



**PHIRE**

# **Public Health Innovation and Research in Europe**

## **WP4 REPORT**

**EU Health Programme Agreement Number 2009 12 14**

**April 2013**

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*This report is one of several publications from the project Public Health Innovation and Research in Europe (PHIRE). PHIRE has run from 1 September 2010 until 28 February 2013.*

*PHIRE has received funding from the European Union, in the framework of the Health Programme (Agreement Number 2009 12 14)*

*PHIRE was aimed to assist development of the European Public Health Association (EUPHA) activities in the EUPHA Sections and the National Associations that are the members of EUPHA, by focusing on EUPHA's primary concern: health research. Work package 4 of PHIRE was coordinated by Karolinska Institutet, Sweden and EUPHA.*

*The PHIRE project was coordinated by EUPHA. Associated partners are School of Public Health (EHESP), France; Faculty of Public Health (FPH), United Kingdom; Institute of Hygiene (LIH), Lithuania; Karolinska Institutet, Sweden; Ministry of Health, the Elderly and Community Care (MHEC), Malta; Netherlands Institute for Health Services Research (NIVEL), the Netherlands; Slovak Public Health Association (SAVEZ), Slovakia.*

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## Abbreviations

(The eight innovation projects with blue background)

**CHOB** - Children, obesity and associated avoidable chronic diseases

**CI** - Country informants

**CSAP** - Child Safety Action Plans, Phase I

**EAAD** - European Alliance Against Depression

**EEA** - European Economic Area

**ENHIS** - Implementing Environmental and Health Information Systems in Europe

**EU** – European Union

**EUCID** - European Core Indicators in Diabetes Mellitus

**EUPHA** - European Public Health Association

**EURO-URHIS I** - European system of urban health indicators

**HA** - Healthy Ageing

**NGO** – Non-governmental organisations

**PHIRE** - Public Health Innovation and Research in Europe

**VENICE** - Vaccine European New Integrated Collaboration Effort

**WP4** – Work package 4

## PHIRE Work package 4 Defining tracer fields and evidence

PHIRE was implemented for 30 months, from 1 September 2010 until 1 March 2013. This is the final report of work package 4, (WP4), one of the several work packages in the PHIRE project. WP4 aimed at gaining knowledge about uptake of EU innovative public health projects within the different EES countries. Several, country specific reports from WP4 are available at: [http://www.eupha.org/site/projects.php?project\\_page=28](http://www.eupha.org/site/projects.php?project_page=28)

### Summary of work package 4

In order to assess the outputs, diffusion, and impact of projects in the first European Public Health Programme, work package 4 (WP 4) of the PHIRE project has identified eight innovative public health projects that were initiated within the first European Public Health Programme (Table 1). *The eight projects were selected, based on their applicability across European countries, for their innovative character, and the potential to provide new, unique knowledge.* Another selection criterion was that the projects were to have been finished at least three years before the start of PHIRE, that is, before 2008. All the European Public Health Association (EUPHA) Sections were initially involved. The selection of the eight innovative public health projects and gathering of information on the projects was done in close collaboration with seven of the then 18 EUPHA Section leads. To assess the uptake of the results and to determine national and regional impact on public health actions from the innovative public health projects across the 30 European Economic Area (EEA) countries, a web-based questionnaire was developed and distributed to informants from each country. Those country informants (CIs) were chosen in different ways, such as through membership lists from EUPHA sections and contacts of Section leads. Also, a questionnaire for the Section leads was developed, as well as detailed methods for organizing the communication, data collection, data management, analyses, and dissemination.

Data collection for all the eight innovative projects could be completed, both regarding CIs and Section leads. However, identification of Country informants and getting responses from them took longer time than anticipated. Also, the response rates in terms of number of included countries were lower than anticipated.

The results showed that there were some – although not necessarily large – impacts from these projects in the different EES countries, however, the type and magnitude of impact varied with country and project. The Country Informants also reported on facilitating and inhibiting factors for the public health innovations. For all projects but one, 40-65% stated that the innovative public health project was relevant ‘to a great extent’. Generally, the estimated impact of respective project on policy, reforms, guidelines and routines varied much, and was highest for National health authorities. In most projects, a very large variety of channels to disseminate project results had been used – more than those reported in the final reports of the projects. The Country Informants also reported on facilitating and inhibiting factors for the public health innovations.

Employing the organisation of EUPHA proved efficient for gaining the type of knowledge focused on in PHIRE, that is, about the uptake of EU public health innovations at country level.

Detailed methods for organizing the communication, data collection, data management, analyses, and dissemination were developed.

### **1. Identification of possible innovative public health projects to include**

In September 2010, the coordinators of WP4 extracted information from the lists of projects funded under the first Public Health Programme. During the period 2003-2005, a total of 202 public health projects were funded. A final list of 198 projects was created excluding the four projects that were conferences and not eligible to be included. For each of 17 of the then 18 EUPHA Sections, a unique list of possible innovative public health projects was set up that included projects that could be of interest for the respective Section. For one section, the Section of Social Security and Health, no eligible projects could be identified. The following information about each project was extracted: project number, title of the project, project funded (year), starting date, strand, duration of project (months), final report online, country leading the project, associated countries, number of associated countries, keywords, aim of the project and suggested EUPHA Section(s). Some projects could be of interest for more than one Section and was therefore presented for several EUPHA Sections. The number of projects presented as a possible innovative public health project to the 17 Sections varied from between 1 to 100 projects (Project list and description, Annexes 1+2). The basic criteria for the Sections in the selection of the innovative public health project were defined as:

- results of the projects should be applicable in several EU countries;
- projects should be innovative in its area of research;
- projects should have the potential to provide new, unique knowledge;
- projects should have been finished at least three years ago.

Additionally, it was discussed that the included intervention project should not be too complex - it must be possible to evaluate the dissemination of the results in the EU countries.

In the work with identifying and extracting information about possible innovative public health projects founded within the first PHP 2003-2005 we had problems to locate the Final Reports from some of the projects. For some of the projects on the list at the European Commission (<http://ec.europa.eu/health/projects/>) the link to the project Final report did not function. To obtain the information we needed, intensive searches at different web sites were therefore conducted.

### **2. Identification of EUPHA Sections to participate**

In October 2010, the Chair of the Section Council<sup>1</sup> (Kristina Alexanderson) sent an *invitation letter* to all the Presidents of the EUPHA Sections to participate in PHIRE. The Presidents were encouraged to discuss participation in PHIRE with their members and to suggest a possible innovative public health project to be evaluated (Letter, Annex 3).

At the European Public Health Conference in Amsterdam in November 2010, the 17 EUPHA Sections for which an innovative project could be of interest, were offered the possibility to get more information about PHIRE and discuss the project with the WP4 coordinators. The coordinators were invited to present PHIRE at the annual meeting of the Section of Food and

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<sup>1</sup> The Section Council is one of the central bodies of EUPHA organisation and all Section Presidents and Vice Presidents are included (eupha.org).

Nutrition and the Section of Infectious Disease Control, and also discussed this with several of the other Section presidents. Additionally, PHIRE was presented at the Section Council meeting, that is, the council of all the presidents of the EUPHA sections (Section leads) (Presentation, Annex 4).

A first planning meeting for PHIRE was held in Amsterdam (Sunday, 14 November 2010) with the coordinators of WP 4 and PHIRE and representatives from two EUPHA Sections: Food and Nutrition and Public Health Epidemiology (Minutes, Annex 5).

Seven of the EUPHA Sections identified relevant innovative projects and decided to participate in PHIRE. One of the Sections took on two projects, which means that eight innovative projects were included (Table 1). Those seven Section presidents, here called Section leads, have all been involved in the PHIRE WP4.

**Table 1: The eight intervention projects, selected from the first EU Public Health Programme, that are focused in the PHIRE project, by the EUPHA Section involved in data collection**

Selected projects from EU Public Health Programme 2003-2005	EUPHA Section Section lead/contact person
<b>VENICE</b> - Vaccine European New Integrated Collaboration Effort	Public Health Epidemiology President Giuseppe La Torre, Professor, Italy
<b>CHOB</b> - Children, obesity and associated avoidable chronic diseases	Food and Nutrition President Christopher Birt, Professor, United Kingdom
<b>EURO-URHIS I</b> - European system of urban health indicators	Urban Public Health President Arpana Verma, Professor, United Kingdom
<b>HA</b> - Healthy Ageing	Public Mental Health President Jutta Lindert, Professor, Germany
<b>EAAD</b> - European Alliance Against Depression	Public Mental Health President Jutta Lindert, Professor, Germany
<b>ENHIS</b> - Implementing Environmental and Health Information Systems in Europe	Environment Related Diseases President Peter van den Hazel, Professor, Netherlands
<b>CSAP</b> - Child Safety Action Plans, Phase I	Injury Prevention and Safety Promotion Vice President Mathilde Sengölge, Dr, Austria
<b>EUCID</b> - European Core Indicators in Diabetes Mellitus	Chronic Diseases President Iveta Rajnicova-Nagyova, Dr, Slovakia

### 3. Methods to obtain information for WP4

A first planning full-day workshop with the Section leads, coordinators from EUPHA, and the coordinators for WP4 was held in Stockholm, Sweden, in December 2010. The next meeting with Section leads and coordinators for the PHIRE took place in Copenhagen in June 2011. For managing the progress and process of WP4, three additional telephone conferences with the Section leads were arranged during 2011, in February, July, and September, respectively. In between, the WP4 coordinators and the PHIRE coordinators had several telephone meetings and other types of contacts.

We agreed that information about the innovative projects and their impact was to be obtained from country informants, using a web-based survey, as well as from Section leads.



### 3. Web survey

#### Identification of Country Informants

It was agreed that each of the seven EUPHA Section leads could use both the old and the new lists of EUPHA Section members<sup>2</sup> to identify one Country Informant (CI) from each of the 30 EU Member States and EEA countries. If the Section did not have any member from a country, other EUPHA Section membership lists or other existing networks could be used. The identification of CIs was to be completed by February 2011. Due to some difficulties in identifying possible country informants, the period was extended to the end of March and the last questionnaires did arrive in December.

#### Development of a PHIRE questionnaire for the CIs

A first draft of an instrument (questionnaire) to collect data on dissemination, uptake, and impact from the innovative public health projects in the 30 EEA-countries was developed at a one-day workshop in Stockholm in December 2010. Participants were the Section leads and their assistants from the participating EUPHA Sections, and the coordinators of WP4, of WP6, and of PHIRE. The aim of the meeting was preparation of the methods for collection of information, to determine criteria and templates for assessment of dissemination, uptake, and impact within countries of the project outputs, and to develop an instrument for this. The discussions were partly based on a proposal from the coordinators of WP4, as well as material from other participants. The workshop involved several intensive and clarifying discussions on concepts, aims, and methods for data collection as well as on what aspects that actually can be assessed through these types of data. These discussions continued intensely over the following months.

Criteria and type of question for the data collection for follow up of innovative public health projects

As a result of the discussions we agreed about the following criteria for the survey:

- There should be a short, effective, and quick core instrument for all projects, with general questions suitable for all projects and attractive to work with for the CI;
- It should be possible to include project-specific items;
- It should be possible to include country-specific items;
- Description of expected ways that the intervention project could have had an impact;
- Both close and open-ended questions should be included – the later in order to obtain richer answers and material as complement, based on the exploratory nature of WP4 and PHIRE;
- One question about the reasons why or why not the tracer<sup>3</sup> project succeeded in the dissemination of the results – e.g. about "lessons learned";
- Suggestion to use a matrix to collect information about how and how much (type and extent of impact) the results of the project have affected activities in the specific country;

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<sup>2</sup> EUPHA had recently changed system for becoming an individual Section member, which is the reason for why there were two types of membership lists.

<sup>3</sup> The innovative projects were initially in PHIRE called 'tracer projects'

- The instrument was to be web based and data collection could be completed with a telephone interview to get as much information as possible.

Based on this, a web-based draft of the questionnaire was developed and distributed among the coordinators and Section leads. Continuous discussions with and input from the Section leads, e.g. by e-mails and telephone meetings after the workshop in Stockholm, led to a second draft of the instrument. During the process it became obvious that there was a need for a deeper discussion regarding the definitions and meaning of the concepts uptake and impact. A telephone conference on 17 February 2011 was arranged with the aim to discuss (1) definitions and meaning of the words uptake and impact, (2) the process for recruiting CIs, (3) the Section leads questionnaire, (4) the web-based questionnaire for the CIs and (5) the invitation letter for the CIs to take part in PHIRE. Also a small pilot study was conducted. A final version of the instrument was accepted by the Section leads at the end of February 2011 (Annex 6, Web-based PHIRE questionnaire).

The invitation of CIs to participate in the PHIRE web survey was administrated by the Karolinska Institutet, Stockholm, Sweden (Annex 7, invitation letter). The invitation letter to the CIs was somewhat modified for two of the projects, namely Healthy Ageing and EAAD, in terms of protection procedures. The invitation e-mail, signed by the EUPHA Section lead for each specific innovative public health projects, was sent to the respective CIs. This e-mail also included the link to the web-based questionnaire. The first web surveys were sent to CIs in March 2011.

### 3. Section leads questionnaire

An instrument to collect general information about the innovative public health projects was developed in close collaboration with the Section leads. Each Section lead was to provide information about their project's aim, goal, and plan for dissemination. This instrument (not web based) also included items about: the process to find country informants in the involved countries, and for the other countries, etcetera. Moreover, specific information about the innovative public health project was asked for: What were the goals regarding the dissemination (e.g. meetings, seminars, publications) and did the project reach these goals? (See Annex 8) All section leads answered the questionnaire and the information is provided below.

### 4. Content of this report

In the following sections of this report, each of the eight innovative public health projects is presented with general information, with a description of the process to identify the CIs, and comments regarding the data collection based on information from each Section lead. Results from the eight web surveys are presented and commented. After that, at page 119 and forward, some general results from all eight web surveys are presented.

Some of the questions in the web survey were open ended with unlimited space to include free text. They are also presented below, and in order to not disclose from which country the comments are made, we have replaced the name of the country with the word *country*. Due to the same reason we in a few cases also have omitted names of individuals or organisations, but without changing the meaning of the text.

The figures in this report are based on the results from the country that have responded to the web-based survey. In some cases, more than one CI responded from a country. The answers from those CIs have been combined, taking the average if they did not agree.

### Categorization of countries presented in the result section

In this report, the results from the different European countries are presented separately for each country and sometimes merged into two types of categorisations of countries. One categorization is based on the *number of inhabitants*, as the possibilities to get a great coverage of the programs differ with size of a country. The other categorization is based on *to what extent the English language can be regarded as well known in each country*, as the questionnaire was provided only in English:

Based on the number of inhabitants, the following three categories of countries were formed:

- **<4 million inhabitants:** Cyprus, Estonia, Latvia, Lithuania, Luxembourg, Malta, Slovenia, and Iceland
- **4-15 million inhabitants:** Austria, Belgium, Bulgaria, Czech Republic, Denmark, Finland, Greece, Hungary, Ireland, the Netherlands, Portugal, Slovakia, Sweden, Norway, and Switzerland
- **>15 million inhabitants:** France, Germany, Italy, Poland, Romania, Spain, and the United Kingdom.

Moreover, based on the general knowledge of the English language in the population, we formed three other categories, namely:

- **English speaking countries:** Ireland, Malta, and the United Kingdom
- **Nordic Countries and the Netherlands:** Denmark, Finland, Sweden, Norway, Iceland, and the Netherlands
- **Other countries:** Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Estonia, France, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, and Switzerland.

In the following sections of this report, the answers from the different countries are presented for each of the eight intervention projects, in the same order as in Table 1.

## **VENICE - Vaccine European New Integrated Collaboration Effort**

### **1. Presentation of VENICE**

#### **General objectives of VENICE**

The general objectives of VENICE were:

- to collect information on vaccination programmes at national and sub-national level;
- to assess variability of vaccine coverage at national and sub-national level;
- to collect information on status of introduction and implementation of new vaccinations;
- to collect and share national key documents representing good practice in immunization policy.

#### **Summary of VENICE, provided by Giuseppe La Torre, Italy**

The Vaccine European New Integrated Collaboration Effort (VENICE) project was performed under the sponsorship of the European Commission's Directorate General for Health and Consumers (DG SANCO). This European project involved all 27 EU Member States and two EEA countries (Iceland and Norway) and represented the first step to promote and share knowledge and best practices in vaccination among European countries.

The outputs of this project had relevant impact in the EU: a collaborative European network of experts working in immunisation programmes was created; a common interest in sharing experience and expertise regarding the theme of vaccination was documented; tools and procedures to facilitate exchanges were designed; relevant information on immunisation programmes, adverse events surveillance systems, vaccine coverage assessment were collected; the process of introduction of two recently licensed vaccines, human papillomavirus (HPV) and rotavirus, was monitored.

#### **Comments in the VENICE final report whether the project accomplished its main objectives**

VENICE has had a relevant impact in the EU: a collaborative European network of experts working in immunization programs was created; a common interest in sharing experience and expertise in theme of vaccination was documented; tools and procedures to facilitate exchanges were designed; relevant information on immunization programs, adverse events surveillance systems, vaccine coverage assessment were collected; the process of introduction of two recently licensed vaccines, HPV, and rotavirus vaccination, was monitored.

#### **Project collaborators/partners/expertise in VENICE**

VENICE had collaborators/partners/expertise from 29 countries.

#### **Project collaborators/partners included**

The following collaborators/partners were included in VENICE: government, health authorities, local/regional authorities, universities, other research organisations, and international organisations.

### Dissemination of results from VENICE

According to the VENICE final report, results from the project were disseminated in all of the 29 participating countries. The following ways of dissemination were used: reports, peer-reviewed articles, poster/oral presentation at international conferences, and websites.

#### Key targets for dissemination

The following were the key targets for dissemination of results from VENICE: government, health authorities, universities, and other research organisations.

## 2. VENICE - introduction to PHIRE WP4

### The process to identify the CIs for PHIRE

The Section lead used the following strategies to identify CIs for the VENICE project:

- Identification of CIs through EUPHA Sections mailing list and membership lists
- E-mail to the project leader of VENICE, asking for additional individuals to contact.
- Searches of the PubMed database using the following search terms: vaccination AND the name of the specific country (e.g. Austria).
- If the CI could not answer, he/she was asked to recommend one or two other possible CIs that could be contacted (Snow-ball method).

The process of identifying CIs and get them to respond to the survey required a great deal of work for the Section lead and his assistants.

## 3. Results regarding VENICE

### 1. Invited and responding CIs

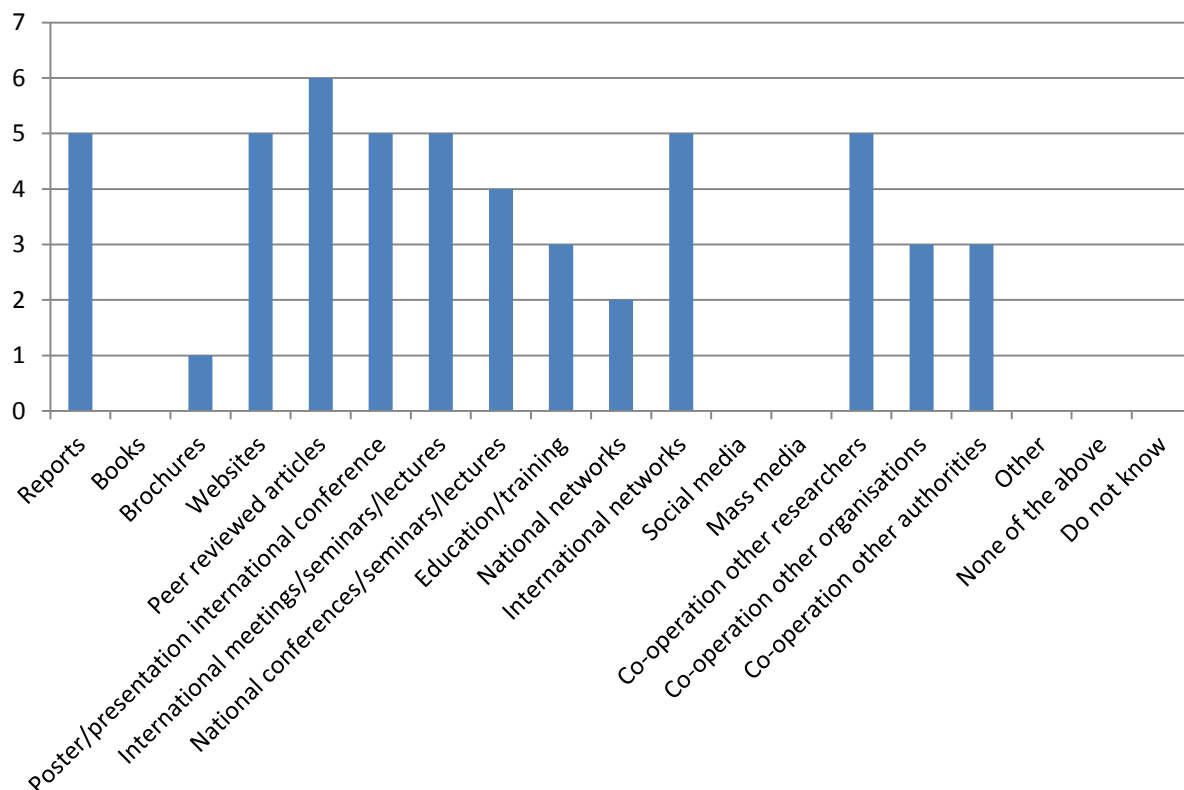
In total, 23 CIs, representing 18 countries, were invited to answer the web-based questionnaire (Table 2, page 22). Questionnaire responses were obtained from 13 CIs, representing the following ten countries: Austria (two respondents), Czech Republic, Denmark, Germany (three respondents), Greece, Ireland, Italy, Malta, Poland and Sweden. These ten countries correspond to 33% of the 30 EEA countries. For the countries with more than one CI responding to the web survey the answers from those CIs have been combined, taking the average if they did not agree.

Twelve of the 23 invited CIs (52%) were in the EUPHA database, that is, were members of at least one EUPHA Section. Of the 13 CIs that finally answered the web survey, four (31%) were in the EUPHA database. Five of the 13 CIs (38%) who participated had been involved in the VENICE project as project leader/coordinator or as a project partner.

### 2. Dissemination of results from VENICE

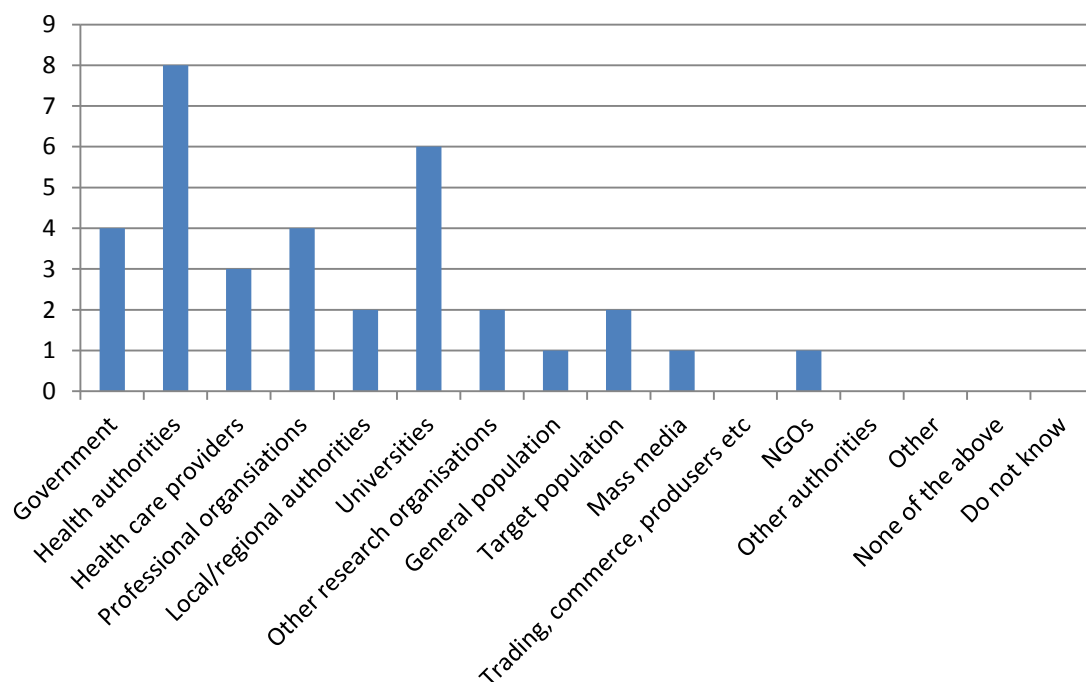
Results from VENICE were disseminated in 13 different ways, according to the web-survey results (Figure 1). Each country indicated between 1 and 12 different ways for dissemination. Among the ten countries that answered the question, it was most common to indicate only one way for dissemination (n=5), however, the mean number of ways for dissemination was 4.4. Mainly, dissemination was done through “Peer reviewed articles” with six countries indicating this, followed by Reports, Websites, Poster/presentations at international conferences, International meetings/seminars/lectures, International networks, and ‘Co-

operation with other researchers', with five countries indicating each of these ways for dissemination. Books, Social media, and Mass media were not mentioned as ways for dissemination of results from VENICE.



**Figure 1.** Number of countries indicating the different types of channels used to disseminate the results from VENICE.

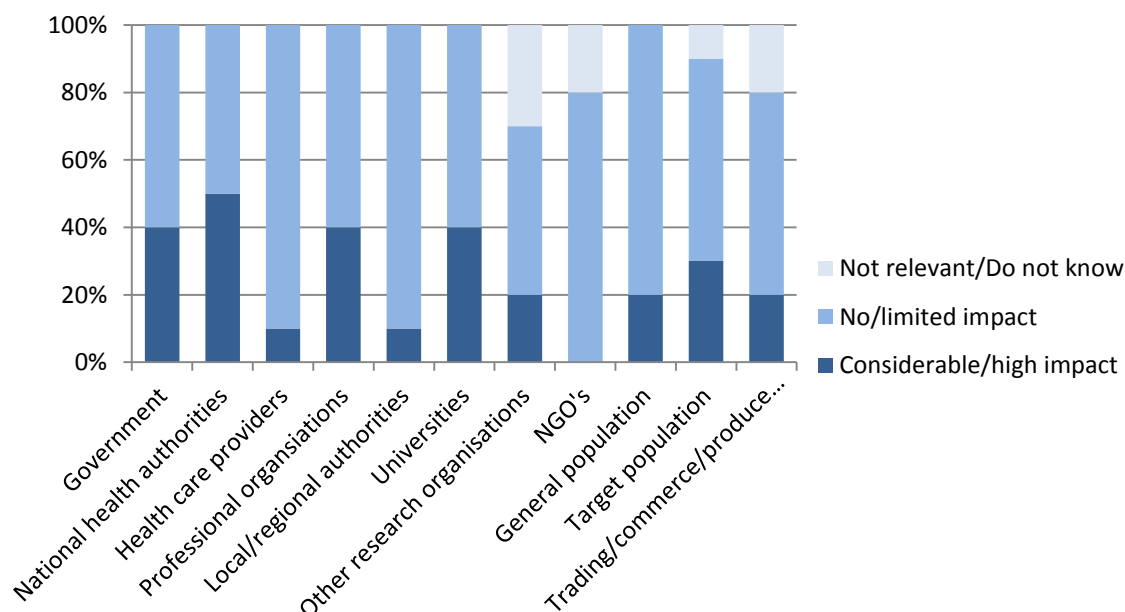
According to the results, 11 different types of groups/organisations were reached by information about VENICE. For each country, zero to ten groups were indicated, with an average number of 5.2 indicated groups/organisations per country. Health authorities were the organisation most often (eight countries) indicated as reached by information about VENICE (Figure 2). This was followed by Universities; six countries indicating this. Four countries indicated that Government and Professional organisations had been reached by information about VENICE.



**Figure 2.** Number of countries indicating different types of groups/organisations that were reached by information about VENICE.

### 3. VENICE impact on knowledge/awareness of stakeholders

National health authorities were the type of stakeholder indicated by most countries (50%) as having had considerable or high impact regarding knowledge/awareness from VENICE (Figure 3). For Government, Professional organisations, and Universities, 40% of the countries expressed considerable or high impact on knowledge/awareness. However, as many as 50-90% of the countries indicated that VENICE had only limited or no impact at all on the different types of stakeholders. None of the countries indicated considerable or high impact of the project on knowledge/awareness of NGOs and 20% of the countries indicated that this was not relevant or that they did not know. This is in accordance with Figure 2, where only one country had indicated that NGOs were reached by information about VENICE.



**Figure 3.** Proportion of countries indicating level of impact on knowledge/awareness among different stakeholders.

#### 4. Comments on the impact of VENICE on knowledge/awareness of stakeholders

Following the questions about impact on stakeholders, the CIs could add further examples or comments in an unlimited free text space. There were large variation between CIs regarding to what extent they used this opportunity. Up to three of the CIs had commented regarding the impact of the project on knowledge/awareness of each of the specific stakeholders. Such examples and comments are presented below.

**Government:** "It helped a lot when reviewing our national immunization policy."

"The impact of VENICE on government is reached mainly through the country-known health authorities (knowledgeable about the project's results) who negotiate vaccination policy with Ministry of Health."

"Practically no impact".

**National health authorities:** "The project has the highest impact on some health authorities, mainly co-workers of program co-ordinators from the National Institute of Health, as well as some authorities from the National Society of Vaccinology who are informed about the project itself and about project results."

"Person specific impact, limited systemic changes."

**Health care providers:** "Unfortunately, the results of the project are not spread in a satisfactory way among average health care providers. The information about the project is not available through some useful and popular websites of national medical societies, professional scientific magazines, bulletins etc."

"Very limited impact on HC providers."

**Professional organisations:** "Authorities and some members from the National Society of Vaccinology are knowledgeable about the project itself and about project results. The results are presented during Society meetings, conferences, congresses etc. and are useful base for the further discussions on vaccination policy in our country."

"Reasonable impact on expert bodies."

**Local/regional authorities:** "Introduction of new vaccination strategy: HPV MMR vaccination program."



"Local/regional authorities are usually not sufficiently informed about the project results. However, some local initiatives based on the project's results are possible, if such results are presented to health authorities directly by project coordinators."

**Universities:** "Generally, universities are not informed about VENICE and its results. However, some academic staff members may be knowledgeable about the project through various sources. In such cases some projects based on the main topics of VENCE are possible to be initiated and the research funding are possible to be obtained through local or national financial resources. Project results are possible to be incorporated into the educational curriculum in cases when academic staff is informed about them."

"University people are aware and some take part."

**Other research organisations:** See above: "Generally, universities are not informed about VENICE and its results..."

"Limited impact."

**NGO's:** "To my knowledge project results have not reached NGOs so far."

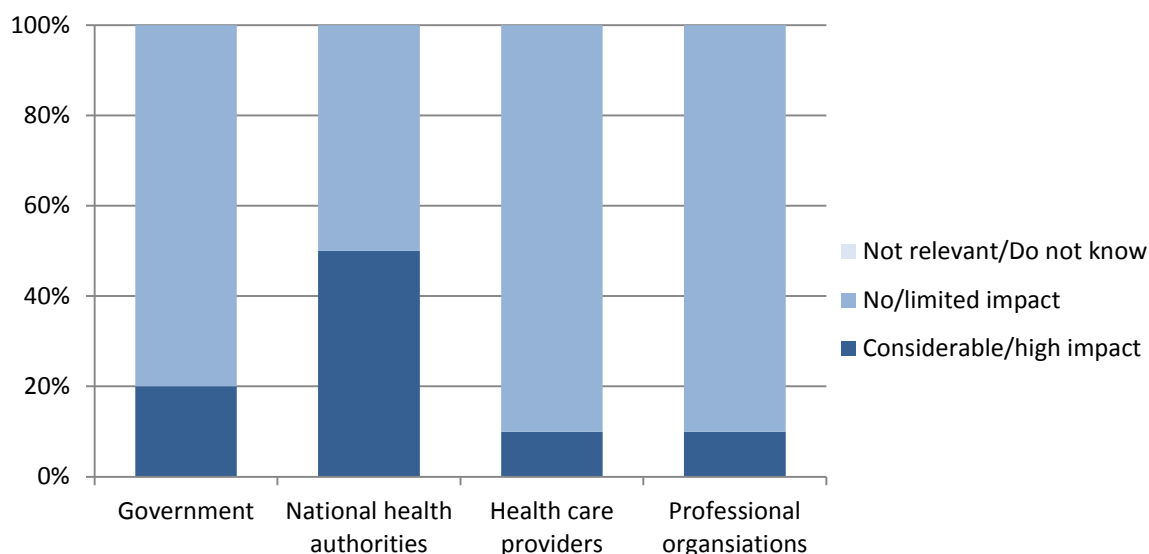
**General population:** "General population is not informed properly about the project. It should have been done through various channels, e.g. media and family doctors. However, there are various media campaigns regarding different aspects of vaccination policy, including new vaccines like HPV, pneumococcal vaccine and benefits of seasonal influenza vaccine and HBV vaccine. There are many local initiatives regarding implementation of some free of charge vaccines (i.e. HPV, pneumococcal vaccine, seasonal influenza and HBV vaccine) to the risk groups".

**Target population:** "See General population above."

"Limited scope."

## 5. The impact of VENICE on policy, reforms, guidelines, and routines

The impact on policy, reforms, guidelines, and routines on the Government, National health authorities, Health care providers, and Professional organisations, respectively, from VENICE was rather low according to the CIs. For National health authorities, five countries (50%) indicated considerable or high impact on policy/guidelines (Figure 4). However, the majority of the countries (80 - 90%) indicated no or limited impact on the other three stakeholders. One explanation for this high proportion could be that it was difficult for the CIs to determine whether any changes in policy, reforms, guidelines, or routines were actually an effect from the project or was the result of other initiatives or ongoing work.



**Figure 4.** Proportion of countries indicating level of impact on policy/reforms/guidelines/routines among different stakeholders

The unlimited free text space for the CI's answers or comments to the question about the likelihood that the impact on the different stakeholders could have occurred without the project was not used to a great extent. The following comments were given from three countries:

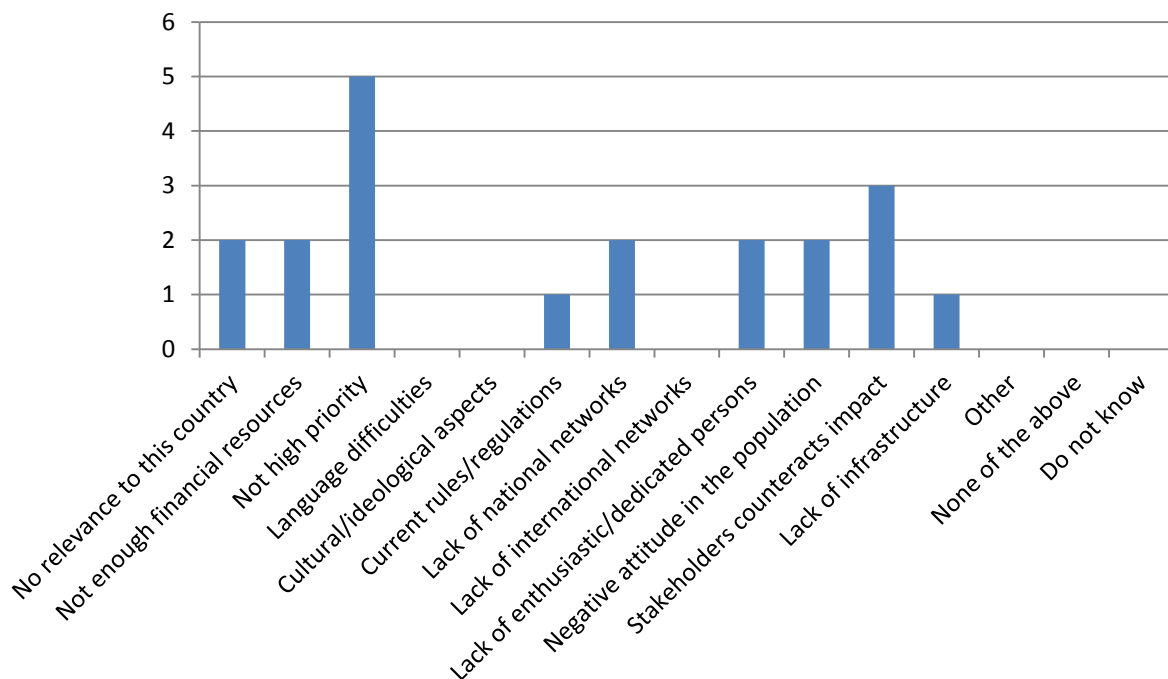
"Impact on Health authority and health professional, university and other research organization."

"I think many health professionals are reassured to see that what we advocate at national level does make sense, and that other countries are doing (or attempting) to do similar activities ... and having data demonstrates overall performance and how well we are able to do things (or not, as the case may be)."

"Some of them may."

## 6. Main factors hindering impact

Regarding factors that might have hindered impact of VENICE, between zero and five of the 13 suggested options of factors that might have hindered impact were indicated for each country. Mostly only one hindering factor was indicated, this was the case for four (40%) of the countries; the average number was two hindering factors. Five (50%) of the ten countries indicated that the main factor that hindered impact was that the issue of the project did not have high enough priority (Figure 5). Furthermore, three countries indicated that Stakeholders counteract impact (e.g. political organisations, corporation, business, lobby organisations) followed by two countries that each indicated that "The project had no relevance to the country", Not enough financial resources, Lack of national networks, Lack of enthusiastic/dedicated persons, and Negative attitude in the population.



**Figure 5.** Number of countries that indicated each type of factor that hindered the impact of VENICE.

Four of the CIs did comment regarding hindering factors for impact of VENICE in their country:

"For instance - vaccination coverage is extremely important part of VENICE- We have seen how some countries are able to provide very good uptake data on risk groups because the disease registers and have invested in good immunisation information systems. Our country has been slow to invest in good information systems and we have as a result not been able to provide data as requested on uptake in some risk groups- which is really necessary information to demonstrate performance and achieve uptake rates that will prevent disease transmission."

"Few human resources involved and those involved have limited time on this issue. Also cultural issues and financial constraints."

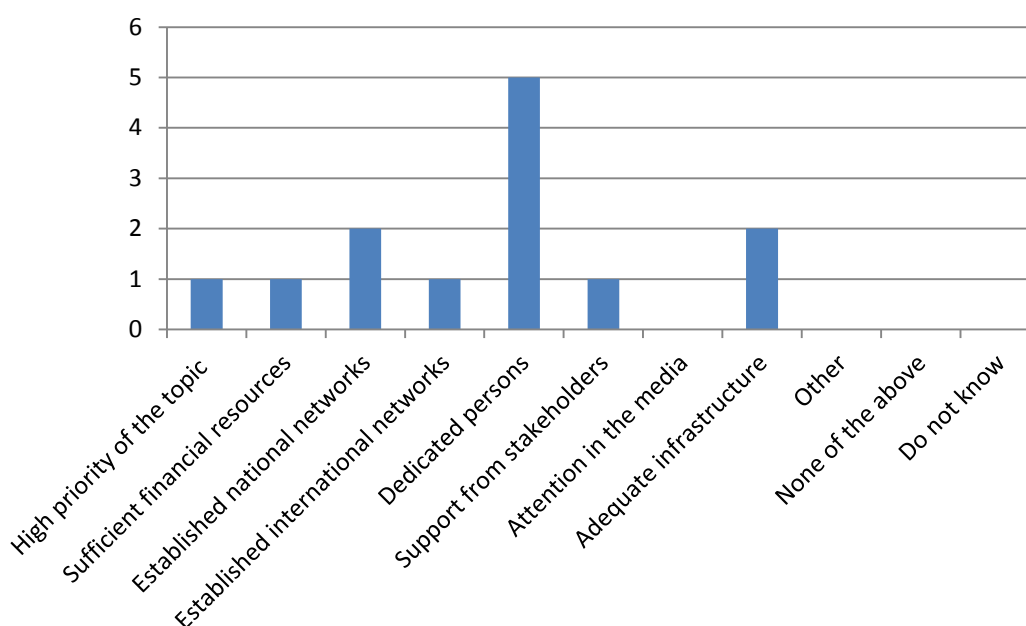
"In my opinion, although the issue has high enough priority in our country, there are limited financial resources for adequate implementation of the projects' results. As an example, in the budget of our Ministry of Health the topic "vaccination" is not listed as a separate item. Any possible financial resources for this issue are available from the item "Various", together with such topics as, for example, "Medication refund."

"As I mentioned previously, limited attention is given even from government to the topics which are not considered as urgent or threatening."

"Few people were dedicated to the project and disseminating knowledge around."

## 7. Main factors facilitating impact

When it comes to factors that facilitated impact of VENICE in the different countries, between zero and five of the nine suggested such factors. Four countries did not indicate any facilitating factor at all. Dedicated persons was the main factor that five (50%) of the ten countries mentioned (Figure 6). Additionally, two countries indicated Established national networks and Adequate infrastructure as an important factor, facilitating impact.



**Figure 6.** Number of countries that indicated different types of factors that had facilitated the impact of VENICE.

There was only one comment regarding facilitating:

"The main factors facilitating impact in our country were, except the high priority which the issue has, dedicated persons who were knowledgeable about the results but also about the enormous impact the project may have on the population health."

