individuals have to leave the labour market are to a small extent physical and to a large extent psychic or social (stress, depression)
Preparatory courses for immigrants with the subjects: Danish language, society subjects, pedagogic and psychology, classes of citizenship competences.

Table 7: Examples of learning settings in which socio-economically disadvantaged persons can be reached<sup>30</sup>

<sup>30</sup> These are examples of learning settings which were inter alia used in the Italian, British, Finnish, German, Rumanian, Danish or Austrian training in the Health Box project

The following list describes typically health problems from male and female trainees participating in labour-market oriented training programmes or similar training settings:

- Unbalanced nutrition
- Drug problems
- Alcohol addiction
- No or little physical activity
- Mental health problems
- Overweight
- Nicotine addiction

As the training conditions can vary the trainer has to be able to adapt the Health Box training materials to the given needs and circumstances. This means that some exercises due to the learning setting or the level of understanding of the trainees might not always be suitable.

### 5.1.1 Place and space for exchange – learning from each other

Learning together with others can happen in formal or informal settings:

#### 5.1.1.1 A theoretical excursion to formal, non-formal and informal education

In regard to possible human learning activities Sandhaas<sup>31</sup> (1986) differentiated between *formal education*, *non-formal education*, *informal education* and *incidental learning*.

These categories have been further defined in the last 20 years:

31 Sandhaas, B. (1986): Bildungsreformen. In: Haller, H.-D/Meyer, H. (Hrsg.): Ziele und Inhalte der Erziehung und des Unterrichts. Enzyklopädie Erziehungswissenschaft, Bd. 3. – Stuttgart

**Formal education** is tied to schools and (higher) education institutions, delivering education on the basis of a standardised curriculum with specifically trained teachers. Pupils and students are grouped in age-related classes<sup>32</sup>. Formal learning leads to recognised diplomas and qualifications<sup>33</sup>.

In formal learning situations, there is a clear consciousness of the educational agenda and related roles: students recognise themselves as students and whether or not they are fulfilling this adequately, they have the feeling of their institutional roles.

School education is seldom linked to the “normal” life of students and their families; in some countries students do not have the right and the power to build up participative structures and thus influence their school life – this is why reality and citizenship happen outside school.

**Non-formal education** comprises all learning activities outside school in which both learner and educational personnel have the intention to learn or to deliver learning. This kind of education does not lead to formalised certificates. It may be provided in the workplace and through the activities of civil society organisations and groups (such as in youth organisations, trade unions and political parties) or through organisations or services that have been set up to complement formal systems (such as arts, music and sports classes or private tutoring to prepare for examinations)<sup>34</sup>.

**Informal education** is characterised by the fact that the learner or the educational personnel/the information source intends to initiate a learning process – but not both of them at once<sup>35</sup>. It is a natural accompaniment to everyday life. Unlike formal and non-

32 Evans, D.R. (1986), The planning of nonformal education, Paris

33 [http://ec.europa.eu/education/lifelong-learning-policy/doc52\\_en.htm](http://ec.europa.eu/education/lifelong-learning-policy/doc52_en.htm)

34 [http://ec.europa.eu/education/lifelong-learning-policy/doc52\\_en.htm](http://ec.europa.eu/education/lifelong-learning-policy/doc52_en.htm)

35 Evans, D.R. (1986), The planning of nonformal education, Paris

formal learning, informal learning is not necessarily intentional learning, and so may well not be recognised even by individuals themselves as contributing to their knowledge and skills<sup>36</sup>.

Watkins and Marsick (1992) proposed the following explanations and differentiations in their “Theory of Informal and Incidental Learning in Organisations”<sup>37</sup>:

*“Non-formal learning“ is the collective name for all forms of learning, happening in the entire environment out of the formalised education system. There is a wide range of partly varying definitions for the term “informal learning”.*

This ranges from a characterisation as unplanned, casual, implicit and often unconscious learning to learning activities as they are developed by the learners themselves without any educational support and up to the equation with “non-formal learning”, i.e. the definition for all learning as it is (consciously or unconsciously) practiced out of the formal educational system.

This means that informal learning is a form of instrumental learning, a means to an end.

The end is not – in contrast to formal learning – the learning itself, but the better solution to an extracurricular exercise, a situation request, a life problem by means of learning.

