



Working Party on Information on Lifestyle, Specific and Deprived Population Groups

Within the Health Information Strand of the Public Health Programme 2003 - 2008,
European Commission, DG SANCO, Luxembourg



Newsletter

Volume 1, Issue 4, February 2007

Newsletter

Topstory 1

Members of the Working Party Lifestyle were invited to comment on the draft Position Paper and Mandate of the Working Party at the last strategic meeting in Stockholm, Sweden, on the 20th October 2006. Their inputs were considered in the revised forms of both strategic documents.

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Topstory 2

In this issue we inform our readers about new projects of the Working Party Lifestyle. The first project introduced by Dr Moller is "Establishing a Monitoring Mechanism on Prison Health Indicators and Determinants".

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Topstory 3

We provide a summary of a recently finished project of the Working Party - Ageing Nutrition.

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News from the Working Party

The next meeting of the Working Party Lifestyle and the WP Core Group will be held in Luxembourg on the 19th of April. At the meeting the renewed WP Position Paper and Mandate shall be approved by the WP members and the further strategic implementation of the WP vision shall be discussed.

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Work on the Strategic Documents of the Working Party - Realization of the Renewed Strategy of the Working Party Lifestyle

by Grit Neumann – Subject Managers

After the position paper and WP mandate were adapted to the renewed WP vision and strategy, they were circulated among Working Party members for feedback. Subject managers were asked to comment on both documents and additionally provide three top priorities for their particular subject. The following top priorities have been included in the Position Paper:

Nutrition and Physical Activity

- 1) Further development and testing of methodologies for assessment of food intake and physical activity, including alcohol intake, with emphasis on validity, reliability, and comparability;
- 2) Implementation and integration of the recommended methodologies for use in the different European monitoring systems currently under development;
- 3) Focus on young individuals (children and adolescents), i.e. food intake and physical activity and its determinants, in collaboration with current EU funded projects.

Tobacco Use

- 1) Biological interaction between smoking and genetic factors in determining chronic diseases;
- 2) Cost-effectiveness of smoking prevention trials in children and adolescents;
- 3) Relation between genetic factors and tobacco use.

Alcohol Consumption

- 1) Harm done to others (than the drinkers themselves), including babies and children;
- 2) Alcohol and health inequalities across Europe;
- 3) Impact of different alcohol policy options on reducing morbidity and mortality, with particular reference to changing the drinking culture.

Illegal Drug Use

- 1) Injecting drug use (Injecting drug use is associated with increased overall mortality and morbidity, particularly that caused by drug overdose and blood borne infectious diseases such as HIV / AIDS, hepatitis B, and hepatitis C.);
- 2) Long duration / regular use of opioids, cocaine and / or amphetamines (Opioid substitution treatment is increasing in Europe. In some European countries at least one in four requests for drug treatment is cocaine related. There is little consensus on what constitutes appropriate treatment for cocaine problems.);



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3) Early use of cannabis and other illegal drugs (Use of cannabis and other psychoactive substances during adolescence has been associated with the later development of problem drug use. In some EU countries trend analysis shows a decrease in age of first use during the past decade.);

4) Regular / intensive use of cannabis and other illegal drugs (see paragraph on cannabis).

Child Health

1) Measuring and monitoring health, well being, and morbidity of children (It is far more important and effective to study the pattern of health of children, their physical and mental well being and its compromises, and identifiable morbidity of a transient or permanent nature – compared to the analysis of patterns of child mortality. It is also essential to focus on health and well being – the positives – as well as on illness as the negative. This would encourage coverage of positive mental health and measurement of mental well being, harmonising with another European priority but measured specifically for children of different ages.);

2) Child impairment, disability, and special needs (Measurement and impact assessment of impairment and disability in children differ significantly from that in adults. The impact of disability on children's lives at different stages of development varies. The development of a variation for children of a measurement tool based on the ability to perform activities of daily living is a priority.);

3) Intentional harm and injury to children (Improvement of information and pooling of information from across Europe. Defining "intentional harm". Providing a platform to support and harmonise efforts to establish statistical reporting systems in hospitals and primary care to seek improved identification and measurement of the problem.).