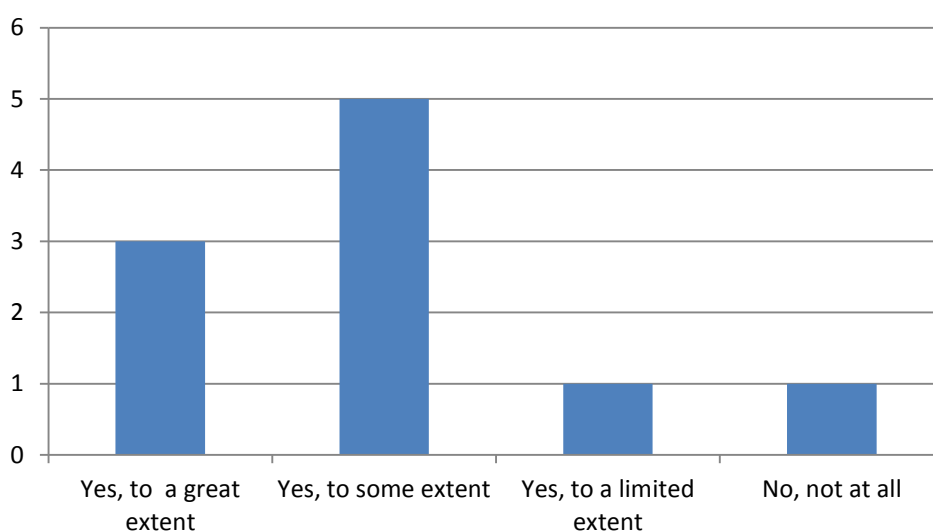
### 8. Coverage of the topic of VENICE in mass media

Seven of the countries indicated that the amount of coverage in mass media of the topic of VENICE had been limited or nonexistent, while two countries indicated that this was not relevant or not known by the CI. One CI expressed it as:

"So far, mass-media are not informed about the project itself in a satisfactory way. However, there is much attention put to the up-to-date vaccination policy and possible benefits of implementation of new vaccines. Lots of commercials regarding this issue appear in local and national media in various forms".

### 9. Relevance of the topic of VENICE

The majority of the countries (n=8) answered that VENICE had relevance to a great or some extent in their country and from two countries it was stated that they did not know or that the project only had relevance to a limited extent (Figure 7).



**Figure 7.** Number of countries indicating different levels of relevance of the topic of VENICE.

The relevance of the topic of VENICE was commented by seven (70%) of the CIs:

"Made information available but did not imply on decisions taken."

"Very useful to have data available with regard to vaccination programmes in other countries; what vaccines are used; how vaccination programmes work in other countries; how they are funded; how vaccination coverage is monitored, and what uptake rates are reported; how decisions regarding introduction of vaccines are made; who delivers programmes."

"Collaboration in the development and operation of vaccination programs could have a great impact on public health. However, so far the project has focused on collection of information of limited value at the country level."

"It was very important to exchange information regarding the different immunization policies in Europe."

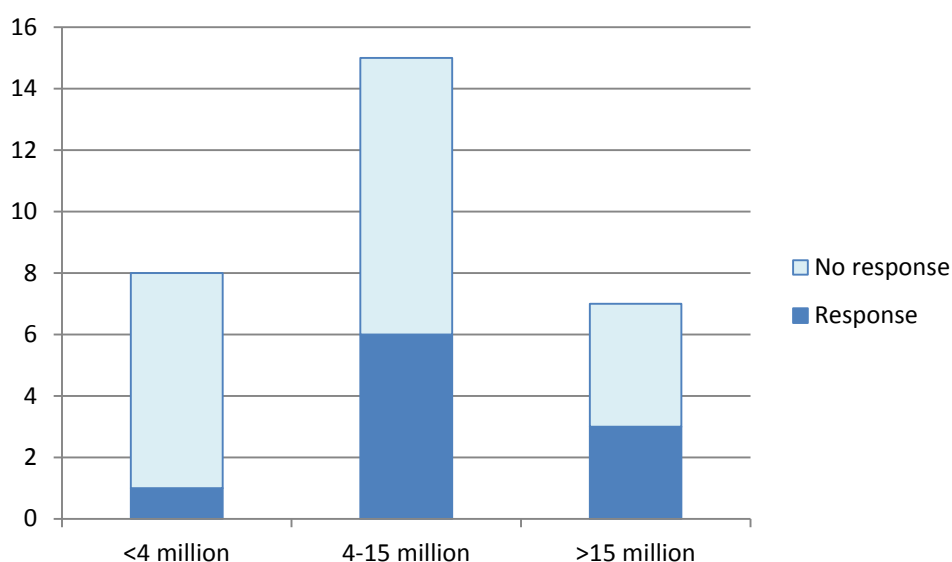
"It helps to compare one's own data with other MS and also to see how other countries obtain their data and to obtain ideas how to tackle certain problems locally from the experiences of other countries."

"Immunisation programs are of great interest and priorities in our country. Vaccine coverage at national level is very high (97-100%) regarding vaccines which are included in the mandatory national vaccination program. As an example, the HBV vaccine, which has been available in since 1989, became instrumental in decreasing the potential for HBV infection. In the country with limited resources, immunisation alone resulted in dramatic decrease in incidence (from 15,000 in 1979 to 1,727 in 2005). Due to the moderate levels of HBV infection in our population, with 350000-450000 carriers of hepatitis B surface antigen (HBsAg), since 1996 the country follows the World Health Organisation recommendations of universal HBV immunisation of children and screening pregnant women for HBsAg. Additionally, the active immunisation is offered to dialysed patients, recipients of blood and blood products, household members and sexual partners of HBsAg carriers. It is also recommended for health care workers (HCWs) and medical university students. Latest studies show that 95-99.5% of medical staff is immunised. However, there are some obstacles regarding wide implementation of seasonal and pandemic influenza vaccination among both: general population and risk groups, as well as childhood pneumococcal vaccination and HPV vaccination."

"For informed people is it an excellent source of international information. PR is however limited. Not everybody knows."

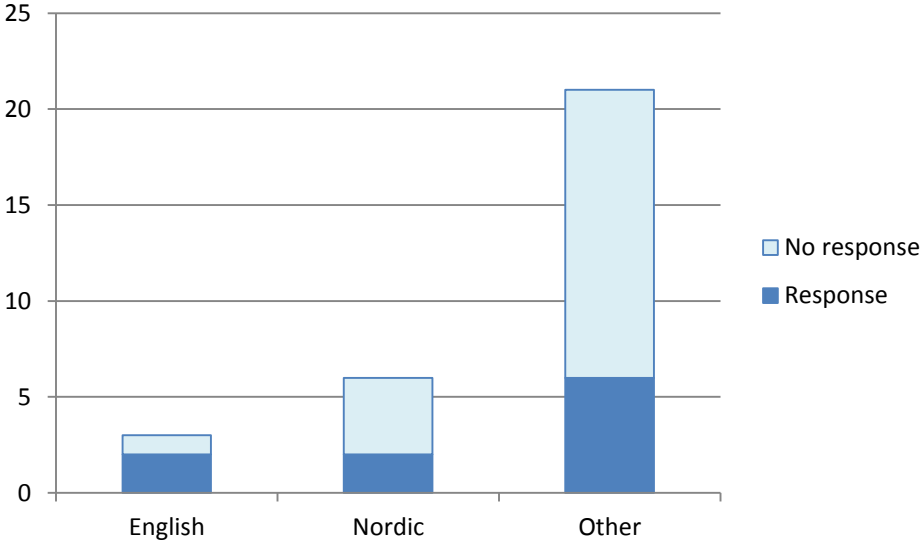
### 10. Responders to the VENICE web survey by category of country

When categorizing the countries according to number of inhabitants (see page 10), most countries that responded to the VENICE web survey were medium-sized. Almost half of the countries in the two groups with four million or more inhabitants responded (Figure 8).



**Figure 8.** Number of participating countries with regard to number of inhabitants in the countries (representing 13%, 40%, and 43 %, respectively, of the counties in each group).

When categorizing the countries according to the general knowledge of the English language, the distribution shows that “Other countries” were in majority among the countries that responded to the VENICE web survey. Nevertheless, the response rate was lowest in that group, and highest in the English speaking group (67%) compared to about 30% in the other two groups (Figure 9).



**Figure 9.** Number of participating countries with regard to three language areas (representing 67%, 33%, and 29%, respectively, of the countries in each area)

**Table 2. VENICE - Summary of number of CIs and countries invited, responding, etceteras**

EEA-country	Project collaborators/ partners/ expertise in this country	VENICE results were disseminated in the country	Invited CI	Invited CI was in the EUPHA database	Responding CIs	Invited Countries	Responding countries	The responding CI was involved in VENICE
Austria	1	1	1		1	1	1	
Austria			1		1			
Belgium	1	1	1	1		1		
Bulgaria	1	1	1	1		1		
Cyprus	1	1						
Czech Rep	1	1	1		1	1	1	
Denmark	1	1	1	1	1	1	1	1
Estonia	1	1						
Finland	1	1						
France	1	1	1	1		1		
Germany	1	1	1		1	1	1	
Germany			1		1			
Germany			1		1			
Greece	1	1	1		1	1	1	1
Hungary	1	1						
Ireland	1	1	1	1	1	1	1	1
Italy	1	1	1	1	1	1	1	
Latvia	1	1						
Lithuania	1	1						
Luxembourg	1	1						
Malta	1	1	1	1	1	1	1	1
Netherlands	1	1						
Poland	1	1	1		1	1	1	
Portugal	1	1	1	1		1		
Romania	1	1	1			1		
Slovakia	1	1						
Slovenia	1	1	1	1		1		
Spain	1	1	1			1		
Spain			1	1				
Sweden	1	1	1		1	1	1	1
UK	1	1	1	1		1		
UK			1	1				
Iceland	1	1						
Norway	1	1						
Switzerland								
<b>Sum</b>	<b>29</b>	<b>29</b>	<b>23</b>	<b>12</b>	<b>13</b>	<b>18</b>	<b>10</b>	<b>5</b>

## **CHOB - Children, Obesity and Associated Avoidable Chronic Disease**

### **Presentation of CHOB**

#### **General objectives of CHOB**

- To measure and analyse the impact of food marketing to children and young people;
- To determine and consider policy options aimed at addressing obesity in children;
- To complement activities and approaches at national level and stimulate concerted action.

#### **Summary of CHOB, provided by Section president Christopher Birt, United Kingdom**

The aim of the CHOB project was to contribute to tackling the obesity epidemic among children and young people. The first phase of the project, March 2004 to February 2005, concentrated on the marketing of unhealthy food to children, not because this is the only reason why children are getting fatter, but because it is clearly part of the problem and is of growing interest in European policy circles. Information was collected on the extent and nature of food marketing to children in 20 European countries and on existing measures (legislation, voluntary agreements, codes, interventions, etc) at national level with regard to counteracting the effects of food marketing to children. Phase two of the project, from March 2005 to November 2005, was dedicated to disseminating the results of the data collection which were published in a report on “The marketing of unhealthy food to children in Europe”. During the last phase of the project, phase three, running from December 2005 to October 2006, a Europe-wide stakeholder consultation on policy options took place with a view to achieving consensus on a small number (five) of policy options to be achieved as priorities within the participating European countries as well as at a European level. This report establishes the fact that the awareness of the problems is high and that various national and international measures are being proposed. It discusses the options available, tools for selecting policy options, international and national approaches as well as the results of the Europe-wide stakeholder consultations’ assessment of policy options carried out in the framework of the CHOB project.

#### **Comments in the CHOB final report whether the project accomplished its main objectives**

Success in accomplishing the stated objectives does not appear to have been discussed precisely. The evaluation section in the Final Technical Report states that:

"The evaluation concluded that the awareness of the (negative) impact of food marketing on consumption patterns has increased. Especially awareness of the impact of internet advertisements increased substantially. Small increases were found in awareness of the impact of food labelling on current patterns and the perceived impact of education at school.

The evaluation also showed that especially at national level, the project has contributed to a substantial increase of information exchange. About one third of the respondents indicated that the level of information in their organisation had increased compared with



the situation in October 2004. Also, most respondents perceived an increase in both the number and the kind of activities organised around the subject of childhood obesity. According to the participants, the CHOB project especially stimulates organisations to give information to parents and/or children to help them make healthy food choices, and it stimulates organisations to promote physical activity.

Furthermore, the evaluation showed that a higher priority was given to the obesity problem compared to October 2004 and the number of organisations which have a policy statement on obesity prevention has increased in most countries compared to October 2004.

The CHOB project also seems to have contributed to a decline in the perceived barriers that are met in carrying out activities aimed at combating the negative effects of food marketing. Especially the barriers with respect to "lack of cooperation between national organisations"; "lack of experience" and "lack of material resources" have declined. Respondents' opinions towards ways to attack the obesity problem among children and young people have not changed significantly during the year. Nearly all respondents share the opinion that more efficient food advertising and food promotion legislation should be introduced. However, opinions on how to tackle the negative effects of food marketing vary considerably."

### **Project collaborators/partners/expertise in CHOB**

A total of 24 partners from 20 countries were represented as collaborators/partners/experts.

### **Project collaborators/partners included**

Non-governmental organisations (NGOs) were included in CHOB. Most, 23 of the 24 partners in this project were either international or national health-related NGOs, associated with heart conditions, and with diabetes; the remaining other organisation was an international association of consumer food organisations. These NGOs gave high priority to health advocacy, but (unsurprisingly) failed to demonstrate any academic approach to their project, either in terms of definition of methodologies, or in terms of defining and measuring outputs.

### **Dissemination of results from CHOB**

According to the CHOB final report, results from the project were disseminated in all of the 20 participating countries. The following means of dissemination were used: brochures, peer-reviewed articles, poster/oral presentation at international conferences, international meetings/seminars/lectures, national conferences/seminars/lectures, education/training, websites, mass media (e.g. television, radio, and newspapers), co-operation with other researchers, and other: advocacy, e.g. lobbying.

### **Key targets for dissemination**

The following were the key targets for dissemination of results from CHOB: government, health authorities, professional organisations, universities, other research organisations, non-governmental organisations, target population addressed in the project, production and trade, and parents and children.

## 2. CHOB - introduction to PHIRE, WP 4

### The process to identify the CIs for PHIRE, WP 4

The Section lead and his assistant used the following strategies to identify, include and contact CIs for the CHOB project: A multiple approach in two main phases has been used in order to identify experts able to answer the online questionnaire in relation to the CHOB project:

*Phase one* (February – March 2011):

Members of the Food and Nutrition Section mailing list were contacted with personalised emails

Members of the Section who replied to the original personalised email who didn't agree to take part in the project were asked to provide additional contacts in their countries.

This “snow-ball method” was successful in some cases, especially when it was the originally contacted member of the Section him/herself who provided the initial information about the PHIRE project, copying us to his email (3 of 18 country informants have been identified thanks to this approach).

*Phase two* (April 2011 – August 2011):

In those countries where there were no members of the Food and Nutrition Section, the two following approaches were used: (i) personal contacts with experts in the field (which were not part of the Section list) and (ii) personalised email to experts identified through PubMed & Google were used; (4 of 18 country informants have been identified thanks to such approaches).

Various reminders have been sent centrally from the Karolinska Institutet, but also through personalized emails. In the latter, direct support was offered both via email and via telephone calls.

### Problems encountered during data collection

The main problems encountered in identifying country informants are summarised in the list below:

- Poor response rate and necessity of using repeated emails and reminders;
- Some expert expressed interest in being involved in publications or in getting financial remuneration for their services;
- In several cases, country experts required access to the questions of the survey before agreeing in taking part in the PHIRE project. This approach has led to various drop-outs in an early phase of the data collection, but not in a later phase;
- Quality of answers was variable. Some answers were very detailed and exhaustive, but in a few cases no further justification to statements made was provided, and/or no examples were provided. These differences were taken into account in presenting the results of the project to support validity of findings;
- The snow-ball approach and the search on the internet have led to an “overlapping” of experts in more than one case. In other words, some experts (i.e. paediatricians or endocrinologists) have been contacted by other section leaders in order to answer the PHIRE questionnaire in relation to their projects (this has been the case of small countries as Luxembourg and Austria for example).

### 3. Results regarding CHOB

#### 1. Invited and responding CIs

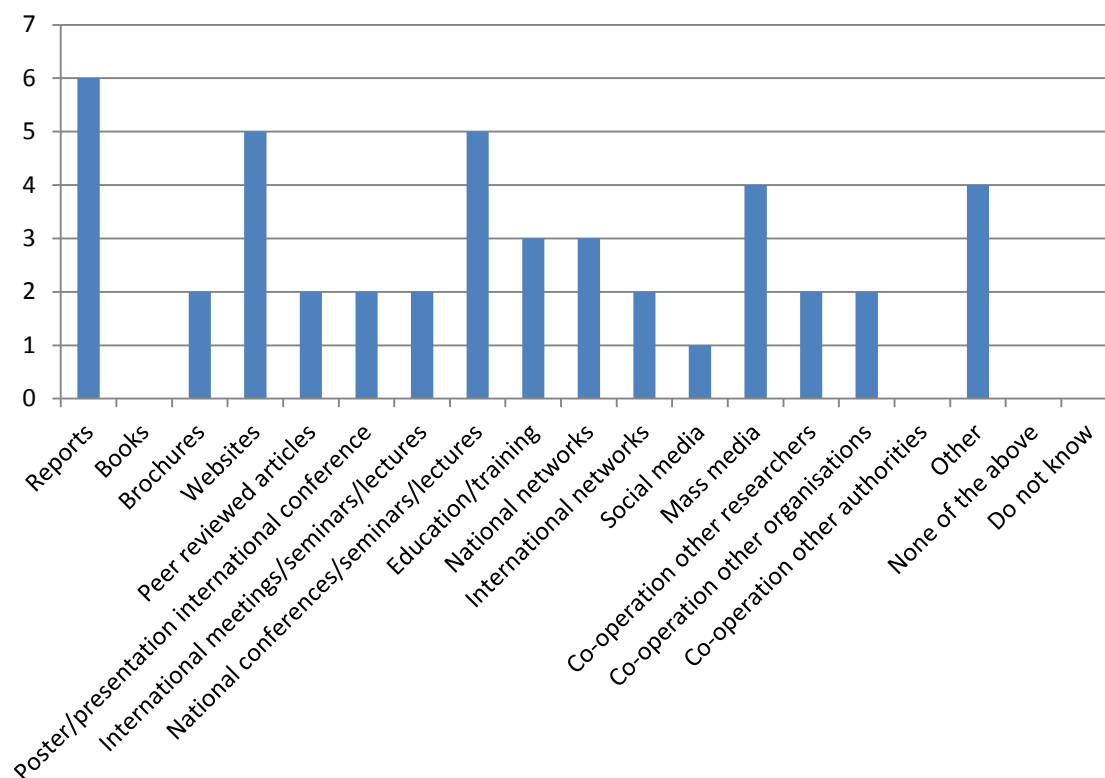
In total, 27 CIs were invited to answer the web-based questionnaire representing 23 countries (Table 3, page 38). Questionnaire responses were obtained from 21 CIs representing the following 20 countries: Austria, Belgium, Bulgaria, Cyprus, Finland, France, Greece, Ireland, Italy, Latvia, Lithuania, Malta, the Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, United Kingdom, and Switzerland (two respondents). These 20 countries correspond to 67% of the 30 EEA countries. For the countries with more than one CI responding to the web survey the answers from those CIs have been combined, taking the average if they did not agree.

Seventeen of the 27 invited CIs (63%) were in the EUPHA database, and of the 21 that finally answered the web survey, 13 (62%) were in the EUPHA database.

One of the 21 CIs that had answered the CHOB web survey had been involved in the project as project leader/coordinator or as a project partner.

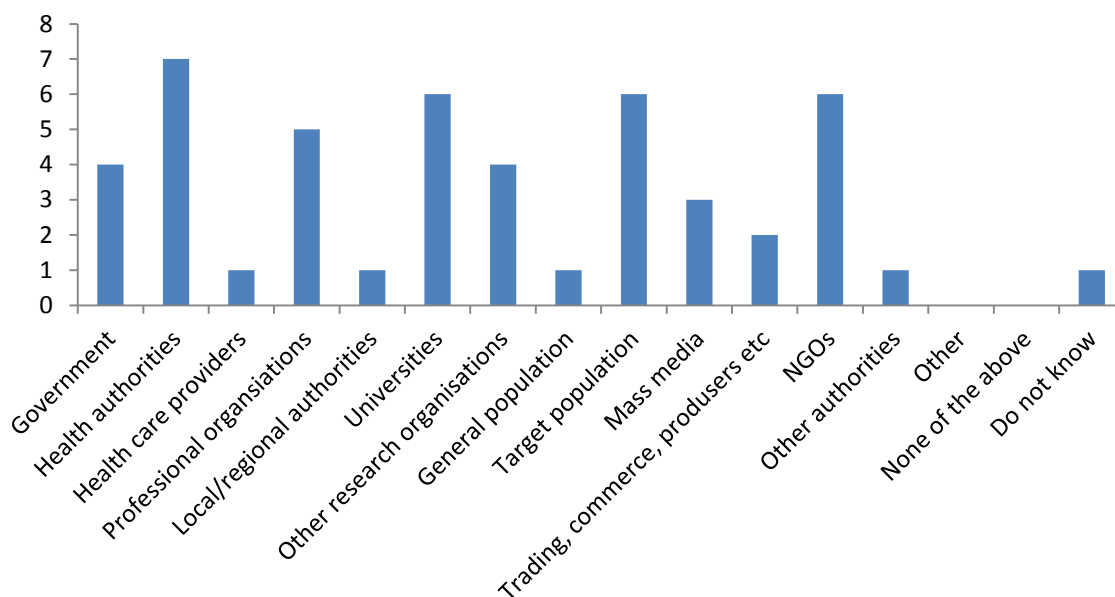
#### 2. Dissemination of results from CHOB

Results from CHOB were disseminated in 15 different ways according to the web-survey results (Figure 10). Each country indicated between zero and nine different means of dissemination. Among the 20 countries that answered the question, the most common was not to indicate any of the suggestions for dissemination (n=5), but the average number was 2.4 ways per CI for dissemination of the results. Mainly, dissemination was through Reports, with six countries indicating this. Thereafter, Websites and National conferences/seminars/lectures, where each of these means of dissemination was indicated by five countries, and Mass media and Other means were each indicated by four countries.



**Figure 10.** Number of countries indicating the different types of channels used to disseminate the results from CHOB.

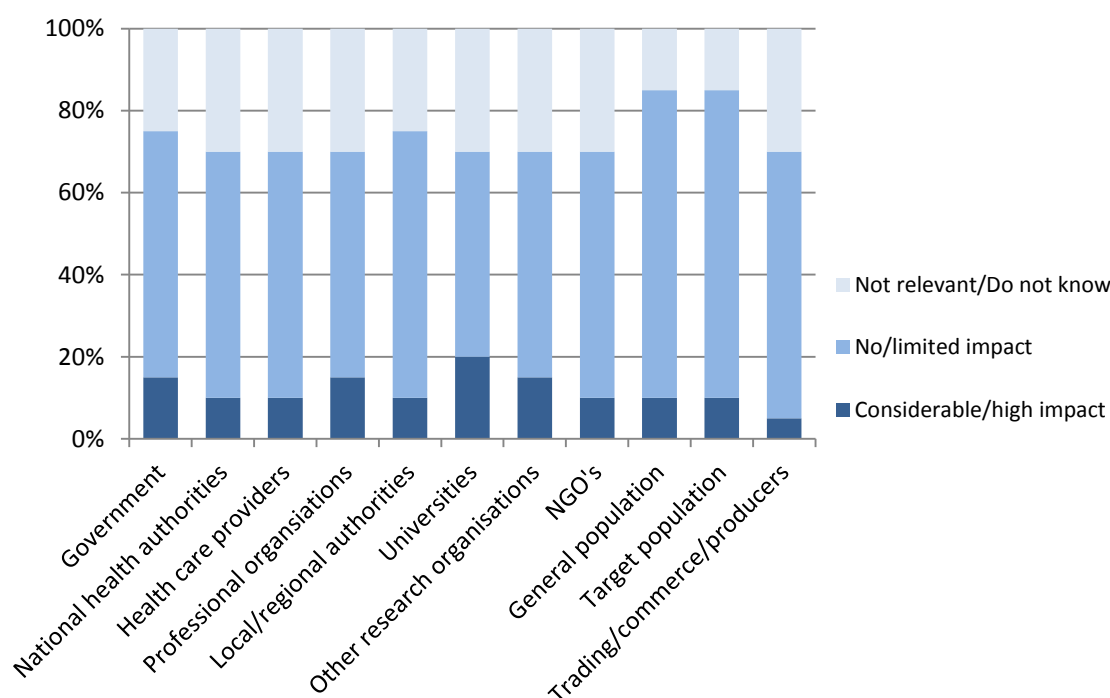
According to the results, 13 different types of groups/organisations were reached by information about the project (Figure 11). For each country zero to ten groups were indicated, with an average number of 2.7 indicated groups/organisations per country. Health authorities were the organisations most often indicated as reached by information about CHOB ( $n=7$ ), followed by Universities, Target population and NGOs ( $n=6$ ).



**Figure 11.** Number of countries indicating groups/organisations that were reached by information about CHOB.

Universities were the stakeholder that most countries indicated (19%) as having had considerable or high impact on knowledge/awareness from CHOB (Figure 12). For Government, Professional organisations, and Other research organisations, 14% of the countries expressed considerable or high impact on knowledge/awareness. However, as many as 48% to 71% of the countries indicated that there was limited or no impact at all on the different stakeholders identified by the project, and on average 30% of the countries indicated that CHOB was not relevant to them or that they did not know about the impact on knowledge/awareness. Although the National health authorities were reached by information about CHOB (Figure 11) it was only 10% of the countries that stated considerable or high impact on the National health authorities. The Universities were reported as being reached by information about CHOB (Figure 11) and this was the stakeholder for which most countries indicated that there had been considerable or high impact on knowledge/awareness.

### 3. CHOB impact on knowledge/awareness of stakeholders



**Figure 12.** Proportion of countries indicating level of impact on knowledge/awareness among different stakeholders.

### 4. Comments on the impact of CHOB on knowledge/awareness of stakeholders

Following the questions about impact on stakeholders it was possible to add further examples or comments in an unlimited free text space. There was large variation between CIs regarding to what extent they used this opportunity. Seven of the CIs did not comment at all, while three of them had comments for all stakeholders. However, several of these comments were the same for almost all of the stakeholders. The comments are presented below.

**Government:** "Our country has not taken part in the study. There have only been limited promotions of exercise and to promote healthy eating. None of these can be linked to the study."

"I was not involved in this project and I heard nothing about it. I asked information to the National Association for Health promotion and they do not know about this project."

"Probably due to poor dissemination and non-involvement of the institutions at national level, the knowledge of CHOB project remained limited to our region, giving political fallout only on regional policy. The impact on Projects initiated was limited to members of working groups. There wasn't impact on regulation/law changes."

"In relation to policy reform evidence from the project may have been used to inform regulation of high sugar, salt and fat foods being prohibited from advertising during television viewing of programmes aimed at children in our country. A nutrient profiling system was developed with support from the National Food Standards Agency to identify those foods high in fat, salt and sugar. In relation to regulation again evidence from the project may have informed the consultation process and response to the government's proposal to prohibit product placement of high fat, sugar, salt foods during TV programming in our country."

"Nor in the national nutrition plan nor in the regional action plan on healthy nutrition and physical activity any reference is made to reports or recommendations of the CHOB project and the recommendations of the CHOB project are not part of the plans. In a very vague way reference is made to the impact of the media and advertisements but the national recommendation does not go any further than making a plea for self regulation of the advertisements of the food industry especially for children. For the moment there is a protocol on advertisements for food on the website of the federation of the food industry."

"The main processes of the regulation were running already during/before the CHOB project ended. There could be some impact in the project funding (in the funding of health promotion projects by the ministry of social affair and health) in our country: stated new focus in projects for children (nutrition and physical activity, prevention of obesity). Project funded have all been based on the governmental policy programmes by the ministry of social welfare and health."

"As far as I know, CHOB has not been really diffused in our country."

"I know about one strategy that was set up by the Ministry of Health and Consumer Affairs, through the National Agency for Food Safety and Nutrition, with the aim of making the population more aware of the problems obesity means for health, and of promoting any initiatives that help to encourage citizens, particularly children and young people, to adopt healthy lifestyles, mainly through healthy diets and regular physical activity."

**National health authorities:** "During the last years, some regulations have come to light, in order, for example, to change the types of foods available in shops near schools. If these changes have or not any connection with the project, I don't know for sure. But as far as I know, there are no links...."

"Our country has not taken part in the study. There is no evidence that any limited action on the part of the National health authorities was linked to this project."

"I was not involved in this project and I heard nothing about it. I asked information to the National Association for Health promotion and they do not know about this project."

"Impact on national health authorities, probably due to poor dissemination and non-involvement of the authorities at national level, the knowledge of CHOB project remained limited to our region, giving political fallout only on regional policy. The impact on Projects initiated was limited to members of working groups. There wasn't impact on regulation changes. The data were used only to be sent to European Heart Network with limited impact on national surveillance."

"Promoting healthy eating and more PH in schools was already decided about 15 years ago in our region (education is a regional matter), there was a boost for the healthy school in 2005 but there was no reference made to the CHOB project in the discussions or documents."

"It is difficult to see any straight impact, however there are now more information of the childhood overweight and its prevention, more local surveys of the incidence of children's overweight, some new interventions going on."

"As far as I know, CHOB has not been really diffused in our country."

"I know about one strategy that was set up by the Ministry of Health and Consumer Affairs, through the National Agency for Food Safety and Nutrition, with the aim of making the population

more aware of the problems obesity means for health, and of promoting any initiatives that help to encourage citizens, particularly children and young people, to adopt healthy lifestyles, mainly through healthy diets and regular physical activity. Maybe some of the areas of action and influence of the strategy and "CHOB - Children, obesity and associated avoidable chronic diseases" are the same. The strategy is addressed to families, schools, the business world and the health system."

**Health care providers:** "Our country has not taken part in the study. No evident impact from the project on health providers."

"I was not involved in this project and I heard nothing about it. I asked information to the National Association for Health promotion and they do not know about this project."

"The number of physician and nurses got work experience in this field is decreased. Nutrition and dietology is not attractive specialty for young doctors."

"Impact on health care providers is very limited due to lack of involvement in the political and institutional and to lack of dissemination on research world."

"We couldn't find any data to show this kind of effect of the CHOB project."

"As far as I know, CHOB has not been really diffused in our country."

"The strategy has spread among health care providers."

**Professional organisations:** "Our country has not taken part in the study. No impact seen on organisations."

"I was not involved in this project and I heard nothing about it. I asked information to the National Association for Health promotion and they do not know about this project."

"Impact on professional organisations is limited only on involved organization, and no Exchange of best practice information was realized due to lack of organization and interaction between the various actors."

"Not any found - nothing to mention."

"As far as I know, CHOB has not been really diffused in our country."

"May be among cardiologists."

**Local/regional authorities:** "Our country has not taken part in the study. No impact seen."

"I was not involved in this project and I heard nothing about it. I asked information to the National Association for Health promotion and they do not know about this project."

"Impact on regional authorities are limited to knowledge by initial report. No impact on funding, other projects or data collection."

"There might be some impact how and why some projects were initiated."

"As far as I know, CHOB has not been really diffused in our country."

**Universities:** "Our country has not taken part in the study. No impact seen. No evidence of change."

"I was not involved in this project and I heard nothing about it. I asked information to the National Association for Health promotion and they do not know about this project."

"Shortage of funding."

"University involvement is not known at any level."

"There are many research projects running in the universities related to children's nutrition/physical activity, prevention of childhood obesity, but we couldn't find any remarks of the CHOB reviewed in the documents."

"As far as I know, CHOB has not been really diffused in our country."

**Other research organisations:** "Our country has not taken part in the study. No evidence of change. Very limited research underway - none on this area."

"I was not involved in this project and I heard nothing about it. I asked information to the National Association for Health promotion and they do not know about this project."

"No impact on research organisations outside of the working group for lack of dissemination of data collected."

**NGO's:** "No evidence of impact on NGOs."

"I was not involved in this project and I heard nothing about it. I asked information to the National Association for Health promotion and they do not know about this project."

"Association of chief professional in our country initiatives "Healthy cooking in school".

"Impact on nongovernmental organisations are limited only on involved organization, and no impact on funding/ resource allocation were realized due to lack of political and institutional involvement at national level."

"The evidence from the project continues to support the evidence base for a NGO's objective to protect the health and well being of children and young people by supporting a ban on all unhealthy food promotion and advertising to children.

"One NGO in our country."

"The national Heart Association developed a method (self appraisal tools for families and children, counselling material etc.) and started to educate the health care staff in child health clinics and schools (school nurses). Implementing this method in health care in some parts of our country - the project is running until 2012. In some parts of our country the implementation of the method in the municipality level is 100 %."

**General population:** "No visibility of the project".

"The population is more and more aware of these health issues, however I cannot find any association with this specific CHOB project.

"No impact on general population for lack of involvement of national institutions and national mass-media."

"Difficult to state any straight impact of the CHOB as a project itself on general population."

"The Programme is very young. It needs some time to see an impact."

**Target population:** "No evidence of any change underway."

"The children and young people are more and more aware of these health issues, however I cannot find any association with this specific CHOB project.

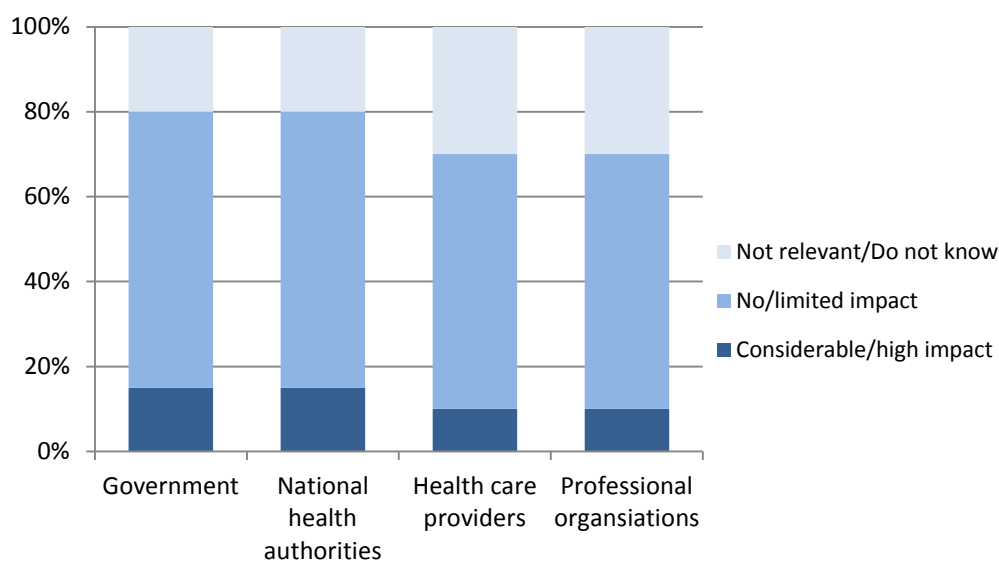
"No impact on target population addressed in the project for lack of involvement of national institutions and national mass-media."

"A new method, described above."

## 5. The impact on policy, reforms, guidelines, and routines

The impact on policy, reforms, guidelines and routines on the Government, National health authorities, Health care providers and Professional organisations, respectively, from CHOB were low according to the results (Figure 13). For Government and National health authorities 15% of the countries indicated considerable or high impact on policy/guidelines. However, most countries indicated no or limited impact on the stakeholders (60-65%). One explanation for this high proportion could be that it was difficult for the CIs to determine whether any changes in policy, reforms, guidelines and routines were actually an effect of the project or of any other initiatives or ongoing work. Of the countries, 5% stated that the impact on policy, reform, guidelines and routines were not relevant for these organisations/groups, while 15% stated that they did not know anything about the impact on Government or National health authorities, and 25% did not know about impact on Health care providers or Professional organisations.





**Figure 13.** Proportion of countries indicating level of impact on policy/reforms/guidelines/routines.

The unlimited free text space for the CIs answers or comments to the question about the likelihood that the impact on the different stakeholders could have occurred in the absence of the project was used to some extent. The following comments were given from eight CIs:

Three CIs stated: "Not applicable."

"Don't know."

"Yes, in fact the knowledge's about risk factors of obesity are well known also in our country and many results are been reached by other projects coordinated at National level with involvement of national institution and national policy.

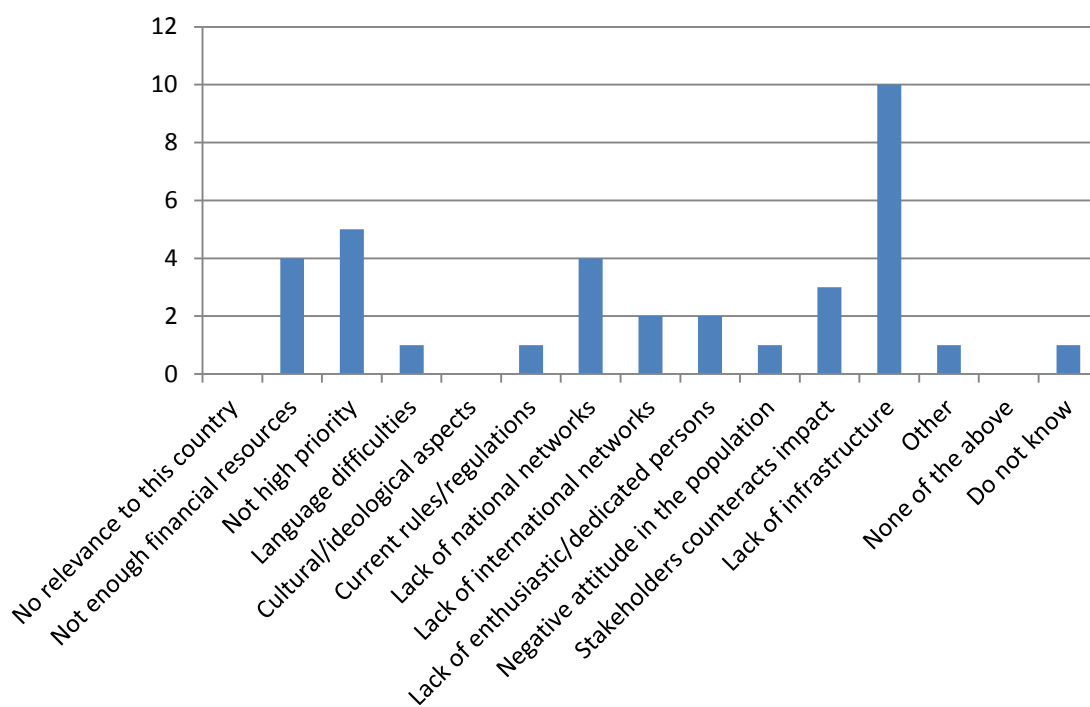
"Yes, it is likely, because the national awareness is quite high in general and the effect of some important national intervention, have arisen the interest, activities and development work focusing on children's health and prevention of chronic diseased starting in the early childhood more that the CHOB."

"Yes, I think so."

"As far as I know, CHOB has not been really diffused in my country."

## 6. Main factors hindering impact

Regarding factors that might have hindered impact of CHOB, from zero and four of the 13 suggested options of factors (that might have hindered impact) were indicated for each country. Usually only one hindering factor was indicated, this was the case for nine (43%) of the countries, and the average number was 1.7 hindering factors. Ten (50%) of the 20 countries indicated that the main factor that hindered impact was Lack of infrastructure (Figure 14). Furthermore, five countries indicated that 'The issue did not have high enough priority' and four countries indicated 'Not enough financial resources allocated' and 'Lack of national networks' as hindering factors for impact.



**Figure 14.** Number of countries that had indicated each type of factor that hindered the impact of CHOB.

Four of the CIs did comment regarding hindering factors for impact of CHOB in their countries:

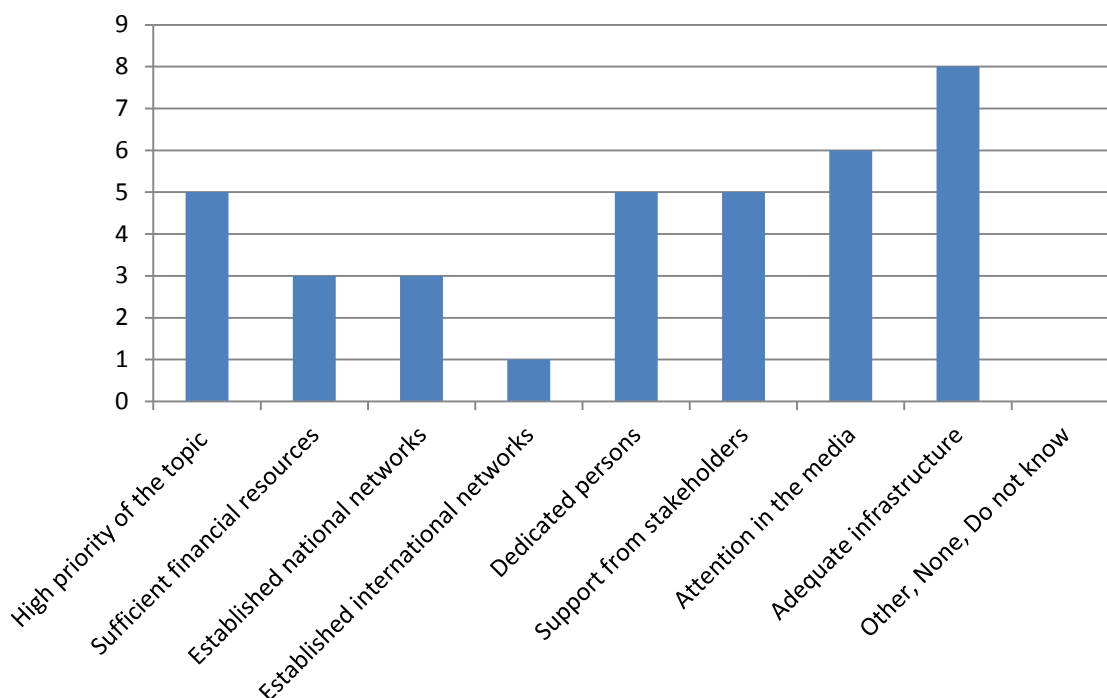
"Because the lack of involvement of university, of political institutions and of governmental institutions, there were no funds for mass-media divulgation and not enough financial resources allocated for project realization. Indeed is not been realized a national network to organize and coordinate the intervention actions at national level."