Informal learning is the generic term, which also comprises this casual and unconscious learning as well as a conscious deliberate learning out of schools – whereupon the transition between both ways is smooth in practice.

As formal education is largely context-free learning, informal learning is bound to a specific context; it mostly means enact-

ing within a reality context which leads to concrete challenges or tasks and to feedback proceedings that are natural (“situated learning”).

Evans<sup>38</sup> characterised the term “*incidental education*” as learning which is not intended – neither from the learner nor from the information source.

#### 5.1.1.2 Consequences for the Health Box project

The project has been aiming at the introduction of healthy living and health related education in rather non-formal or informal learning situations in order to create a positive impact on the behaviour of disadvantaged target groups. Since Health Box is closely connected with “the real life” of the beneficiaries and their real living and learning contexts it takes place outside the “formal” education.

It is important to state that “non-intentional” learning or “incidental learning” is out of the scope of the Health Box project since an aim, objective or aspired competence is missing, there is no learning process in the sense of guided instruction and there may not even be a measurable output because one cannot evidence it.

Overwien (2005) states that generally, when reflecting informal learning processes, at least two perspectives have to be considered:

1. The learner takes initiative in learning and discovers new contents and circumstances – or seen from a different angle – tries to explain own questions arising from its (everyday life or specific) context
2. The second aspect is related to the learning environment and context that decisively influence the learning process.<sup>39</sup>

36 [http://ec.europa.eu/education/lifelong-learning-policy/doc52\\_en.htm](http://ec.europa.eu/education/lifelong-learning-policy/doc52_en.htm)

37 Watkins, K. E., and Marsick, V. J. (1992), Towards a theory of informal and incidental learning in organizations. *International journal of life long education*. 11 (4), p. 287–300

38 Evans, D.R. (1986), *The planning of nonformal education*, Paris

39 Overwien, B. (2005), Stichwort: Informelles Lernen. In: *Zeitschrift für Erziehungswissenschaft*, Heft 3, S. 339–359

However, according to the more profound definitions delivered by Sandhaas and Haller Health-Box takes place in non-formal and later-on also informal learning environments, maybe first starting in courses that serve to improve employability and later (if successful) also create rather informal learning communities that foster healthy living, e. g. in common cooking activities.

Independently if people learn in formal or informal learning settings, learning from each other is always an important part of the learning experience. Having the chance to exchange not only knowledge but also experience can be enriching for oneself. However the precondition for this is to take part in any kind of learning environment. Providing this possibility also for people with a low education and/or migration background goes already hand in hand with the Health Box approach: socio-economically disadvantaged people should have the chance to learn on the one hand new health related issues which will influence their future health behaviours. On the other hand these persons should have enough time and space to exchange their experiences into changing life habits such as how to stop smoking or implement physical exercises in the daily routine. Getting in touch with other persons and their personal history can be a positive support also in terms of becoming more open for new ways. Self reflection, which can be important for one's health behaviour, can be practiced and improved as well as being a role model for other participants.

## 5.2 The role of the trainer and the decision for the Health Box implementation

Encouraging and supporting people to exercise more, eat healthier, drink less alcohol, live with less stress, stop smoking cigarettes and using drugs is the overall aim of the Health Box implementation. Although these behaviour patterns are healthy for everybody and not only for socio-economically disadvantaged people there might be trainers who smoke, like to drink a beer a

day or don't like exercising. Although their behaviour does not go hand in hand with the Health Box's goal the Health Box can be implemented also by these adult educators: Addressing for example the negative aspects of smoking or how to stop with this habit can be also done by a smoking trainer as talking about it does not necessarily mean that the trainer wants to stop his/herself. On the contrary – the trainer should not take over the role of a “preacher” but should act authentically and professionally.

### 5.2.1 The flexibility of the Health Box and its possible impact of employability

As already mentioned the Health Box is constituted in a way so that its content can be implemented in any class – also in trainings not related to health (see 5.1). The exercises are flexible in regard to structure and time. This means that there is no given order which has to be followed and the trainer can decide to which intensity he/she wants to work on the topics (depending on the flexibility of the training curriculum). Nevertheless the most important precondition to implement the Health Box into informal and non-formal trainings is that the adult educators themselves are convinced of the Health Box content and the positive impact. If this is not the fact they will not apply any activity of the developed materials.

