doi 10.2478/v10152-012-0002-3 Zdrav Var 2012; 51: 5-7

SPEAKING ALLOWED: THE POLITICAL VOICE OF PUBLIC HEALTH

Friedli Lynne[1]

Guest Editorial

It seems we are at a crossroads in approaches to tackling health inequalities and understanding the role of public health in Europe. The economic downturn is reinforcing existing inequalities and generating new ones: as inequalities by age, gender, ethnicity, disability and socio-economic status intersect with the impact of globalisation and demographic change, including migration patterns (1). Recent data on suicide and road traffic accidents shows how rapidly health responds to declining economic circumstances. Changes in mortality coincide with changes in unemployment and the insecurity of anticipating job loss. Across Europe, suicide rates have risen sharply since 2007, with the greatest increases in those countries most affected by the recession. Road traffic fatalities also fell, reflecting lower road use during periods of economic decline (2).

The nature and pattern of health challenges is also changing, with chronic non-communicable disease (NCD) and mental health problems contributing a growing proportion of mortality, morbidity and/or disability (3).

What is evident is the strong relationship between life expectancy, years of healthy life and socio economic trends and the marked social gradient, or health gap, between every rung on the ladder of socio economic status (4). While there are health inequalities between countries in both the EU 27 and across the 53 Member States of the WHO European Region, the greatest inequalities lie within countries (3, 5). At the same time, countries differ markedly in the health conditions and health determinants responsible for their health gap – which means that health inequalities are neither fixed nor inevitable (6).

It also means that tackling individual diseases or individual risk factors looks increasingly flawed. Life course epidemiology shows the power of environmental influences to determine health outcomes over two or three generations (7, 8). Premature ageing, cardiovascular disease, metabolic syndrome, type two diabetes and musculoskeletal disorders may all have common antecedents (9). In addition, as causes of death and disease are socially patterned, the removal of one risk factor (e.g. smoking) will simply be replaced by another (e.g. obesity) unless material inequalities are addressed (10). Increasing the price of alcohol is widely recommended as an evidence-based remedy for reducing alcohol-related harm, but if fatal patterns of alcohol consumption are a response to poverty and cultural despair, cheaper and even more harmful alternatives will be found (11).

Improvements in health have not resulted in reductions in health inequalities (6), just as growth in the GDP has tended to increase, rather than decrease, the gap between rich and poor (12). In a major revisiting of the evidence, the Commission on the Social Determinants of Health has demonstrated where attention should be focussed: health inequalities are a symptom, an outcome, of inequalities in power, money and resources (13, 4).[1] These structural and material inequalities result in unequal exposure, depending on social position, to a range of health risks and health advantages.

Although public health has a special responsibility to address health inequalities, treating the symptoms should not be confused with addressing the causes: questions of power and political voice cannot be avoided.

Recognition of these issues has stimulated some important emerging literature on the value of a greater focus on political analysis (14, 2). This includes acknowledging the political determinants of health inequalities and exploring political explanations of why regions with similar levels of deprivation may have very different levels of resistance or susceptibility to poor health (15). Central to these accounts is an acknowledgement of vested and competing interests and their expression in struggles concerning employment, pay, income, social protection and housing. From this perspective, the collective analysis of and resistance to inequalities in power, privilege and resources – for example feminism, trades unions, gay liberation, civil rights and disability rights – is a significant health asset (16). Therefore, the first crossroads involves political direction, with one route clearly signalling a public health agenda that addresses human rights and social justice: the distribution of the determinants of health and health inequalities.

[1] Health 2020, a new public health policy being developed by the WHO Regional Office for Europe, will also focus on equity and social determinants http://www.euro.who.int/en/what-we-do/event/first-meeting-of-the-european-health-policy-forum/health-2020

[1]Freelance researcher, London, United Kingdom
Correspondence to: e-mail: lynne.friedli@btopenworld.com

The second crossroads concerns how public health should respond to the increasing emphasis on psycho-social determinants. This is not a new debate (17), but it has been given a new impetus by the growing interest in mental wellbeing (18) and the growing influence of *salutogenesis* or 'assets-based approaches' to health (19).