"Political will to regulate on this particular issue in my country further than existing regulation. Reliance on voluntary action and codes of practice from industry to self regulate."

"The limitation is the number of partners involved in the project in my country (only one non-governmental organization). In general, there should always be several, governmental, non-governmental and other stakeholders together, and piloting cities/municipalities (local authorities) involved in the process at the same time to get real impact on the population level. Practise based and evidence based knowledge and policy making should be combined together. The prevention of childhood obesity and children as a target group were not the main strategy or in the main focus in the action plan of the National Heart Association at the time of CHOB project. (But stated later in 2006; and this might be the most important impact of CHOB project in my country)."

## 7. Main factors facilitating impact

Regarding factors that facilitated impact of CHOB in the different countries between zero and six of the nine suggested such factors. The majority (60%) indicated one factor that had facilitated impact. Adequate infrastructure was the main factor that eight (40%) of the 20 countries mentioned (Figure 15). Additionally, six countries mentioned Attention in the media and five mentioned Dedicated persons and Support from stakeholders as important factors facilitating impact.



**Figure 15.** Number of countries that indicated types of factors that had facilitated the impact of CHOB.

The following free text was given in connection with facilitating factors:

"Probably not sufficient financial resources were allocated because there is not been the involvement of right institutions, it is not been established a valid national network, there is not been support from suitable stakeholders, especially political organisations, business company, university departments. Also attention in the media has been inadequate."

"The awareness of importance of children's health promotion has increased especially during 2008 - 2011 by the political programs implemented in my country. The CHOB project was in very minor role in this national process, like explained above."

"The awareness raising activities were well designed and got good media coverage also because the National heart foundation had good visibility already before. Two meetings with stakeholders involved professionals and policy makers advancing the agenda, but it was not seen from the stakeholders that this project actually moved anything, since at the ministry of health they even didn't remember it."

"Obesity is a priority in my country for the high prevalence among children and adolescents."

### 8. Coverage of the topic of CHOB in mass media

Only one CI indicated that mass media had had considerable or high coverage of the topic of CHOB, while 70% of the CIs indicated that coverage of the topic in mass media had been limited or nonexistent. Five of the CIs used the free text space to express the following regarding the role of mass media on CHOB:

"No influence on mass media."

"The mass media are referring more and more these health issues, however I cannot find any association with this specific CHOB project."

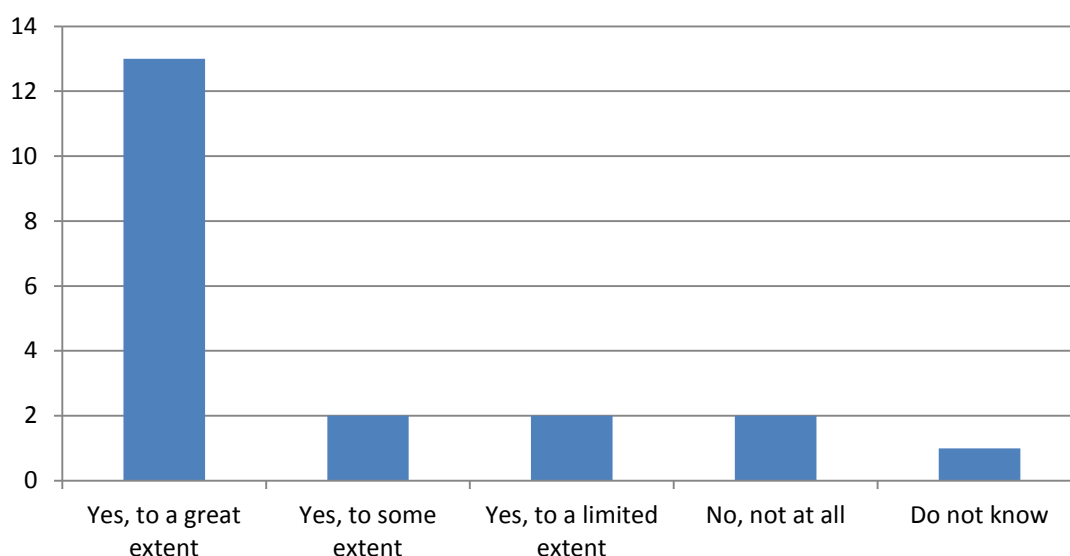
"A TV cooking show."

"No impact on mass media for lack of national involvement."

"There are articles and news in the newspapers, TV and radio related to children's health, diet, physical activity and obesity prevention, but which of these could have had any effect of CHOB itself is difficult to state. The leading news paper in my country published one article "How advertising effects on children's food choice", which could be seen as a result of the CHOB (2005). In the professional journals there are some articles, where the CHOB project and its results have been cited."

### 9. Relevance of the topic of CHOB

The majority of the countries (n=13) answered that the topic of CHOB had relevance to a great or some extent in their countries, but in one country it was stated that they did not know whether or not the project had relevance (Figure 16).



**Figure 16.** Number of countries indicating the level of relevance of the topic of CHOB.

The relevance of the topic of CHOB was commented by 18 (90%) of the CIs:

"The prevalence of obesity at early ages in our country is rather low.

"According to a European survey, our country has one of the highest rates of child obesity in Europe. Adult obesity rate is the third highest in /.../. Obesity is the main factor in cardiovascular diseases which is the leading cause of death in our country."

"The issue of childhood obesity was becoming a concern as highlighted by several surveillance studies which examined childhood obesity. In addition the influence of food marketing to children was also a concern. The Green Party in our country had highlighted food marketing as something they wanted to address."

"I have not heard of this CHOB project before. I couldn't find in the national research projects databases."

"Traditional national meal was substituted by unhealthy food. Eating behaviour has been changed recently."

"Data from the National Institute of Statistics demonstrate that in our country 24% of children aged 6 to 17 years show an excess weight, a phenomenon that seems to affect the lower age groups and be more frequent some parts of our country."

"In our country the issue of overweight and obesity in children is of growing concern. Currently 16% of girls and 15% of boys aged 2yrs to 15yrs are classified as obese and 31% of boys and 28% of girls aged 2yrs to 15yrs are classified as either overweight or obese. Data from 1995 to 2001

shows that mean BMI increased among both boys and girls aged 2-15 years yet between 2001 to 2009 there was no significant change for either boys or girls. However amongst boys aged 11-15 years the proportion that was obese in 2009 was 20% which is amongst the highest levels recorded. Therefore there is some evidence to suggest that the increase in rates is beginning to level off."

"Our country has not participated in the project "CHOB - Children, obesity and associated avoidable chronic diseases"."

"At the start of the CHOB project in 2003 there was not yet a national nutrition plan. Several policy options as price setting and food labelling can only be decided at the national level in our country (to implement European legislation). At regional level there is a health target on nutrition formulated since 1998 but the regional level is only responsible for health promotion initiatives. All "personalised" matters can be decided on at the regional level. So there is no level on which all decisions can be taken regarding and as it happens in politics the different levels do not always coordinate their activities or even bloc each other initiatives."

"There have been limited numbers of actors in our country (The National Heart Association) in the CHOB project. Other projects and other processes concerning children's overweight and its prevention have been going on at the same time, or before and it is difficult to see which one has affected. They have simultaneous effect on the national processes and policy making. However, the results of the project could be considered as the common frames for all the processes, but not any special effect of this one. The advantage of the CHOB project could be seen as a common and encouraging background information for the actors of the same field in our country."

"The prevalence of overweight and obesity in children has been growing in our country in recent decades. Prevention is considered to be the most effective way how to prevent obesity related health complications. Unhealthy foods for children have been advertised in media - which was (and still is) considered generally undesirable by many health professionals and parents."

"Overweight and obesity are on the rise in our country"

"Childhood obesity is an important public health challenge in our country. The prevalence of obesity in children and adolescents was estimated in 2000 and was found to be among the highest in Europe. There has been evidence that the impact of childhood obesity is similar as reported in the literature, mainly in terms of hyperlipidemia, insulin resistance, and raised blood pressure. There is also recent evidence that the prevalence of obesity in children and adolescents in our country, continue to escalate, despite the levelling off reported in other developed regions."

"Obesity is increasing as in many developed countries. Beside the medical problems the costs for treating obesity related diseases are tremendous."

"In our country, the prevalence of obesity among adults and children is considered to be lower than that reported in most industrialized countries. However, since the end of the 1980s, our country, like many developed countries, has had to face a rapid increase in the prevalence of overweight and obesity. Some of the obese children already have multiple risk factors for type-2 diabetes, heart disease and a variety of other co-morbidities and long-term health complications of obesity in children are important."

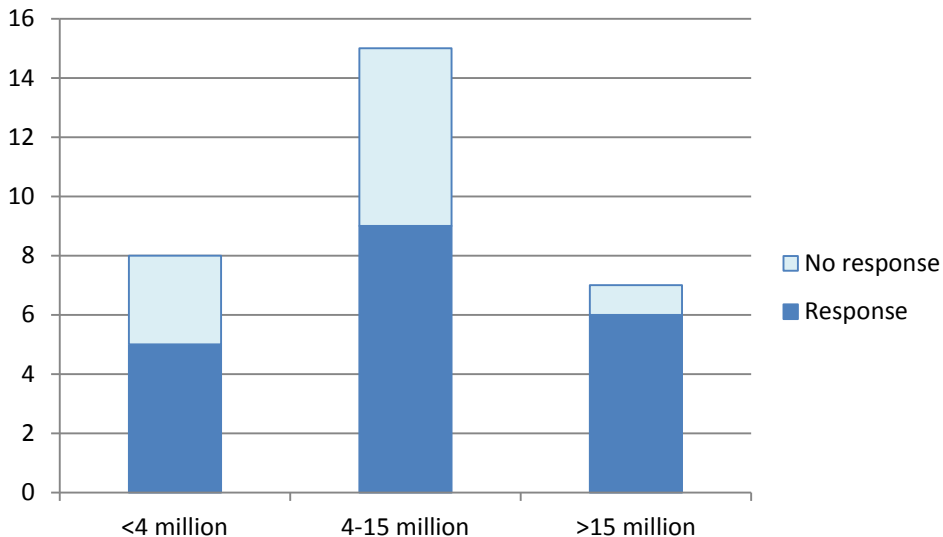
"CND and obesity, especially among children are serious public health issues also in our country. 10 years trend in obesity shows significant increase in all socio-economic groups among children (NIPH, 2011). Leading cause of death in our country is cancer, after successful intervention of cardiovascular diseases for past 10 years, which now dropped to 2nd place."

"The prevalence of obesity in our country's children is still low in comparison with the other European countries and US: it varies between 0 up till 5 % at different age and sex groups in 2000-2005. Nevertheless, it started to growth during the last few years steady, especially among preschool children."

"In my opinion, really among paediatricians it was not extended. May be, it was only known among heart specialists."

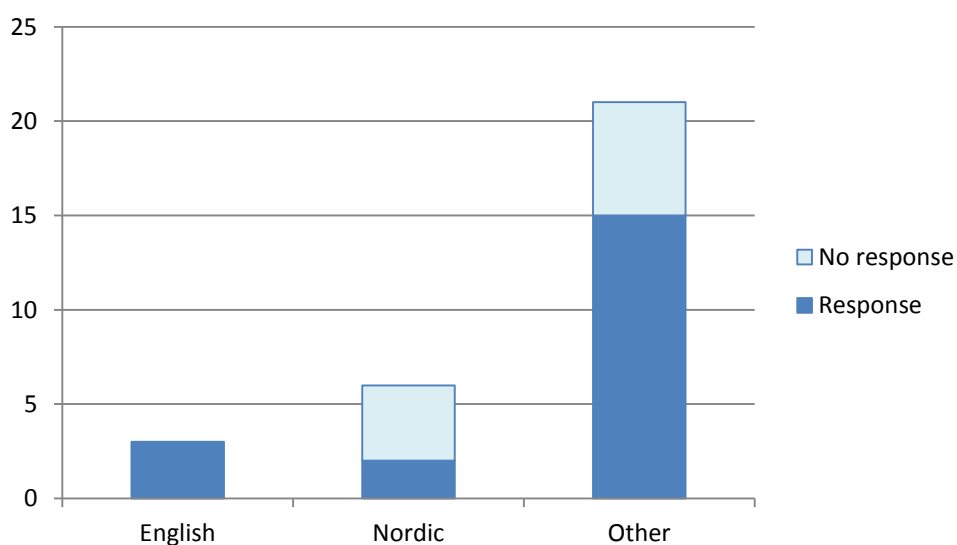
### 10. Responders to the CHOB web survey by category of country

When categorising the countries according to number of inhabitants (see page 10), most countries that responded to the CHOB web survey were medium-sized. Almost two thirds of the countries in the two groups with less than 15 million inhabitants each responded, as did six of seven countries each with more than 15 million inhabitants (Figure 17).



**Figure 17.** Number of participating countries with regard to number of inhabitants in the countries (representing 63%, 60%, and 86 %, respectively, of the countries in each group)

Based on the categorization regarding the knowledge of English language within the general population, the distribution shows that Other countries were in the majority among the countries that responded to the CHOB web survey. All in the English speaking group, one third in the Nordic group and more than two thirds in the “Other” group responded (Figure 18).



**Figure 18.** Number of participating countries with regard to three language areas (representing 100%, 33%, and 71%, respectively, of the countries in each area)

**Table 3. CHOB - Summary of number of countries involved, regarding different aspects**

EEA-countries	Project collaborators /partners/ expertise in these countries	CHOB results were disseminated in these countries	Invited CIs	Invited CIs was in the EUPHA database	Responding CIs	Invited countries	Responding countries	Responding CIs involved in CHOB
Austria	1	1	1		1	1	1	
Belgium	1	1	1	1	1	1	1	1
Bulgaria			1	1	1	1	1	
Cyprus			1		1	1	1	
Czech Rep	1	1						
Denmark	1	1						
Estonia	1	1						
Finland	1	1	1	1	1	1	1	
France	1	1	1	1	1	1	1	
Germany	1	1						
Greece	1	1	1	1		1	1	
Greece			1		1			
Hungary	1	1	1	1		1		
Ireland	1	1	1	1	1	1	1	
Italy	1	1	1	1	1	1	1	
Latvia			1		1	1	1	
Lithuania			1		1	1	1	
Luxembourg								
Malta			1	1	1	1	1	
Netherlands	1	1	1	1	1	1	1	
Poland								
Portugal	1	1	1	1	1	1	1	
Romania			1	1	1	1	1	
Slovakia			1		1	1	1	
Slovenia	1	1	1	1	1	1	1	
Spain	1	1	1		1	1	1	
Sweden	1	1	1			1		
Sweden			1					
Sweden			1	1				
UK	1	1	1	1	1	1	1	
Iceland	1	1						
Norway	1	1	1	1		1		
Switzerland			1	1	1	1	1	
Switzerland			1		1			
<b>Sum</b>	<b>20</b>	<b>20</b>	<b>27</b>	<b>17</b>	<b>21</b>	<b>23</b>	<b>20</b>	<b>1</b>

## **EURO-URHIS I - European System of Urban Health Indicators**

### **Presentation of URHIS I**

#### **General objectives of EURO-URHIS I**

The project aimed to develop a comprehensive urban health information and knowledge system to:

1. Help to identify and prioritise urban health problems
2. Enable the monitoring of the effects of actions taken to address them
3. Ensure timely access to information
4. Contribute in building advocacy, communication and education strategies
5. Use standardized methodology for data collection, processing and dissemination, allowing transnational comparisons and time trend analysis

#### **Summary of URHIS I, provided by Arpana Verma, United Kingdom**

The project proceeded very well, met all its milestones, and produced all its agreed deliverables although some partners were behind schedule in returning these. The flow of the Work packages worked as expected, with the initial literature reviews (WP 4 and 5) providing excellent information for the questionnaire development (WP 6 and 7), which was subsequently sent to relevant individuals for completion. A key part of the work was to identify a method of defining an urban area, and the definition developed during WP5 was used to inform the questionnaire data collection. Questionnaires were retrieved from 60 European Urban Areas in 30 countries. A large majority of Urban Areas delivered questionnaires of near 100 pages filled with information about local health indicator availability, definitions and sources. The local respondents were painstaking, conscientious and hard-working. A variety of comparable health indicators are available in the 30 countries. No clear patterns of indicator availability emerged – availability did not seem to depend on country size, location or EU status. Questionnaire responses were transferred to a database, forming the basis for the work of WPs 8 and 10. WP 10 prepared a detailed examination of each of the proposed indicators leading to the proposed final set of indicators to be used. This produced a set of 39 Urban Health Indicators (UHIs), together with their definitions, which can form the basis of an UHI Indicator system. In addition, a number of gaps were identified with the need for the development work required to produce further indicators of relevance to urban health. As part of WP10, a closer study of the process of urban health data collection was performed. This highlighted a number of issues involved with the identification of data sources, many of which were common across European countries and are therefore likely to relate to other research on comparable topics. However, despite the existence of these barriers, and some problems with the international comparability of questions to elicit information, data collection was completed for many of the indicators. Therefore the project succeeded in identifying both the utility of using some UHIs and the availability of data, and has gained an enhanced knowledge of how urban health data are used and routinely collected across Europe. In addition, through the work of WP9, we identified a number of ways in which health indicators may be presented to enhance their usefulness to health policymakers. A website



and two out of three newsletters were produced to assist in the dissemination of the results of the project (WP 2).

The two conferences planned under Deliverables 9 and 10 were combined into one for budgetary reasons (as agreed with DG SANCO during the budget discussions prior to the study commencement). This resulted in a final conference for peer reviewers and policy makers, attended by more than 100 people (the implications arising from the conference were reported as part of the WP10 report). The conference identified ways in which the indicators might be incorporated into an EU wide system of urban health indicators. Feedback from the conference showed that all delegates felt the conference had increased awareness of urban health indicators, 89% felt the findings of the EURO-URHIS project would be helpful to policy makers and 86% felt that there was now enough evidence to support inclusion of urban health in all policies. The EURO-URHIS indicators were deemed by all delegates to be useful and not requiring revision despite the need for further development work on additional indicators and methods of implementation. Many different strategies for the implementation of UHIs were discussed through future projects including EURO-URHIS 2, continuing the EURO-URHIS network and formation of a sub-national working group.

### **Comments in the URHIS I final report whether the project accomplished its main objectives**

The work demonstrated that urban health and its measurement is of major relevance and importance for Public Health across Europe. The study constructed an initial system of European UHIs to meet the objectives of the project, but has also clearly demonstrated that further development work is required. The importance and value of examining UHIs has been confirmed, and the scene set for further studies on this topic.

### **Project collaborators/partners/expertise in URHIS I**

EURO-URHIS I had collaborators/partners/expertise from 30 countries. The following collaborators/partners were included in EURO-URHIS I: government, health authorities, health care providers, professional organisations, local/regional authorities, universities, non- governmental organisations, and international organisations (WHO).

### **Dissemination of results from EURO-URHIS I**

The project had a discreet dissemination work package (WP2) which was the responsibility of and led by our partners in the North-West Health Brussels Office (NWHBO). These partners carried out the strategies detailed below (with the collaboration of the other project partners) on behalf of the project.

The strategies for dissemination were that the results would be disseminated to a range of audiences with a multitude of methods such as:

- Report writing (made available via EUROPA website and the project website)
- Newsletters and a 'user-friendly' summary report
- Submission for publication on scientific journal and scientific conference presentations
- Dissemination through existing partners' networks

- A peer review event to be combined with a policymakers conference on urban health indicators and publication of its proceedings
- Establishment and maintenance of a website

Wide dissemination of the project report was planned to stimulate further development of the information system.

### **Key targets for dissemination**

The following were the key targets for dissemination of results from EURO-URHIS I: government, health authorities, professional organisations, local/regional authorities, universities, other research organisations, and mass media.

## **2. URHIS I - introduction to PHIRE, WP 4**

### **The process to identify the CIs for PHIRE, WP 4**

The CIs were collated by gather contacts from previous research projects including European Urban Health Indicator System (EURO-URHIS) 1 and EURO-URHIS 2, and combining those with a list of individual members of the Sections of The European Public Health Association (EUPHA).

The contacts were included if their profession was in public/urban health and if they had an interest in the innovative project, initially called the Tracer Project. The people on the compiled contact list totalling 321 members throughout 30 countries was then sent a MailMerge asking them to take part in the PHIRE project by answering a 30 minute questionnaire that reviewed EURO-URHIS 1. After the contact provided consent this questionnaire was to be distributed by email.

### **Problems encountered during data collection**

There were some difficulties recruiting sufficient contacts from each of the thirty countries specified. This was particularly true for the smaller countries where the University of Manchester has very limited contacts, like Iceland, Estonia, Malta and Cyprus. It was easier to recruit CIs for the countries where the University of Manchester has had frequent contact, e.g. the Netherlands, Sweden, UK, and Italy.

As part of the procedure, the researcher is required to conduct a follow up phone call to any CIs where responses have been low. The difficulty here is that few of the researchers at the University of Manchester are bilingual and have to heavily rely on the CI being able to speak English.

The researcher has found that some CIs find that a more senior colleague is required to answer the evaluation questions on EURO-URHIS 1. This obviously increases the response time for evaluation as the researcher has to establish contact with a new CI and begin the procedure again.

The researcher has noted that some of the contact information is incorrect (telephone numbers, email addresses) and as such cannot be immediately contacted. Furthermore the researcher is required to search for the contact on the Internet or locate another CI.

Some of the CIs have stated they cannot take part in the evaluation of EURO-URHIS 1 as they contributed to the said piece of research initially and as such would provide biased answers.

### **3. Results regarding URHIS I**

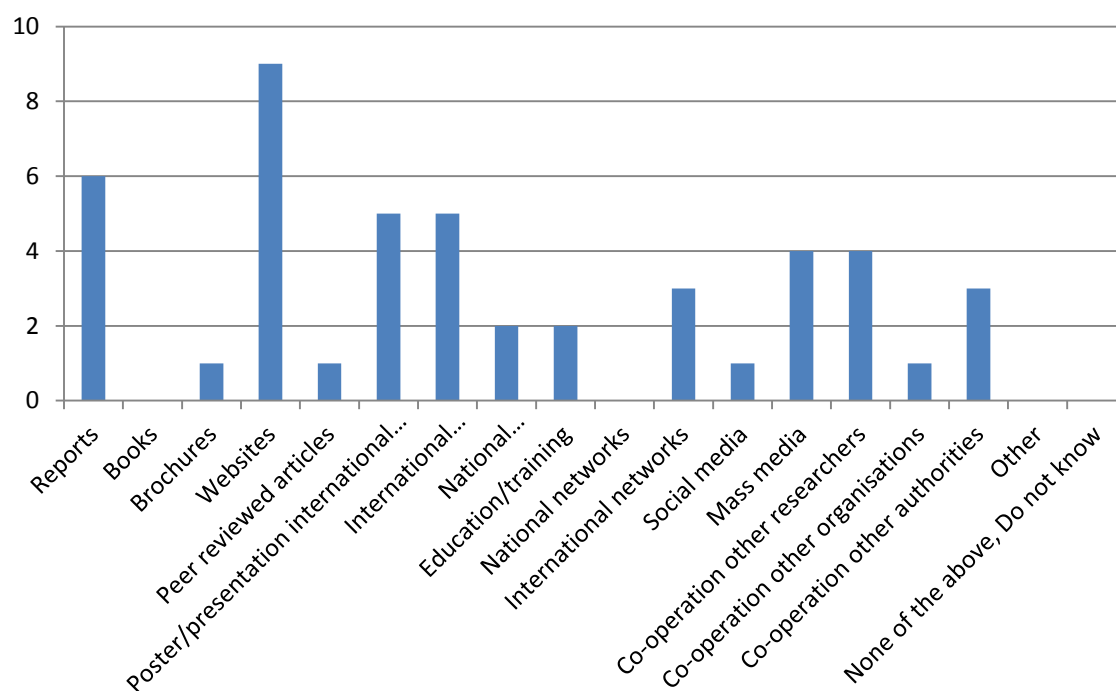
#### **1. Invited and responding CIs**

In total, 47 CIs were invited to answer the web-based questionnaire representing 20 countries (Table 4, page 52). Questionnaire responses were obtained from 19 CIs representing the following 15 countries: Austria, Belgium, Germany, Italy, Lithuania, the Netherlands, Poland, Portugal, Romania (two respondents), Slovakia (two), Slovenia, Spain (two), Sweden (two), United Kingdom, and Norway. These 15 countries correspond to 50% of the 30 EEA countries. For the countries with more than one CI responding to the web survey, the answers from those CIs have been combined, taking the average if they did not agree.

Forty of the 47 invited CIs (85%) were in the EUPHA database of individual Section members and of the 19 CIs that finally answered the web survey, 17 (89%) were in the EUPHA database. Three (16%) of the 19 CIs who participated in the URHIS I web survey had been involved in the project as project leader/coordinator or as a project partner.

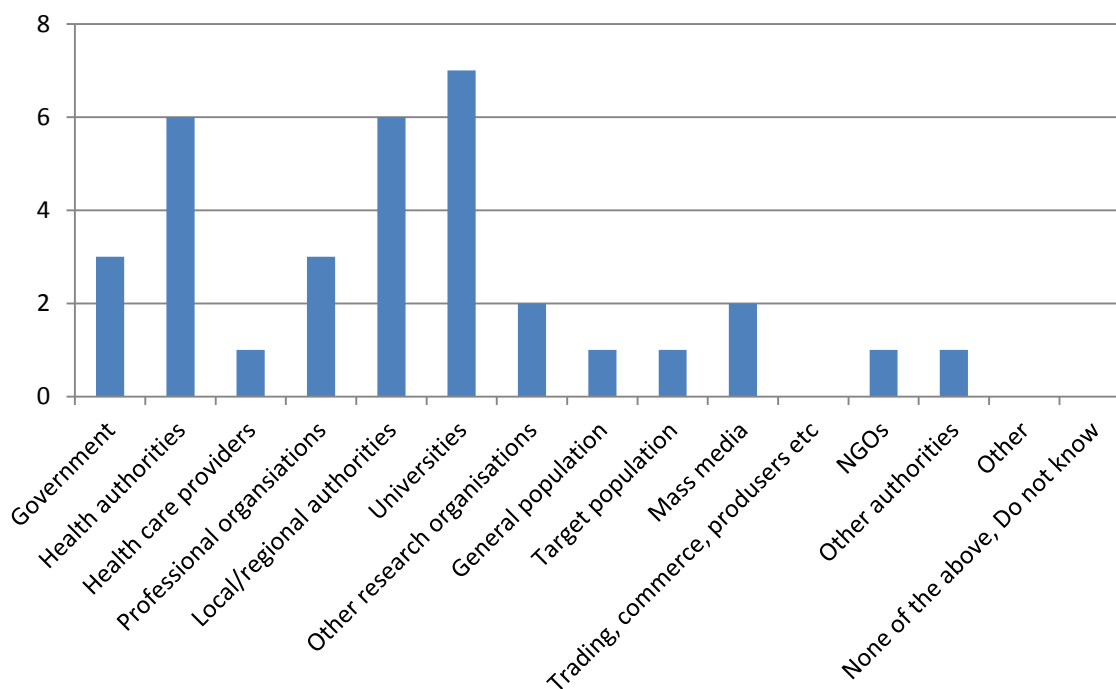
#### **2. Ways for dissemination of results**

Results from URHIS I were disseminated in 14 different ways according to the web-survey results (Figure 19). Each country indicated between 0-12 different ways for dissemination. Among the 11 countries that answered the question, the most common was to indicate five of the suggestions for ways of dissemination (n=3), but the average number was 4.3 ways per country for dissemination of the results. Mainly, dissemination was through Websites, nine countries indicated this. Six countries indicated Reports and five countries indicated Poster/presentation at international conference and International meetings/seminars/lectures as ways of dissemination.



**Figure 19.** Number of countries indicating the channels used to disseminate the results from URHIS I.

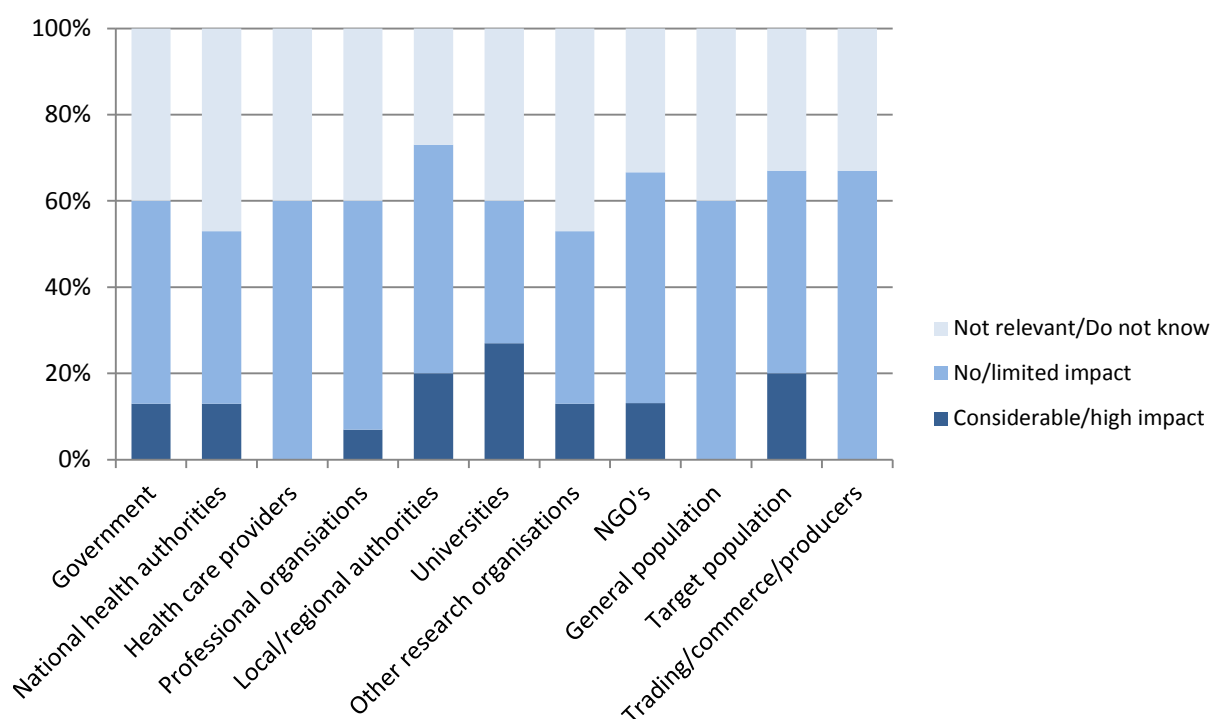
According to the results, 12 different types of groups/organisations were reached by information about the project (Figure 20). For each country, zero to seven groups were indicated, with an average number of 2.9 indicated groups/organisations per country. Universities was the most often reported as reached by information about URHIS I (n=7, 64% of all countries). Health authorities and Local/regional authorities were reported by six countries and Government and Professional organisations by three.



**Figure 20.** Number of countries indicating groups/organisations that were reached by information about URHIS I.

### 3. Impact on knowledge/awareness of stakeholders

Universities were the stakeholder that most countries indicated (27%) as having had considerable or high impact on knowledge/awareness from URHIS I (Figure 21). For Local/regional authorities and Target population 20% of the countries expressed considerable or high impact on knowledge/awareness. However, as many as 33% to 67% of the countries indicated that there were limited or no impact at all on the stakeholders from the project, and on average 38% of the countries indicated that it was not relevant or that they did not know about the impact on knowledge/awareness. These results are in accordance with that the Universities were reached by information about URHIS I (Figure 20) and 27% of the countries stated considerable or high impact on the Universities (Figure 21). None of the countries indicated considerable or high impact on Health care providers or General population, which is consistent with that only one country stated that Health care providers were reached by information about URHIS I and only one, other, country that the General population was reached by such information.



**Figure 21.** Proportion of countries indicating level of impact on knowledge/awareness among different stakeholders.

### 4. Comments on the impact on knowledge/awareness of stakeholders

Following to the questions about impact on stakeholders it was possible to add further examples or comments in an unlimited free text space. There were large variation between countries regarding to what extent they used this opportunity. Nine of the countries did not comment at all, while two countries had comments for all stakeholders. However, several of these comments were the same for almost all of the stakeholders. The comments are presented below.

**Government:** "The project did not have any impact on government as from its nature it was not aimed to result in policy actions."

"This project dealt with a city/municipality, and the Government has very little to do with municipal health."

"The government is not so much interested in urban public health as a separate category. Impact only at local city level."

"The political instability (chronic transition) and economic crisis could excuse the low level of impact on government."

"It's the first time I heard about this project. In the public health field of the xxxx nobody know the project. In xxx, in the public health field there has been no dissemination of the project."

"There is a conceptual inconsistency: at national/EU level at regional level at urban level: if any utility it should be oriented toward the city authority. If it is intended for a higher level then it is a higher level indicator stratified by level of urbanisation."

**National health authorities:** "Limited impact on national health authorities is mainly due to the character of the project, but also due to political circumstances in the country. As EURO-URHIS 1 aimed to survey the feasibility of collection and accessibility of selected urban health indicators it only demanded the cooperation with respective health authorities."

"Again, national authorities have little to do with local matters."

"Projects: Maybe... there was a study on urban health. But maybe not funded/initiated by the national health authorities but rather by our city. And most likely before the URHIS project."

"Presently, at a national level, HIS is standardized. Experiences of the 4 major cities in my country are leading."

"The political instability (chronic transition) and economic crisis could excuse the low level of impact on national health authorities."

"I don't have precise information about this issue"

**Health care providers:** "Health care providers were neither involved nor needed for this phase of the project."

"This project had nothing to do with health care providers, as they are organised in this country."

"Local health care providers rely on the epidemiological information presented by the public health service. This means the results of URHIS-1 are only indirectly translated toward health care providers. The results are primarily of importance for our own organisation (Public Health Service)."

"The political instability (chronic transition) and economic crisis could excuse the low level of impact on healthcare providers. Only research field reacted more visible, by becoming involved in the subsequent URHIS 2 project."

**Professional organisations:** "Professional organisations were partially involved in the phase of data collection."

"Local project - not national data."

"The political instability (chronic transition) and economic crisis could excuse the low level of impact on professional organisations."

"Local health care providers rely on the epidemiological information presented by the public health service. This means the results of URHIS-1 are only indirectly translated toward health care providers. The results are primarily of importance for our own organisation (Public Health Service)."

**Local/regional authorities:** "There was in general a limited impact on local health and municipal authorities regarding the awareness on the importance of urban health indicators. Project didn't facilitate further or more intensive data collection in this field."

"I am not sure... there was this study, in fact a report based on the collection of existing data (institute of social medicine) and I believe commissioned regional authorities."

"As local Public Health Authority the results of URHIS-1 are highly relevant, and made us to decide to be one of the partners in URHIS-2."

"The political instability (chronic transition) and economic crisis could excuse the low level of impact on regional and local authorities."

**Universities:** "EURO-URHIS 1 had a considerable impact on universities, which appointed 1 PhD student and 1 junior researcher to further investigate on this topic. Moreover, it offered a

background for the second phase of the project (EURO-URHIS2). A theme on urban health is currently among topics from which students can choose for their Bachelor or Master thesis."

"If a research institution was a project partner this institution would know about URHIS. I do not know the list of project partners. If no university institute was involved I assume there is no awareness among universities about the project."

"The political instability (chronic transition) and economic crisis could excuse the low level of impact on universities too."

**Other research organisations:** "Based on collaboration 1 PhD student and 1 junior researcher were appointed to further investigate on this topic."

"Which organisations? They are all national, I know of no local ones within this field."

"If a research institution was a project partner this institution would know about URHIS. I do not know the list of project partners. If no university institute was involved I assume there is no awareness among universities about the project."

"The political instability (chronic transition) and economic crisis could excuse the low level of impact on research."

**NGOs:** "It had a considerable impact on the National Public Health Association, which realizing the importance of research in this field is actually involved also in the second phase of this project."

"I have some insight in health and environmental NGOs in our country. So I am pretty sure that these were not influenced by URHIS. There are other fields of work for NGOs (social aid, immigration policy, developmental aid,...) and I cannot speak about these NGOs"

"The political instability (chronic transition) and economic crisis could excuse the low level of impact on NGOs, on our knowledge."

"The National Union of Hygienists and Epidemiologists."

**General population:** "Project didn't have any impact on population as it was not a target of this project."

"None needed."

"The project is primarily aimed to support (local) policy makers to give inside in the health situation of the local urban population. So, potential health benefits in the population depend on the translation of urban health indicators into local health policy and prevention programmes. This means, only an indirect effect (but still of importance!)."

"The low level of reaction from the levels mentioned above could be the low level of impact on general population."

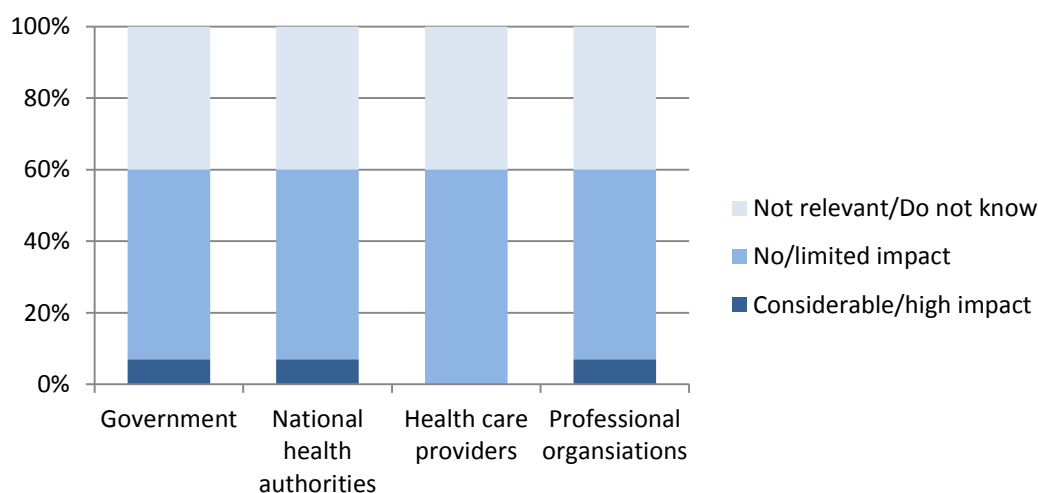
**Target population:** "The project didn't have any impact on specific population as it was not its aim. The aim of the project was descriptive; it was targeted to collecting information on availability / existing data on selected urban health indicators."

"What do you mean by 'target population' in this sense? If local policy makers are meant: in that case the impact in knowledge is obvious."

"The low level of reaction from the levels mentioned above could be the low level of impact on general population."

## 5. The impact on policy, reforms, guidelines, and routines

The impact on policy, reforms, guidelines and routines on the Government, National health authorities, Health care providers and Professional organisations respectively from URHIS I were very low according to the results. For Government National health authorities, only one country (7%) indicated considerable or high impact on policy/guidelines (Figure 22). Additionally, a large proportion of the countries (53% - 60%) indicated no or limited impact on the stakeholders. Six countries (40%), stated that the impact on policy, reform, guidelines and routines were not relevant for these organisations/groups, or they did not know anything about the impact. Obviously these questions were not easy to answer for the CIs. One explanation for this could be that it was difficult for the CIs to determine whether any changes in policy, reforms, guidelines and routines were actually an effect from the project or from was the result of other initiatives or ongoing work.



**Figure 22.** Proportion of countries indicating level of impact on policy/reforms/guidelines /routines.

The unlimited free text space for the CIs answers or comments to the question about the likelihood that the impact on the different stakeholders could have occurred without the project was used to some extent. The following comments were given from six CIs:

"No. In my opinion, the fact that our country was involved in this project facilitated the further research in the field of urban health. The project gave a great opportunity to assess the feasibility of data collection on urban level. Moreover, it focused our attention to this emerging issue which have not actually been addressed before."

"It is important to know what kind of population health information is available. This project, for the first time, made this information available and comparable."

"Probably not."

"Yes."