Gender-specific Health

1) The implementation of gender mainstreaming is a core prerequisite for any biomedical research; in particular any agenda setting requires a mandatory reflection how women and men are potentially affected by the "chain of research", i.e. hypothesis, diagnostic tools, therapies, prevention rehabilitation programmes, and finally health information messages. Examples of diseases relevant to gender research are cardiovascular diseases, e.g. acute coronary syndrome, and mental illnesses, e.g. depression and schizophrenia

2) "Gender" needs to be operated as a top priority strategy as it needs to be explicitly integrated into any "social" and "economic" development for the embetterment of the health of European populations.

Social and economic inclusion of all European populations requires that the resources and risks of all – diverse – groups are recognized. It is adamant that gender equality and the empowerment of women are recognized as one top health priority to try to achieve the Millennium Development Goals.

Health of the Elderly

- 1) Long-term care in the elderly and social networks;
- 2) Potentially avoidable admission rates for chronic diseases among the elderly;
- 3) Economic effects of the burden of chronic disease among the elderly.

Migrant Health

- 1) Collection and analysis of descriptive data, in order to compare health and health determinants (including health care utilization) among migrants between countries (including countries of origin where feasible);
- 2) Studies of the causes of higher rates of certain health problems among migrants (e.g. hepatitis, diabetes, schizophrenia, traffic injuries ...);
- 3) Development and evaluation of interventions and policies, by carrying out studies of promising approaches (e.g. to improve health care access and responsiveness).

Health of Deprived Population Groups

- 1) Improved monitoring, by looking at trends over time of health and health determinants by socioeconomic group in different European countries (e.g. to check whether certain agreed upon targets are likely to be met in the future);
- 2) More explanatory work, taking advantage of on-going longitudinal studies in different European countries, aiming at finding entry-points for policies to reduce health inequalities (e.g. to assess the role of various lifestyle factors, occupational risks, psychosocial stress, health care quality);
- 3) Development and evaluation of interventions and policies, by carrying out controlled (quasi-) experimental studies of promising approaches in different settings, and by assessing the transferability of results from one setting to the other

The top priorities were included in the Position Paper. Comments on both documents were considered in the revised version of the Positions Paper and Mandate.

It was decided that the new name of the Working Party shall be "Working Party on Information on Lifestyle and Specific Subpopulations". The new name will be introduced to Working Party members at the next meeting, which will be held in Luxembourg on the 19 April 2007. At the meeting the revised strategic documents will be presented for approval.



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Working Party Meeting Operating Principles

by John Mason

To establish a framework to best create efficient and effective progress for the group some key principles have been proposed and agreed upon. This is particularly important to the large scope covered by the group.

- Working Party members should share a clear set of goals → Working Party vision.
- The group priorities should be clear to everyone.
- Working Party members should be open and prepared to share their expertise and knowledge to contribute to the group's goals.
- There should be a culture of mutual support within the Working Party to make each other successful and hence make the group successful.
- At Working Party meetings, everyone should be allowed to contribute to the success of the event. Respect should be shown to those sharing information. Discussions should be, where ever possible, concise and to the point.
- Everybody should focus at a European level.
- Project leaders should act on behalf of the European Commission.

New Projects of the Working Party Lifestyle

Establishing a Monitoring Mechanism on Prison Health Indicators and Determinants

by Lars Moller

Among the greatest challenges in public health in the last two decades are: the resurgence of communicable diseases such as TB; the rise and rapid spread of a new life threatening disease HIV/AIDS; and the seemingly uncontrollable pandemic of problematic use of psychotropic drugs. Each of these has huge negative economic implications for all societies. What has become clear is that the most vulnerable sections of our populations suffer disproportionately from these conditions. Prison is a setting where we find a very high prevalence of HIV, TB and of life threatening life styles.