So it has to be clear for the trainers that the Health Box does not only provide (new) crucial information about health and healthy lifestyles but also can encourage the learners to change unhealthy behaviour into a healthier one. Apart from feeling “better” the improvement of one's health condition can also influences one's employability: the fitter and healthier a person feels the more active he/she gets also in regard of job hunting and (then) working. An unhealthy lifestyle can make us lethargic and inactive whereby a healthy one activates and animates. Especially trainers working in the labour market related field should take this

important issue into account while deciding upon or against the implementation of the Health Box in their courses.

### **5.2.2 Accessibility to socio-economically disadvantaged persons in the adult education field**

Adults who are socio-economically disadvantaged, with a low level of education and those with a migration background belong to the groups of adults most at risk of acquiring a physical or mental lifestyle disease. These groups of adults are, however, rather unlikely to be reached by health information campaigns or to be willing to participate in traditional health education. Thus, any strategy to help them to acquire a healthier lifestyle and thus prevent illness must seek to address these hard-to-reach groups where they can be found instead of waiting for them to come to health education seminars. Adequate settings might be labour-market oriented training programmes, vocational training seminars, evening classes on subjects other than health, or informal community or social work environments.

### **5.2.3 Social responsibility of the trainer**

Although adult persons are responsible for their health conditions meaning their behaviour regarding healthy nutrition, sports activities, alcohol abuse, use of drugs or smoking as well how stressful they arrange their life, the adult trainer in settings such as labour market seminars should take over some part of a social responsible. This should not happen in terms of telling the training participants how to behave and what to avoid but the trainer should feel comfortable to address specific health topics such as mentioned before within the learning environment. Social responsibility shall here be understood as keeping one's eyes open and to make behaviors that can harm a person subject of discussion. The trainer should not act as a parental figure to the learners in terms of paternalism but more as an objective mirror that points

up unhealthy life habits in general. If necessary he/she should interrelate lifestyle diseases directly to the training participants.

Notwithstanding the social responsibility of the trainer, the Health Box training interventions themselves put much emphasis on empowerment of disadvantaged learners to take over full responsibility for their physical and mental well-being. This empowerment needs to be seen in the context of pervasive healthcare and active citizenship.

### **5.2.4 Knowledge transfer of health issues**

The Health Box provides on the one hand crucial information about typically unhealthy lifestyle habits such as smoking, alcohol consumption, substance misuse, unbalanced nutrition, physical inactivity or stress. On the other hand the training participants reflect with the help of the Health Box exercises their personal behaviour regarding daily manners and attitudes. This means that socio-economically disadvantaged persons who are reached through adult educators pick up not only knowledge regarding common lifestyle diseases caused by unhealthy life habits but also keep a close eye on their own daily doing.

One of the main aims of the Health Box's implementation in adult education, especially in learning and trainings settings in which people who due to their educational, migration and/or financial background feel restricted in their behaviour take part, is to provide a common understanding about health, lifestyle and lifestyle diseases. This at the same time aims at counteracting popular misunderstandings, false myths or missing information within the social society also due to different health, lifestyle and lifestyle diseases definitions and approaches. Teaching and explaining issue related aspects demands not only interest but also a minimum of knowledge on the mentioned topics out of the trainers' perspective.

Sometimes a training for trainers aiming at changing (some aspects of) their teaching routine could be necessary as not every trainer will be totally convinced of the Health Box topics (e. g. the adult educator is smoking and does not want to quit this habit or does not exercise very much him/herself, etc.). In these cases it is important to motivate the teaching persons addressing the issues such as reduction (dispensation) of alcohol, drugs and nicotine consumption, healthy nutrition, physical activity or stress prevention and to explain to them that the integration of the Health Box into their courses can have a positive impact on their learners. This can demand a reorganisation of the lessons which has to be taken into account by the adult educators.