Both assets approaches and the wider wellbeing debates are strongly associated with a non-materialist position – money doesn't matter as much as relationships, a sense of meaning and purpose, opportunities to contribute and autonomy: *there's a difference between starving and fasting* (20). The importance of the psycho-social domain is also central to critiques of consumerism, materialism and the dominance of marketised solutions to health and social problems. These critiques come together in calls to value the contribution of those outside the money economy: the *core economy* of friends, family, neighbours and civil society (21). The Stiglitz Report, commissioned by President Sarkozy, calls for measures of social progress that include non-market activities, sustainability and quality of life, as does the OECD Global Project on Measuring the Progress of Societies (12).

A strong focus on psycho-social factors is part of a wider acknowledgement of the non material dimensions of poverty, perhaps most famously in Amartya Sen's call for '*the ability to go about without shame'* to be recognised as a basic human freedom (22). People living in poverty, as well as other vulnerable or excluded groups, consistently describe the pain of being made to feel of no account, which is often experienced as more damaging than material hardship. From this perspective, inequalities greatly exacerbate the stress of coping with material deprivation (23, 24). What's at stake here is the social, emotional and spiritual impact of poverty and inequality, the belief that '*wellbeing does not depend solely upon economic assets'* (20) and a wider resistance to 'deficit models' of public health (19).

What we're seeing here could be a cause for celebration: a richer, more nuanced account of the social determinants of health – one that recognises the relationship between physical and mental health and that respects the strength, resilience, skills and potential of people living in poverty. Too often however, psycho-social factors are abstracted from the material realities of people's lives and opportunities. Psychological skills and attributes – optimism, self-efficacy, confidence, self-esteem, hopefulness and 'sense of coherence' – are detached from an economic, political, cultural and historical context, obscuring the links between social psychology and social structure (25). Public health is not immune to the seductive powers of the happiness industry, where a cheerful disposition and a thankful heart are the primary determinants of health and wellbeing (26).[2] In this world of a '*single indicator observational epidemiology'* (25), psycho-social factors are used to account for 'health-damaging behaviours', not to tackle structural inequities.

Although it is rarely mentioned, in most of the EU 27, the education and income of public health professionals places them well within the top quintile of power, privilege and wealth. This makes addressing the power gap between public health systems and the people they serve an urgent priority (27) and solidarity with those struggling for social justice the most important road to travel.

References

1. European Commission. Economic crisis in Europe: causes, consequences and responses. Luxembourg: Directorate General for Economic and Financial Affairs, 2009. Pridobljeno15. 09. 2011 s spletne strani: http://ec.europa.eu/economy_finance/articles/article15893_en.htm.
2. Stuckler D, Basu S, Suhrcke M. et al. Effects of the 2008 recession on health: a first look at European data. *Lancet* 2011; 378: 124-125.
3. WHO. European health report 2009: health and health systems. Geneva: WHO, 2009.
4. Solar O, Irwin A. A conceptual framework for action on the social determinants of health Geneva: WHO, 2001.
5. Mackenbach J, Meerding WJ,Kunst A. Economic implications of socio-economic inequalities in health in the European Union. Luxembourg: European Commission, 2007.
6. Mackenbach J. Health inequalities: Europe in profile. London: Department of Health, 2006.
7. Alastalo H, Raikkonen K, Pesonen AK, Osmond C, Barker DJ, Kajantie E, Heinonen K, Forsen TJ, Eriksson JG.Cardiovascular health of Finnish war evacuees 60 years later. Ann Med 2010; 41: 66-72.
8. Eriksson JG, Kajantie E, Osmond C, Thornburg K, Barker DJP. Boys live dangerously in the womb. Am J Hum Biology 2009; 22: 330-335.
9. Burton GJ, Barker DJP, Moffett A, Thornburg K, editors. The placenta and developmental programming. Cambridge: University Press, 2011.
10. Scott-Samuel A. Further evidence that effective interventions on health inequalities must tackle the root causes. Pridobljeno15. 09. 2011 s spletne strani: http://www.bmj.com/content/342/bmj.d3460.full/reply#bmj_el_266479
11. Walker S. Russia's alcohol problem. BMJ 2011; 343 (v tisku).
12. Stiglitz JE, Sen A, Fitoussi JP. Report by the Commission on the Measurement of Economic Performance and Social Progress. Pridobljeno15. 09. 2011 s spletne strani: http://www.stiglitz-sen-fitoussi.fr/documents/rapport_anglais.pdf.
13. CSDH. Closing the gap in a generation: health equity through action on the social determinants of healt. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization, 2008.