In order to increase our knowledge of prison health, trends in prison health and the importance for public health it was decided to establish a system to collect relevant prison health indicators and other health determinants.

With a few exceptions (Norway, France, England and Wales) prison health is generally an integral part of the judicial or security system rather than of the health system, thus isolating health in prisons from the mainstream of public health and bringing along many questions about independence, quality, accessibility and level of (preventive and curative) health services provided.

Prisons have become focal points for communicable diseases and many illicit drug users have their first drug experience in prison. The poor health status of prisoners impacts on society, through early release, through contact with staff, family and others in the community and increases the risk of re-offending. The objective is to obtain greater understanding of the importance of the integration of prison health into the public health system through increased knowledge of prison health and health determinants. Prison health data will also improve our knowledge of how diseases and life threatening behaviour can be prevented in order to improve prisoners' health, decrease the spread of diseases from prisons to the society and to decrease re-offending.



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The specific objectives are:

- To establish a monitoring mechanism on prison health, leading to a greater understanding of the incidence/prevalence and spread of disease and ill-health in prisons and between prisons and the society.
- To establish an European Network of national experts on prison health in order to facilitate the implementation of a data collection procedure.
- To support and encourage EU Member States and applicant countries to implement a system to monitor prison health.
- To develop a practical manual on prison health.
- To develop evidence-based guidance on cost-effective disease control and health promotion in prisons as part of national strategies for public health protection and promotion.

Develop an early warning system on communicable diseases and changes in psychotropic drug use in prisons in order to protect public health.

In order to avoid overlap of other databases and actors working with prison health data the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) and the European Network on Drugs and Infections in Prison (EN-DIPP) were invited to join the development of a database

During October 2005 the network for prison and health had a meeting in London to discuss the database work and the expectations of the system. Indicators and the draft questionnaire were discussed. Some countries will probably encounter difficulties with some of the indicators, as a national system for collecting prison health related data has not yet been established. However, some countries are willing to set up such systems, as there is a need to be able to compare public health data with prison data. It was decided to develop a tool for data-entry that should be on-line and accessible through the Internet for national counterparts. This would ensure the continuation of the system after the funding period, as resources for daily running will be minimal. Such a system is new for WHO but with technical support from WHO a draft version was made available for national counterpart as per 1 July 2006. The on-line data entry system is connected to a database and in order to give public direct access to data, a system for data presentation has been developed, and at a network meeting in October 2006 in Romania the system was opened for public access (<http://data.euro.who.int/hip/>).

The national counterparts have started to enter data and it is expected to have data from most Member States available by October 2007. The project is co-sponsored between World Health Organization Regional Office for Europe and the Public Health Programme of the European Commission.

Recently Finished Projects of the Working Party Lifestyle

Ageing Nutrition

by Stefanie Lesser

The Ageing Nutrition Project funded by the European Commission, started in May 2004. It included partners from 15 countries, i.e. 5 Central-Western/ Southern European and 10 Baltic, Central and Eastern European countries. In the first phase, information on already existing data was collected in each participating country (Austria, Belgium, Bulgaria, Czech Republic, Estonia, Germany, Greece, Hungary, Latvia, Poland, Romania, Slovak republic, Slovenia, Spain and Turkey). The following topics were covered: General study information, basic characteristics of participants, nutritional status, food intake, nutrient intake, dietary habits and lifestyle. In total, 22 studies from the Central-Western/ Southern European and 47 studies from the Eastern, Baltic, and Central regions were available from all participating countries. Several of these studies had to be excluded because they were in conflict with the inclusion criteria defined for this project or contained only health but not nutrition related parameters. Finally, 36 studies remained for compilation, 22 from "new" and 14 from the "old" EU Member States. All of these studies are characterised briefly in national reports. Raw data for recalculation were not accessible in every country.