#### **5.2.5 Possible obstacles for the Health Box implementation out of the trainer's point of view**

Although the idea of implementing small exercises into adult education dealing with health issues will make sense for many trainers working with socio-economically disadvantaged people it may not necessarily do so for the learners. This means that the educators might face different obstacles such as lack of interest in the topic, limited motivation to change one's habit etc. which could make this integration process more challenging. Being aware that not all people with a low education and/or migration background might be very open to change their daily (unhealthy) behaviour the Health Box can only be understood as a supporting instrument for the trainer – containing the training material and important information regarding lifestyle behaviour and there from resulting diseases. Convincing the trainees of the importance of everyone's health has to be done on the one hand by the trainer and on the other hand by the learning participants themselves. Factors that add to the dislike for change could be cultural or traditional (“the food was always cooked with lard”, “men always drink beer with their dinner in our family”, etc.) but

also out of personal thinking. So for example people with financial restrictions often have the wrong estimate that healthy nutrition is more expensive than unhealthy. Smoking and drinking alcohol are attitudes that sometimes are excused as the only “fun” an unemployed person has left. Therefore the motivation to quit the behaviours can be very low.

Also the autonomy and the right of every person to decide how to live have to be accepted and taken into account by the trainers while implementing the Health Box in existing training courses.

#### **5.3 Expected outcomes of the Health Box implementation**

Consequences that can be expected by the implementation of the Health Box in adult education in which socio-economically disadvantaged learners participate can be, besides from no changes at all, to short, middle and long term changes. The range depends above all on the learner, but also the trainer and the other participants can influence each other regarding sustainability. It is less about getting new knowledge or information on healthy lifestyle but the dealing and interaction with the topics within the group. This means that setting a common aim for the group (exercising 3 times a week at least 30 minutes) or being a role model for others (telling how I experienced stopping smoking, what was easier – what was difficult, which situations tempt to smoking? etc.) can be important in the changing process. Beside this a group dealing with a topic such as excessive alcohol consumption or substitute misuse can in the given learning settings give the group members time and space to reflect not only theoretically but also practically by observing one's own behaviour. Depending on the openness and personality of the learners as well as from the trainers' competences dealing with such special issues, consequences of the Health Box implementation can be different.

### **5.3.1 Short term changes on individual and interpersonal level**

A short term consequence of using the Health Box can be changes in one's (daily) behaviour that are more or less short-lived. The learner changes his/her daily habits regarding smoking, alcohol abuse, substitute misuse, unhealthy nutrition, stressful living and physical inactivity for not much longer than the time of training course or for a bit longer. This time the persons return to their old habits after a short period but probably they may have been reflecting about their unhealthy behaviour which could lead to change another time. The short time consequence (behaviour change for a short period) could also have a long term impact (sustainable change at a later point).

The influence of the group, as mentioned above plays an important role when it comes to the question of motivation: if for example one person starts to tell the others about the experience of sports activities and how they affect his/her body perception and wellbeing the odds are that others also start with physical exercises. Starting a changing process seems to be more difficult if no external motivator such as a person is present. Therefore short term changes of the Health Box – similar to long term consequences – can very much depend on the group dynamic and on the trainer's involvement.

### **5.3.2 Long term consequences on individual and interpersonal level**

Long term consequences of thematic training programmes/ courses that focus on lifestyles and lifestyle diseases in which

socio-economically disadvantaged learners participate last longer than the lifetime of the training/learning course itself in comparison with the short term effects. Here the participants acquire more than superficial and short term motivation factors as described above. Although having a role model in the group can be a helpful motivator as he/she can demonstrate new paths out of routine, in the long run each person has to find his/her own motivation factor which will achieve success in terms of a healthier lifestyle.

However support groups lasting longer than the training course – which can be informal as a consequence of the training or formal such as Alcoholic Anonymous – play an important role especially in alcohol, substitute or smoking cessation. Here mutual help, time for experience exchange and professional support make the often difficult steps easier. The role of the trainer in initiating such groups that continue after the official learning time is crucial as he/she can strengthen, together with the team members, the sense of togetherness in the precarious group building phase. Therefore it is not absolutely necessary that he/she stays in the group after the training period if the group has developed its own identity. Community learning and support (cooking healthy food together, planning common physical activities, etc.) can have a very positive impact in terms of achieving sustainability.

Apart from this a healthy lifestyle, as already mentioned before, has a positive impact of one's employability as a healthy body asks for activity and mental or physical work.