[2] http://www.actionforhappiness.org/

14. Beckfield J, Krieger N. Epi + demos + cracy: a critical review of empirical research: linking political systems and priorities to the magnitude of health inequities. Epidemiol Rev 2009; 31: 152–177.
15. Collins C, McCartney. The impact of neoliberal 'political attack' on health: the case of the 'Scottish effect'. Int J Health Services 2011; 41: 501-523.
16. Friedli L. Reasons to be cheerful: the 'count your assets' approach to public health Perspectives. Pridobljeno10. 09. 2011 s spletne strani: http://democraticleftscotland.wordpress.com/perspectives/
17. Lynch JW, Davey-Smith G, Kaplan G, House JS. Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. BMJ 2000; 320: 1200-1204.
18. Friedli L. Mental health, resilience and inequalities: a report for WHO Europe and the Mental Health Foundation. London, Copenhagen: Mental Health Foundation and WHO, 2009. 19. Morgan A, Davies M, Ziglio E, editors. Health assets in a global context - theory, methods, action. London: Springer, 2010.
20. Sen A. Inequality reexamined. Cambridge, MA: Harvard University Press, 1992.
21. Cahn E. No more throw away people: the co production imperative. Washington DC: Essential Books, 2004.
22. Zaveleta RD. The ability to go about without shame: a proposal for internationally comparable indicators of shame and humiliation. Working Paper 3. Oxford: University of Oxford, 2007. Pridobljeno 10. 09. 2011 s spletne strani: http://www.ophi.org.uk/pubs/Zavaleta_Shame_Humiliation_Final.pdf.
23. Wilkinson RG, Pickett KE. Income inequality and population health: a review and explanation of the evidence. Soc Scienc Med 2006; 62: 1768-1784.
24. Wilkinson RG, Pickett KE. The spirit level: why more equal societies almost always do better. London: Penguin, 2009.
25. Muntaner C. Social capital, social class and the slow progress of psychosocial epidemiology. Int J Epidem 2004; 33: 674-680.
26. Pressman S, Cohen S. Does positive affect influence health? Psychological Bulletin 2005; 131: 925-971.
27. Rasanathan K, Villar Montesinos E, Matheson D. et al. Primary health care and the social determinants of health: essential and complementary approaches for reducing inequities in health. J Epidemiol Community Health 2011; 65: 656-660.

doi 10.2478/v10152-012-0002-3 Zdrav Var 2012; 51: 8-10

SPREGOVORITI NA GLAS: POLITIČNI VIDIK JAVNEGA ZDRAVJA

Friedli Lynne[1]

Gostujoči uvodnik

Zdi se, da se nahajamo na križišču pristopov k odpravljanju neenakosti v zdravju in razumevanja vloge javnega zdravja v Evropi. Gospodarska kriza krepi obstoječe neenakosti in ustvarja nove: neenakosti zaradi starosti, spola, narodne pripadnosti, invalidnosti in socialno-ekonomskega statusa se križajo z učinki globalizacije in demografskimi spremembami, vključno z migracijskimi vzorci (1). Najnovejši podatki o samomorih in prometnih nesrečah kažejo, kako hitro se zdravje odziva na slabšanje gospodarskega položaja. Spremembe smrtnosti sovpadajo s spremembami brezposelnosti in negotovostjo, povezano s pričakovanjem izgube zaposlitve. V Evropi se je stopnja samomorilnosti od leta 2007 močno povečala, z največjim porastom v tistih državah, ki jih je recesija najbolj prizadela. Zmanjšalo se je tudi število smrtnih žrtev prometnih nesreč, kar kaže na manjšo uporabo cest v obdobju gospodarske krize (2). Spreminjata se tudi narava in vzorec izzivov na področju zdravja, pri čemer neprenosljive kronične bolezni in težave z duševnim zdravjem prispevajo vedno večji delež k smrtnosti, obolevnosti in/ali invalidnosti (3).