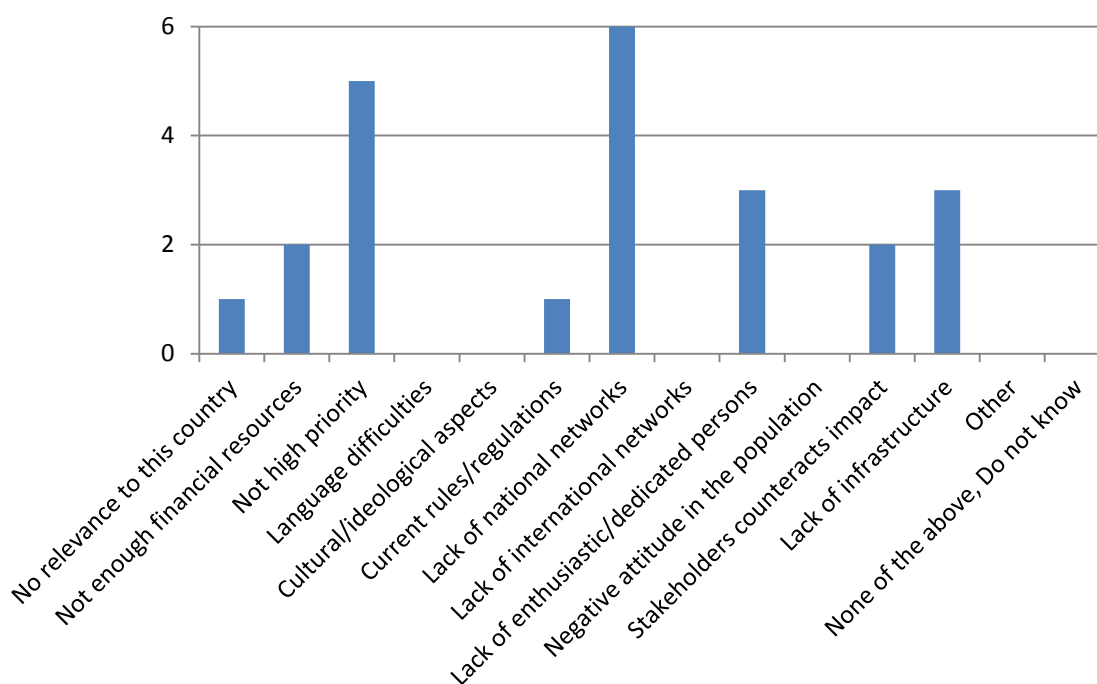
"Perhaps."

"I guess so, due to the census."

## 6. Main factors hindering impact from URHIS I

Regarding factors that might have hindered impact of URHIS 1, between zero and four of the 13 suggested options of factors that might have hindered impact were indicated for each country (Figure 23). Two of the countries indicated no hindering factors at all, while four countries indicated two hindering factor each. On average, the countries indicated 1.8 hindering factors. Five (33%) of the 13 countries indicated that the main factor that hindered impact was Lack of national networks. Furthermore, five countries indicated that 'The issue did not have high enough priority'.





**Figure 23.** Number of countries that had indicated each type of factor that hindered the impact of URHIS I.

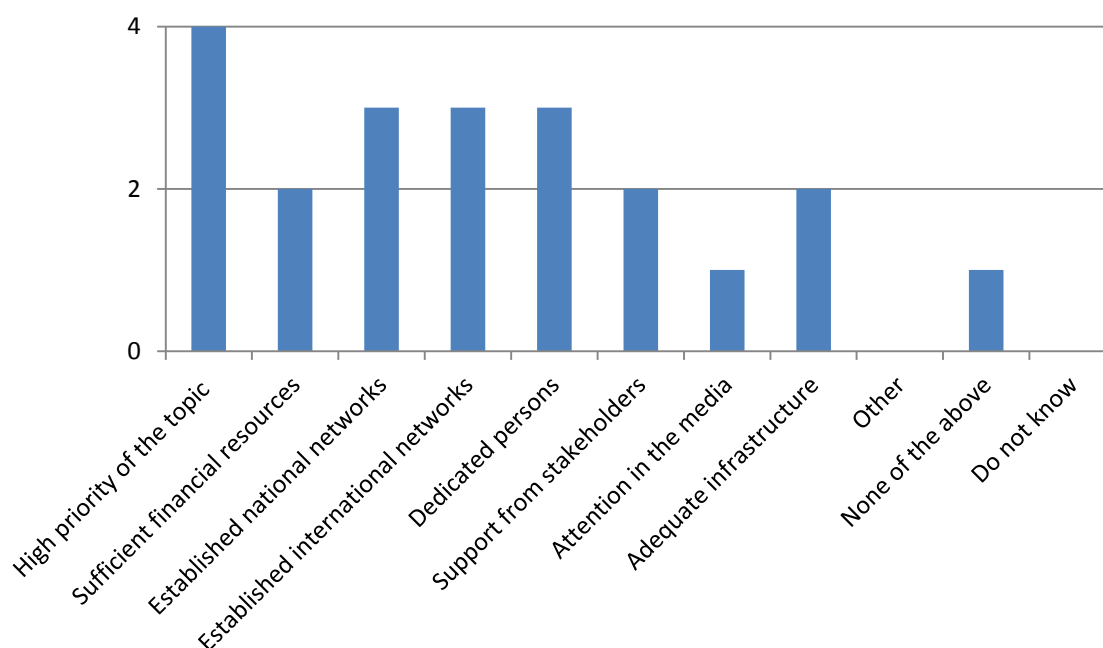
Two of the CIs did comment regarding hindering factors for impact of URHIS I in their country:

"There weren't any hindering factors, apart a scatteredness of data on urban level. The infrastructure of data in this field is bit complicated, as some are collected on local level and later processed to national authority, and some are processed other way round extracted from national data to local. Further, the variety of selected 45 urban health indicators (UHIs) was collected and administered by 29 institutions, although there were only 3 major ones - Statistical Office, National Centre for Health Information, and Public Health Authority and its regional branches."

"No country impact, apart from within the NIPH, but some impact within the relevant urban area."

## 7. Main factors facilitating impact of URHIS I

Regarding factors that facilitated impact of URHIS 1 between zero and five of the nine suggested such factors. Of the 10 countries, five (50%) indicated one factor- as a facilitating impact (Figure 24). There were not so many facilitating factors that were in common among the countries Four countries (27%) each indicated High priority of the topic as a facilitating impact. Additionally, three countries mentioned Established national networks, Established international networks and Dedicated persons as factors facilitating impact.



**Figure 24.** Number of countries that indicated different types of factors that had facilitated the impact of URHIS I.

The following free text was given in connection with facilitating factors:

"The coordinating organization of the project had quite easy access to excellent experts in the field (based on previous collaboration) so this made the process easier."

"Not really relevant, since we already had quite good data."

"The low impact makes difficult to say which of the above could be considered as "main factor(s)" facilitating the URHIS I impact at national level."

### 8. Coverage of the topic of URHIS I in mass media

Only one country indicated that mass media had had considerable or high coverage of the topic of URHIS I, while 67% of the countries indicated that the coverage of the topic in mass media had been limited or nonexistent. Three of the CI used the free text space to express the following regarding the role of mass media on URHIS I:

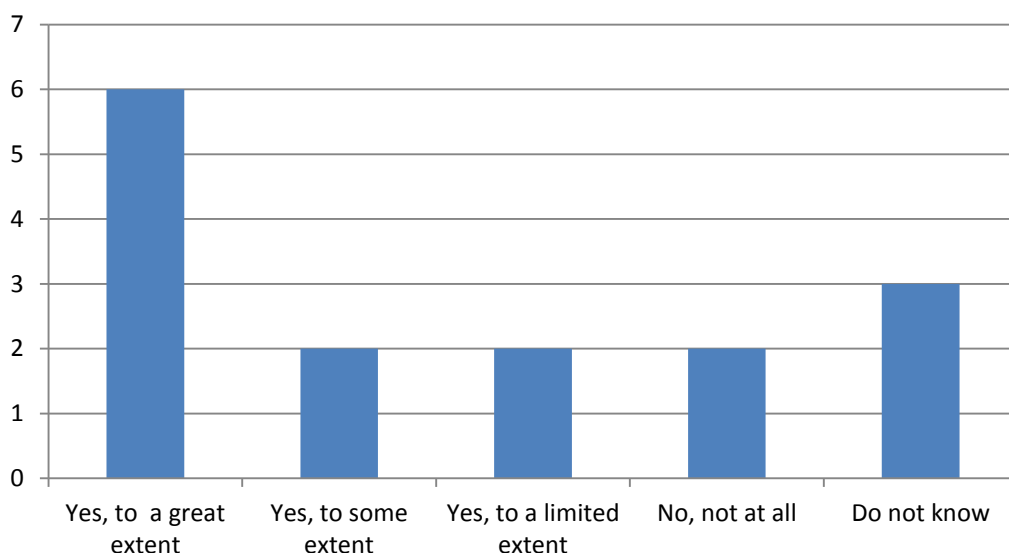
"Descriptive outcomes of the project didn't demand a media involvement."

"Press release sent; nothing published."

"Merely, the local mass media asked for information and updating such information during the URHIS I running project."

### 9. Relevance of the topic of URHIS I

A majority of the countries (n=8, 53%) answered that the topic of URHIS I had relevance to a great or some extent in their country (Figure 25). From three countries it was stated that they did not know if the topic had relevance.



**Figure 25.** Number of countries indicating the level of relevance of the topic of URHIS I.

The relevance of the topic of URHIS I was commented by 12 (63%) of the countries:

"In our country, the EURO-URHIS I project was relevant because of several reasons. Firstly, the issue of urban health was appropriate to be addressed in changing economy and rapid urbanization process. Secondly, the project offered an opportunity to select suitable indicators that could describe health status of city residents. Further, as a new member of the European Union (since 2004) our country found it important to be in the beginning of the process when urban health indicators are defined, with a potential of a mandatory reporting requirements to respective EU institutions in the future."

"The City was informed about the project, but the people in charge saw no need to increase the number of indicators available. Parenthetically, the set of indicators is among the better found in the survey."

"Environmental Health Indicators are of importance for our country. The urban environment is also a relevant environment regarding public health because a high proportion of people live in urban areas. In the capital city of our country alone and its surrounding agglomeration more than 25% of the population are living and working. But on the other hand the city is the only "true" big city in our country. All the other "bigger" cities are rather small compared to international standards and even our capital city is not a "very" large agglomeration. Therefore maybe other environments are of higher importance in our country."

"Within my city public health policy should be based on valid health indicators."

"The first time I heard about this project was the request to complete this questionnaire"

"The urban environment is developing since 1990 significantly. There are no specific studies, surveys and regulations on Urban Public Health issues."

"Until last year I was not aware of the URHIS 1 project!"

"The use of health indicators is more and more important in order to perform a monitoring of health and health outcomes in our country"

"The new public health strategy take in account the Health in all policies European vision and we are implementing and developing a health impact assessment as a standard tool including human needs objectives related to transport, infrastructures, build environment etc."

"Relevant to current policy discussions."

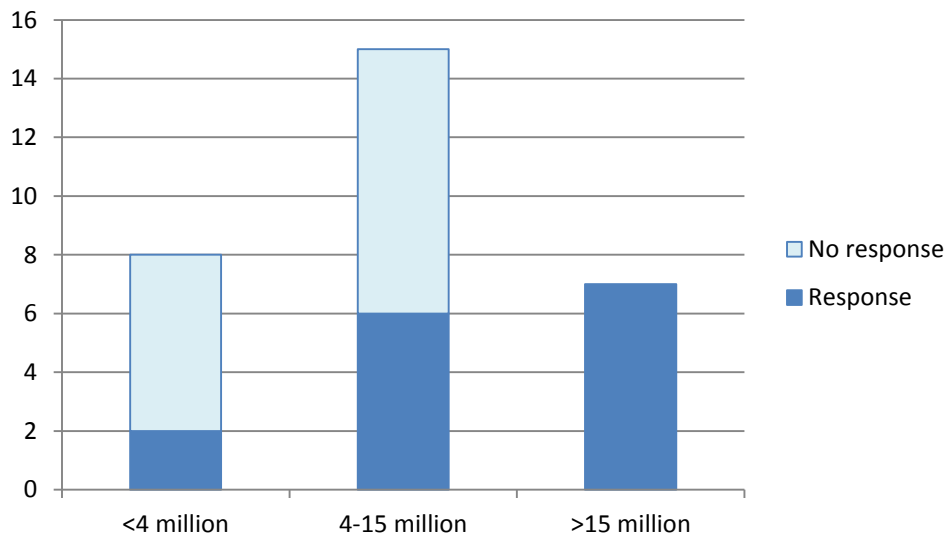
"I work at the University of Medical Sciences. Did not reach me here about this, at most, very limited."

"Our country does not have a lot of large urban areas therefore I believe this project just has relevance to some extent. However, there is a need to develop a standardized system to measure

and monitor the life's quality of European cities and therefore one may consider this project has relevance in our country."

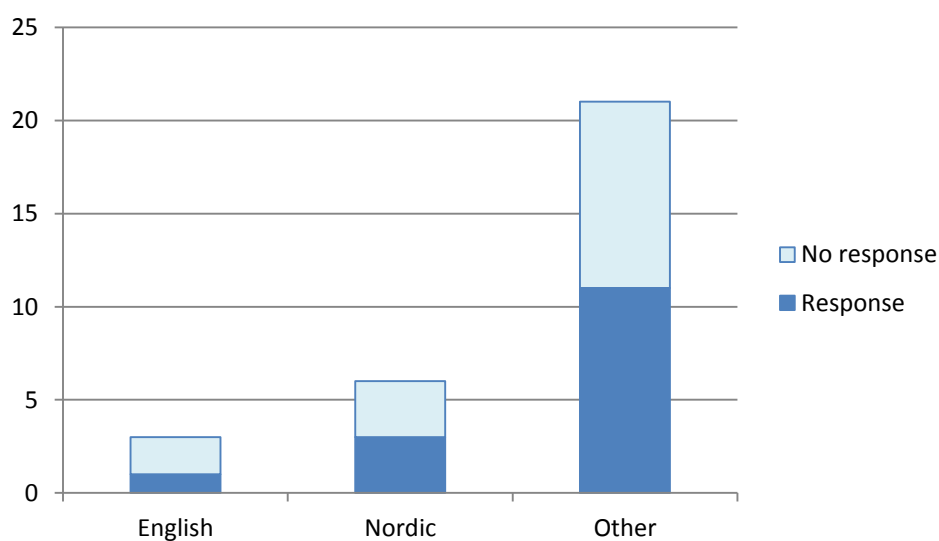
### 10. Responders to the URHIS web survey by category of country

When categorizing the countries according to number of inhabitants (see page 10), almost half of the countries that responded to the URHIS 1 web survey had more than 15 million inhabitants. Every country in this group responded, while less than one third in the group with less than 4 million inhabitants responded (Figure 26).



**Figure 26.** Number of participating countries with regard to number of inhabitants in the countries (representing 16%, 40%, and 100%, respectively, of the counties in each group)

Based on the categorization regarding the knowledge of English language within the general population, the distribution shows that Other countries were in majority. One third of the countries in the English speaking group and half of the countries in the other two groups responded (Figure 27).



**Figure 27.** Number of participating countries with regard to three language areas (representing 33%, 50%, and 52%, respectively, of the countries in each area)

**Table 4. URHIS I - Summary of number of countries and CIs involved, regarding different aspects**

EEA-countries	Project collaborators/ partners/expertise in these countries	URHIS results were disseminated in these countries	Invited CIs	Number invited CIs in the EUPHA database	Responding CIs	Invited countries	Responding countries	Responding CIs involved in URHIS
Austria	1	1	1	1	1	1	1	
Belgium	1	1	1		1	1	1	
Bulgaria	1	1						
Cyprus	1	1						
Czech Rep	1	1						
Denmark	1	1	1			1		
Estonia	1	1						
Finland	1	1						
France	1	1	1	1		1		
France			1	1				
Germany	1	1	1	1	1	1	1	
Greece	1	1						
Hungary	1	1	1			1		
Ireland	1	1	1	1		1		
Italy	1	1	1	1	1	1	1	
Italy			1	1				
Italy			1	1				
Italy			1	1				
Italy			1	1				
Latvia	1	1						
Lithuania	1	1	1	1	1	1	1	
Luxembourg	1	1						
Malta	1	1	1	1		1		
Netherlands	1	1	1	1		1		1
Netherlands			1	1				
Netherlands			1	1				
Netherlands			1	1	1		1	
Netherlands			1	1				
Poland	1	1	1	1		1		
Poland			1	1	1		1	
Portugal	1	1	1	1		1		
Portugal			1	1				
Portugal			1	1	1		1	
Portugal			1	1				
Romania	1	1	1	1		1		
Romania			1	1				
Romania			1	1	1		1	1
Romania			1	1	1			
Romania			1	1				
Slovakia	1	1	1	1	1	1	1	
Slovakia			1	1	1			
Slovenia	1	1	1			1	1	
Slovenia			1	1				
Slovenia			1	1	1			
Spain	1	1	1			1	1	
Spain			1					
Spain			1	1	1			
Spain			1		1			
Sweden	1	1	1	1	1	1	1	
Sweden			1	1				
Sweden			1	1	1			
Sweden			1	1				
UK	1	1	1	1		1	1	
UK			1	1	1			
Iceland	1	1						
Norway	1	1	1	1	1	1	1	1
Switzerland		1						
<b>Sum</b>	<b>29</b>	<b>30</b>	<b>47</b>	<b>40</b>	<b>19</b>	<b>20</b>	<b>15</b>	<b>3</b>

## HA - Healthy Ageing

### 1. Presentation of HA

#### General objectives of HA

The aim of the Healthy Ageing project was to promote healthy ageing in later life stages (older people aged 50 and above). The project focused on different aspects of health and promoted healthy ageing through the development of an integrated holistic approach to health in later life.

#### Summary of HA, provided by Jutta Lindert, Germany

The intention of the project was 1) to review and analyse existing data on mental health of older people at EU and member state level and to produce a report in liaison with EU and national information system organisations, 2) to make recommendations for a policy at EU and member state level based on current evidence and practice for promoting the health of older people, taking into account cultural differences and 3) to disseminate the findings by developing a comprehensive strategy.

To achieve the above aims, following objectives were put into practice: collection and reviewing data and current practices and policies for older people's health across EU member states, accession states and members of European economic area (horizontal approach) and from those data producing a report. The project was funded in 2003 with the start at 01/08/2004. The “strand” was three and the duration was 36 months. The methods were 1) to establish sustainable partnerships at EU and individual Member State level and engage with professionals, public and policy makers at EU and Member State level in this process, 2) to build sustainable healthy ageing working partnerships including policy makers, practitioners, older people, Non-governmental organisations (NGOs), and International organisations including WHO, 3) to raise awareness of an integrated approach of ageing and health, with the emphasis on health promotion in the later life stages (50plus years) to the population in general, older people, practitioners and policy makers, 4) to develop a strategic approach to communicating, implementing and disseminating the findings and recommendations of the report, taking into account local cultural, organisational circumstances.

#### Comments in the HA final report whether the project accomplished its main objectives

According to the final report the project accomplished its objectives.

#### Project collaborators/partners/expertise in HA

Eleven countries were involved in the project, as well as the World Health Organisation (WHO), the European Older People's Platform (AGE) and EuroHealth Net.

#### Dissemination of results from HA

According to the final report from Healthy Ageing the results were disseminated through brochures, peer-reviewed articles, poster/oral presentation at international conferences, national conferences/seminars/lectures, websites, mass media, co-operation with other researchers, and co-operation with other organisations.

## Key targets for dissemination

Results were disseminated to the following key targets: government, universities, other research organisations, and the general population.

## 2. HA - introduction to PHIRE, WP 4

### The process to identify the CIs for PHIRE, WP 4

The Section lead and her assistant used several methods for contacting HA informants. Three steps can be distinguished in approaching the potential country informants:

#### Step 1: Purposive sampling

In step one purposive sampling was applied and informants personally known to the leader of the EUPHA Public Mental Health section were contacted. The contact persons were leading individuals in the field of Public Mental Health.

#### Step 2: Purposive sampling and snow-balling

To increase the number of informants, snow-balling (i. e. the individuals initially contacted but not yet having answered were asked to name one or two alternative person/s with expertise in the Public Mental Health field) was additionally applied as sampling strategy to increase number of potential interviewees.

#### Step 3: Reminder and new purposive sampling

As the questionnaires were sent out before the European summer, reminders were sent out at the beginning of September and also in mid October.

## 3. Results regarding HA

### 1. Invited and responding CIs

In total, 40 CIs were invited to answer the web-based questionnaire representing 30 countries (Table 5, page 64). Questionnaire responses regarding HA were obtained from nine CIs representing the following nine countries: Belgium, Greece, Hungary, Italy, Latvia, Malta, the Netherlands, Portugal, and Spain. The nine countries correspond to 30% of the EEA countries.

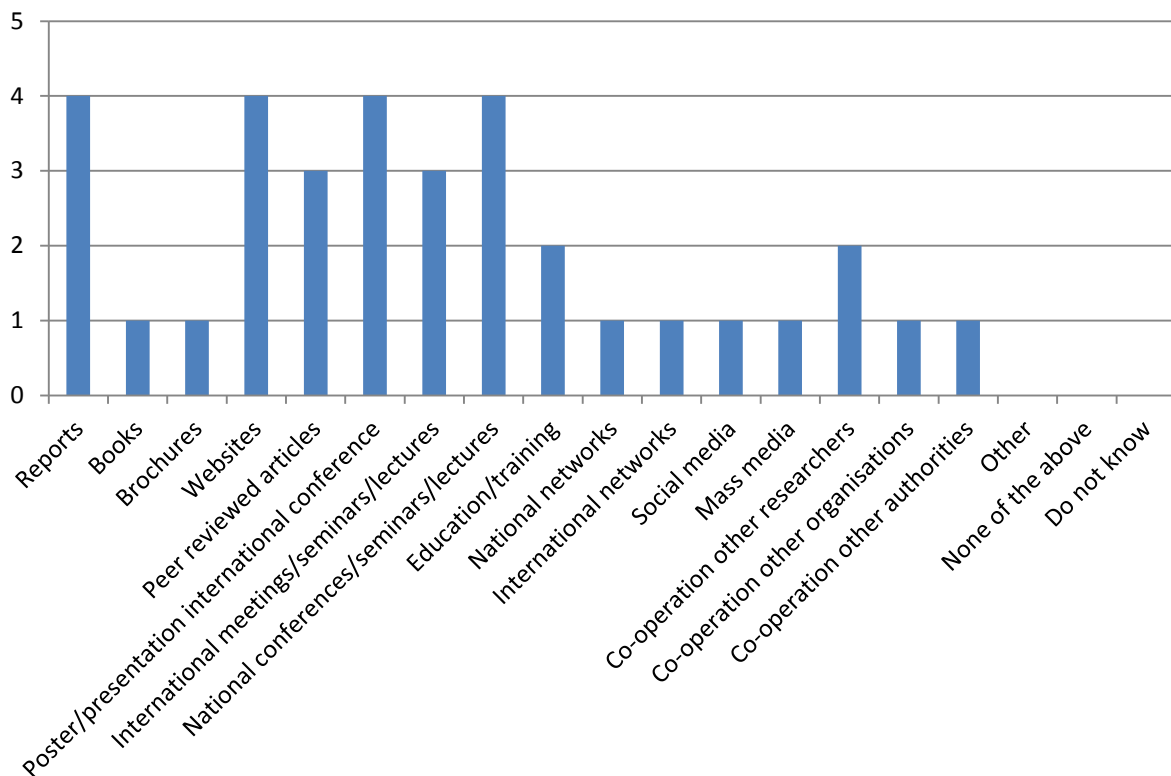
Thirteen of the 40 invited CIs (33%) were members of at least one EUPHA Section. Of the nine CIs who finally answered the web survey, four (44%) were such members of EUPHA Section.

None of the 9 CIs who participated in the HA web survey had been involved in the project as project leader/coordinator or as a project partner.

### 2. Dissemination of results from HA

Results from HA were disseminated in 16 different ways according to the web-survey results (Figure 28). Each CI indicated between zero and ten different ways for dissemination. Among the nine that answered the question, most of them indicated only one way for dissemination (n=3), but the average number was 3.7 different ways per CI for dissemination of the results. Mainly dissemination was through Reports, Websites,

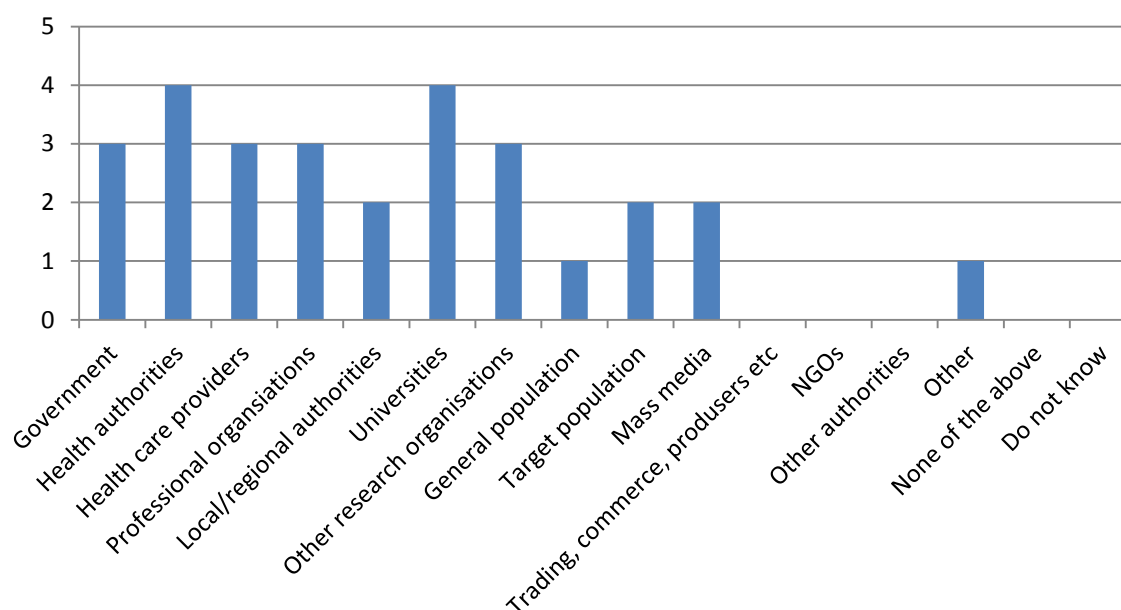
Poster/presentation at international conferences, and National conferences/seminars/lectures, four CIs indicated this. Thereafter, Peer reviewed articles and International meetings/seminars/lectures where each way of dissemination was indicated by three CIs. The CIs stated more ways for dissemination of results than was mentioned in the final report of HA. Books, Education/training, Networks and Social media are examples of additional ways for dissemination that the CIs mentioned.



**Figure 28.** Number of CIs indicating the channels used to disseminate the results from HA.

According to the CIs, 11 different types of groups/organisations were reached by information about the HA project. The CIs indicated one to nine groups each, with an average number of 3.1. Health authorities and Universities were most often indicated, with four CIs each indicating this (Figure 29).

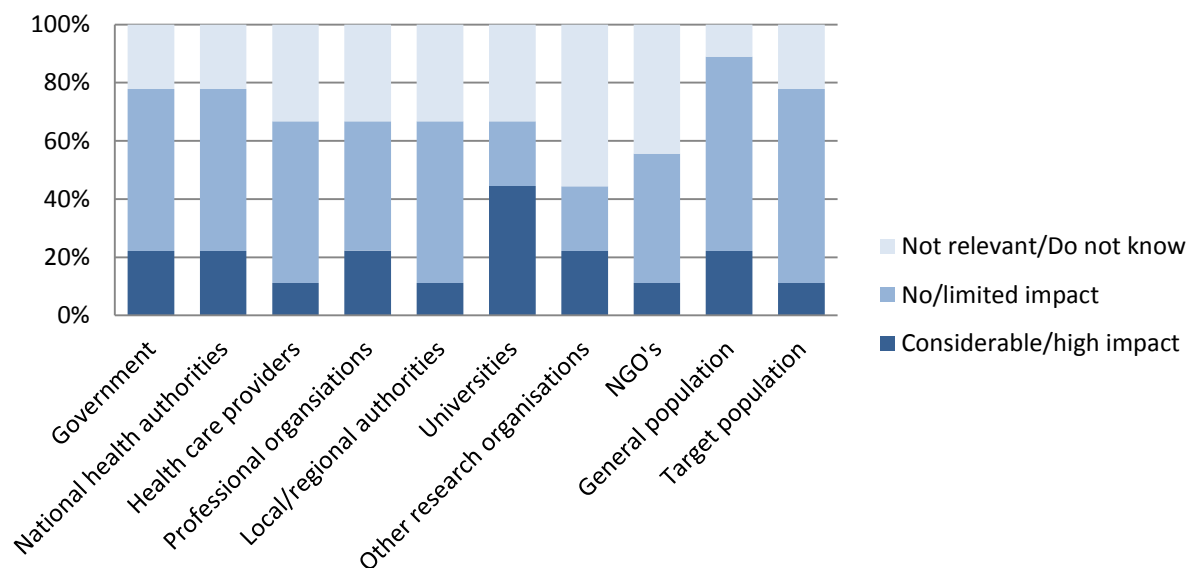




**Figure 29.** Number of CIs indicating groups/organisations that were reached by information about HA.

### 3. HA - Impact of HA on knowledge/awareness of stakeholders

Universities was the stakeholder that most CIs indicated (44%) that HA had had considerable or high impact on knowledge/awareness (Figure 30), followed by 22% of the CIs that stated considerable/high impact on Government, National health authorities, Professional organisations, Other research organisations, and General population. However, as many as 67% of the CIs indicated that there were limited or no impact at all on knowledge/awareness of the General population and the Target population. The Universities were reached by information about HA (Figure 29) and it was also the stakeholder where most CIs indicated considerable or high impact on knowledge/awareness (Figure 30). However, this was not found for Health authorities, an organisation that also was indicated by the CIs as reached by information about HA (Figure 29).



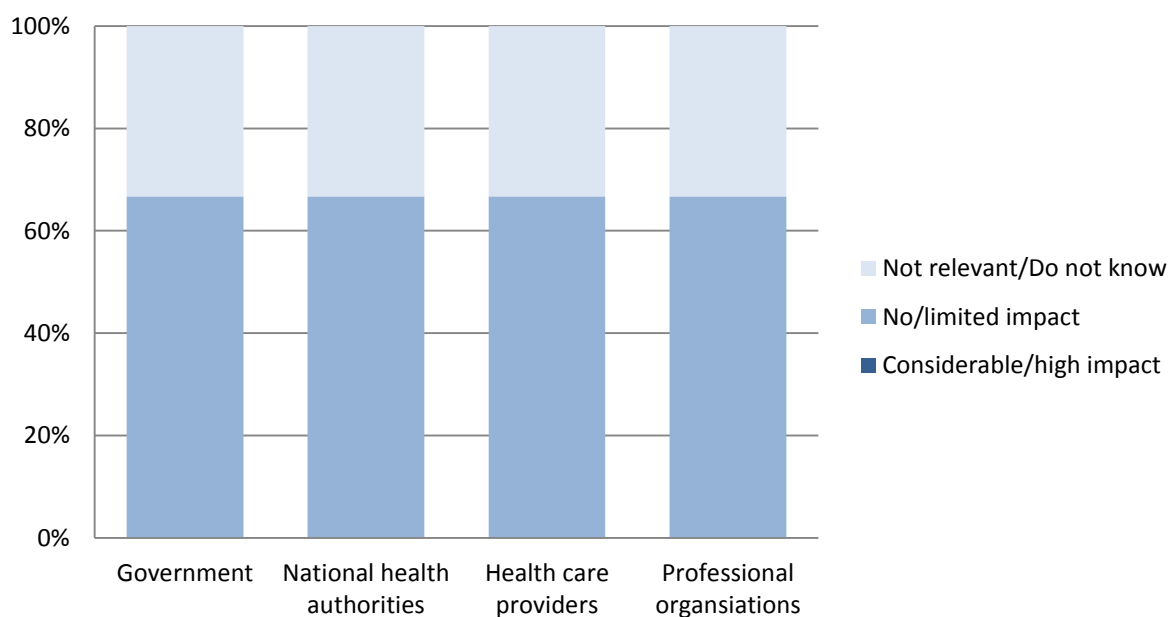
**Figure 30.** Proportion of CIs indicating level of impact of HA on knowledge/awareness among different stakeholders.

#### 4. Comments on the impact on knowledge/awareness of stakeholders

Following the questions about impact on stakeholders it was possible to add further examples or comments in an unlimited free text space. This opportunity to develop the information about impact on stakeholders was not used by any of the CIs.

#### 5. The impact of HA on policy, reforms, guidelines, and routines

None of the CIs stated considerable or high impact on policy, reforms, guidelines, and routines on the Government, National health authorities, Health care providers, and Professional organisations. Two thirds of the CIs stated no or limited impact on policy, reforms, guidelines, and routines while 1/3 stated that they did not know.



**Figure 31.** Proportion of CIs indicating level of impact of the innovative project on policy/reforms/guidelines/routines.

The unlimited free text space for the CI's answers or comments to the question about the likelihood that the impact on the different stakeholders could have occurred without the Healthy Ageing project was used to some extent by the CIs. Following comments were given to this question:

"No."

"The results could be interpreted as a synergy of projects with similar directions."

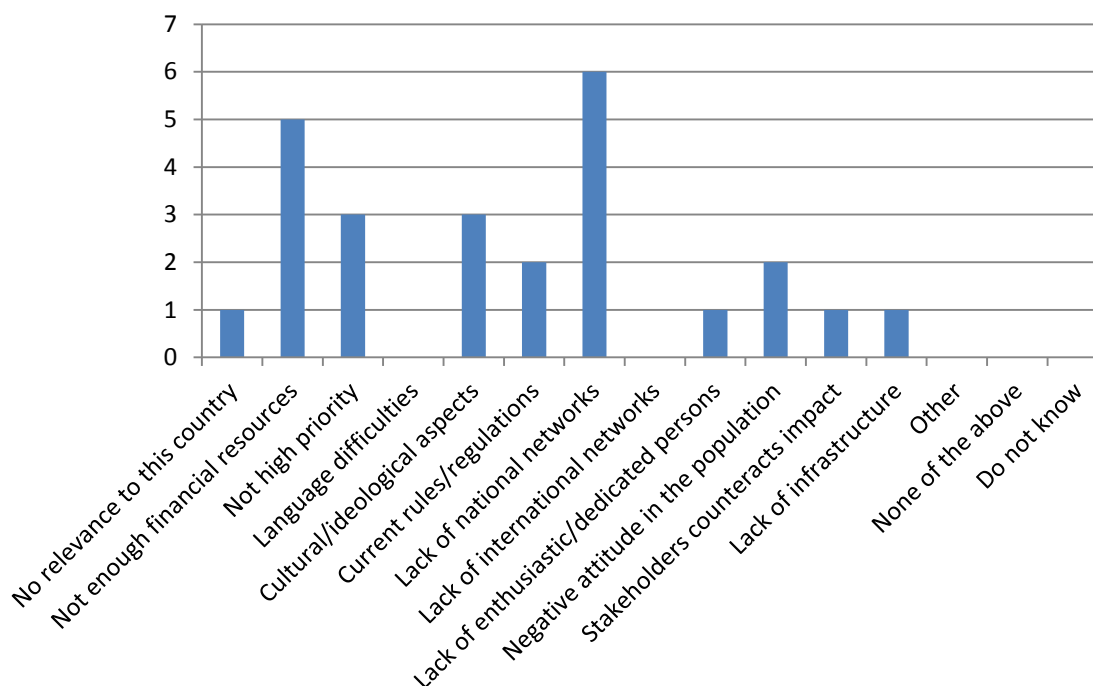
"Yes."

"The project surely increased the opportunity to review and analyse existing data on health and ageing, to make recommendations for policy at EU and member state levels, to disseminate the findings among stakeholders (e.g. Regions) and facilitate implementation-exchange of good practice. The project increased also the opportunity to have training material, networking, to have collaboration by people throughout the community, to draw the attention of government, national health authorities, health care providers, local/regional authorities, universities, (NGOs), population, on social capital and physical activity as most common major topics in the 'good practice' projects.

"Yes."

## 6. Main factors hindering impact of HA

Ten of the 13 suggested options of hindering factors were indicated by the nine CIs. Each of the CIs indicated between one and five of these factors and on average, the CIs indicated 2.8 hindering factors. Six (67%) of the nine CIs indicated that the main factor that hindered impact was Lack of national networks (Figure 32), followed by five CIs (56%) indicating that Not enough financial resources allocated as a hindering factor for impact from HA. Furthermore, three CIs each indicated Not high priority and Cultural/ideological aspects as hindering factors for impact from HA.



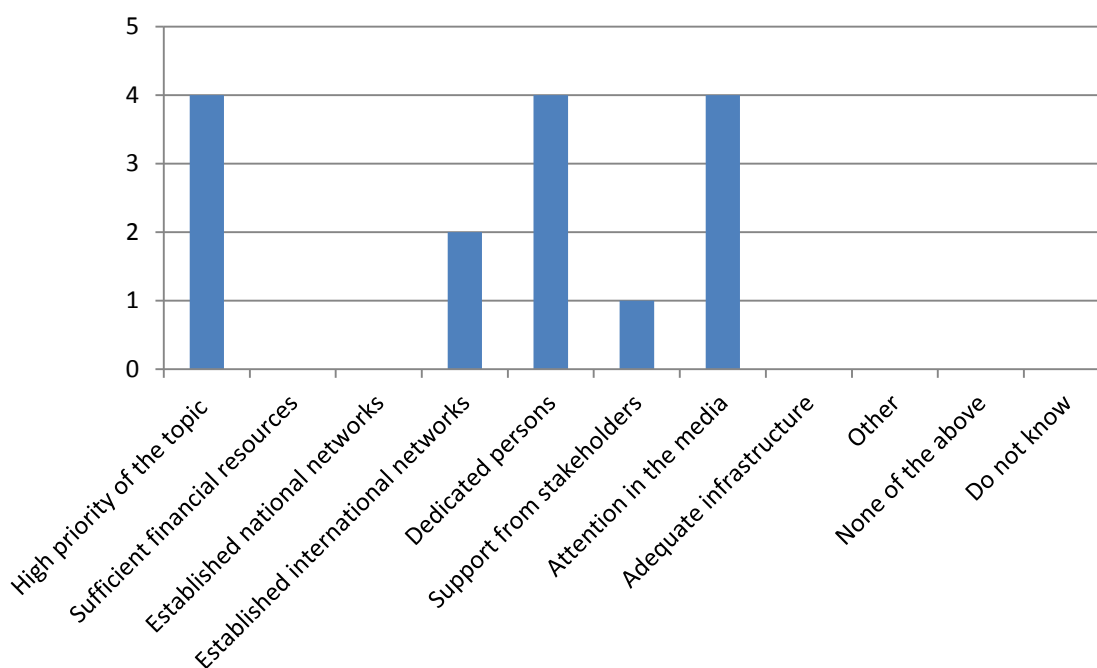
**Figure 32.** Number of CIs that indicated each type of factor that hindered impact of HA.

One of the CIs provided this comprehensive compilation regarding hindering factors for impact of HA:

"Lack of funding: long-term funding is important for sustainable healthy ageing work. Actually the need for funding of health promoting projects directed towards older people are further threatened by the financial crisis. Regions are key implementers but face fragmentation of work, many difference e.g. in organizing and delivering and home care (some Municipalities have own rules and there is a lack of common guidelines and instruments for assessing the needs of the elderly) Scarce integration-cooperation of health and social services is a major problem (it's actually a reality only in some northern regions of the country). A law in 2000 aimed at promoting an integrated system of services and sometimes there are agreements between Municipalities and Local Health Authorities for the integrated provision of social and health services (ADI) but many Regions haven't still set the rules for the organizational and financial integration. Gaps between public and private actions, lack of cooperation and coordination between actors in order to ensure successful work. Lack provision of information about healthy ageing, negative image of the elderly through media. Indeed politicians, practitioners, older people themselves often have the opinion that health promoting and preventive work are of no use: It's too late! There is a need for more positive attitudes towards ageing and older people. There is a much greater focus on targeting older people that are already in great need of health care; a large proportion of the projects place the focus on this group while a smaller proportion target more or less healthy older people. Gender differences and invisible groups should be more taken into account. As for elderly women, especially in some parts of our country, they live a double exclusion (as women and as elderly women) connected with old traditional customs. People belonging to ethnically minor communities, and also elderly immigrants were not involved in the projects. About this aspect we have to remark that immigrants' average age is quite low and the specific problem of elderly immigrants will be faced only in the future. Health inequalities: lack of universal and equal access to health advice, preventive services, quality health treatment and long-term care for physical and mental health. There are difficulties in accessing services as: bureaucratic/complicated procedures, lack of information on existence/access to service, long waiting lists. Barriers to innovation: lack of training for end-users, end-users' resistance to new ideas, end-users (patients, older people, health care professionals) are not involved closely enough in the development and use of new innovative solutions Evaluation of policies and projects is one of the most important parts in an implementation process. There is no mention of evaluations in a large number of articles concerning health promotion projects (over 45%)."

## 7. Main factors facilitating impact of HA

Five of the nine suggested options of factors facilitating impact of HA were indicated by the CIs (Figure 33). Each CI indicated zero to five of these factors and on average they indicated 1.7 factors. However, most common was to not indicate any such factors at all (33%). High priority of the topic, Dedicated persons, and Attention in the media were the three main factors that facilitated impact, with four CIs (44%) each indicating these options.