The 36 studies varied broadly in general design, in data assessment and management and in parameters and methods used. Especially different methods to assess the nutritional situation comprising anthropometry, blood lipid profile, dietary methods and food intake, were used and, thus, the results were difficult to impossible to compare. Consequently, data comparison between "old" and "new" Member States by recalculation of raw data had to be restricted to few distinct parameters. For each participating country, one major representative and apt study was chosen for the comparative evaluation. Therefore, data from ten studies of Baltic, Central, and Eastern European countries and five studies from Central-Western and Southern European countries were recalculated. Recalculated data are presented in a descriptive manner.



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This project provides a comprehensive overview on existing current data on nutrition and lifestyle of the ageing population in Europe. The situation in the "old" and "new" EU Member States is described. Thereby, more similarities than differences between "old" and "new" EU Member States become obvious. Anyhow, variations between studies from participating countries dominate differences from regional analysis. Identified deficiencies in research apply to both regions. The study results may serve as basis for further monitoring of nutrition and lifestyle of the European elderly population, as the need for further prospective studies with a coordinated design has been determined. Recommendations for improvements are given

Recent Publications

Current Aspects of the Effect of Maternal Smoking during and after Pregnancy

By Natalie M Schmitt, Wilhelm Kirch

In Western countries, 20% to 40% of women at reproductive age smoke. Many women – about 66% – quit smoking during pregnancy and consequently reduce the risk of adverse pregnancy outcomes including low birth weight babies. (Al Mamun 2006, Levine 2004, Röske 2006).

Smoking during pregnancy seems to directly affect the development of obesity in offspring during childhood and adolescence. There is evidence that the in utero exposure to tobacco is responsible for the negative health effects observed in adolescence: Adolescent offspring of mothers who reported having smoked during pregnancy are about 40% more likely to be obese than those whose mothers did not smoke. (Cut-off for obesity is equivalent to the 95th percentiles of the Centers for Disease Control and Prevention's year 2000 growth charts.) BMI as well as the prevalence of overweight and obesity are significantly increased among adolescents whose mothers smoked during pregnancy if compared to persons without in utero exposure to tobacco. Offspring of mothers who smoked before and/or after, but not during pregnancy, are not at increased risk for developing obesity compared to children of mothers who have never smoked. The described findings seem to be quite robust as adjustment for a variety of potentially confounding factors did not substantively alter the results in a prospective population-based cohort study of more than 3,200 children. Potentially confounding factors which were considered include maternal age and education, family income, marital status, breastfeeding, sex, childhood intelligence and behaviour patterns as well as childhood diet and physical activity patterns. (Al Mamun 2006)

As only observational studies have been conducted on this topic so far, the possibility of residual confounding cannot be ruled out. Women who smoke during pregnancy may e.g. educate their children less health-consciously than women who quit during pregnancy. The difference in BMI and the prevalence of obesity and overweight in adolescence may be partly explained with the variety in quality of education. Ethical considerations do not allow randomized controlled trials (RCT) of the consequences of maternal smoking during pregnancy, which may lead to higher evidence. However, the follow-up of children of mothers included in RCTs in which maternal smoking status was assessed may add to existing evidence.

It is most likely that nicotine causes the effect on body weight, although the impact of the estimated 4,000 chemicals in cigarette smoke on appetite control and the development of obesity have not been further examined yet. (Al Mamun 2006)

These findings emphasize the need for greater efforts to persuade women not to smoke and encourage pregnant smokers to quit.

Another topic of interest is women's relapse to smoking postpartum after a successful period of nicotine abstinence during pregnancy. Reasons for smoking relapse in this population are currently discussed in the literature.