Očitna je močna povezava med pričakovano življenjsko dobo, leti zdravega življenja in socialno-ekonomskimi trendi ter izrazitimi razlikami med družbenimi sloji, ali vrzeljo v zdravju, med vsako stopnjo lestvice socialno-ekonomskega statusa (4). Čeprav obstajajo neenakosti v zdravju tako med državami EU-27 kot med 53 državami članicami Evropske regije Svetovne zdravstvene organizacije, pa največje neenakosti obstajajo znotraj držav (3, 5). Hkrati se države močno razlikujejo glede zdravstvenih pogojev in odločilnih dejavnikov zdravja, ki so odgovorni za njihovo vrzel v zdravju – kar pomeni, da neenakosti v zdravju niso niti nespremenljive niti neizogibne (6).

Pomeni tudi, da je odpravljanje posameznih bolezni ali posameznih dejavnikov tveganja vedno bolj pomanjkljivo. Epidemiologija skozi življenjski cikel kaže moč okoljskih vplivov pri določanju zdravstvenih rezultatov skozi dve ali tri generacije (7, 8). Prezgodnje staranje, srčno-žilne bolezni, metabolični sindrom, sladkorna bolezen tipa 2 in mišično-skeletne motnje imajo lahko isti vzrok (9). Poleg tega, ker so vzroki smrti in bolezni odvisni od družbenih vzorcev, bo odprava enega dejavnika tveganja (npr. kajenja) preprosto nadomeščena z drugim (npr. debelostjo), razen če se odpravijo bistvene neenakosti (10). Povišanje cene alkohola se na splošno priporoča kot ukrep, ki temelji na dokazih in je namenjen zmanjšanju z alkoholom povezane škode, vendar če so usodni vzorci uživanja alkohola odziv na revščino in kulturni brezup, se bodo našle cenejše in še bolj škodljive alternative (11).

Izboljšave zdravja niso povzročile zmanjšanja neenakosti v zdravju (6), prav tako pa tudi povečanje BDP povečuje, in ne zmanjšuje, vrzel med bogatimi in revnimi (12). Pri glavnem ponovnem pregledu dokazov je Komisija za socialne determinante zdravja pojasnila, čemu je treba nameniti pozornost: neenakosti v zdravju so simptom, rezultat neenakosti v moči, denarju in sredstvih (13, 4).[1] Te strukturne in materialne neenakosti povzročajo neenako izpostavljenost, po družbenem statusu, številnim tveganjem in koristim za zdravje.

Čeprav ima javno zdravstvo posebno odgovornost za obravnavanje neenakosti v zdravju, se zdravljenja simptomov ne sme zamenjevati z odpravljanjem vzrokov: ni se mogoče izogniti vprašanju moči in političnega glasu.

Prepoznanje teh težav je spodbudilo pomembno porajajočo se literaturo o vrednosti večje osredotočenosti na politično analizo (14, 2). To vključuje priznavanje političnih determinant neenakosti v zdravju in raziskovanje političnih razlag, zakaj se lahko v regijah s podobnimi stopnjami pomanjkanja stopnje odpornosti oziroma dovzetnosti za slabo zdravje močno razlikujejo (15). Skupno tem razlagam je priznavanje osebnih in konkurenčnih interesov ter njihovega izražanja v prizadevanjih, povezanih z zaposlitvijo, plačo, dohodkom, socialno zaščito in nastanitvijo. Iz tega vidika predstavljata skupna analiza neenakosti v moči, privilegijih in sredstvih (na primer feminizem, sindikati, liberalizacija homoseksualcev, civilne pravice in pravice invalidov) ter odpornost nanje pomembno korist za zdravje (16). Prvo križišče se torej nanaša na politično

[1] Zdravje 2020, nova politika na področju javnega zdravja, ki jo razvija regionalni urad Svetovne zdravstvene organizacije za Evropo, bo usmerjena tudi na enakost in socialne determinante http://www.euro.who.int/en/what-we-do/event/first-meeting-of-the-european-health-policy-forum/health-2020.

[1]Svobodna raziskovalka, London, Velika Britanija
Kontaktni naslov: e-pošta: lynne.friedli@btopenworld.com

usmeritev, pri čemer ena smer jasno signalizira program javnega zdravja, ki obravnava človekove pravice in socialno pravičnost: porazdelitev determinant zdravja in neenakosti v zdravju.