**Figure 33.** Number of CIs that indicated different types of factors that had facilitated the impact of HA.

The following comment regarding facilitating factors was provided:

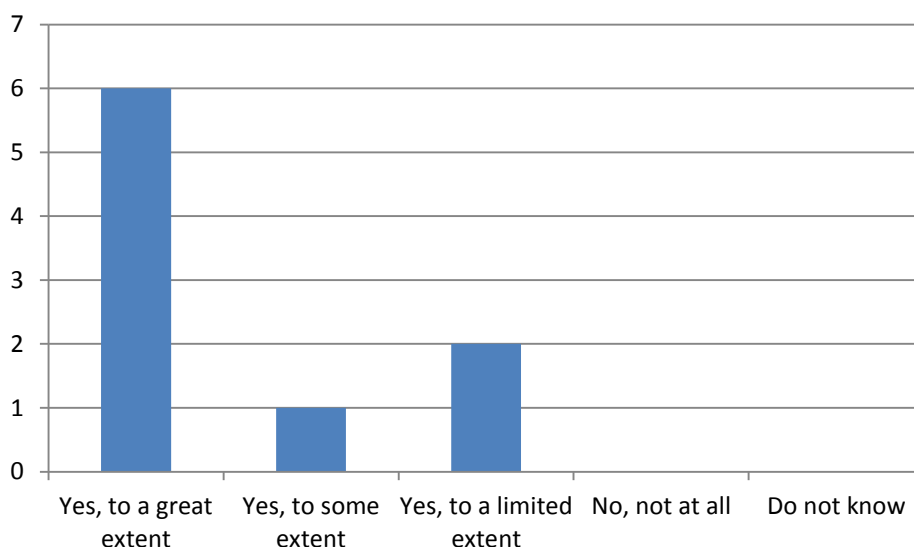
"Existing policies has strengthened in some way health promotion work directed towards older people and made it easier for practitioners and other professionals to keep in consideration the issue of healthy ageing Collaboration with NGOs and other organisations (dialogue between national, regional and local levels as well as with NGOs). The European dimension creates great opportunities by developing policies, strategies and work programmes (e.g. the EU legislation to combat age discrimination)."

### 8. Coverage of the topic of HA in mass media

Two of the nine CIs indicated that mass media had had considerable or high coverage of the topic of HA, while five of the CIs indicated that the coverage of the topic in mass media had been limited or not covered at all. None of the CIs used the free text space to express the role of mass media on Healthy Ageing.

### 9. Relevance of the topic of HA

A majority of the CIs (n=7) answered that the topic of Healthy Ageing had relevance to a great or some extent in their country (Figure 34).



**Figure 34.** Number of CIs indicating the level of relevance of the topic of HA.

The relevance of the topic of HA was commented by six (67%) of the CIs:

"We are an extremely rapidly ageing society. We have been involved in raising the importance of Ageing at the UN back in the 1960s."

"It is not considered as a high priority issue."

"The age structure of the population in our country is tending to be an unfavourable one with a rapidly growing proportion of age group 60 and above. The financing of the National Health Insurance System is facing serious difficulties; the life expectancy at birth is about 5-7 years below the EU average."

"Our country has a high proportion of ageing population. In some regions the proportion of people older than 65 years is 25%, in some provinces 30%, and many rural areas most of habitants are older people. There is a public debate on how the demographic change will influence the health and social service systems, on how to delineate a sustainable system. There is a public concern on neurodegenerative diseases such as dementia and their impact on the family and society."

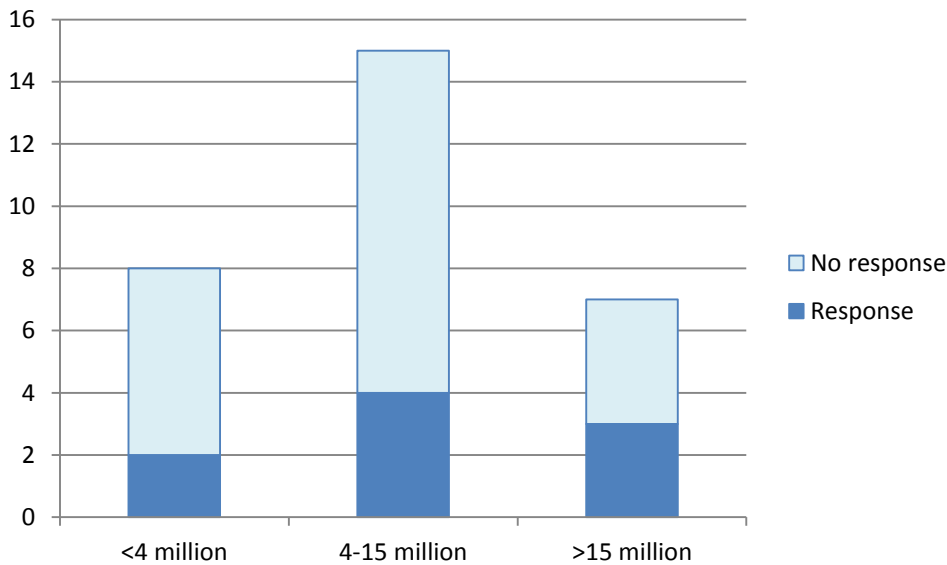
"Our constitution requires the Government to treat health "as a fundamental right of the individual citizen and the community". Our country has a public medical service, NHS - National Health Service which had as its cardinal points solidarity, universal coverage of medical assistance and the public nature of the health service. The NHS has a national level (Ministry of Health, responsible for the National Health Plan), a regional government, and a local level through self-governing Local Health Authorities. Due to the model of "health for all", all citizens are entitled to receive hospital care and general practitioner (primary care) free of charge. Further health services are free of charge for some particular categories. In addition, regulations regarding prevention and health promotion for the elderly have been included in by laws passed by the Ministry of Health. Anyway, traditionally, the care of the elderly in our country is a task accomplished by the family, and within this, mainly by its female members (wives, daughters). Also many migrants are employed for the help and care of older people. Among the most important behavioural risk factors are cigarette smoking, excessive consumption of alcohol, and an unhealthy diet, although these statements have not been adequately investigated in the literature. Among the biological risk factors, obesity and hypercholesterolemia are well known, but large scale data relative to the elderly are unfortunately scarce. In our country, social participation of older people plays an important role in the policies adopted at a regional level for the promotion of rehabilitation, recreation and socialisation, particularly for people who are not self-sufficient physically or suffering from disease. There are also programmes to prevent falls in old age, and for reducing architectural barriers and adapting the environment to meet the needs of older people with decreased mobility as a means of falls

prevention. On the whole, health promoting activities are delivered by physicians, community nurses and social workers, sometimes individually and other times collectively in a multi-disciplinary approach. The issue of inequalities due to physical and geographical factors is also investigated in our country. Some health promotion projects for older people at regional or local level have lead to a partial re-orientation of health and social services, giving increased attention to the needs of the elderly. These projects are seen to have a great positive balance in terms of cost-effectiveness in the sense that the health of the elderly population is actively supported and promoted. With regard to ICT and adoption of tele-care technologies in the community, as personalised systems for monitoring patients in their home, we had some sporadic examples. According to national statistics telecare is mainly used for the elderly and the disabled people. The National Health Plan gives citizens the opportunity to live as healthily as possible. To tackle the problem of an ageing population, the Ministry of Health has developed an inter-sectorial collaboration policy. This includes promotion of healthy lifestyles and environments, prevention and decrease of the burden of most frequent chronic diseases (cardiovascular diseases, tumours, mental and locomotor diseases). Different forms of support for active ageing have to be made available to the public. The National Health Service plan, and consequently the plans for the regions, is increasingly directed towards the grass roots, and to ensure that the services become more human and personal. This requires the encouragement of socio-health services which are tailored and delivered, where possible, in a domestic family environment. The National Health Research Institute) is the leading technical and scientific public body of the National Health Service. Its activities include research (from cutting-edge molecular and genetic research to population-based studies of risk factors for disease and disability), control (e.g. inspection and quality control of medical and diagnostic devices and equipment, food products and packaging), documentation (e.g. (national epidemiological bulletin), training and consultation in the interest of public health protection. The Institute also plans, implements and evaluates international health projects. Also an association is to be mentioned, whose aim is to develop social promotion and solidarity activities, especially for the elderly and between generations; to improve quality of life and relationships with other people; to maintain and develop active cognitive skills; to create, in collaboration with public institutions, structures for social networks and family support services.“

““HA - Healthy ageing" topic is relevant in our country because the proportion of old people is growing each year and this problem requires additional attention in the future."

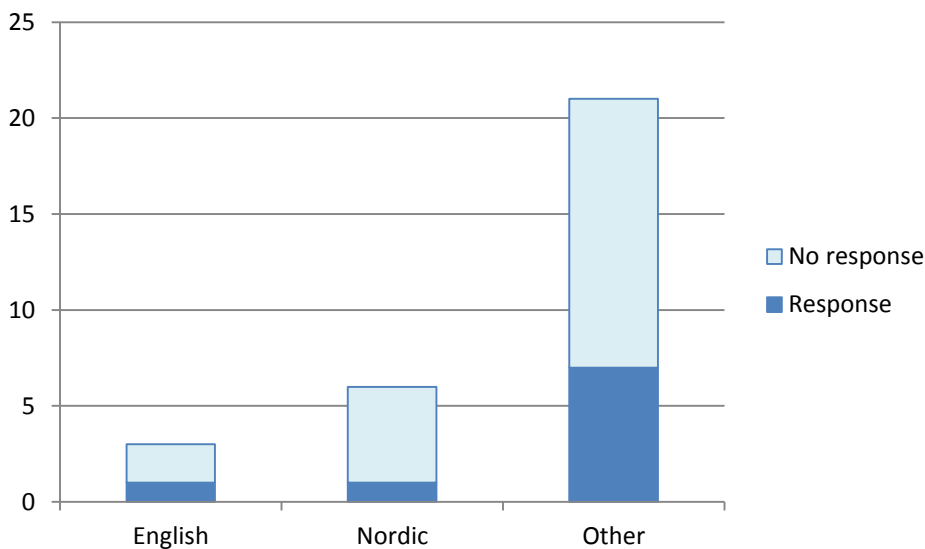
## 10. Responses by categories of country

When categorizing the countries according to number of inhabitants and general knowledge of English, as described on page 10, the response rates were as follows. According to the number of inhabitants, a majority of the CIs that responded to the HA web survey represented a country in the group with 4-15 million inhabitants. One fourth of the CIs in countries with up to 15 million inhabitants and almost half of the CIs in countries with more than 15 million inhabitants responded (Figure 35).



**Figure 35. Number of participating countries with regard to number of inhabitants in the countries (representing 25%, 27%, and 43 %, respectively, of the counties in each group)**

Based on the categorization regarding the knowledge of English language within the general population, Other countries were in majority. One third of the countries in this and the English speaking group and less than one third in the Nordic group responded (Figure 36).



**Figure 36. Number of participating countries with regard to three language areas (representing 33%, 17%, and 33%, respectively, of the countries in each area)**



**Table 5. Healthy Ageing (HA) - Summary of number of countries and CIs involved, regarding different aspects**

EEA-countries	Project collaborators/ partners/ expertise in these countries	HA results were disseminated in these countries	Invited CIs	Invited CIs in the EUPHA database	Responding CIs	Invited Countries	Responding countries	Responding CIs involved in HA
Austria	1	1	1			1		
Austria			1	1				
Belgium	1	1	1	1	1	1	1	
Belgium			1					
Bulgaria			1			1		
Cyprus			1			1		
Czech Rep.	1	1	1			1		
Denmark			1	1		1		
Estonia			1			1		
Finland	1	1	1			1		
France			1	1		1		
France			1	1				
Germany			1	1		1		
Greece			1		1	1	1	
Hungary			1	1	1	1	1	
Hungary			1					
Ireland			1			1		
Italy	1	1	1		1	1	1	
Italy			1					
Latvia			1			1		
Latvia			1		1		1	
Lithuania			1	1		1		
Luxembourg			1			1		
Malta			1	1	1	1	1	
Malta			1					
Netherlands	1	1	1		1	1	1	
Poland			1			1		
Portugal	1	1	1		1	1	1	
Romania			1	1		1		
Slovakia			1			1		
Slovenia			1			1		
Spain			1	1	1	1	1	
Sweden	1	1	1	1		1		
Sweden			1					
Sweden			1					
UK	1		1			1		
Iceland			1			1		
Norway	1	1	1			1		
Switzerland	1	1	1	1		1		
Switzerland			1					
<b>Sum</b>	<b>11</b>	<b>11</b>	<b>40</b>	<b>13</b>	<b>9</b>	<b>30</b>	<b>9</b>	<b>0</b>

## **EAAD - European Alliance Against Depression**

### **1. Presentation of EAAD**

#### **General objectives of EAAD**

The aim of the EAAD project was to improve the situation of individuals suffering from depression and individuals being at risk to die by suicide.

#### **Summary of EAAD, provided by Jutta Lindert, Germany**

The EAAD-project was conducted from 2004 to 2008 including four levels: Intervention with primary care physicians, initiation of a public media campaign, intervention with community facilitators, and intervention with affected persons and their relatives. The adaptation of this approach in various countries throughout Europe began in 2004 with the formation of the EAAD. Since then, community based multilevel interventions have been initiated and a catalogue of "best practice" materials has been adopted with input from all partner countries (EAAD comprised 20 international partners representing 18 different European countries). Evaluation criteria have also been established. Due to increasingly high rates of suicide attempts among adolescents in some countries of the European region, additional emphasis has been placed on the topic of depression among young people, and special materials are being created to address this particular population. In October 2008, the non-profit organisation EAAD was founded (homepage: [www.EAAD.net](http://www.EAAD.net)). "The Nuremberg Alliance against Depression" (NAAD) was targeted at improving mental health, especially at reducing prevalence of depression and number of suicidal acts, i.e. suicide attempts plus completed suicides. The project provides a concept as well as many methods that are currently being implemented in several other intervention regions in Germany and in other countries.

#### **Comments in the EAAD final report whether the project accomplished its main objectives**

According to the final report, the project was successful.

#### **Project collaborators/partners/expertise in EAAD**

Fifteen EU countries, Switzerland, the WHO task force and the European Commission.

#### **Dissemination of results from EAAD**

According to the final report from EAAD the results were disseminated through: reports, brochures, peer-reviewed articles, poster/oral presentation at international conferences, national conferences/seminars/lectures, education/training, international networks, websites, mass media, co-operation with other researchers, and co-operation with other organisations.

#### **Key targets for dissemination**

Results were disseminated to the following key targets: government, health authorities, health care providers, professional organisations, local/regional authorities, universities, other research organisations, non-governmental organisations, the general population, and the target population addressed in the project.

## 2. EAAD - introduction to PHIRE, WP 4

### The process to identify the country informants for PHIRE, WP 4

The Section lead and her assistant used several methods for contacting EAAD informants. Three steps can be distinguished in approaching the potential country informants:

#### Step 1: Purposive sampling

In step one, purposive sampling was applied and informants personally known to the president of the EUPHA Public Mental Health section were contacted. The contact persons were leading persons in the field of Public Mental Health.

#### Step 2: Purposive sampling and snow-balling

To increase the number of informants, snow-balling (i.e., the individuals initially contacted but not yet having answered were asked to name one or two alternative person/s with expertise in the Public Mental Health field) was additionally applied as sampling strategy to increase number of potential interviewees.

#### Step 3: Reminder and new purposive sampling

As the questionnaires were sent out before the European summer holidays, reminders were sent out at the beginning of September and also in mid-October.

## 3. Results regarding EAAD

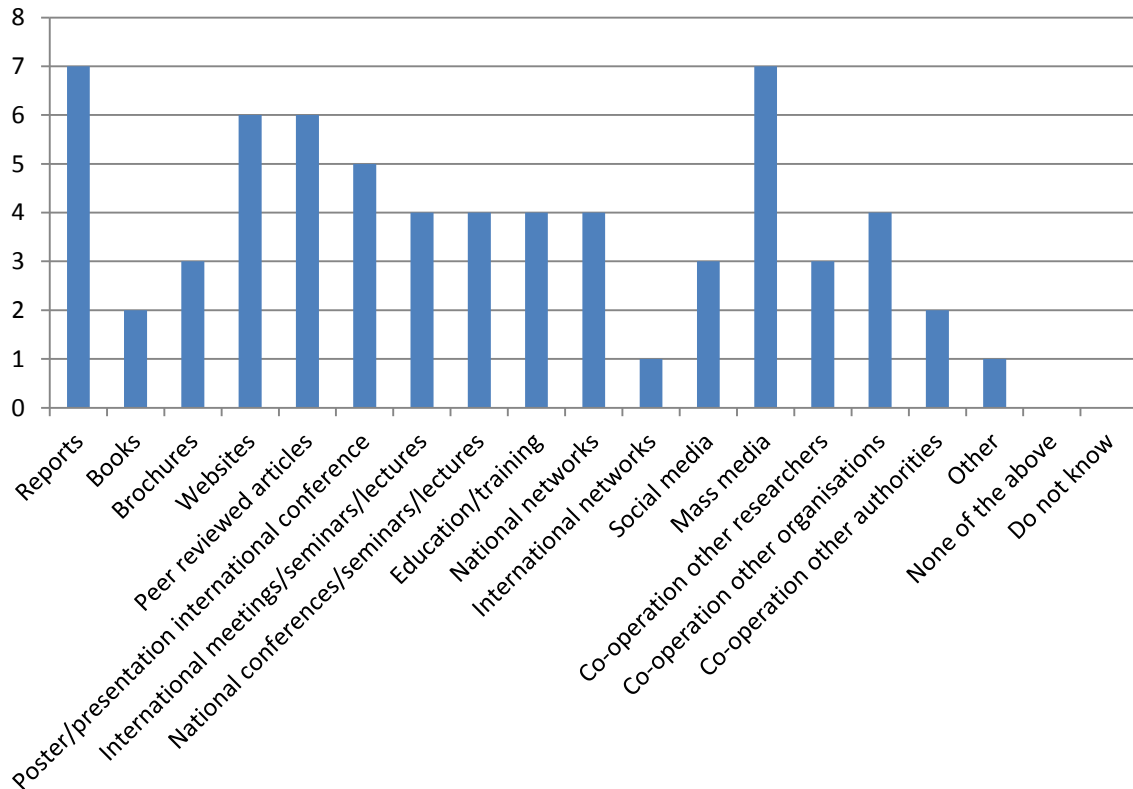
### 1. Invited and responding CIs

In total, 47 CIs were invited to answer the web based questionnaire representing 30 countries (Table 6, page 76). Questionnaire responses were obtained from 13 CIs representing the following 13 countries: Czech Republic, Denmark, Germany, Hungary, Italy, Latvia, the Netherlands, Portugal, Romania, Slovenia, Spain, Sweden and Iceland, corresponding to 47% of the EEA countries.

Fifteen of the 47 invited CIs (32%) were individual members of EUPHA Sections. Of the CIs who finally answered the web survey five (38%) were in the EUPHA database. Three (23%) of the 13 CIs who participated in the EAAD web survey had been involved in the project as project leader/coordinator or as a project partner.

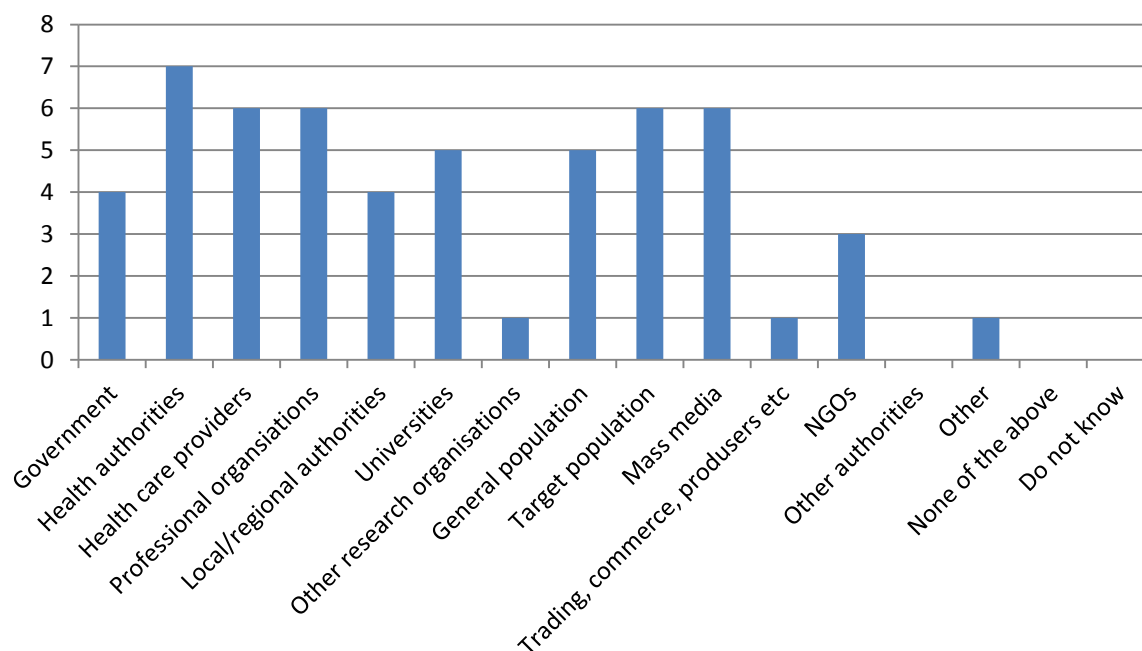
### 3. Dissemination of results from EAAD

Results from EAAD were disseminated by many different ways according to the web-survey results (Figure 37). Each CI indicated between zero and eleven different ways for dissemination. Among the 13 that answered the question, the most common was to not indicate any of the suggestions for dissemination (n=4), while the average number of ways for dissemination of the results was 4.2 per CI. According to the CIs, dissemination was mainly done through Reports and Mass media, 7 CIs indicated this. Thereafter, Web sites and Peer reviewed articles were indicated as ways of dissemination by six CIs. Some of the CIs reported that results were disseminated by Books, National networks and Social media, which were not mentioned in the final report from EAAD (page 65).



**Figure 37.** Number of CIs indicating the channels that were used to disseminate the results from EAAD.

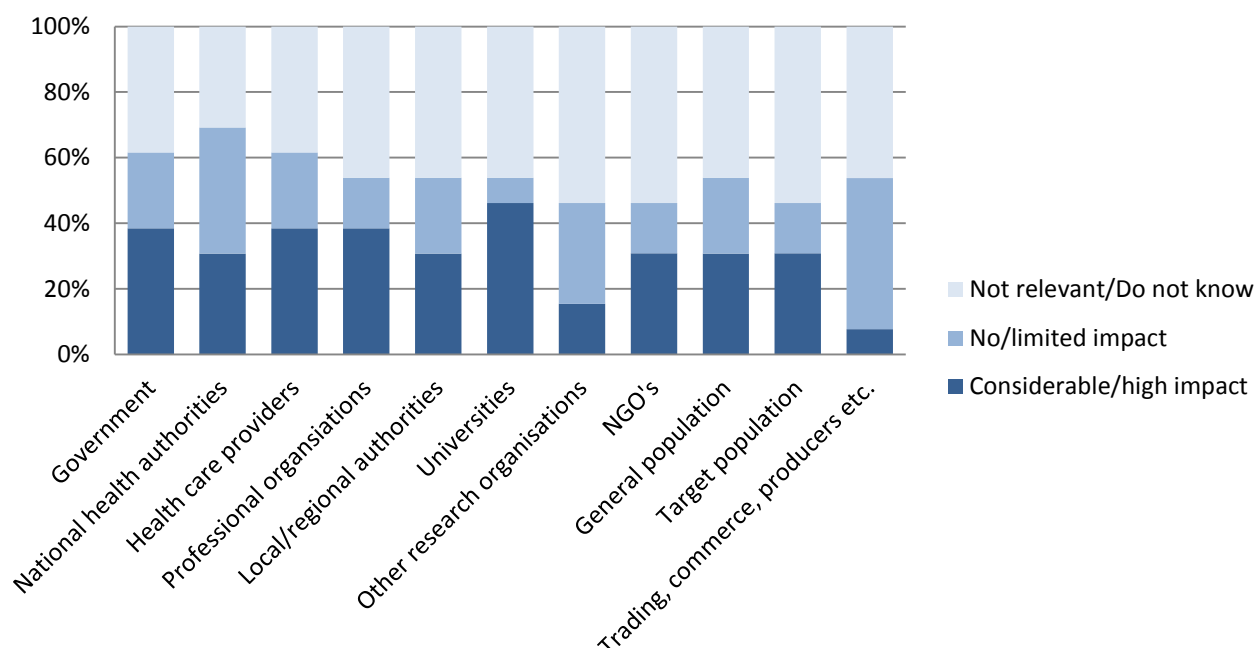
According to the CIs, 13 different types of groups/organisations were reached by information about the project. Each CI indicated between zero and ten groups, with an average number of 4.1 indicated groups/organisations per CI. Health authorities was most often indicated as reached by information (n=7; 54%), followed by Health care providers, Professional organisations, Target population and Mass media, with six CIs each indicating these (Figure 38).



**Figure 38.** Number of CIs indicating groups/organisations that were reached by information about EAAD.

### 3. EAAD - Impact on knowledge/awareness of stakeholders

Universities were the type of stakeholder that most CIs (46%) indicated that EAAD had had considerable or high impact on their knowledge/awareness (Figure 39). For the stakeholders Government, Health care providers, and Professional organisations, 39% of the CIs expressed considerable or high impact on knowledge/awareness. As many as 31-54% of the CIs reported that they did not know about the impact of EAAD regarding knowledge/awareness of the different stakeholders. Also, two CIs reported that this was not relevant.



**Figure 39.** Proportion of CIs indicating level of impact on knowledge/awareness among different stakeholders.

#### 4. Comments on the impact on knowledge/awareness of stakeholders

Following the questions about impact on stakeholders, the CI could add further examples or comments in an unlimited free text space. There were large variation between CIs regarding to what extent they used this opportunity. Six of the CIs had comments for all stakeholders, as presented below.

**Government:** "Mass media, especially TV."

**National health authorities:** "Organization of public pole regarding mental health, depression and suicidal activity."

"Funding in beginning mostly from business, with some funds made available by Government and some local authorities. Funding became increasingly difficult and mostly dried up in 2008. The Directorate of Health (highest health authority) sponsored the EAAD from the start, with support from the Ministry of Health."

"Project initiated: The National Public Health Agency started an awareness campaign with short TV clips at the end of 2007."

**Health care providers: -**

**Professional organisations: -**

**Local/regional authorities:** "Regional meetings and training sessions with professionals and key holders, public meetings."

**Universities:** "Again knowledge/awareness of the problem and increased research funding have been happening in my university, but I am unable to estimate the role of the project."

**Other research organisations: -**

**NGOs:** "Centre for the development of mental health care."

"Red Cross, Lion's, Church."

**General population:** "de-stigmatization of the word depression, more frequent contacts of sufferers with experts."

"Impact through vigorous dissemination of information about depression and suicide with pamphlets, through mass media, posters disseminated widely, hot-line which is widely used etc."

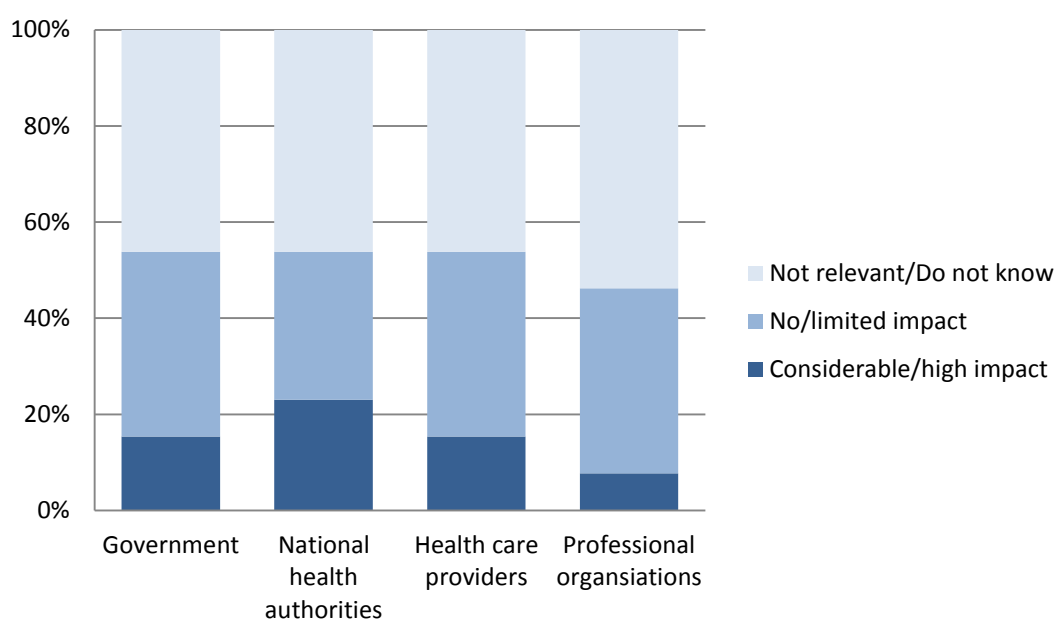
"The coverage of the problem has increased in the media and as a result I think it is reasonable to estimate that there has been an impact on the general population. I do not know what role the project had on this."

"TV clips were translated rarely."

**Target population:** "The use of medication for depression has reached the 310% in the period 2000-2008. Change in public opinion about the depressive pathology."

### 5. Impact on policy, reforms, guidelines, and routines

The impact of EAAD on policy, reforms, guidelines, and routines on the Government, National health authorities, Health care providers and Professional organisations was low according to the CIs. Regarding National health authorities, three CIs (23%) indicated considerable or high impact on policy/guidelines (Figure 40). However, the majority of the CIs, 46-54%, indicated that they did not know about the impact. None of the CIs stated that the question was not relevant.



**Figure 40.** Proportion of CIs indicating level of impact from EAAD on policy/reforms/guidelines/routines.

The unlimited free text space for the CIs answers or comments to the question about the likelihood that the impact on the different stakeholders could have occurred without the EAAD project was used to some extent. Such comments follow below:

"No."

"Difficult to say as the population as well as health care professionals and other professionals we worked with is a heavy internet user where all this information is available instantly."

"I think the project is not known in my country - I asked a psychiatrist very well informed and did not know anything about the project. It is possible that some of the promoters of different projects to know something about it but if it was the case, they never mentioned anything about EAAD. "

"I do not know."

"The project had a great extent in the impacts."

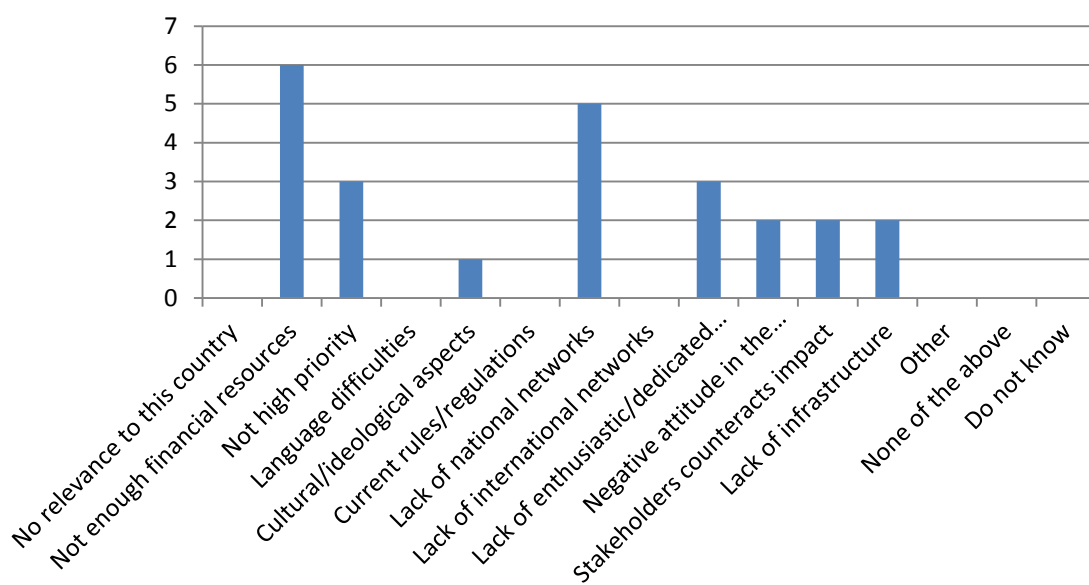
"The EAAD project has created a lot of occasions to have the above mentioned impacts. The strategy of the project, due to a low budget (200,000 Euros over 2 years, and without funding from pharmaceutical companies) has created working groups and activities on voluntary bases, constantly open to new participants and collaborators. Groups, associations and institutions were invited to take part of the project. An important cooperation with school, church, social services, municipalities and trade unions led to the realization of the prevention project in one region. In this region the

implementation of the campaign was entrusted to the Health and Social Policy Department, in collaboration with various groups, institutions and associations."

"Perhaps only knowledge could be obtained from other sources, but TV clips about depression and suicide topic were something new in my country."

## 6. What main factors hindered impact in your country?

The CIs indicated between zero and five of the 13 suggested options of factors that might have hindered impact of EAAD. Most CIs indicated only one hindering factor, this was the case for five (38%) of the CIs (Figure 41). On average, the CIs indicated 1.5 hindering factors. Six (46%) of the 13 CIs indicated that the main factor that hindered impact was Not enough financial resources allocated. Furthermore, five (38%) of CIs indicated that Lack of national networks was a hindering factor for impact of EAAD. One CI reported Cultural/ideological aspects as a hindering factor.



**Figure 41.** Number of CIs that had indicated hindering factors on impact of EAAD.

Four of the CIs included comments regarding hindering factors for impact of EAAD in their country:

"Mental health care in our country is not a priority."

"Our message got easily across but did not always result in positive response from persons in power, i.e. often lip service responses as opposed to dedication and support."

"The EAAD team in our country had about thirty professionals throughout one Province of the country. However, all this prepared and organized effort, plus the political will and economic support from Regional Administration in favour of the project, has clashed with the existing staff limits. Indeed, unlike the most European EAAD partners, institutionally represented by institutions or university specialized in the field of suicide, all or almost all our participants were at the same time employees of local health units, with the problem of managing the performance of their work daily and the tasks due to the EAAD project in which they were engaged. This means that their efforts to the EAAD, was to the need to ensure their individual routine performance in the workplaces. One region – as a medical doctor explained – “has joined the European Alliance Against Depression, whose prevention programs in another country have led to a decrease of 10% of suicidal acts. I tried to propose to our Region the same thing, but actually it takes time. I think there is a problem of budget: talking more about depression can lead to a greater use of specialist doctors and medicines among



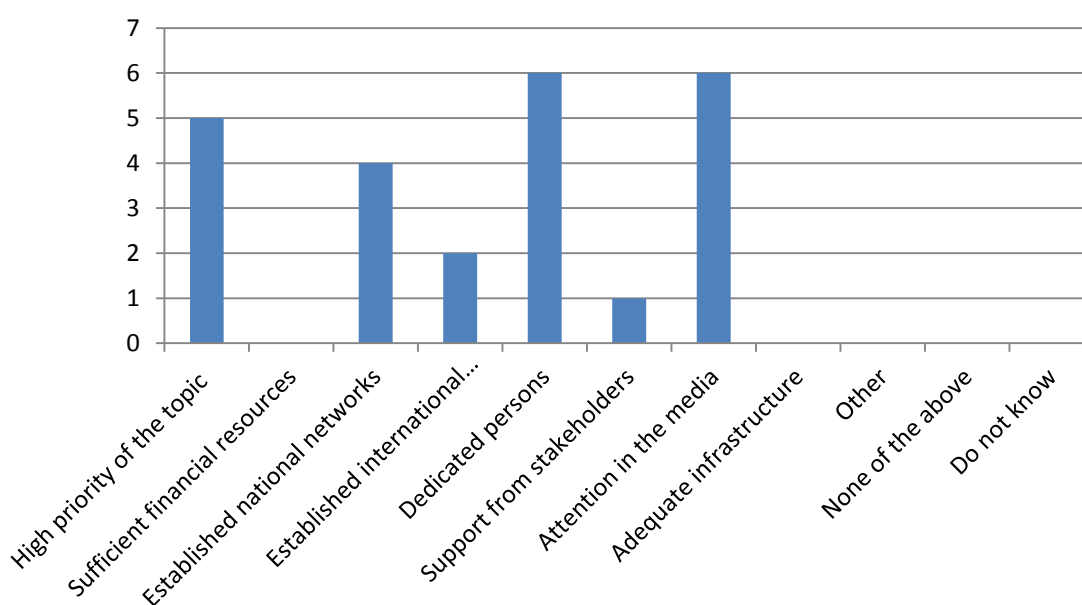
population, and this context could result in a growth of the public expenditure. But my heart bleeds when I see someone feel bad and I know that maybe he must ask for the private sector because the public one cannot provide adequate support. Moreover, the health costs of the prevention campaigns, in the short term, weigh on the expenses of the health care units."

"During economic crisis in (starting in 2008) financial resources were limited and a number of national public health institutions were merged and reorganized (including Public Health Agency)."

### 7. What main factors facilitated impact of EAAD in your country?

The CIs indicated between zero and five of the nine suggested facilitating factors for impact on stakeholders, and on average the CIs indicated 1.8 facilitating factors. Dedicated persons and Attention in media were the main factors that six (46%) of the 13 CIs each mentioned as facilitating impact of EAAD in the country that the informant represented (Figure 38).

Additionally, five (38%) CIs mentioned High priority of the topic and four (31%) mentioned Established national networks as important factors facilitating impact (Figure 42).



**Figure 42.** Number of CIs that indicated each factors as having facilitated the impact of EAAD.

Additionally, one CI commented facilitating factors in free text:

"Depression and suicides were important public health problems in our country."

### 8. Coverage of the topic of EAAD in mass media

Five (38%) of the thirteen CIs indicated that mass media had had considerable or high coverage of the topic of EAAD, while three (23%) of the CIs stated that the coverage of the topic in mass media had been limited or not covered at all. The remaining five CIs reported that they did not know about the coverage of the topic in mass media. In the free text space the CIs expressed it as followed:

"It was initiated a mass media project."

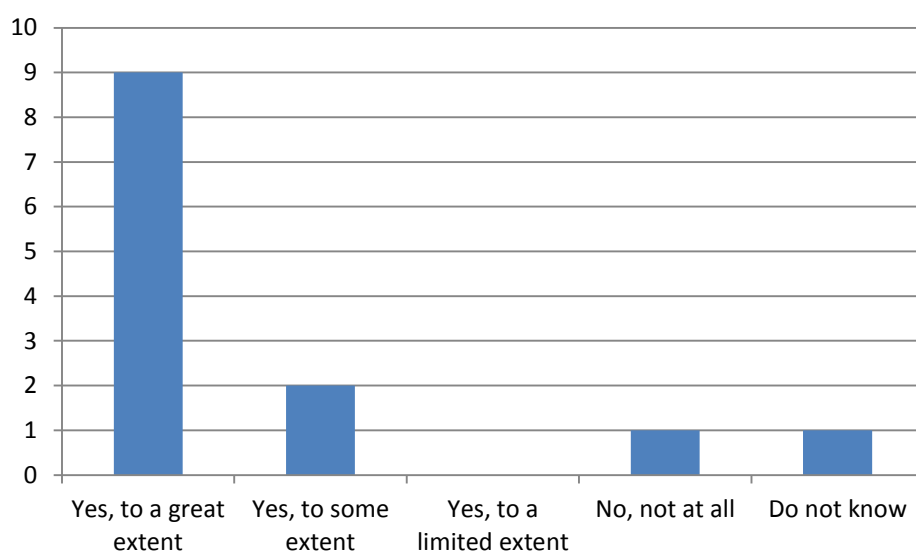
"More interest in serious articles about mental health care, depression and suicides."

"Easy access to journalists and mass media. Mass media have dealt with suicides in a very professional and ethical manner, so there was not much need for change."

"The coverage of the problem has increased in the media. I do not know what role the project had on this."

## 9. Relevance of the topic of EAAD

A majority of the CIs (n=9) answered that the topic of EAAD had relevance to a great extent in their country (Figure 43).



**Figure 43.** Number of CIs indicating the level of relevance of the topic of EAAD in their country.

The relevance of the topic was commented by nine (69%) of the CIs:

"The topic of depression and suicide are very relevant for our country. Conducting workshops with GP's resulted in better depression recognition and treatment, campaigns for broader public led a change in attitudes towards depression."

"We started co-operating on suicide prevention programs with the Dpt. of Psychiatry in 2002. As a consequence, we were among the founders of the EAAD, and were one of the first centres outside xxxxx to launch the prevention program."