Up to two-thirds of women who quit smoking during pregnancy. These women, resume smoking within 6 months postpartum. Smoking does not only affect women's health but also the health of the whole family exposed to second-hand smoke. Passive smoking is particularly harmful to children's and adolescents' physical and cognitive development. Children who are exposed to second hand smoke in their homes are at higher risk of sudden infant death syndrome (SIDS) and show a higher prevalence of impaired lung function, respiratory diseases, otitis media, and allergies. (Röske 2006)

Social disrespect which pregnant smokers face may be one reason for the observed temporary abstinence. Society does not seem to be as conscious and concerned about the negative health consequences of second hand smoke which babies and children are subjected to compared to the detrimental effects of in utero exposure. Therefore, women may not feel obliged – from a societal perspective – to stay abstinent.

Women's intention to restart using tobacco after delivery, weight concerns, depression, inadequate coping strategies, and stressful life events are identified predictors of smoking relapse in the postpartum period.

Within 6 months postpartum, significantly more women who intended to start smoking actually resumed smoking (about 66% relapse) compared to women without intention to resume smoking postpartum (about 25% relapse). (Röske 2006)



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After delivery, women are often concerned about their body weight. These concerns may decrease motivation to stay abstinent because of the positive effects of smoking on body weight. Unfortunately, many women overestimate the effects of tobacco use on weight changes and consequently resume smoking. Alternative approaches to treating post cessation weight gain concerns should be actively promoted in women who stopped smoking during pregnancy and are concerned about body weight. (Levine 2006, Levine 2001)

Changes in mood are common during the postpartum period and seem to affect women's postpartum smoking behaviour. Mood changes may be due to postpartum hormonal changes, baby blues, stresses of young motherhood, and changes in role and self perception. Depressive disorders increase women's vulnerability to smoking relapse. Relapse prevention programs seem to be most successful if delivered prenatally and during the postpartum period. (Levine 2004, Levine 2003)

Interventions which support women's smoking abstinence are highly recommended. It is a great success that most women quit smoking during pregnancy (mostly without any support).

After delivery, smoking does not only affect the health of the smoker, but has a huge negative impact on the growing and developing offspring affecting their health over the whole life span. In Germany, almost 20% of children under the age of 5 years are exposed to their mothers' second hand smoke. (Röske 2006) Effective interventions should aim at enabling these children to grow up in a healthier environment.

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A similar version of this article will be published in German language in the Public Health Forum (Schmitt NM, Schmitt J, Kirch W. Aktuelle Aspekte zum mütterlichen Nikotinkonsum während und nach der Schwangerschaft. *Public Health Forum* Nr 54, March 2007, DOI: 10.1016/j.phf.2007.01.002)

Use of family planning Methods by Women in the Municipality of Nis (Serbia)

by O. Radulovic, M. Nikolic, C. Sagric, Lj. Stosic, A. Stankovic, S. Milutinovic

The use of family planning methods reduces maternal mortality, prevents unwanted and high-risk pregnancies, the need for (un)safe abortion and protects from sexually transmitted diseases. The objective of the study was to assess the use of family planning methods by women in the municipality Nis. We applied an observational cohort study that included 1,584 women age 15 – 49, who lived in the municipality of Nis. Data was collected through the opinion poll examination, which took place in the municipality of Nis from February to September 2002. We found 81.9% of interviewees having sexual relations protect themselves from unwanted pregnancy permanently or occasionally; 18.1% do not. Of interviewees who do not use protection and have sexual relations, 28.1% think it harms health and 27.7% think it is unsafe. Among women who use contraceptive protection, 57.9% use traditional (unsafe) methods while 42.1% use modern methods. Interviewees who use contraception mostly choose a particular method of their own accord without consultation (52.9%); 58.2% estimate their method of contraception as partly safe, 6.8% as unsafe and 35% as completely safe. As to the reason for contraception use, 40.4% state they already have their preferred number of children, 22.4% use contraception for health reasons, 17% because they are not married, 7.6% because of poor economic condition, and other reasons are present in significantly lesser percentages. Of the interviewees, 29.3% had intentionally interrupted pregnancies. The use of family planning methods is unsatisfactory. Therefore, it is necessary to promptly begin promoting protection of reproductive health and the use of modern family planning methods as a part of the nurturing of healthy lifestyles.