Drugo križišče se nanaša na zaskrbljenost, kako naj se javno zdravstvo odzove na vedno večji pomen psiho-socialnih determinant. To ni nova polemika (17), vendar je dobila novo spodbudo z naraščajočim interesom za duševno zdravje (18) in naraščajočim vplivom *salutogeneze* oziroma »pristopov k zdravju, ki temeljijo na premoženjskem stanju« (19).

Tako pristopi, ki temeljijo na premoženju, kot tudi širše razprave o zdravju so tesno povezani z nematerialističnim stališčem – denar ni tako pomemben kot odnosi, občutek smisla in namena, priložnosti za sodelovanje in neodvisnost*: obstaja razlika med stradanjem in postenjem (20).* Pomen psiho-socialnega področja je tudi v središču kritik potrošništva, materializma in prevlade tržno usmerjenih rešitev za zdravstvene in socialne probleme. Te kritike so združene v pozivih k spoštovanju prispevkov tistih, ki se nahajajo zunaj denarne ekonomije: *temeljne ekonomije* prijateljev, družine, sosedov in civilne družbe (21). Poročilo Stiglitz, ki ga je naročil predsednik Sarkozy, poziva k ukrepom družbenega napredka, ki vključujejo netržne dejavnosti, trajnost in kakovost življenja, kot je globalni projekt OECD za merjenje napredka družb (12).

Velik poudarek na psiho-socialnih dejavnikih je del širšega priznavanja nematerialnih dimenzij revščine, morda najbolj znanega v pozivu Amartya Sena k temu, da se *»zmožnost preživljanja brez sramote«* prepozna kot osnovna človeška svoboščina (22). Ljudje, ki živijo v revščini, pa tudi druge ranljive ali izključene skupine, enotno opisujejo bolečino, ki jo doživljajo ob občutku nepomembnosti, kar je pogosto bolj pogubno kot materialne težave. Iz tega vidika neenakosti močno povečujejo stres pri soočanju z materialno prikrajšanostjo (23, 24). Tu gre za socialni, čustveni in duševni vpliv revščine in neenakosti, za prepričanje, da *»dobro počutje ni odvisno samo od ekonomskih sredstev«* (20), ter večjo odpornost na »modele primanjkljaja« v javnem zdravju (19).

Vse našteto bi bilo lahko vzrok za slavje: večje, bolj razčlenjeno upoštevanje utemeljitev socialnih determinant zdravja, ki priznava povezavo med fizičnim in duševnim zdravjem ter moč, prilagodljivost, spretnosti in potencial ljudi, ki živijo v revščini. Vendar pa so psiho-socialni dejavniki prepogosto vzeti iz materialnih dejstev življenja ljudi in njihovih priložnosti. Psihološke spretnosti in lastnosti - optimizem, samoučinkovitost, samozavest, dobro mnenje o samem sebi, upanje in »občutek povezanosti« – so ločene od ekonomskega, političnega, kulturnega in zgodovinskega konteksta, kar postavlja v senco povezave med socialno psihologijo in socialno strukturo (25). Javno zdravje ni imuno na mamljivo moč industrije sreče, v kateri sta veselo razpoloženje in zadovoljna duša primarni determinanti zdravja in dobrega počutja (26).[2] V tem svetu *»epidemiologije enotnega kazalnika, ki temelji na opažanju«* (25), se psiho-socialni dejavniki uporabljajo za utemeljitev »zdravju škodljivega vedenja« in ne za odpravo strukturnih neenakosti.

Čeprav se to redko omenja, se strokovnjaki s področja javnega zdravja s svojo izobrazbo in dohodkom v večini držav EU-27 uvrščajo v sam vrh moči, privilegijev in bogastva. Zato je odpravljanje vrzeli v moči med sistemi javnega zdravja in ljudmi, ki so jim ti sistemi namenjeni, nujna prednostna naloga (27), solidarnost s tistimi, ki se borijo za socialno pravičnost, pa najpomembnejša pot, ki jo je treba prepotovati.