"The depression prevalence rates are higher among elderly. The access of to psychiatric care is limited in our country. The functional impairment is important. The variation by age of mood disorders of Lifetime prevalence, is as follows: for the major depressive episode, we can see a minor increase at age 35-49 (2%) compared to 18-34 (1.8%), becoming double for those of 50-64 years old group (3.9%) and increasing further (to 5%) for those of 65 years old. 12 months MDE prevalence increased continuously from the youngest age till the age group of 50-64 years old, decreasing slightly for those of 65 years old and over. (1.3% for 18-34 age group, 1.5% for 35-49 age group, 2.4% for 50-64 age group and 2.2% for the last age group). Life-time prevalence was 3.3%, 4.1% for females and 2.5% for males Work Role Impairment of 12-Month MDE in the worst month of the past year was moderate for all (4.8), mild (mean score 2.7) in age group 18-34 but moderate (mean score 4-6) for all other age groups. For 35-49 age group mean score was 6, at upper limit of the interval, for the group 50-64 was 5.3 and mean score was 5.4 for 65+. The females were more impaired (mean score of 5.1 for females compared to 4.3 for males). The females appeared slightly more impaired by depression in work functioning role at age 18-34 (mean score 3.1 for females versus 2.2 for males) even both genders were in mild impairment category. The gender difference was obvious at age 50-64 where mean score was 6.8 for females (moderate impairment at upper limit of the interval) vs. 3.7 mean score (mild upper limit) for males. At age 35-49, depression impaired mostly the males in work functioning (mean score was severe 7.1, for males but 5.5 moderate for females). Over 65 years old, the MDE males appeared more impaired compared to women (mean score is higher, 5.4 for males compared to 4.6 for females but both are in moderate category) Interference with the social functioning was 4.7 for all ages, following pretty close the work functioning: "mild" impairment for the age group 18-34 (mean

score 2.7), "severe" (6.6) for the group 35-49 and "moderate" for the age groups 50-64 (mean score 4.7) and 65+ (mean score 5). Depressive females appeared more impaired in social functioning (Sheehan social score of 5.5 moderate impairment for females compared to 3.4 mild impairment for males). This disadvantage of females compared to males is kept for almost all group ages: at age group 18-34 the females and males are in the same mild category of social impairment but the score for females is twice higher than for males (3.2 for females compared to 1.6 for males). At age group 50-64 the females are moderately impaired (mean score 6.5) compared to the males mildly socially impaired (2.7). Almost the same situation can be noticed for the depressive subject of 65+ (mean score 5.8 for females compared to 2.8 for males). Only for the age group 35-49, the males appeared more impaired than the females (mean score 8.1 severe impairment for males compared to 6.1 social score for females of moderate impairment). The global functioning Sheehan score: moderate global impairment (6.3 Sheehan score, at upper limit of the interval) with no gender difference. At 18-34 age group, almost equally impairment (Sheehan score 5.1 for males vs 4.7 for females). At age group 35-49, the male more impaired Sheehan score being severe (8.8) for males compared with moderate at upper limit (6.7) for females. But at oldest age groups, the global functioning is slightly more impaired for women. At group age 65+, the global Sheehan score is 6.5 for females, 5.4 for males with moderate impairment. At age group 50-64, the impairment is severe for females (Sheehan score 7.5) and moderate at upper limit for males (Sheehan score 6.2) From the 46 cases of major depressive episode, more than one fourth (27.3%) received any treatment, mainly as health care (26.5%) (diagram 5). Within the health care, 17.2% of those with major depressive episode in treatment used general medical services and 13.8% mental health care."

"In our country, as far as I know there is a very high prevalence rate of depression."

"Depression is topic on which every day is something else written and/or proposed new. It means that there is somehow a certain saturation. Beside that new, really new things are not commonly appear."

"Depression is one of the major public health problems and responsible for a large amount of morbidity and disability."

"In our country there was not (and there is still not) a full awareness of the depression as a problem that can addressed with the collaboration among doctors, chemists and psychologists, nurses, assistants in old people's homes, teachers, religious, police, initiatives of self-mutual-help, counsellor for relatives and patients, information plan for the population. Depression is still managed as an individual problem of the single person, who often doesn't "revel" it and doesn't use the services (when available). One study highlighted our country's bad position in the list of European Countries using health services dedicated to mental disorders. The same study highlights the low availability of such services (e.g. Psychologists). Moreover, the use of medication for depression has reached the 310% in the period 2000-2008. We had also some projects/surveys on the topic and some dedicated web site.

Anyway, "In our country doing research on depression is not easy," was summed up by the president of the World Psychiatric Association "For decades we have had to fight against the prejudice that depression would be an existential distress not studied with the methods of medical research. In addition, public funding for research on depression is still very low compared to those for the study of other diseases with equal diffusion and social importance, such as hypertension and diabetes. Moreover, some types of studies on depression require that the patient is hospitalized, but the few departments of public psychiatric beds in our country are usually occupied by psychotic people. Therefore it is very difficult even to recruit patients for research"

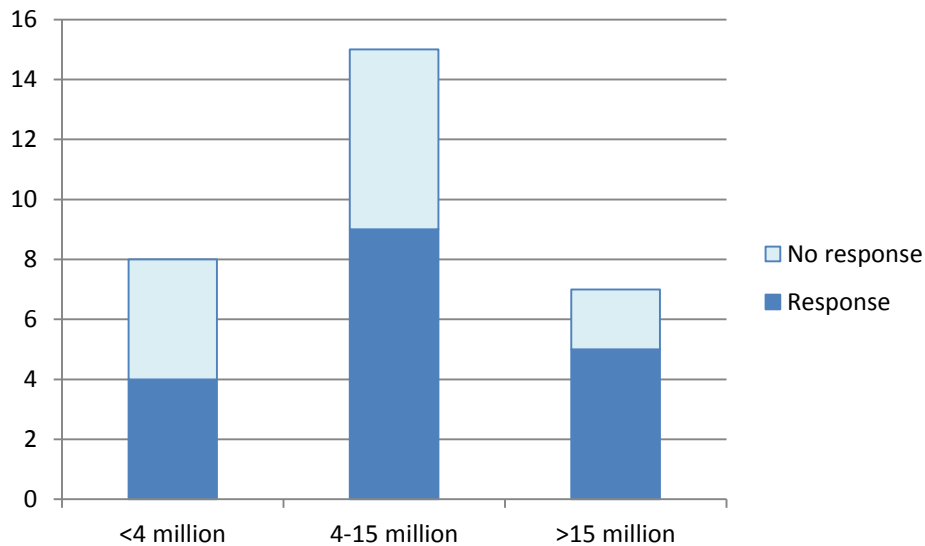
"The topic of the project "EAAD - European alliance against depression" is relevant in our country, because it is one of the European Union leading countries in suicide rates and depression is important suicide risk factor."

"Depression constitutes a substantial Public Health Burden in our country."

## 10. Responders to the EAAD web survey by category of country

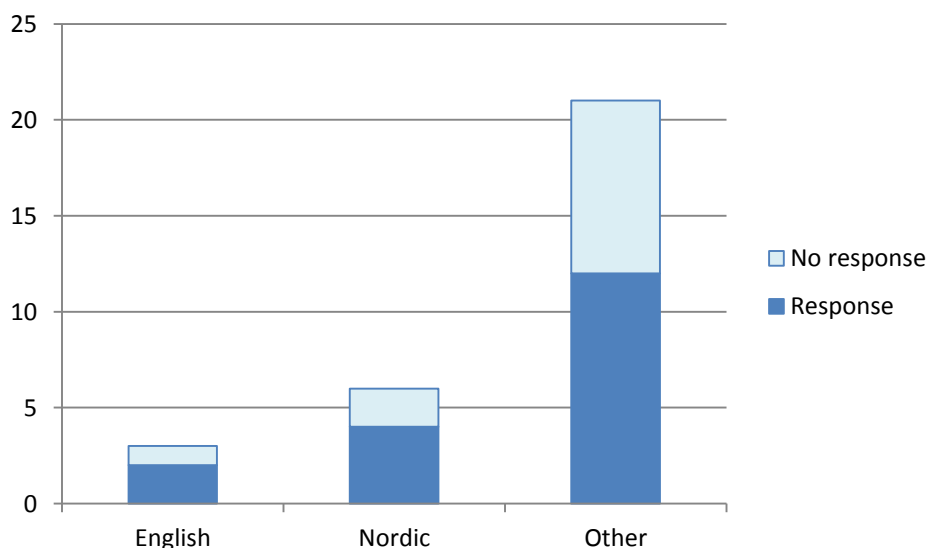
When categorizing the countries according to number of inhabitants and general knowledge of English, respectively, as described on page 10, the response rates were as follows: Most countries that responded to the EAAD web survey represented a country in the group with 4-

15 million inhabitants. Almost half of the countries in the two groups with four million or more inhabitants responded (Figure 8). Four of ten of the CIs in countries with up to 15 million inhabitants and almost three quarters of the CIs in countries with more than 15 million inhabitants responded (Figure 44).



**Figure 44.** Number of participating countries with regard to number of inhabitants in the countries (representing 38%, 40%, and 71%, respectively, of the counties in each group)

Based on the categorization regarding the knowledge of English language within the general population, the distribution shows that the group with CIs in Other countries were in majority. One third of the CIs in the English speaking group and two thirds in the Nordic group responded (Figure 45).



**Figure 45.** Number of participating countries with regard to three language areas (representing 33%, 67%, and 43%, respectively, of the countries in each area).

**Table 6. EAAD - Summary of number of countries and CIs involved, regarding different aspects**

EEA-countries	Project collaborators/partners/expertise in these countries	EAAD results were disseminated in these countries	Invited CIs	Invited CIs in the EUPHA database	Responding CIs	Invited countries	Responding countries	Responding CIs involved in EAAD
Austria	1	1	1	1		1		
Austria			1					
Belgium	1	1	1	1		1		
Belgium			1	1				
Bulgaria			1			1		
Cyprus			1	1		1		
Czech Rep.			1		1	1	1	
Denmark			1	1		1	1	
Denmark			1	1	1			
Estonia	1	1	1			1		
Finland	1	1	1			1		
France			1	1		1		
Germany	1	1	1	1	1	1	1	
Germany			1					
Greece			1			1		
Hungary	1	1	1		1	1	1	
Hungary			1					
Ireland	1	1	1			1		
Ireland			1					
Italy	1	1	1		1	1	1	
Italy			1					
Italy			1					
Latvia			1			1	1	
Latvia			1		1			
Lithuania			1	1		1		
Luxembourg	1	1	1			1		
Malta			1			1		
Netherlands	1	1	1			1	1	
Netherlands			1		1			1
Poland			1			1		
Portugal	1	1	1	1	1	1	1	
Portugal			1					
Romania			1	1	1	1	1	
Slovakia			1			1		
Slovenia	1	1	1		1	1	1	1

Table 6 continues on next page!

Cont. Table 6 EAAD EEA- countries	Project collaborators/part ners/expertise in these countries	EAAD results were disseminated in the following countries	Invited CIs	Invited CIs in the EUPHA database	Responding CIs	Invited countries	Responding countries	Responding CIs involved in EAAD
Slovenia			1	1				
Spain	1	1	1		1	1	1	
Spain			1					
Sweden			1	1	1	1	1	
Sweden			1					
Sweden			1	1				
UK	1	1	1			1		
UK			1					
Iceland	1	1	1		1	1	1	1
Norway	1	1	1			1		
Switzerland	1	1	1			1		
Switzerland			1	1				
<b>Sum</b>	<b>167</b>	<b>17</b>	<b>47</b>	<b>15</b>	<b>13</b>	<b>30</b>	<b>13</b>	<b>3</b>

## ENHIS - Implementing Environmental and Health Information Systems in Europe

### 1. Presentation of ENHIS

#### General objectives of ENHIS

To reduce hazardous environmental exposures and their health effects, reliable information on population's health and the environment is essential for prioritizing, planning and evaluating national and local policies and interventions. The European Environment and Health Information System supports decision-makers, informs citizens and professionals, and facilitates the exchange of information, data, knowledge and good examples.

The objectives of the system:

- Enable Member States and the EC to focus policy actions on priority areas most relevant to health;
- Enable tracking progress in environment and health, and the effectiveness of respective policies across Europe;
- Provide Member States with appropriate EH information to make international comparisons and support their ongoing national policies;
- Increase effectiveness of the use of the existing information;
- Enhance national and international capacities for effective processing, exchange and use of environmental health information.

The 1-year project aimed at the establishment of solid methodological and organizational basis for implementation of the System in all countries covered by the EC Public Health Programme in a longer project to be proposed in response to the next calls. The work focused on the priorities set by the proposed EC EH Strategy, and in particular on children environment and health.

#### Summary of ENHIS, provided by Peter van den Hazel, the Netherlands

Network of collaborating centres was established for sharing environmental health information and expertise and as an important mechanism to maintain the system operational and to assure its relevance for the Member States.

European and national policies dealing with environmental health issues related to air and water quality, housing conditions, traffic accidents and safety, noise and radiation were analysed and their information needs – assessed. This is a basis to formulate recommendations on the scope and focus of the relevant monitoring in order to increase the health accountability of the policies.

Methodology for a core set of environmental health indicators was developed enabling assessment of environmental health situation and progress in Europe as well as of the effectiveness of relevant actions. The indicators focused on children's environmental health and the priority action areas identified in the Children's Environmental Health Action Plan for Europe.

'Hands-on' guidelines were developed to support extensive and effective use of existing European databases for generation of the environmental health indicators as well as to improve harmonization of national data systems.

Health impact assessment (HIA) methods were selected and applied to assess the health impacts of outdoor air particles and ozone in 31 European cities. Report on drinking water pollution and health in ENHIS participating countries was prepared because of the HIA non-feasibility due to lack of appropriate data.

Guidelines for reporting on environmental health indicators were developed and applied for the preparation of fact-sheets. The information system architecture was designed and a prototype web site developed.

Comments in the ENHIS final report whether the project accomplished its main objectives

The main methodological and technical elements of a uniform system for analysis and reporting on the European environmental health situation and relevant policies were developed.

The set of methodological guidelines prepared by the project support public health authorities in the Member States in building and upgrading existing environmental health information systems according to harmonized practices and increasing data exchange and comparability.

The set of project pilot products highlight the methodological developments providing an illustration to potential users and stakeholders of the future system operation for information generation and reporting.

### **Project collaborators/partners/expertise in ENHIS**

ENHIS had collaborators/partners/expertise from 11 countries (Table 7, page 89).

### **Project collaborators/partners included**

The following collaborators/partners were included in ENHIS: government, health authorities, universities, and international organisations.

### **Dissemination of results from ENHIS**

According to the ENHIS final report, results from the project was disseminated in 27 of the EEA countries. The following ways of dissemination were used: reports, peer-reviewed articles, international meetings/seminars/lectures, national conferences/seminars/lectures, international networks, websites, co-operation with other researchers, co-operation with other organisations, and co-operation with other authorities.

The web site created enabled access to the information generated, indicator fact-sheets and health impact assessment reports and case studies by a wide range of users: environmental and public health professionals, researchers, local networks, interested citizens.

Results from the project were published both in printed form and on the WWW. They were more widely disseminated to the relevant European Community health and environment stakeholders as well as to the ones of the environment and health in Europe process. The knowledge gained was transferred to other non-participating in the project countries.

Papers on specific issues (e.g. indicators, health impact assessments) as well as information on the project have been published in scientific journals and newsletters.



## Key targets for dissemination

The following were the key targets for dissemination of results from ENHIS: government, health authorities, and other authorities (Environment and health institutes). This was described in more detail in the text as: European Community health and environment stakeholders as well as to the ones of the environment and health in Europe. More specifically: Four groups of users were distinguished: policy makers, general population, environmental health professionals, and members of the ENHIS network. The first project year of ENHIS focused on the information needs of policy makers.

## 2. ENHIS - introduction to PHIRE, WP 4

### The process to identify the country informants for PHIRE, WP 4

The original participants of ENHIS were contacted as well as the WHO connecting officers in the European countries in so far these were known to the Section lead. They were contacted by email. A total of 22 countries were contacted with a total of 10 responses from 10 countries.

### Problems encountered during data collection

For participating countries it was easier to identify informants who are already partners. The WHO – connecting officers in different countries, tended to be exchanged by other persons, which made tracing them sometimes difficult. Each country has a WHO responsible officer at the ministry. This person can be more or less active. They are not easy to identify. Those which were known to us got an invitation. Furthermore, people who were referred to by active partners in the project were also invited for the questionnaire.

## 3. Results regarding ENHIS

### Invited and responding CIs

In total, 28 CIs were invited to answer the web-based questionnaire representing 22 countries (Table 7, page 89). Questionnaire responses were obtained from ten CIs representing the following countries: Austria, Belgium, Bulgaria, France, Germany, Lithuania, Romania, Spain, Sweden, and United Kingdom, corresponding to 33% of the 30 EEA countries.

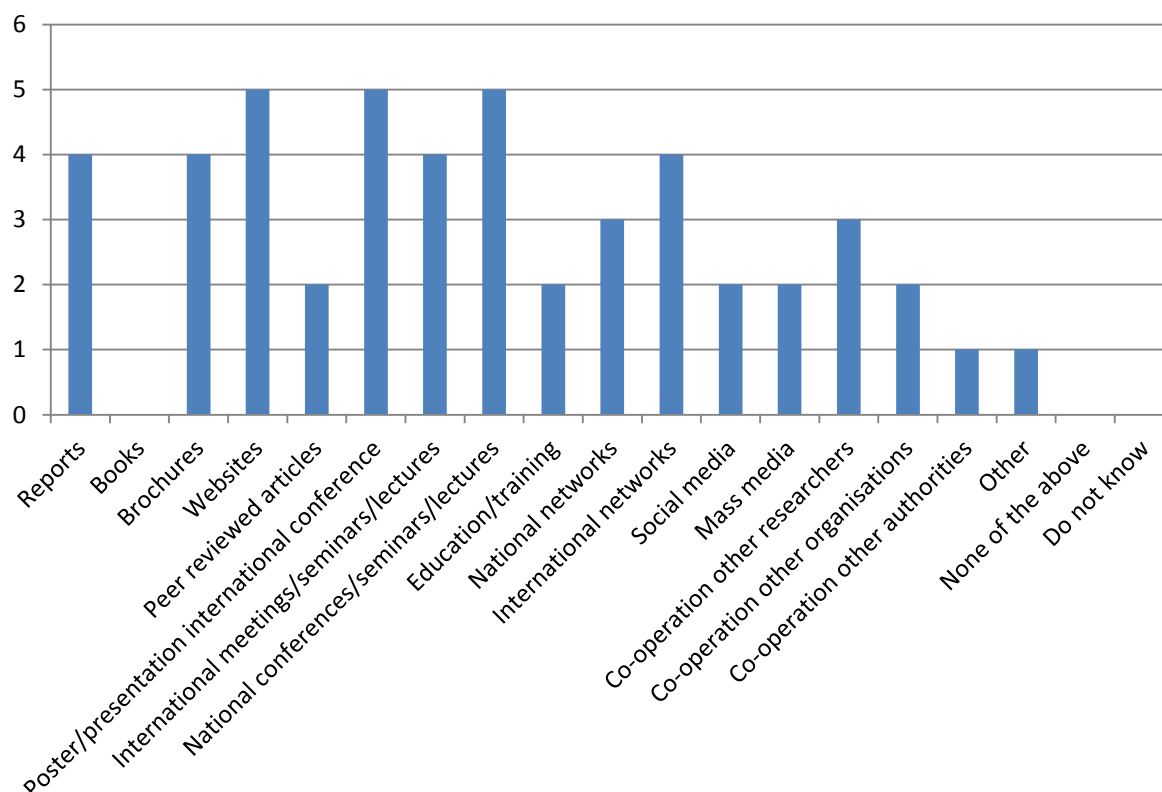
Fifteen of the 28 invited CIs (54%) were members of EUPHA Sections. Of the ten CIs that finally answered the web survey seven (70%) were members of EUPHA Sections.

Seven (70%) of the ten CIs that participated in the ENHIS web survey had been involved in the project as project partners.

### Ways for dissemination of results

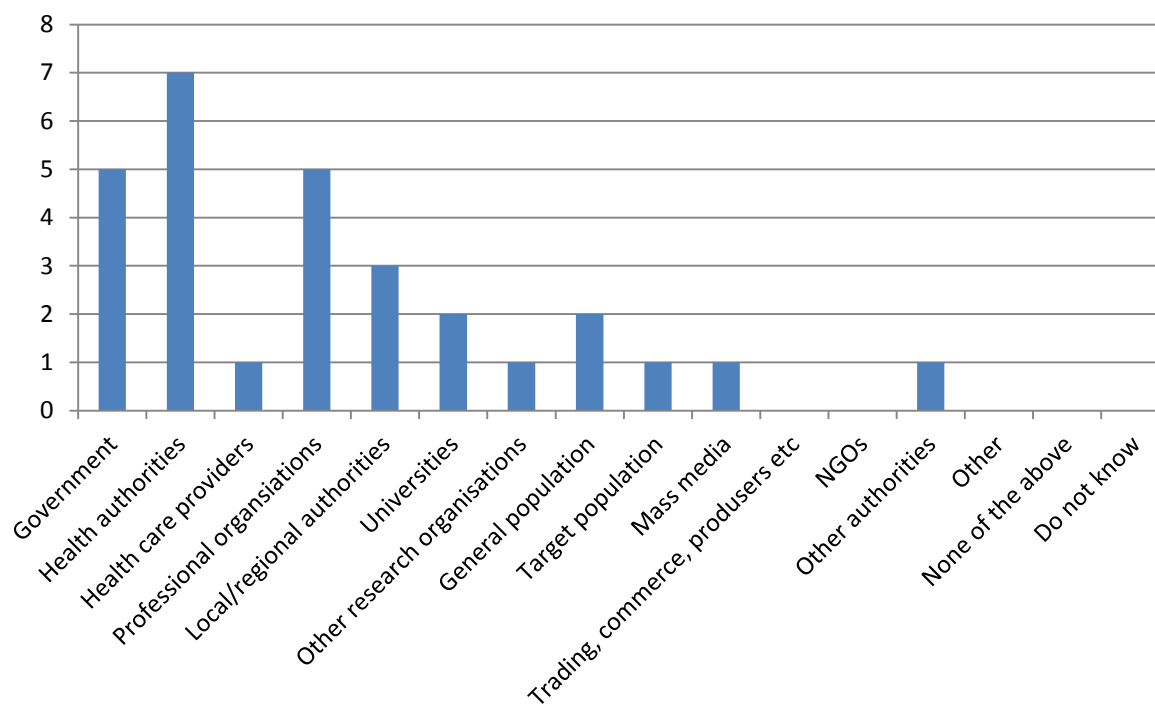
Results from ENHIS were disseminated in 16 different ways according to the web-survey results (Figure 46). Each CI indicated between zero to twelve different ways for dissemination. Among the ten that answered the question, the most common was to indicate five of the suggestions for dissemination (n=3), and the average number was 4.8 ways per CI for dissemination of the results. Mainly, dissemination was through Websites, Poster/presentation at international conference, and National conferences/seminars/lectures with five CIs each indicating this. Thereafter, Reports, Brochures, International meetings/seminars/lectures, and International networks were indicated by four CIs each.

Compared with the information from ENHIS final report (see page 79) the CIs reported the following additional ways of dissemination: Brochures, Education/training, National networks, Social media, and Mass media.



**Figure 46.** Number of CIs indicating the channels used to disseminate the results from ENHIS.

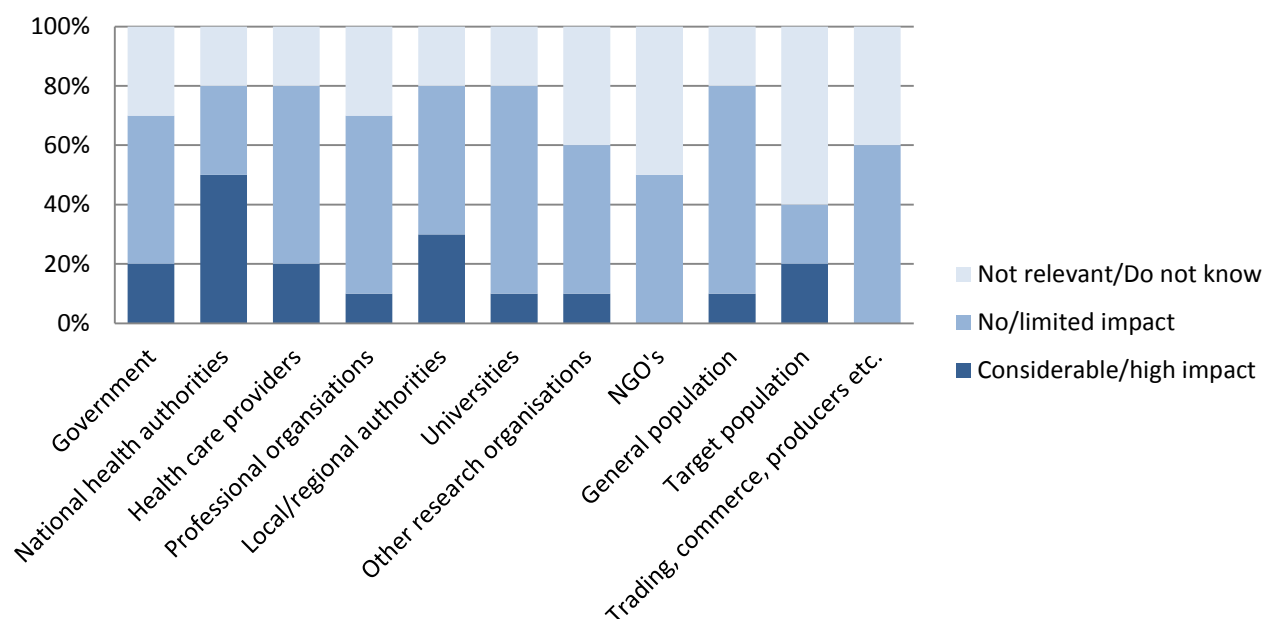
According to the results, 11 different types of groups/organisations were reached by information about the project. Each CI indicated between zero and five groups, with an average number of 2.7 indicated groups/organisations per CI. Health authorities was the group that most CIs indicated as reached by information (n=7), followed by Government and Professional organisations which each were reported by five CIs (Figure 47).



**Figure 47.** Number of CIs indicating groups/organisations that were reached by information about ENHIS.

### 3. Impact of ENHIS on knowledge/awareness of stakeholders

National health authorities was the stakeholder that most CIs (50%) indicated that ENHIS had had considerable or high impact on knowledge/awareness (Figure 48), followed by Local/regional authorities with 30% of the CIs indicating considerable or high impact on knowledge/awareness. Considerable or high impact on knowledge/awareness from ENHIS was not reported by any of the CIs regarding NGO's or Trading/commerce/production, while 20% stated this for Government and Target population. The response option 'Not relevant' was only used by one CI for the different stakeholders.



**Figure 48.** Proportion of CIs indicating level of impact on knowledge/awareness from ENHIS among different stakeholders.

#### 4. Comments on the impact on knowledge/awareness of stakeholders

Following the questions about impact on stakeholders it was possible to add further examples or comments in an unlimited free text space. There were large variation between CIs regarding to what extent they used this opportunity. Five of the CIs had comments for one or several of the stakeholders; comments are presented below.

**Government:** "Environment and health information collection and analysis was included in the National Public Health Programme adopted by the Government of our country."

"Results from EU research projects in Public Health are very rarely visualised as a source of knowledge or information by Governmental authorities in our country. There is a poor interaction between policy makers and researchers.

ENHIS improved the collaboration between the Ministry of Health and the Ministry of Environment, it is one the best practice of intersectoral collaboration."

**National health authorities:** "As a consequence of the excellent collaboration and solid network in ENHIS, part of the ENHIS partners (including the National Institute of Public Health) started in 2010 the UNIPHE (Use of sub-National Indicators to improve Public Health in Europe) project. UNIPHE is a logical continuation of ENHIS, testing part of the core set of ENHIS indicators at regional and local level."

**Health care providers:** "Health Care providers in our country are normally very detached from Public Health issues especially those related to Environmental Health. There is still much work to be done to incorporate a desirable interdisciplinary approach."

Professional organisations: -

**Local/regional authorities:** "Local authorities are closely working with the National Institute of Public Health, being the main data providers for the national EHIS."

Universities: -

Other research organisations: -

**NGOs:** "Environmental NGOs were informed about ENHIS and EH indicators through the association "Doctors for the Environment"."

**General population:** "There exists some awareness that environmental quality does have an impact on health. But this is independent of ENHIS and often environmental factors not even covered in ENHIS

are debated more heatedly while other factors (e.g. tobacco smoke) are highly neglected in the people's perspective.”

“No national system on Environmental Health System was possible to be established after ENHIS project, partially due to the competitiveness among Regional Governments of different political parties. Without it, no impact on general population is possible to be measured.”

**Target population:** “If by target population the experts in the agencies are meant: their work, their way of data collection and reporting, etc. has been affected by ENHIS.”

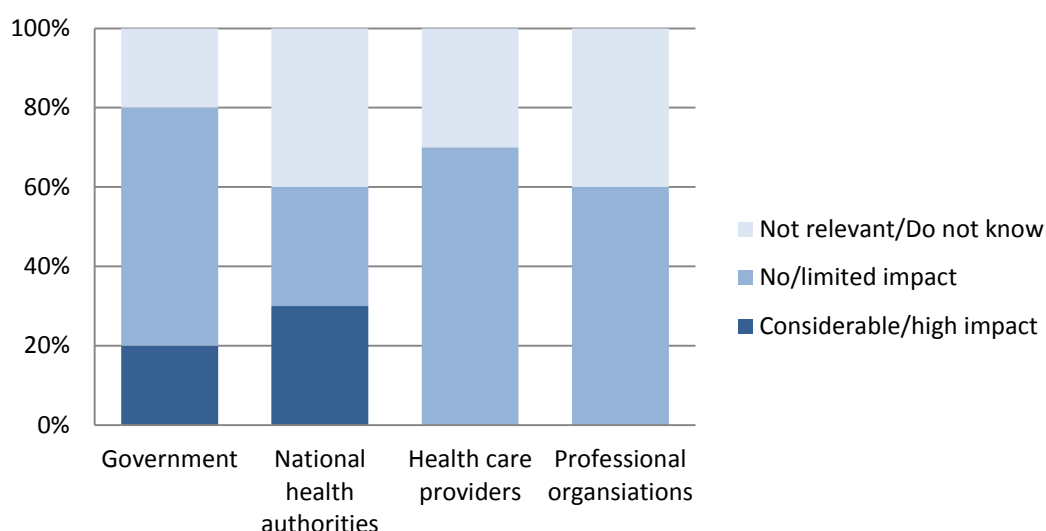
“ENHIS is not targeted at influencing the population.”

“Target population were basically children and also policy makers.”

**Trading/commerce/producers etc:** “It's a health indicators management project, few in common with trade.”

## 5. Impact on policy, reforms, guidelines, and routines

The impact on policy, reforms, guidelines, and routines on the Government, National health authorities, Health care providers and Professional organisations from ENHIS were low according to the responses. For National health authorities, three CIs (30%) indicated considerable or high impact on policy/guidelines, followed by 20% of the CIs that stated so for Government (Figure 49). The majority of the CIs, 60-70%, indicated that they did not know about the impact on policy/guidelines for Health care providers and for Professional organisations. None of the CIs stated that the question was not relevant.



**Figure 49.** Proportion of CIs indicating level of impact of ENHIS on policy/reforms/guidelines/routines.

The unlimited free text space for the CIs answers or comments to the question about the likelihood that the impact on the different stakeholders could have occurred without the ENHIS project was used to some extent. The following comments were given from the five CIs that had commented on this question:

"Not applicable."

"Nowadays funding for EH research in our country mostly comes from EU. WHO still has high reputation in our country. So we do need (a) EU projects to keep the focus on these topics and (b) projects lead by WHO (or e.g. WHO Bonn office as was the case with ENHIS) are important for our country's EH policy. But I doubt it is the very specific single project. There were other international projects that got more support from our ministries, mostly in preparation for the E&H conferences

(London 1999, Budapest 2004, Parma 2010) and thus had a more profound impact on our country's policy. But ENHIS was important background work also to this WHO Euro E&H process."

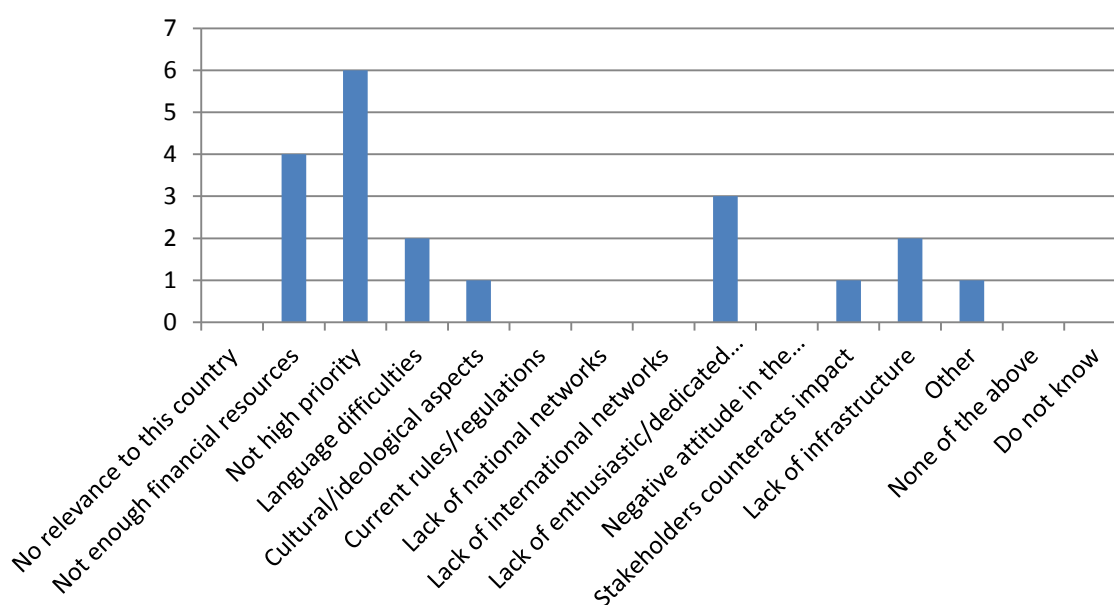
"No. Project was crucial and the only driving force and methodological, technical help in developing and fulfilling the idea of environment and health information system."

"Yes."

"Some of them yes, they could have occurred due to EC Directives in the field (water, noise etc.) or due to some other research projects."

## 6. What main factors hindered impact of ENHIS in your country?

The CIs indicated between zero and four of the 13 suggested options of factors that might have hindered impact. Most often only two hindering factor was indicated, this was the case for five (50%) of the CIs (Figure 50). On average, the CIs stated 2.0 hindering factors. Six (46%) of the 13 CIs indicated that a main hindering factor was 'The issue does not have high enough priority'. Further, four (40%) of the CIs stated that 'Not enough financial resources allocated' was a hindering factor for impact of ENHIS, followed by three CIs (30%) that reported 'Lack of enthusiastic/dedicated persons' as a hindering factor.



**Figure 50.** Number of CIs that indicated each type of factors that hindered impact of ENHIS.

Three of the CIs used the free text space to comment regarding hindering factors for impact of ENHIS in their country:

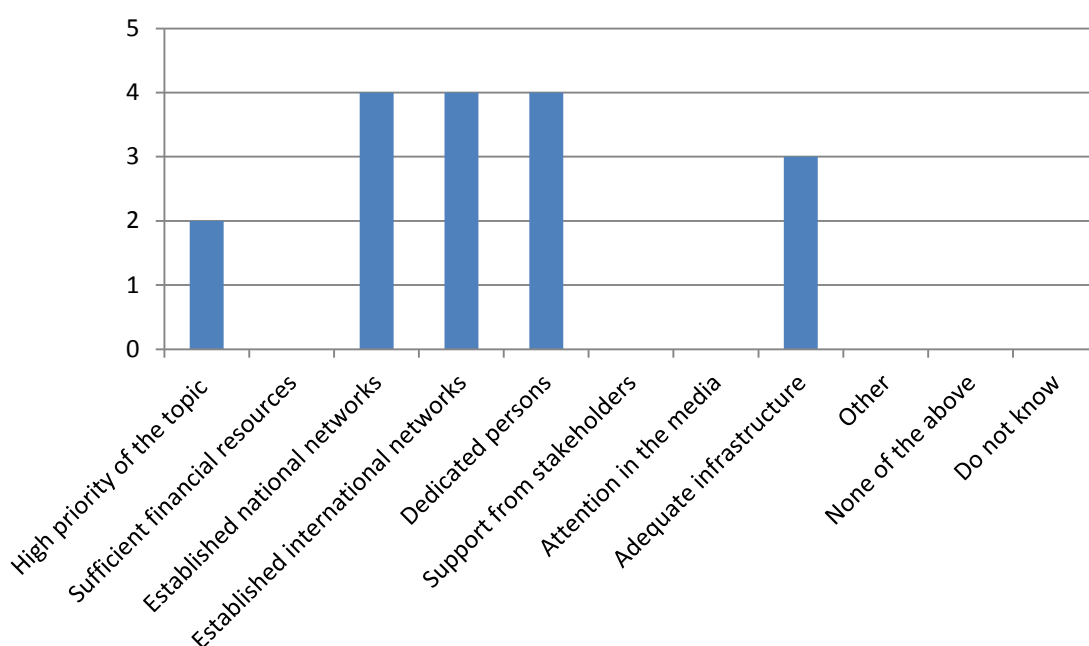
"The person responsible for international E&H processes at the health ministry openly stated that discussing air quality issues in our country might be detrimental for tourism and therefore should be discouraged. Well, at that time we had a minister who stated that a little drinking and smoking is good for health. So what could one expect regarding environmental aspects of health?"

"The results of the project were highly appreciated by health authorities, policy makers and other researchers. However, the political confrontation existing in our country paralyzed our initiative to put forward a national research project for the development of a National Environmental Health information System."

"Unfortunately, the issue has never reached a very high priority at national level, consequently the financial resources were always rather insufficient. Another important factor that hindered the impact was the smaller and smaller specialists working in the field that is less and less attractive."

## 7. What main factors facilitated impact in your country?

The CIs indicated between zero and three of the nine suggested facilitating factors for impact of ENHIS on stakeholders. Most common was to state three facilitating factors; this was done by four of the CIs. On average, the CIs reported 1.7 facilitating factors. Established national networks, Established international networks, and Dedicated persons were the main factors that four (40%) of the 10 CIs mentioned as facilitating impact of ENHIS in the country that the informant represented (Figure 51). Additionally, three (30%) CIs stated 'Adequate infrastructure' as facilitating impact.



**Figure 51.** Number of CIs that indicated each factors as having facilitated the impact of ENHIS.

Three CIs commented facilitating factors as followed in free text:

"Impact in my country was rather limited!"

"Strong willingness to be part of an EU funded project, although the financial support, allocated for our country was miserable and did not cover the expenses our state created during the project implementation."

"The results of the project were highly appreciated by health authorities, policy makers and other researchers. However, the political confrontation existing in our country paralyzed our initiative to put forward a national research project for the development of a National Environmental Health information System."

## 8. Coverage of the topic of ENHIS in mass media

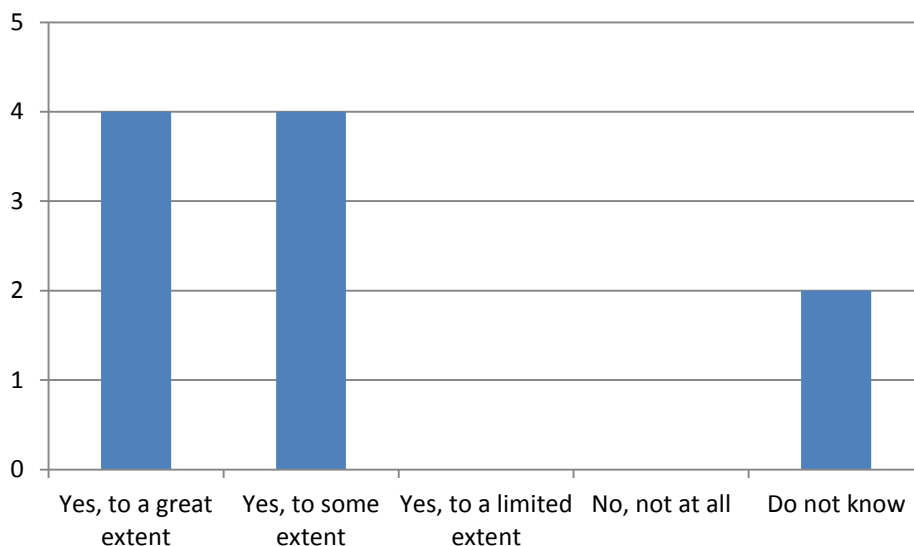
One (10%) of the ten CIs indicated that mass media had had considerable or high coverage of the topic of ENHIS, while five (50%) of the CIs reported that the coverage of the topic in mass media had been limited or nonexistent. The stated four CIs indicated that they did not know about the coverage of the topic in mass media. In the free text space the CIs expressed it as followed:

"The Aphis II results were the one part of ENHIS that maybe got the most media coverage. But it is difficult to say if this was ENHIS because Aphis II was only a follow up project of Aphis (which was a project that was)."

"Several mass media outputs concerning the project were there, as far as I know."

## 9. Relevance of the topic of ENHIS

A majority of the CIs (n=8) reported that the topic of ENHIS had relevance to a great or to some extent in their country (Figure 52).



**Figure 52.** Number of CIs indicating the level of relevance of the topic of ENHIS.

The relevance of the topic was commented by seven (70%) of the CIs:

"I have been given no information about it. Please note however, I have just completed at the request of the WHO-UNEP office, an Implementation Plan for the management, control and prevention of health risks associated with tourism ....."

"ENHIS involved also participants from our Public Health Agency and National Statistics. By that it helped to harmonise European data collection and reporting and thus also affected these tasks in our country. The tools produced in the WP Apehis (spread sheets for HIA) were used by us in several instances for the evaluation of local measures to improve air quality. The ENHIS list of indicators was fed into other (European) projects that were performed with the participation of partners from our country and thus the indicators were also applied in research partly conducted in our country."

"The collection of metadata and the collection and interpretation of environmental health indicators concerns also our country as a European state."

"Topic of creation of integrated environment and health information system was considered in our country from 1994. The need was seen in combining environment and health data and information for assessment of possible environmental influence on health."

"Our country was involved in the process of defining its National Environmental Health Action Plan when this project was taking place, and the definition of specific indicators on Environmental Health was identified as a key element."