Literatura

1. European Commission. Economic crisis in Europe: causes, consequences and responses. Luxembourg: Directorate General for Economic and Financial Affairs, 2009. Pridobljeno15. 09. 2011 s spletne strani: http://ec.europa.eu/economy_finance/articles/article15893_en.htm.
2. Stuckler D, Basu S, Suhrcke M. et al. Effects of the 2008 recession on health: a first look at European data. *Lancet* 2011; 378: 124-125.
3. WHO. European health report 2009: health and health systems. Geneva: WHO, 2009.
4. Solar O, Irwin A. A conceptual framework for action on the social determinants of health Geneva: WHO, 2001.
5. Mackenbach J, Meerding WJ,Kunst A. Economic implications of socio-economic inequalities in health in the European Union. Luxembourg: European Commission, 2007.
6. Mackenbach J. Health inequalities: Europe in profile. London: Department of Health, 2006.
7. Alastalo H, Raikkonen K, Pesonen AK, Osmond C, Barker DJ, Kajantie E, Heinonen K, Forsen TJ, Eriksson JG.Cardiovascular health of Finnish war evacuees 60 years later. Ann Med 2010; 41: 66-72.
8. Eriksson JG, Kajantie E, Osmond C, Thornburg K, Barker DJP. Boys live dangerously in the womb. Am J Hum Biology 2009; 22: 330-335.
9. Burton GJ, Barker DJP, Moffett A, Thornburg K, editors. The placenta and developmental programming. Cambridge: University Press, 2011.
10. Scott-Samuel A. Further evidence that effective interventions on health inequalities must tackle the root causes. Pridobljeno15. 09. 2011 s spletne strani: http://www.bmj.com/content/342/bmj.d3460.full/reply#bmj_el_266479
11. Walker S. Russia's alcohol problem. BMJ 2011; 343 (v tisku).
12. Stiglitz JE, Sen A, Fitoussi JP. Report by the Commission on the Measurement of Economic Performance and Social Progress. Pridobljeno15. 09. 2011 s spletne strani: http://www.stiglitz-sen-fitoussi.fr/documents/rapport_anglais.pdf.

[2] http://www.actionforhappiness.org/

13. CSDH. Closing the gap in a generation: health equity through action on the social determinants of healt. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization, 2008.
14. Beckfield J, Krieger N. Epi + demos + cracy: a critical review of empirical research: linking political systems and priorities to the magnitude of health inequities. Epidemiol Rev 2009; 31: 152–177.
15. Collins C, McCartney. The impact of neoliberal 'political attack' on health: the case of the 'Scottish effect'. Int J Health Services 2011; 41: 501-523.
16. Friedli L. Reasons to be cheerful: the 'count your assets' approach to public health Perspectives. Pridobljeno10. 09. 2011 s spletne strani: http://democraticleftscotland.wordpress.com/perspectives/
17. Lynch JW, Davey-Smith G, Kaplan G, House JS. Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. BMJ 2000; 320: 1200-1204.
18. Friedli L. Mental health, resilience and inequalities: a report for WHO Europe and the Mental Health Foundation. London, Copenhagen: Mental Health Foundation and WHO, 2009. 19. Morgan A, Davies M, Ziglio E, editors. Health assets in a global context - theory, methods, action. London: Springer, 2010.
20. Sen A. Inequality reexamined. Cambridge, MA: Harvard University Press, 1992.
21. Cahn E. No more throw away people: the co production imperative. Washington DC: Essential Books, 2004.
22. Zaveleta RD. The ability to go about without shame: a proposal for internationally comparable indicators of shame and humiliation. Working Paper 3. Oxford: University of Oxford, 2007. Pridobljeno 10. 09. 2011 s spletne strani: http://www.ophi.org.uk/pubs/Zavaleta_Shame_Humiliation_Final.pdf.
23. Wilkinson RG, Pickett KE. Income inequality and population health: a review and explanation of the evidence. Soc Scienc Med 2006; 62: 1768-1784.
24. Wilkinson RG, Pickett KE. The spirit level: why more equal societies almost always do better. London: Penguin, 2009.
25. Muntaner C. Social capital, social class and the slow progress of psychosocial epidemiology. Int J Epidem 2004; 33: 674-680.
26. Pressman S, Cohen S. Does positive affect influence health? Psychological Bulletin 2005; 131: 925-971.
27. Rasanathan K, Villar Montesinos E, Matheson D. et al. Primary health care and the social determinants of health: essential and complementary approaches for reducing inequities in health. J Epidemiol Community Health 2011; 65: 656-660.