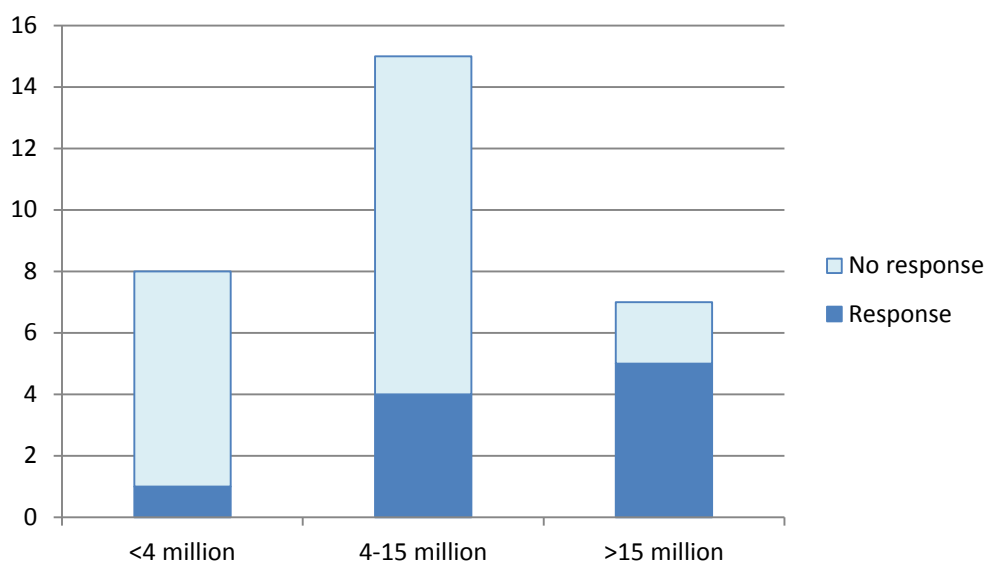
"The National Institute of Public Health is composed of 4 main National Centres. One of them is the National Centre for Monitoring the Environmental Health Risks. ENHIS project was extremely important for this centre because it established at European level a set of harmonised, based on commonly agreed definitions, environmental health indicators to monitor the situation in our country, following the DEPSEEA model. Participating very actively in ENHIS, our country was able to update its Environmental Health Information System based on harmonised indicators and reporting tools."

"Respiratory cardiovascular and chronic diseases related to environmental determinant are a top topic for concern for the authorities. Coordination of environment and health policy."



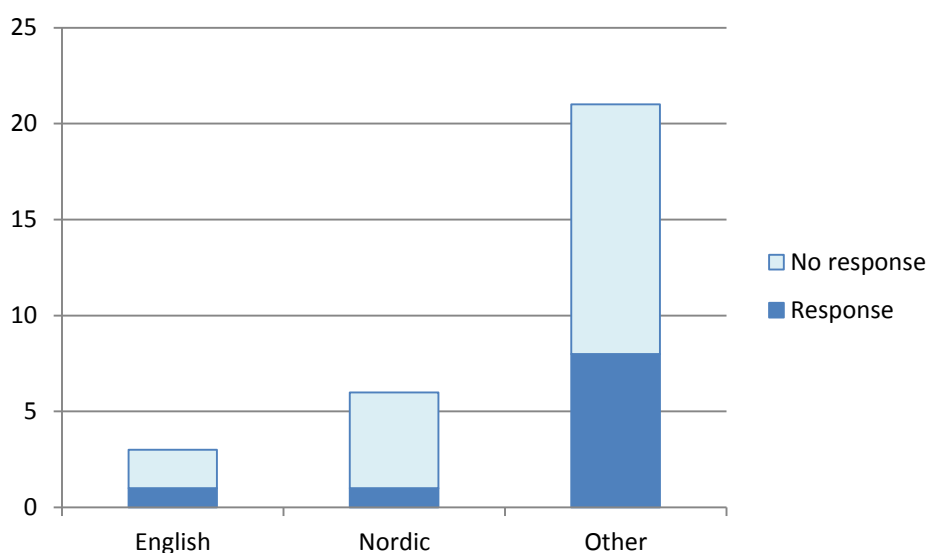
### 10. Responders to the ENHIS web survey by category of country

According to the number of inhabitants, a majority of the CIs that responded to the ENHIS web survey represented a country in the group with more than 15 million inhabitants. Almost three quarters of the CIs in that group responded (Figure 53).



**Figure 53.** Number of participating countries with regard to number of inhabitants in the countries (representing 13%, 27%, and 71%, respectively, of the countries in each group)

Based on the categorization regarding the knowledge of English language within the general population, the distribution shows that the group with CIs in Other countries were in majority. One third of the CIs in this and the English speaking group and less in the Nordic group responded (Figure 54).



**Figure 54.** Number of participating countries with regard to three language areas (representing 33%, 17%, and 38%, respectively, of the countries in each area)

**Table 7. ENHIS - Summary of number of CIs and countries involved, regarding different aspects**

EEA-countries	Project collaborators/ partners/ expertise in these countries	ENHIS results were disseminated in these countries*	Invited CIs	Invited CIs in the EUPHA database	Responding CIs	Invited countries	Responding countries	Responding CIs involved in ENHIS
Austria	1	1	1	1	1	1	1	1
Belgium		1	1		1	1	1	
Bulgaria		1	1	1	1	1	1	1
Cyprus		1	1			1		
Czech Rep.	1	1	1	1		1		
Denmark		1						
Estonia		1	1			1		
Estonia			1					
Finland	1	1	1			1		
Finland			1					
France	1	1	1		1	1	1	1
Germany	1	1	1	1	1	1	1	1
Greece		1	1			1		
Hungary	1	1	1	1		1		
Ireland		1						
Italy		1	1	1		1		
Latvia		1						
Lithuania		1	1	1	1	1	1	1
Luxembourg		1						
Malta		1						
Netherlands	1	1	1			1		
Netherlands			1	1				
Poland	1	1	1			1		
Poland			1	1				
Portugal		1	1			1		
Portugal			1	1				
Romania	1	1	1	1	1	1	1	1
Romania			1	1				
Slovakia		1						
Slovenia		1	1			1		
Spain	1	1	1	1	1	1	1	1
Sweden		1	1		1	1	1	
UK	1	1	1	1	1	1	1	
Iceland								
Norway			1	1		1		
Switzerland								
<b>Sum</b>	<b>11</b>	<b>27</b>	<b>28</b>	<b>15</b>	<b>10</b>	<b>22</b>	<b>10</b>	<b>7</b>

\*All countries were addressed either directly or indirectly through conferences or meetings.

## CSAP - Child Safety Action Plans, Phase I

### 1. Presentation of CSAP

#### General objectives of CSAP

The overall purpose of the Child Safety Action Plan (CSAP) project is to contribute to reducing child and adolescent injury across Europe by working with 18 countries to develop national child and adolescent safety action plans. The aim of the action plans is to increase awareness of the child and adolescent injury issue and implementation of effective measures by government, industry, professionals and organisations in areas that relate to child and adolescent safety, and families themselves.

**Objective 1:** To develop and disseminate a core set of indicators addressing injury to children and adolescents to serve as an assessment/benchmarking tool for countries, including the assessment of current ability to examine burden of injury in this age group.

**Objective 2:** To conduct a mapping exercise and directory of good practice and interventions to serve as “Action Indicators” providing strategies to undertake that will address the injury indicators identified in objective 1, and to provide an evidence-based approach for action planning.

**Objective 3:** To develop and implement a capacity building seminar and mentoring programme for public health practitioners focusing on injury prevention and safety promotion which would enable countries to undertake strategic and action planning with the use of indicators as planning, assessment and benchmark tools (objective 1), as well as the application of good practice strategies that can serve as action indicators (objective 2).

#### Summary of CSAP, provided by Mathilde Sengölge, Austria

After 30 months several countries are close to having a government endorsed CSAP (Austria, Czech, Hungary, Italy, Poland, Scotland) and several others are at various stages of plan development (Belgium, Netherlands, Portugal). In other countries the CSAP timetable has not coincided with national timetables, so that in Estonia, France, Sweden and Norway, government is proceeding on their own timetable although there will still be the opportunity for a CSAP to be developed in 2008 or 2009. Several countries have also struggled to move forward (Denmark, Greece and Spain) and in Germany although government was aware of the process and participated to some degree, they have not engaged and encouraged the now complete CSAP to go forward as an NGO led plan.

#### Comments in the CSAP final report whether the project accomplished its main objectives

It is notable that all countries have made some progress; at minimum by completing assessments designed to measure starting point for planning and monitoring progress, at maximum by developing a CSAP through collaboration with multi-disciplinary, multi-sectoral working groups that is now awaiting ministerial endorsement. Country partners have expressed many anticipated and unanticipated outcomes and most have reported and/or demonstrated increased capacity as a result of participating in the project.

### **Project collaborators/partners/expertise in CSAP**

CSAP had collaborators/partners/expertise from 25 countries (Table 8, page 103).

### **Project collaborators/partners included**

The following collaborators/partners were included in CSAP: government, health care providers, professional organisations, universities, non-governmental organisations (Grosse schützen Kleine, KfV), and international organisations (HEAL, UNICEF, WHO Europe). This was further described in detail: A European initiative led by the European Child Safety Alliance of Eurosafe with co-funding and partnership with the European Commission, the Health and Environmental Alliance (HEAL), the UNICEF Innocenti Research Centre, the Universities of Keele and West of England, WHO European office and the participating partners from 18 countries: Austria, Belgium, Czech Republic, Denmark, Estonia, France, Germany, Greece, Hungary, Italy, Netherlands, Northern Ireland, Norway, Poland, Portugal, Scotland, Spain and Sweden.

### **Dissemination of results from CSAP**

According to the CSAP final report, results from the project was disseminated in 18 countries (Table 8, page 103). The following ways of dissemination were used: reports, brochures, peer-reviewed articles, poster/oral presentation at international conferences, international networks, websites, electronic mailing lists, and mass media.

### **Key targets for dissemination**

The variety of actors in child injury and child safety in Europe, at European and national levels and media were the target groups for dissemination. More specifically the following were the key targets for dissemination of results from CSAP: professional organisations, non-governmental organisations, target population addressed in the project, and mass media.

## **2. CSAP - introduction to PHIRE, WP 4**

### **The process to identify the country informants for PHIRE, WP 4**

The starting point was sending the questionnaire to the members of the European Child Safety Alliance and the next step was sending the PHIRE questionnaire to the individual members of the EUPHA Section of Injury and Safety Promotion. A few country informants (CI) contacted the Section lead for clarifications or to decline to respond.

In all, twenty-seven countries were invited to participate in the CSAP survey and answers were obtained from 18 countries (Table 8).

## **3. Results regarding CSAP**

### **Invited and responding CIs**

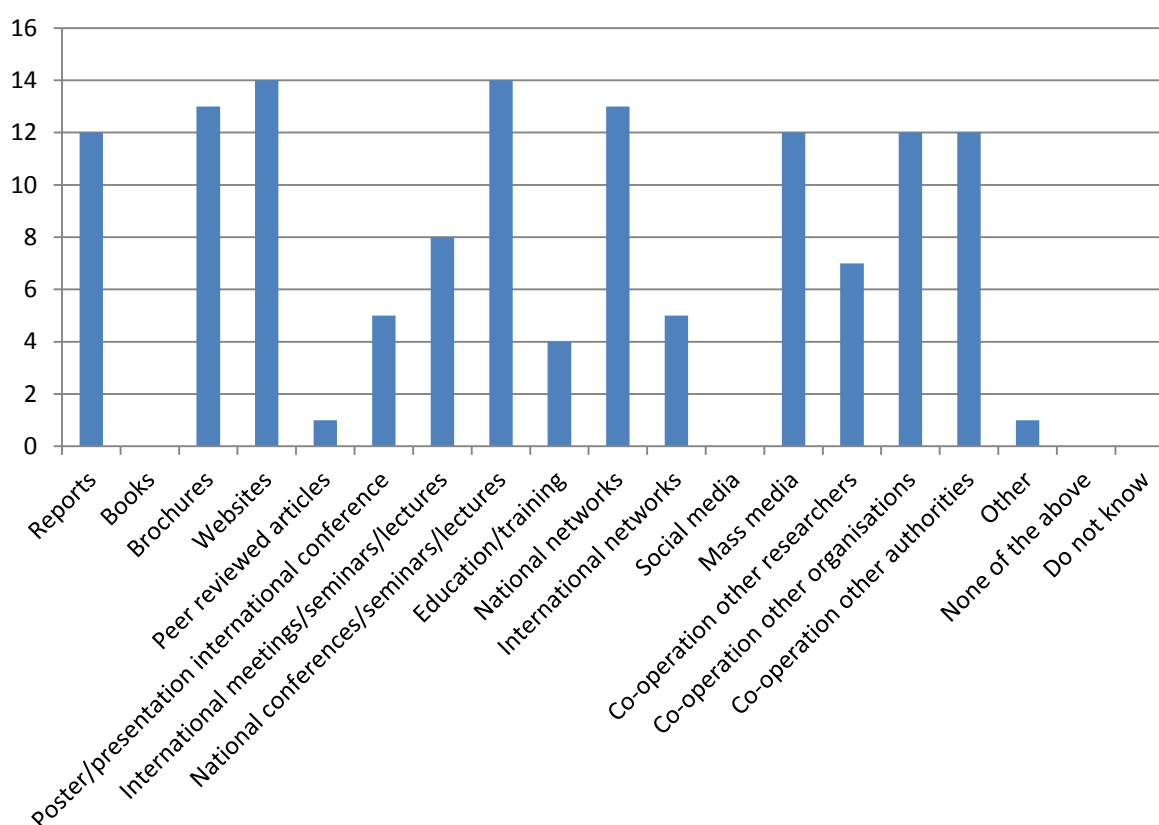
In total, 40 CIs representing 28 countries were invited to answer the web-based questionnaire (Table 8, page 103). Questionnaire responses were obtained from 18 CIs representing the following 18 countries: Austria, Czech Republic, Denmark, Estonia, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Poland, Portugal, Spain, Sweden, United Kingdom, Iceland, and Norway, corresponding to 60% of the EEA countries.

Ten of the 40 invited CIs (25%) and three of the 18 CIs who responded (17%) were in the EUPHA data base.

All 18 CIs who answered the CSAP web survey had participated in the project. Five (28%) of the CIs had participated as a project leader/coordinator and 13 (72%) as project partners.

### Ways for dissemination of results

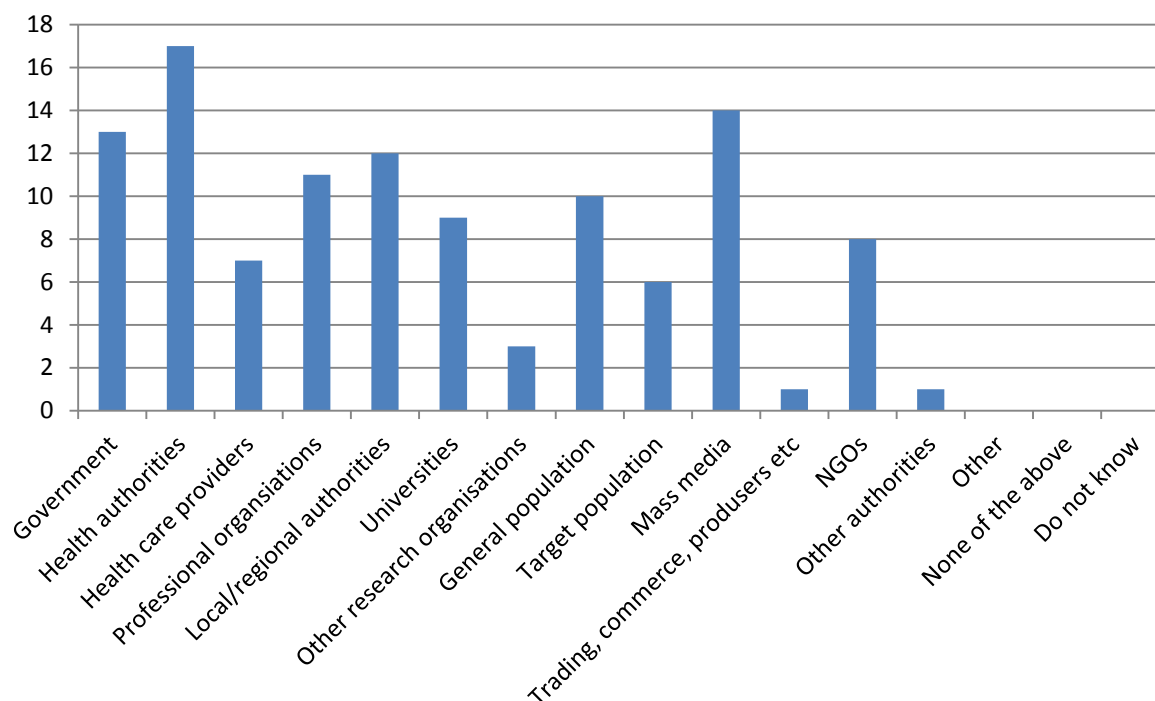
Results from CSAP were disseminated in 15 different ways according to the web-survey results (Figure 55). Each CI indicated between 0 to 14 different ways for dissemination. Among the 18 that answered the question, the most common way was to indicate six and seven of the suggestions for dissemination (n=6), and the average number was 7.3 ways per CI for dissemination of the results. Mainly, dissemination was through Websites and National conferences/seminars-/lectures with 14 CIs each indicating this, followed by Brochures and National networks, indicated by 13 CIs. Thereafter, 12 CIs each indicated Reports, Mass media, Co-operation with other organisations and Co-operation with other authorities as ways for dissemination of results. Compared with the information from CSAP's final report (see page 91) several CIs reported the Co-operation with other researchers, other organisations, and other authorities as ways of dissemination of results from CSAP.



**Figure 55.** Number of CIs indicating the channels used to disseminate the results from CSAP.

According to the CIs, 13 different types of groups/organisations were reached by information about the project (Figure 56). The CIs indicated between 0 and 12 groups each. Most common was to report six different types of groups/organisation which six of the CIs did. The average number was 6.2 indicated groups/organisations per CI. Health authorities was the group that most CIs indicated as reached by information about CSAP (n=17, 94%), followed by Mass media (14 CIs), Government (13 CIs), and Local/regional authorities (12 CIs) as the leading groups that had been reached by information about CSAP (Figure 50). According to the CIs,

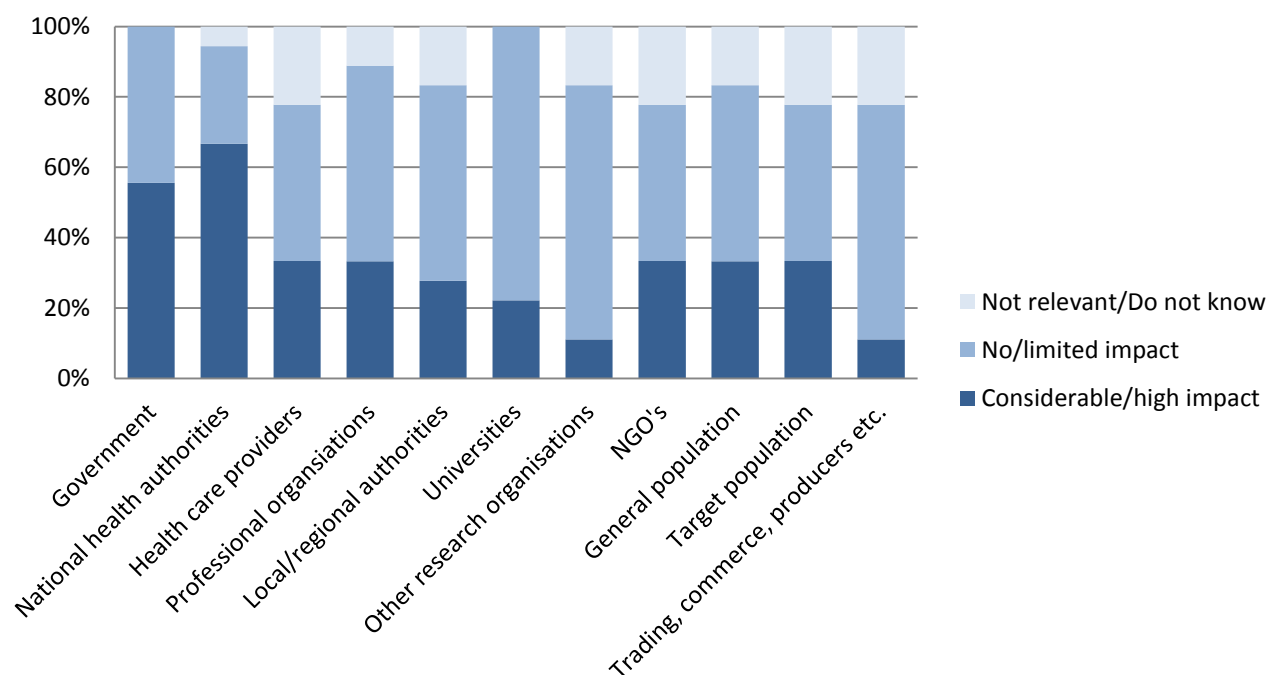
there were several other key targets that were reached by information about CSAP compared to the key targets specifically reported from the original project (page 91), e.g. Government, Health authorities, Health care providers, Universities and General population



**Figure 56.** Number of CIs indicating groups/organisations that were reached by information about CSAP.

### 3. CSAP - Impact of ENHIS on knowledge/awareness of stakeholders

National health authorities was the stakeholder that most CIs (67%) indicated as having had considerable or high impact on knowledge/awareness from ENHIS (Figure 57), followed by Government with 50% of the CIs indicating considerable or high impact on knowledge/awareness. One third of the CIs also indicated impact on knowledge awareness among Health care providers, Professional organisations, NGO's, General population and among Target population. Seventy-eight percent of the CIs reported 'None or limited impact' on Universities, followed by Other research organisations, Trading/commerce/production Professional organisations and Local/regional authorities. The response option 'Not relevant for knowledge/awareness among the different stakeholders' was sparsely used among the CIs.



**Figure 57.** Proportion of CIs indicating level of impact on knowledge/awareness among different stakeholders.

#### 4. Comments on the impact on knowledge/awareness of stakeholders

Following the questions about impact on stakeholders it was possible to add further examples or comments in an unlimited free text space. There were large variation between CIs regarding to what extent they used this opportunity. Eight of the CIs had comments for one or several of the stakeholders, comments are presented below.

**Government:** “The CSAP was combined with the National Health and Environmental Action Plan for Children.”

“A new development of a national strategic plan for prevention of all accidental injury was launched short time after this child safety project was finalised. It might be that this project had an impact on this decision.”

“Main impact on government related with project was actualization of child safety problem as national problem and implementation of child safety activities as part of Public Health Guidelines for 2011 – 2017.”

“Ministry of Education, Ministry of Interior Affairs (Police, Fire Brigade).”

“Government officials were regularly updated with the progress of CSAP in our country. This was done through meetings and via circulation of the CSAP for the Steering Group minutes of meetings. It was clearly communicated that the Government included child injury prevention as one of the four key priorities for its new approach to child environment and health because of the focus provided by the CSAP process. Likewise, the interest in progressing a national data collection system, was raised because of the focus provided by CSAP. New departments within the government are taking an interest in Child Safety and this has been shown through increased funding from the Community Safety Unit for roll out of blind cord safety projects and funding for Child Safety Week.”

“A 20 years' work with the government about child safety.”

**National health authorities:** “During these years, quite a few initiatives on injury prevention were launched by the health authorities: a new strategic plan and a new injury registration system. It might be that this European child safety activities influenced the decisions to start this new national initiatives.”

“Main impact on national health authorities gave good practice examples, data assessment and international comparison.”

“The National Board of Health was in charge of a cross ministerial project which was running parallel with CSAP i 2004-2007. The National Board of Health held a national conference inviting experts in the field of child health and environmental health to get together and come up with solutions and advice on how to improve the life of children in our country. I participated and gave a presentation about the CSAP project. The input from the conference together with additional inputs from experts was used to produce an inspirational catalogue for the municipalities in our country on the subject of Children's health and environment. Injuries are also includes in the catalogue.”

“Ministry of Health did not show any interest in this topic.”

**Health care providers:** “Health care provider note enhanced cooperation with Ministry Health Representative from xxxxx “The Child Safety Action Plan not only provides evidence for the need to prevent unintentional injuries in children, it also reinforces the need to use an evidence-based approach with multi-agency partners to prevent injuries which could be serious, life threatening or disabling. It demonstrates the severity and scale of unintentional injuries to children and provides a clear need for action. It has been very useful as a basis for the development of local plans and programmes in the NHS.”

**Professional organisations:** “It is hard to judge the impact on professional organisations. I know that the public health nurses were to some extent interested in this project, at least some of them. With regards to the organisation, I doubt that there was some impact.”

“Recommendations are developed during this year and will be finished at the beginning of next year. Recommendations include different aspects of prevention 0-5 years old children, food, active live style, violence and social adaptation and also injury prevention.”

“Professional Association of Nurses and Midwives.”

**Local/regional authorities:** “This project was mainly national in its idea and the activities that came out of it. Some municipalities were (and still are) members of the National Safety Forum. They were informed about the project.”

“Should be provided more activities for involvement of local authorities in the child safety policy.”

“Some local authorities have included 'child safety', 'home safety', 'road safety' and/or 'fire safety' as key priorities for local communities. However, because of the analytical process in securing such topics in local 'assessments' and the lack of data on injuries (hospital attendances), many have not included child safety. It cannot be confirmed but it is assumed the CSAP process served to highlight existing information and, along with existing work to raise the profile of child safety ensured it was considered at least in some areas.”

**Universities:** “At the universities in our country, there is very little activity on research on child injuries and prevention. Hence, it is supposed this project had very little, if any impact on universities.”

“During od 2010 curriculum of XXXX was adopted for universities of our country and this learning model also related with methods of CSAP.”

Other research organisations: “I don't know.”

“The situation is the same as for the universities: At the universities, there is very little activity on research on child injuries and prevention. Hence, it is supposed this project had very little, if any impact on universities.”

“Institute of Occupational Medicine in and Institute of Mother and Child.”

**NGOs:** “Three of the NGO used the results for preparing their targets and goals.”

“I do not know what you mean by governmental "organisations". I think we do not have any of that kind in our country.”

“Web site for parents produced informative material what will be disseminate between young mother at the maternity houses and looking for possibly to take par at the new project to develop informative material about school children and adolescents safety.”

“NGO's: the National Red Cross, Voluntary Water Rescue Guard, especially targeting primary and secondary schools.”

“Initial funding allocated to run a pilot blind cord safety campaign. The project was well evaluated and further funding was secured from the community Safety Unit of the Government to roll the project out to three new geographical areas with another area agreeing to self-fund. The Government is now a



major funder of a Child Safety Week to ensure adequate coverage. Government funding continues to be allocated to a NGO whose work with CSAP has helped to keep it on the political agenda (especially in these austere times).”

“The national life saving association has taken up more injury prevention than before.”

**General population:** “General awareness was considerably raised, media are more interested in the problem and seek the information from reliable sources.”

“The population might have got some knowledge of this project through mass media. However, it is not measured, and it hard to judge.”

“Should be provided more activities focused on public information about child safety.”

“Impact of general population was not evaluated.”

“Over the 20 year a new pattern has come to life parents are more aware than before. People don't accept an accident as they did before.”

**Target population:** “The awareness and changes in behaviour are reflected in the child injury mortality decrease in the last years.”

“The target population of this project was mainly national authorities. The impact on this group is answered above.”

“Should be provided more activities focused on public information about child safety.”

“Impact of target population was not evaluated. The target population was reached by mass-media, special magazines/ journals for parents.”

**Trading/commerce/producers etc:** “The information proceeded from international information on dangerous products RAPEX is now disseminated through media with the information how to deal when you have the product in your possession. The general safety of the products for children is obligatory by Law.”

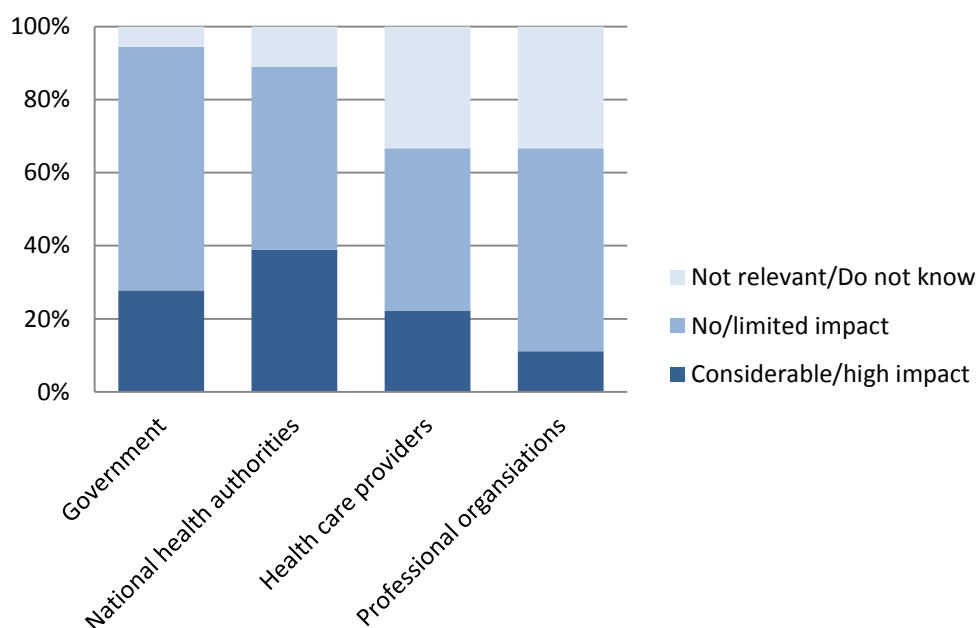
“Probably no impact on this group.”

“Should be more provided activities to involve public sector in the child safety policy. There are some separate informative campaigns that are related with advertisement of concrete products.”

“More Active are insurance companies.”

## 5. The impact of ENHIS on policy, reforms, guidelines, and routines

The impact on policy, reforms, guidelines and routines on the Government, National health authorities, Health care providers, and Professional organisations from CSAP varied according to the results. For National health authorities seven CIs (39%) indicated considerable or high impact on policy/guidelines, followed by 28% of the CIs that stated so for Government (Figure 58). A majority of the CIs reported No/limited impact on Policy/reforms etc for Government (67%), Professional organisations (56%) and for National health authorities (50%).



**Figure 58.** Proportion of CIs indicating level of impact on policy/reforms/guidelines/routines.

The unlimited free text space for the CIs answers or comments to the question about the likelihood that the impact on the different stakeholders could have occurred without the CSAP project was used to some extent, by ten CIs:

"One cannot exclude this possibility, but I do believe that the process in our country was influenced by the project, the project could very usefully and effectively help the national process."

"I think, that Project was very timely and the beginning for later processes and project ideas had some influence on professionals and population."

"Possibly, but the project helped a lot."

"It is hard to say, however, I might say that this project increased the motivation for the authorities to carry out the development of a new national strategy for all accidental injuries, and also the new injury registration project."

" Yes , but the project gave us the possibility to act in collaboration with other European countries which was of great importance."

"This is difficult question, because parallel also WHO injury prevention network give high impact on situation in our country, but I am sure that this project gave main impact on child safety actualization as part of public health policy and development of national child safety action plan."

"It is difficult to relate cause and effect categorically but there is no question participation in CSAP project ensured maintained momentum and provided a focus for child safety activities. Government focus on environment and health and the data collection are both directly related to our participation in the CSAP process."

"No."

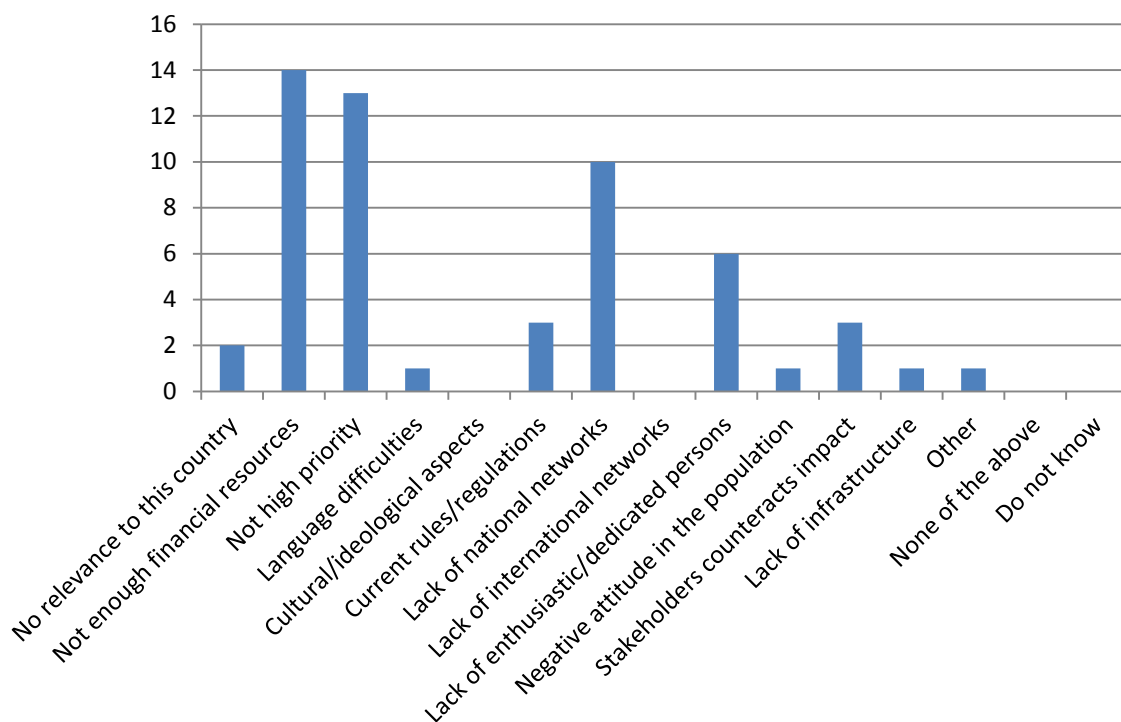
"I can say without this we would have much more injuries and deaths for example drowning if the government would not have been involved. We have information before and after."

"Yes, but project contributed a lot."

## 6. What main factors hindered impact from ENHIS in your country?

The CIs indicated between one and seven of the 13 suggested options of factors that might have hindered impact. Most often three hindering factor was indicated, this was the case for seven (39%) of the CIs (Figure 59). On average, the CIs indicated 3.1 hindering factors. Fourteen (78%) of the 18 CIs indicated that a main hindering factor was 'Not enough

financial resources allocated', followed by 'The issue does not have high enough priority' (72%). Furthermore, ten (56%) of the CIs indicated that Lack of national networks was a hindering factor for impact of CSAP. A few CIs also mentioned No relevance to this country, Language difficulties, Current rules/regulations, Negative attitude in the population, and Lack of infrastructure as hindering factors for impact.



**Figure 59.** Number of CIs that indicated each type of factor that hindered the impact of CSAP.

Six of the CIs used the free text space to comment regarding hindering factors for impact of CSAP in their country:

"It might be that there is a negative attitude in the population about child safety - "too much safety now". However, there will always be parts of the population that will be interested, especially parents to small children, and especially the mothers. It might be that the rest of the population has a more negative attitude than before (when there were many more children that died in injures)."

"The issue is not of a high priority and is considered more an "accident" than a preventable cause of death."

"The only obstacle is insufficient financial and personal resources."

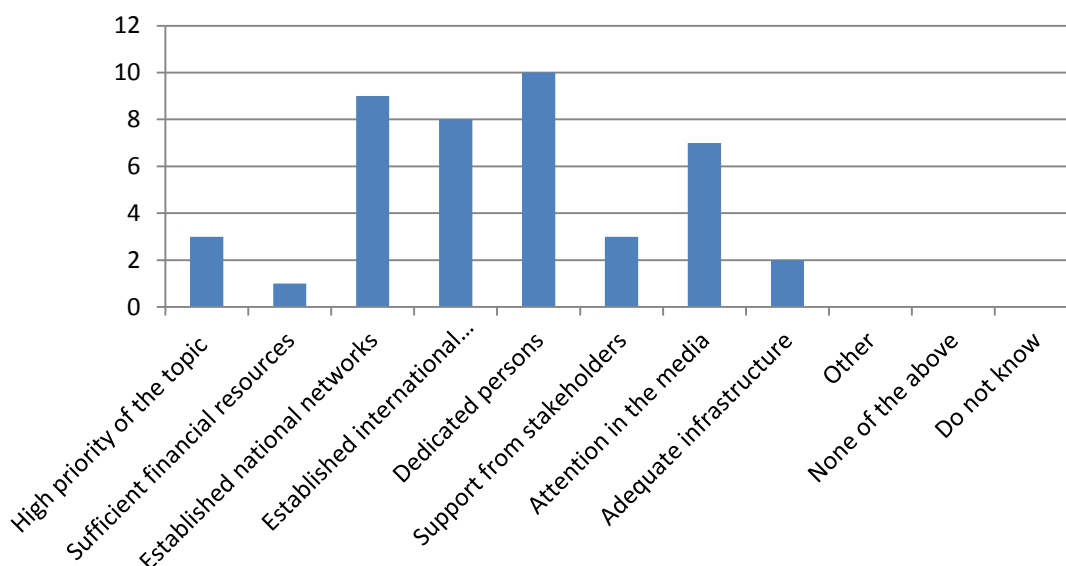
"It was not possible to get relevant authorities to engage in the project or support it financially/politically. E.G the National Board of Health insisted that child safety is not under their jurisdiction and that they do not have the resources to take on board child safety in the work. The National Safety Technology Authority was showing some interest in the project but could not support the project financially."

"The only thing lacking was funding to employ someone to specifically take forward CSAP in our country. Although organisations already focussed on child safety it was difficult to give any more time to the project with limited staff the specific organisation exists to promote the safety of all age groups and does this with very limited resources."

"The program is still fighting to stay a life a lot of energy goes into that to get money all the time."

## 7. What main factors facilitated impact from ENHIS in your country?

The CIs indicated between zero and four of the nine suggested facilitating factors for impact on stakeholders, and most common was to indicate two facilitating factors. This was done by seven (39%) of the 18 CIs. On average, the CIs indicated 2.4 facilitating factors. Dedicated persons was the facilitating factor that was reported by most CIs, ten (56%) of them did so (Figure 60). This was followed by Established national networks (50% of the CIs) and Established international networks that was reported by eight (44%) of the CIs.



**Figure 60.** Number of CIs that indicated different types of factors that had facilitated the impact of CSAP.

Five CIs commented facilitating factors as followed:

"The most effective was the accepting the injury prevention as a priority by Ministry of Health, and dissemination of the targets through dedicated persons in different sectors."

"Development of Public health guidelines and child safety action plan coordinate and strengthening information change between different stakeholders."

"Re 'Dedicated' persons: If this refers to specific people employed to take the project forward then the answer is 'no', this was not a factor facilitating impact. However, the 'dedication' to the topic of child safety shown by several people (champions) in our country undoubtedly led to the impact the project had. The support given by all the members of the CSAP Steering Group also played a key role."

"The dedication of the person that has run the program for 20 years if she would not constantly go we would not have a program."

"At the beginning of the Project, there was a real interest from authorities to develop it and I received help and collaboration, but for political reasons."

## 8. Coverage of the topic of CSAP in mass media

Eight (44%) of the 18 CIs indicated that mass media had had considerable or high coverage of the topic of CSAP, while ten (56%) of the CIs stated that the coverage of the topic in mass media had been limited. In the free text space six of the CIs expressed it as followed:

"The media cover now not only the dramatic and fatal events but offer the prevention information and possibilities of increase of safety."

"Mass media involved was active during the week of launching the results in our country. During the years, there have been quite many articles on child safety. It was more in previous years, when the numbers of fatalities were much higher than now. There has been more than a 50% decrease of child injury fatalities during the last 20 years in our country. Now there are about 20-30 children (0-14 years) that die in an injury each year. It might be that the problem is considered so minor so that it is hard to engage both media and the population in this issue. We have also noticed a shift in the attitude of the population during the last 20 years with regard to child safety, from being more protection orientated before to more outward orientated now. "We have to be cautious about not protecting our children too much!"."

"Should be more work with representatives of mass media to involve them in the child safety information activities."

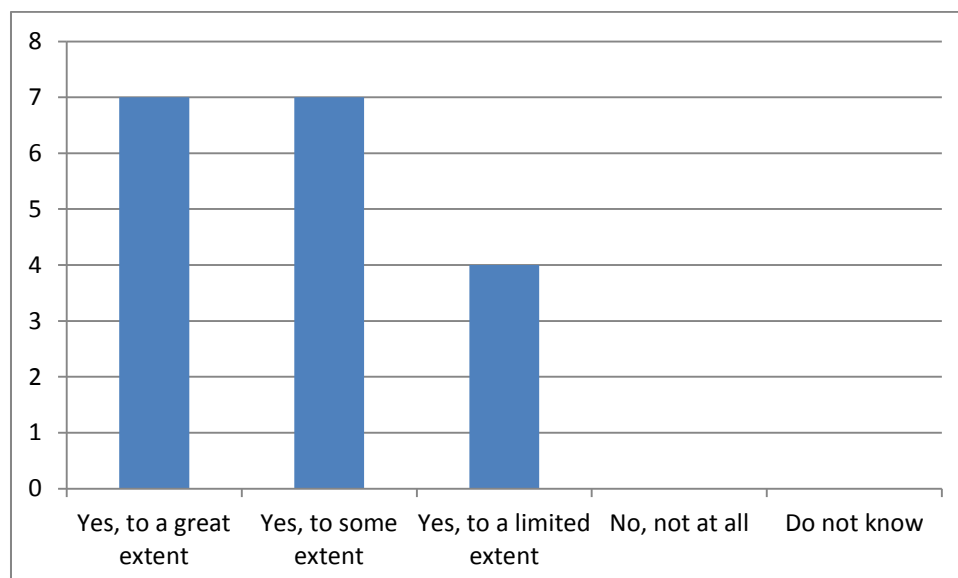
"Daily and weekly published newspaper and monthly published magazines for parents/caregivers."

"Media contacts are aware of CSAP and an increase in frequency of child safety related articles has been noticed."

"Media is now more likely to make news about injuries than they did before."

### 9. Relevance of the topic of CSAP

Fourteen of the CIs (78%) answered that the topic of CSAP had relevance to a great or to some extent in their country (Figure 61).



**Figure 61.** Number of CIs indicating the level of relevance of the topic of CSAP.

The relevance of the topic was commented by 15 (83%) of the CIs:

"Injury is the number 1 cause of death from 1 to 25 years in our country, but did not get enough attention in child health programs. Political commitment, strategic planning and intersectoral cooperation with clear leadership and responsibilities are the key factors of a successful preventive program. CSAP helped countries to exchange knowledge, and helped a lot to go through the steps of action planning, and sharing evidence based good practices."

"Project start in 2008 in our country. It was very timely, because injury rates and death rates related injuries are among the highest compared with other European countries."

"The child injury incidence in our country was high, twice compared with the best performing countries. The Ministry of Health choose the child injury prevention as a priority of the health sector and formed the interdepartmental working group to coordinate the activities across the sectors."

"Injuries is still the leading cause of death for children aged 0-14 years."

"The National Safety Forum, a national NGO on all types of accidental injuries, had an intention to establish a national child safety action plan during those years. The participation in the EU-project gave us ideas and support in order to promote the national development."

"Our country has no overall coordinated child safety policy. There is much happening at individual injury area level i.e. Road Safety, Water Safety etc."

"Injuries prevention is not of a high priority in the political agenda of our Ministry of Health. CSAP give us the opportunity by developing common actions through EU to make our efforts more efficient and we have more possibilities to be heard by the politicians. But still we are not satisfied of the reactions of the ministry of health. On the other hand the CSAP is very well known in schools and kitten gardens."

"In addition to the project child safety start as a one of the priority of public health policy. We should to do more activities to involve more public, young parents, school children and adolescents and mass media in the child safety activities. More collaboration with non-governmental organizations. great challenge is involvement of municipalities."

"Child Safety was to some extent covered in different plans and government strategies, but a cross ministerial focus on the topic was lacking."

"The CSAP opportunity came along at exactly the right time for child safety in our country. Lobbying work was already carried out (for many years) by different organisations. The CSAP was a natural progression on from the research paper - Stone DH, Jeffrey S. Injury in children – a research briefing paper. Edinburgh, Health Scotland. 2004 - which then led to a high level Seminar being held in Edinburgh in December 2004. Joanne Vincenten of ECSA attended the seminar to tell us more about CSAP and our country signed up to CSAP thereafter."

"The safety of children was rarely addressed specifically by policies or interventions. Children's safety was mostly included in the more generic safety interventions and legislation regarding the whole population."

"Child safety is not on top of the political agenda, but by the CSAP the topic got more interest and more political drive. By the European comparison (report cards) we reached to communicate, that our country has to strengthen its efforts to become better and to focus on specific issues."

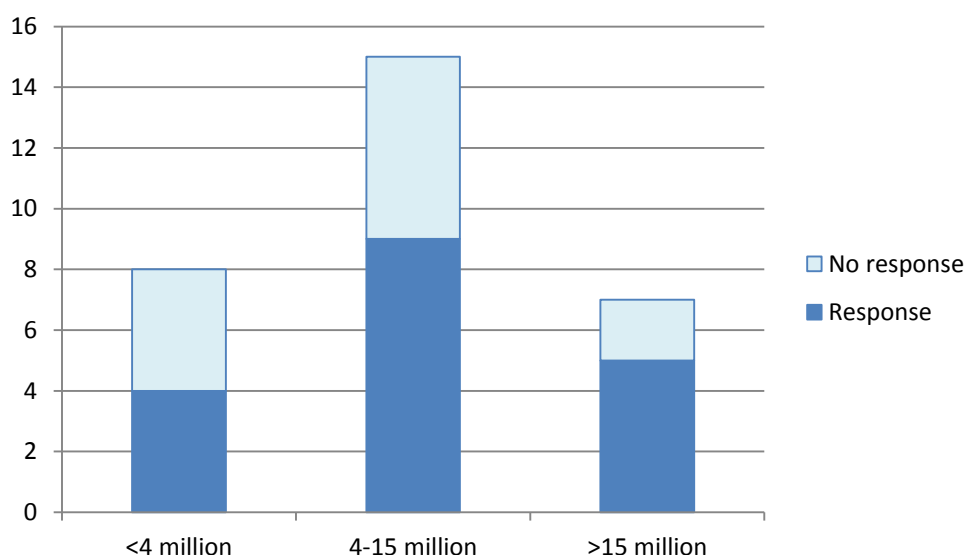
"It supports a lot of the work that I do. And it is also important to have a group you can get help from or information and knowledge and also give information and help to others."

"The mortality and prevalence of injuries was (and still is) much higher than European average in our country. National Health Plan was currently under the development."

"Very few institutions were interested in the Project, due to some indifference to Prevention."

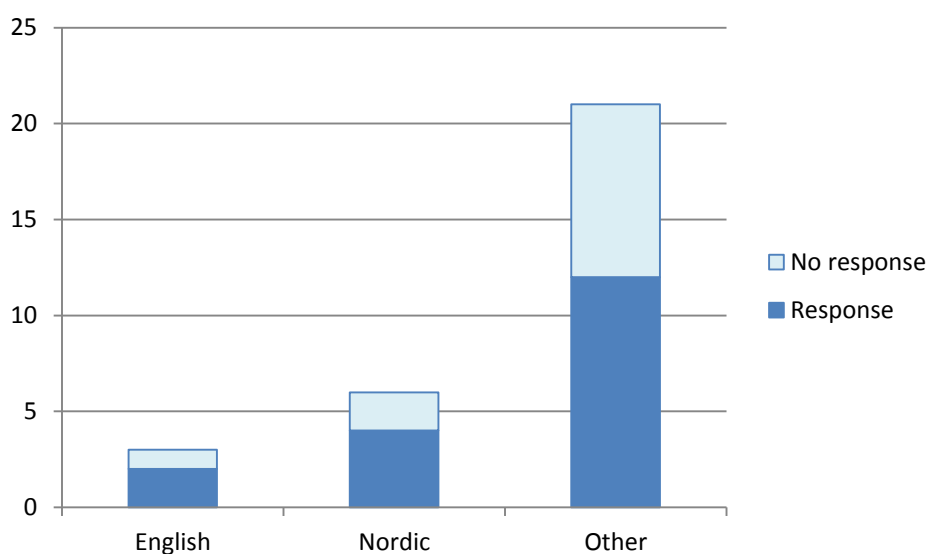
### **Responders to the CSAP web survey by category of country**

According to the number of inhabitants, a majority of the CIs that responded to the CSAP web survey represented a country in the group with 4-15 million inhabitants. More than half of the CIs in the three groups responded (Figure 62).



**Figure 62.** Number of participating countries with regard to number of inhabitants in the countries (representing 50%, 60%, and 71 %, respectively, of the countries in each group)

Based on the categorization regarding the knowledge of English language within the general population, the distribution shows that the group with CIs in Other countries were in majority. Almost two thirds of the CIs in all the three groups responded (Figure 63).



**Figure 63.** Number of participating countries with regard to three language areas (representing 67%, 67%, and 57%, respectively, of the countries in each area)

**Table 8. CSAP - Summary of number of countries and CIs involved, regarding different aspects**

EEA-countries	Project collaborators/partners/expertise in these countries	CSAP results were disseminated in these countries	Invited CIs	Invited CIs in the EUPHA database	Responding CI	Number invited countries	Responding countries	Invited CIs involved in CSAP
Austria	1	1	1		1	1	1	1
Belgium	1	1	1	1		1		
Belgium			1					
Bulgaria								
Cyprus	1		1			1		
Czech Rep.	1	1	1		1	1	1	1
Denmark	1	1	1	1	1	1	1	1
Estonia		1	1		1	1	1	1
Finland	1		1	1		1		
France	1	1	1			1		
France			1					
Germany	1	1	1			1		
Germany			1		1		1	1
Greece	1	1	1		1	1	1	1
Hungary	1	1	1		1	1	1	1
Hungary			1					
Ireland	1		1		1	1	1	1
Ireland			1					
Italy	1	1	1	1		1		
Italy			1		1		1	1
Latvia	1		1		1	1	1	1
Lithuania	1		1		1	1	1	1
Luxembourg	1	1	1			1		
Malta	1		1	1		1		
Netherlands	1	1	1			1		
Poland	1	1	1	1	1	1	1	1
Portugal	1	1	1			1		
Portugal			1		1		1	1
Romania								
Slovakia	1		1			1		
Slovenia	1		1	1		1		
Spain	1	1	1			1		
Spain			1		1		1	1
Sweden		1	1		1	1	1	1
Sweden			1					
UK	1	1	1			1		
UK			1		1		1	1
UK			1	1				
UK			1	1				
Iceland	1		1		1	1	1	1
Norway	1	1	1	1	1	1	1	1
Switzerland			1			1		
<b>Sum</b>	<b>25</b>	<b>18</b>	<b>40</b>	<b>10</b>	<b>18</b>	<b>28</b>	<b>18</b>	<b>18</b>



## EUCID - European Core Indicators in Diabetes Mellitus

### 1. Presentation of EUCID

#### General objectives of EUCID

The aim of the project European Core Indicators in Diabetes (EUCID) was to collect and compare data about risk factors for diabetes, complications and quality of care indicators in member or future member countries of the European Union in order to promote the planning for a good diabetes health status and diabetes care organization in the different countries.

Furthermore several objectives were formulated for the project:

- The first objective was to show the feasibility of the data collection;
- The second objective was to create a stable platform for the data collection;
- The third objective was to create a reporting platform for the indicators using the existing structure of the EC.

Nineteen countries provided data for a list of indicators by age band which were representative at a regional or a national level for 2004, 2005, or 2006. The indicators for this project were designed during the European Diabetes Indicators Project - EUDIP. Data were age-standardized for comparisons performed in the general population.

#### Summary of EUCID, provided by Iveta Rajnicova-Nagyova, Slovakia

While European epidemiologic systems can provide diabetes indicators, major indicators as blindness are still missing. Most of the European countries achieve remarkable good testing of people with diabetes. Risk factors and outcomes vary across countries, reflecting a mixture of genetic background, societal and cultural factors, as well as public health politics.

To be more specific:

- Among the least available indicators, incidence of blindness in people with diabetes was provided by only 4 countries, and impaired fasting glucose in general population by 2.
- The standardized prevalence of diabetes varied from 2.6% in Finland to 7.6% in Cyprus; crude incidence of diabetes (0-14 yrs) from 11 in Spain to 60 per 100,000 in Finland; standardized prevalence of overweight (25-74 yrs) from 37% in Germany to 60% in Cyprus; standardized mortality rates linked with diabetes from 7 in Luxembourg to 56 per 100,000 in Finland.
- Among people with diabetes (>25 yrs), process indicators ranged: for HbA1c testing once a year, from 51% in Ireland to 99% in the Netherlands, France and Belgium; for lipid testing, from 45% in Ireland to 99% in the Netherlands; for microalbuminuria testing, from 25% in Finland to 97% in the Netherlands; for fundus examination, from 12% in Ireland to 84% in the Netherlands.
- Risk factors in people with diabetes varied: HbA1c>7%, 32% in Ireland to 83% in Cyprus; total cholesterol>5mmol/l, 14% in Ireland to 68% in Cyprus; microalbuminuria, 9% in Finland to 41% in England; blood pressure>140/90mmHg, 17% in France to 46% in Sweden; smoking, 10% in Ireland to 37% in Denmark.

- Complication incidence rates were: dialysis and transplantation, 4 in Cyprus to 149 per 100,000 diabetes clients in Scotland; stroke, 37 in Cyprus to 2675 in Germany; myocardial infarction, 21 in Cyprus to 2135 in Austria; major amputation, 78 in Scotland to 574 in Spain.

### **Comments in the EUCID final report whether the project accomplished its main objectives**

According to the final report most of the European countries achieved remarkable good testing of people with diabetes, however, all the data originated from databases that might not reflect the average situation and the true numbers might be different.

All of the indicators collected in this project were not complete for all countries, some were available for almost all countries, like prevalence of diabetes, while others were almost non-existing, like timely laser treatment for diabetic retinopathy. Also, the sources for the data were different, so that the comparability of the indicators was not optimal. Some have national databases, while others have more or less representative regional data. Risk factors and outcomes vary across countries, reflecting a mixture of genetic background, societal and cultural factors, as well as public health politics, in combination with local quality of health care. Furthermore, comparisons were also difficult when different standards were used for measurement. Sweden for instance had to calculate their HbA1c values to international standard before it was possible to compare their data with the rest of Europe. Thus, as authors of the final report highlighted, the standards of measurement is an issue that should be addressed in the future.

### **Project collaborators/partners/expertise in EUCID**

EUCID had collaborators/partners/expertise from 17 of the 30 EEA-countries, as well as one collaborator/partner from Turkey (Table 9, page 117).

### **Project collaborators/partners included**

Several different types of collaborators/partners were included. Such as the government, health authorities, health care providers, professional organizations, universities and other research organisations and international organisations. As the final report of the EUCID project was not available and as many involved organisations do not have their web-site in English language, there might be more.

### **Dissemination of results from EUCID**

According to the final report the results of EUCID would be used within countries to try to influence the policies towards diabetes care. For the European Commission these data would support the discussion on diabetes risk factors and diabetes care in the European Union.

Furthermore, the final report highlighted the need of two kind of information on indicators for diabetes risk and diabetes care: first national data on risk factors and prevalence and incidence of diabetes and major complications like stroke, blindness and kidney function replacement therapy and second data on regional or even local quality and quantity of care from clinical databases like indicators on blood pressure and average blood glucose. These indicators will be provided by a system called EUBIROD (European Best Indicators through Regional Outcomes Diabetes), that will combine national and regional indicators in an automated way, so that care planners can always have reliable indicators at their disposal. In this way Diabetes

Europe will be put on the map in a more robust and stable way. No information was provided in the final report on how many countries results from the project were disseminated to.

### Key targets for dissemination

The key targets for dissemination were: government, the policy makers and health authorities, and other authorities (the European Commission). Information about ways of dissemination that were used was not provided in the final report.

## 2. EUCID - introduction to PHIRE, WP 4

### The process to identify the country informants for PHIRE, WP 4

The process of identification of CIs for evaluation of the EUCID project has been done in several steps:

1. Firstly, an e-mail with an invitation to being a CI for the EUCID project was sent to all members of the EUPHA Section on Chronic Diseases.
2. Secondly, in the next phase, partners of the EUCID project have been identified and sent an invitation to evaluate the project.
3. Thirdly, the diabetes organisations from the countries which have not responded in the first and second round have been identified and asked for cooperation.
4. Fourthly, we have identified possible CIs in the diabetes field based on abstracts presented at the EUPHA conferences (both oral and poster) that have been published in the European Journal of Public Health.
5. Finally, we relied on our personal contacts in countries, which had not replied in steps 1-5.

In total 13+1 countries have responded: 13 out of 30 EEA countries (43.3% response rate) and 1 not from EEA (Turkey)<sup>4</sup>. The ratio between countries that had been involved in the project or not was similar, although it was a bit higher for countries that have been involved in the project. 11 of the 19 project partners (57.8% response rate) have responded on our invitation to evaluate the innovative project in which they have been involved. This difference was not statistically significant, however (with proportions test).

## 3. Results regarding EUCID

### 1. Invited and responding CIs

In total 46 CIs, representing 24 countries were invited to answer the web-based questionnaire (Table 9, page 117). Questionnaire responses were obtained from 19 CIs representing the following 13 countries: Czech Republic, France, Ireland, Italy (three CIs), Lithuania, Luxembourg, the Netherlands, Portugal (two CIs), Romania (two CIs), Slovakia, Slovenia, Spain, and United Kingdom (three CIs). The 13 countries correspond to 43% of the 30 EEA countries. Additionally two CIs representing countries outside EEA responded, one CI each from Turkey and Croatia. However, their results are not included in the present analyses. For the countries with more than one CI responding to the web survey, the answers from those CIs have been combined, taking the average if they did not agree.

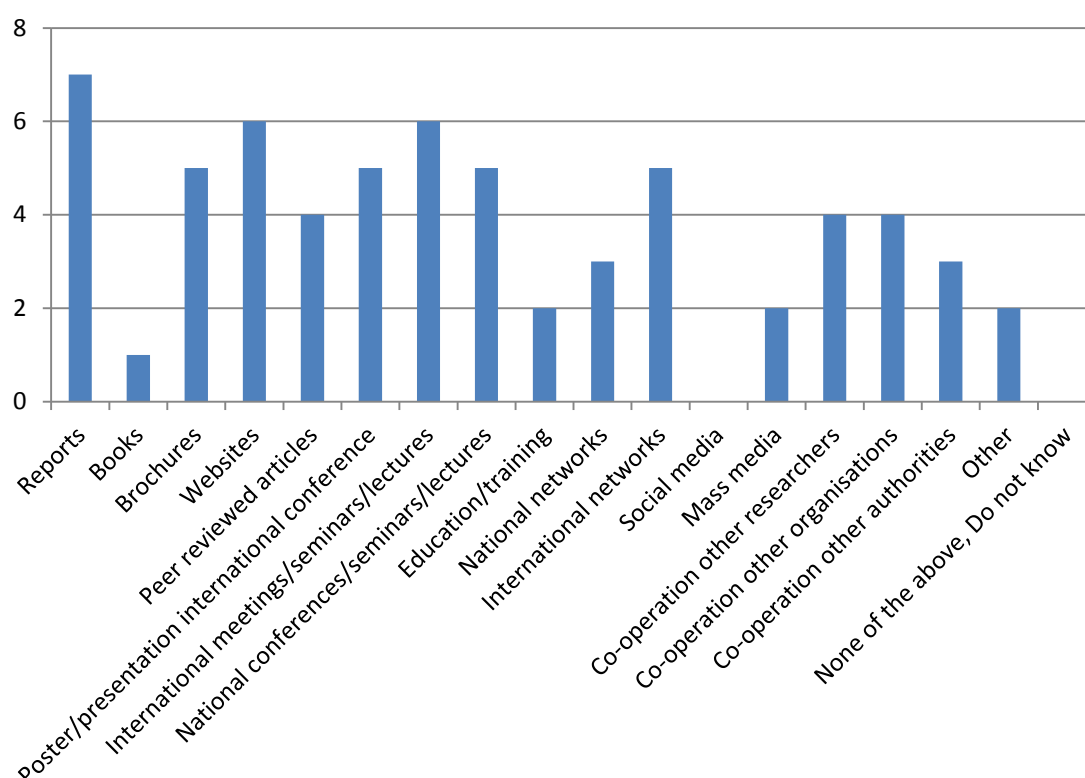
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<sup>4</sup> Not included in the report.

Fifteen of the 46 invited CIs (33%) were in the EUPHA database of individual Section members and of the 19 CIs that finally answered the web survey, ten (53%) were in the EUPHA database. Eight (42%) of the 19 CIs that answered the EUCID web survey had been involved in the project. Three (16%) of the CIs who participated had been involved as a project leader/coordinator and five (26%) as project partners.

## 2. Dissemination of results

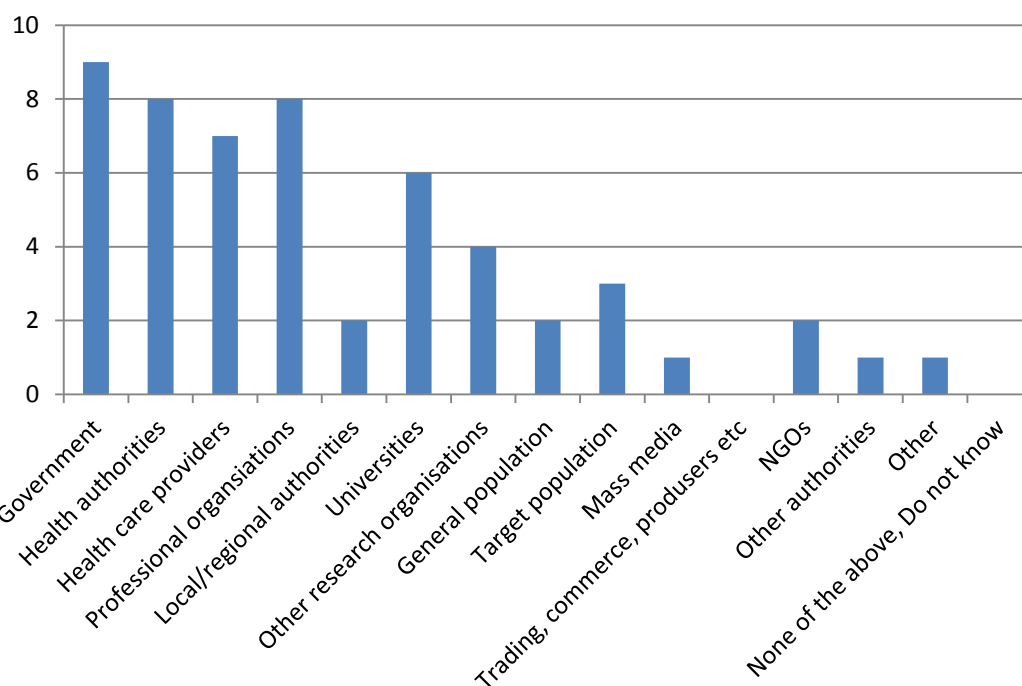
Results from EUCID were disseminated in 16 different ways according to the web-survey results (Figure 64). Each country indicated between 0 to 14 different ways for dissemination. Among the 11 countries that answered the question, the most common was to indicate one of the suggestions for dissemination (n=2), while the average number was 5.6 ways per country for dissemination of the results. Mainly, dissemination was through 'Reports' with seven countries (64%), followed by Websites and International meetings/seminars/lectures with six countries (55%) indicating this. Further, four countries (36%) each indicated Brochures, Poster/presentation at international conference, National conferences/seminars/lectures, and International networks as ways for dissemination.



**Figure 64.** Number of countries indicating the channels used to disseminate the results from EUCID.

According to the results, 13 different types of groups/organisations were reached by information about the project (Figure 65). For each country, between two to nine groups were indicated. Most common was to report six different types of groups/organisation which three of the countries did. The average number was 5.4 indicated groups/organisations per country.

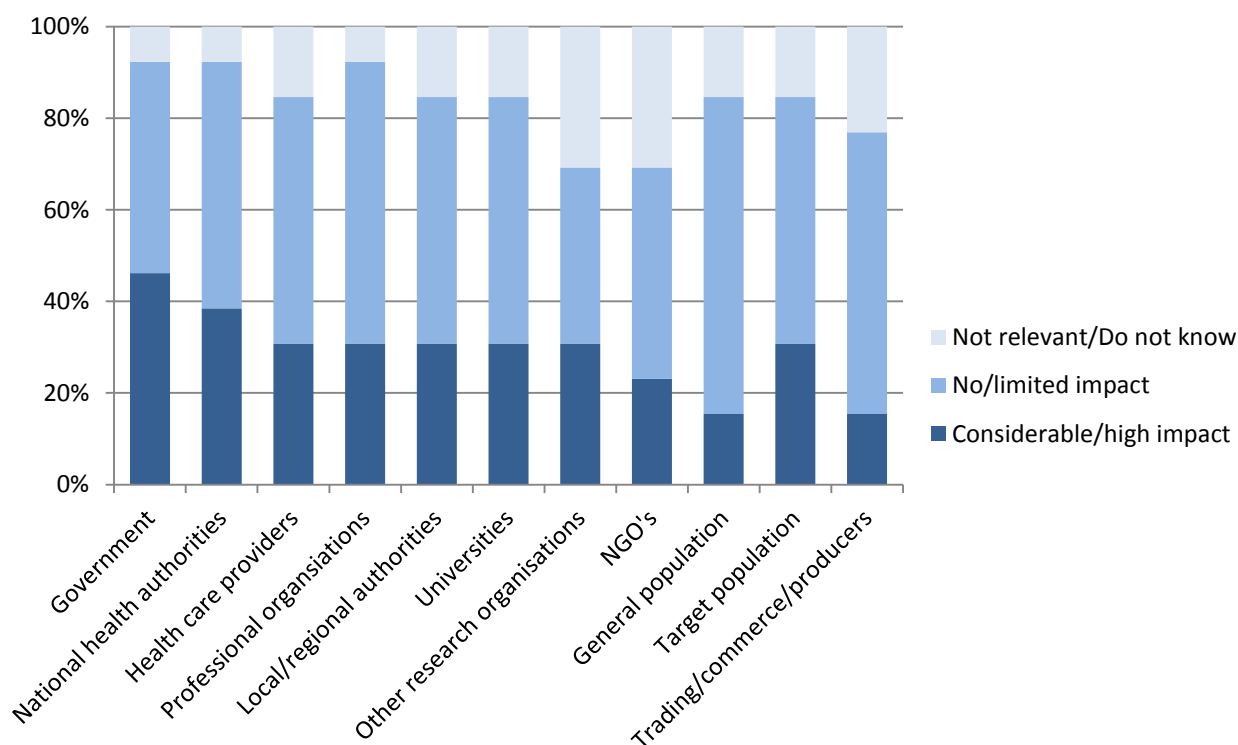
Government was the group that most countries indicated as reached by information about EUCID (90%), followed by Health authorities and Professional organisations with 8 countries (80%) stating this. The group 'Health care providers' was indicated by seven countries (70%). Compared to the key targets for dissemination of results from EUCID that was mentioned in the final report (page 107) the CIs additionally indicated also e.g. Universities and Other research organisations.



**Figure 65.** Number of countries indicating groups/organisations that were reached by information about EUCID.

### 3. EUCID impact on knowledge/awareness of stakeholders

Government was the stakeholder that most countries (43%) indicated as having had considerable or high impact on knowledge/awareness from EUCID (Figure 66), followed by National health authorities (36%), and Health care providers, Professional organisations, Local/regional authorities, Universities and Target population with 29% of the countries indicating considerable or high impact on knowledge/awareness. Not unexpected few countries stated Considerable/high impact on the General population and Trading, commerce and producers.



**Figure 66.** Proportion of countries indicating level of impact on knowledge/awareness among different stakeholders.

#### 4. Comments on the impact of EUCID on knowledge/awareness of stakeholders

Following the questions about impact of EUCID on stakeholders, it was possible to add further examples or comments in an unlimited free text space. One stated that "Our country was not involved in this project". There were large variation between CIs regarding to what extent they used this opportunity. Four of the CIs did not use the opportunity of the free text space while the additional eight had comments for one or several of the stakeholders. Comments are presented below.

**Government:** "Our country was not involved in this project."

"Known at government level, but without impact."

"Government supports the development of a diabetes plan, such as the breast cancer plan."

"As previously said, the national program for diabetes surveillance has an important impact on knowledge, policy... EUCID added a cross country comparison, which was very much limited by differences in surveys, methods, population... Our country stood at the middle of the comparison, which could not be used very much as an example."

"EUCID Report was used by the NIPH as reference methodology for the project in 2011-2012 aimed to provide a national set of indicators and development of data sources."

**National health authorities:** "Not very known by health authorities"

"EUCID Report was used by the NIPH as reference methodology for the project in 2011-2012 aimed to provide a national set of indicators and development of data sources."

"Funding is a problem."

**Health care providers:** "Not very known by health care providers."

"This legal modification is probably not directly or not at all linked to the diabetes projects, but with some possible spin off for diabetes care."

**Professional organisations:** "One project is now achieving what was sought in setting up a harmonised and hopefully in the next two years exhaustive information on pediatric t1 and t2 dm population EU BIROD needs to better define their indicators to obtain the same reliable information."  
"A national clinical network for diabetes has been initiated."

**Local/regional authorities:** "Not very known by local/regional health authorities."  
"The final report was circulated to national partners, with the expectation that they would cascade to colleagues locally/regionally."

"Difficult to evaluate as our country is very small."

**Universities:** "Not very known by universities."

"Only information from web sides."

"University is new, but there has been collaboration with the National public health research in developing further projects IN the university diabetes is as well one of the key topics, and this awareness does come from the different interactions between patient organisation , medical research , public health research."

**Other research organisations:** "Only from web sides and from journals."

"May be this is the one from above ...National public health research."

"Grant from the Health Research Board was obtained around time of EUCID."

**NGOs:** "CBO."

"ALD , CHL(local main hospital has been definitely more involved)."

"One project has had a high impact on the lives of children and young people living with diabetes in our country."

**General population:** "The final report was not widely circulated to the general population, although it was made available through a publically available web portal so could have been accessed by a wider general population."

"Some more information has been transmitted to the general population and I do not think I can identify // isolate the effect of the EUCID project and the other actions."

"Coupled with healthy lifestyle and health eating campaign, there has been a general increase in the uptake of healthy eating options including exercises. Screening of diabetes has been improving tremendously and most people respond to the call for testing and checking of diabetes with their GP."

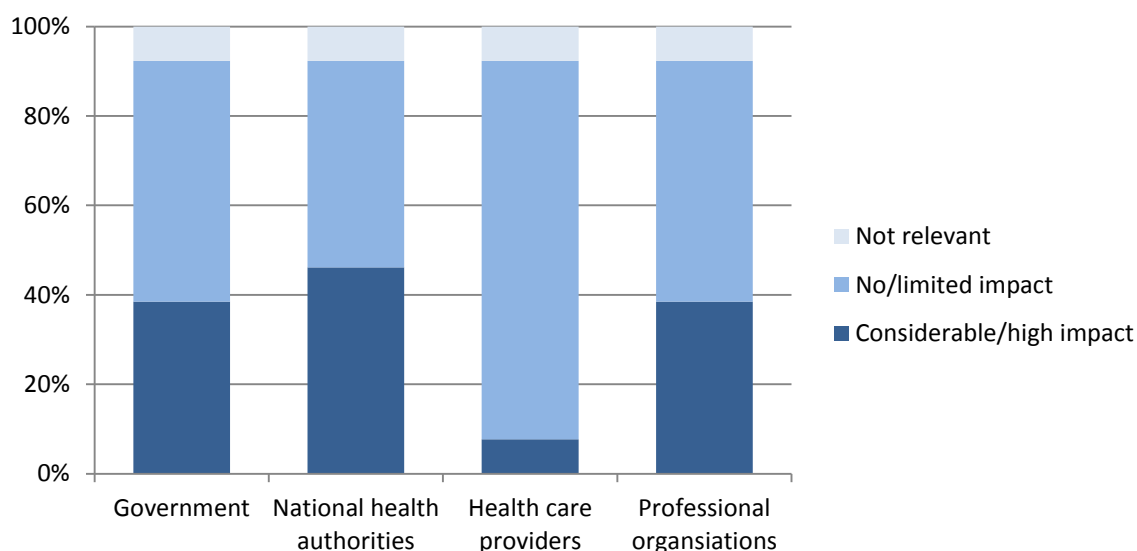
**Target population:** "Limited pilots were very successful however - at a national level progress is required."

**Trading/commerce/producers etc:** "Pharmaceutical companies are providing support for people with diabetes through provision of training to professionals and support of campaign awareness including provision of support for equipment used in the monitoring of diabetes management in people living with the condition."

### **Impact of EUCID on policy, reforms, guidelines, and routines**

Considerable or high impact from EUCID on policy, reforms, guidelines, and routines was indicated for the Government (36%), National health authorities (43%), and Professional organisations (36%). Regarding Health care providers, only one country (7%) indicated considerable or high impact on policy/guidelines (Figure 67). Additionally, a large proportion of the countries (53-60%) indicated no or limited impact on the stakeholders. One country (7% of all) stated that the impact on policy, reform, guidelines, and routines was not relevant for these organisations/groups.





**Figure 67.** Proportion of countries indicating level of impact on policy/reforms/guidelines/routines.

The unlimited free text space for the CIs answers or comments to the question about the likelihood that the impact on the different stakeholders could have occurred without the EUCID project was used to some extent. Such comments were given by CIs from ten countries (77%):

"No idea, there would have been other projects probably."

"Not relevant for our country."

"Most of the impacts above have happened independent of the EUCID project. Already having these initiatives allowed us to contribute to EUCID in a far more comprehensive way. If such initiatives were not already in place, the EUCID project may have prompted our country to adopt some or all of them."

"I do not know."

"Yes, we have a good health care prevention policy (in this time)."

"Country didn't participated in the project"

"Might but not certain. It does create awareness when discussing the incidence and mobilising all health care professionals to answer questionnaires."

"No impact."

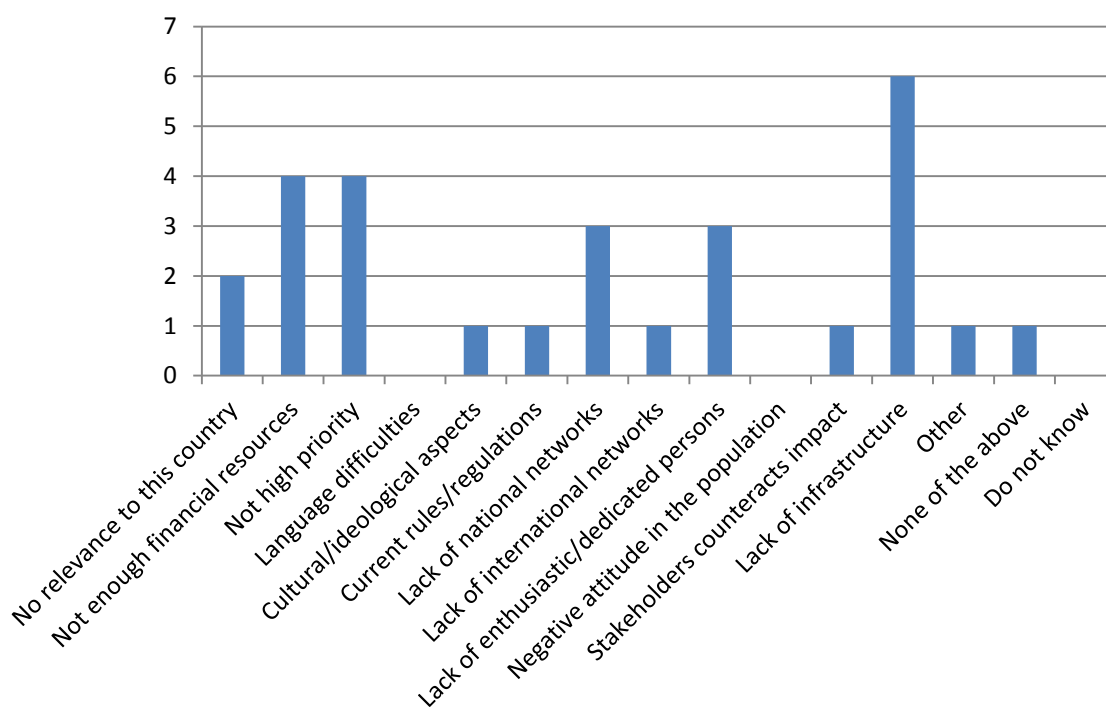
"The project was one of many contributors to any improvements that occurred."

"Yes, but the project contributed in part to the increase the awareness of diabetes burden and suboptimal care."

## 6. Main factors hindering impact

Regarding factors that might have hindered impact of EUCID, one to six of the 13 suggested options of factors that might have hindered impact were indicated for each country. Most often one hindering factor was indicated, this was the case for 4 (36%) of the countries (Figure 68). On average, the countries indicated 2.5 factors. Six (55%) of the 11 responding countries indicated that a main hindering factor was Lack of infrastructure, followed by four countries (36%) that stated that Not enough financial resources allocated and that That the issue does not have high enough priority were hindering factors for dissemination in their countries.





**Figure 68.** Number of countries that had indicated each type of factor that hindered the impact of EUCID.

Three of the countries did use the free text space to comment regarding hindering factors for impact of EUCID in their country:

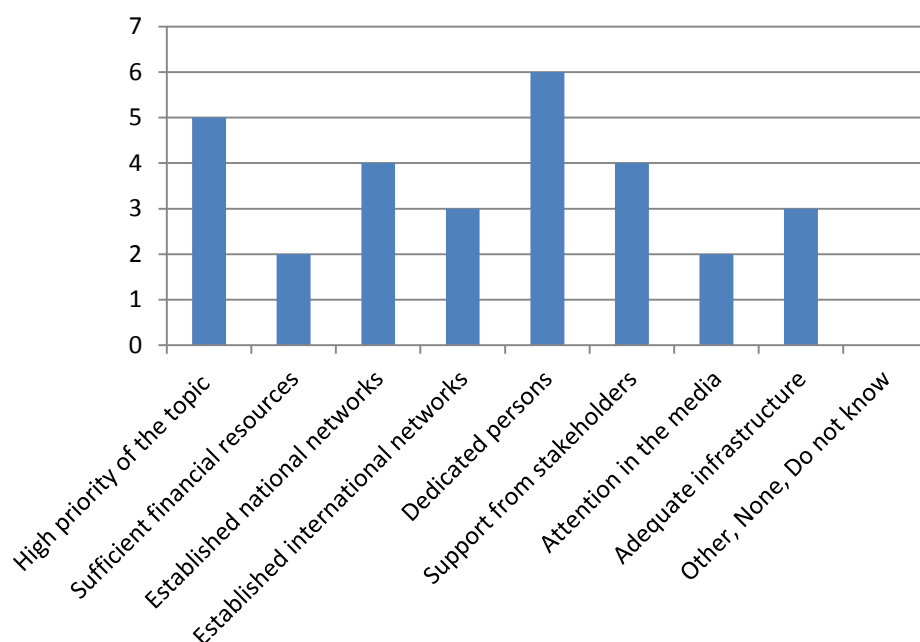
"Our country, while happy to contribute to the EUCID project, was already advanced in the development of diabetes networks and shared datasets. If we had not been in such a fortunate position, the EUCID project would have had a greater impact than it did"

"Please comments for question 6 - a major hindering factor related to the quality of the submitted data and the lack of potential comparators."

"We do move forward but at a speed which is not as fast as I would like, but maybe I'm impatient. i think that the goodwill is clearly there , but you do have a small country with many different interests which need to be addressed as well . Overall a positive reception but we need to continue the efforts and stop reinventing the wheel."

## 7. Main factors facilitating impact

Regarding factors that facilitated impact of EUCID in the different countries, between one and five of the nine suggested such factors were mentioned per country. On average the countries indicated 2.6 facilitating factors. Most common was to indicate three facilitating factors, which 36% of the countries did. Dedicated persons were the most reported factor, with six countries (55%) stating this (Figure 69), followed by High priority of the topic (45%), and Established national networks and Support from with 36% of the countries reporting this.



**Figure 69.** Number of countries that indicated different types of factors that had facilitated the impact of EUCID.

Additionally, three countries commented on the facilitating factors as followed in free text:

"Diabetes has been identified as a priority condition and has a mature infrastructure facilitated by regional Managed Clinical Networks and the National Diabetes Group. There was however interest in the EUCID results within these regional and national groups for European comparison purposes."

"Working group, collaboration between research institute, clinical doctors and government."

"High on the agenda of the Ministry of Health."

### 8. Coverage of the topic of EUCID in mass media

Five (38%) of the 13 countries indicated that mass media had had considerable or high coverage of the topic of EUCID, five (38%) indicated that the coverage of the topic in mass media had been limited or had no impact. In the free text space three of the CIs expressed it as followed:

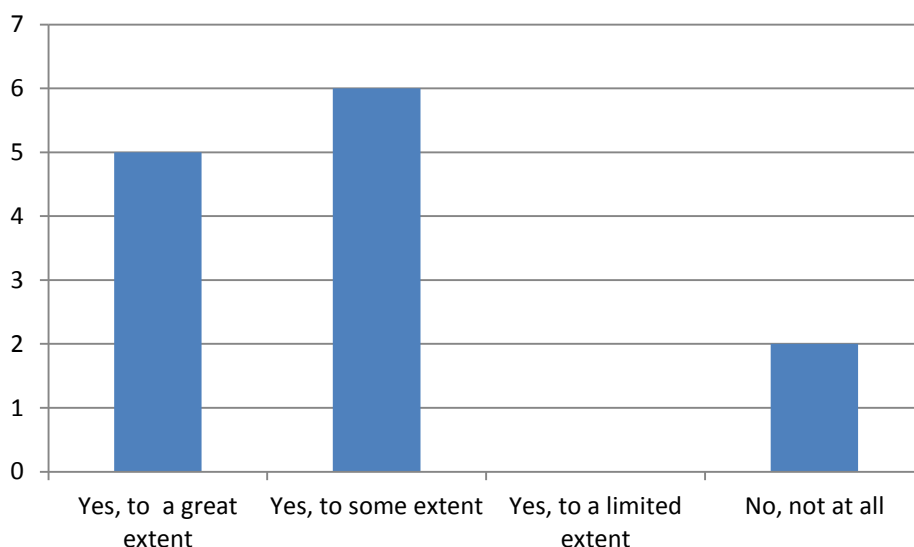
"I do not have further information."

"We had for the different diabetes actions and therefore some TV coverage and some major journal coverage. Not only on EUCID."

"Details were published in the press."

### 9. Relevance of the topic of EUCID

Eleven (85%) of the countries reported that the topic of EUCID had relevance to a great or to some extent (Figure 70).



**Figure 70.** Number of CIs indicating the level of relevance of the topic of EUCID.

The relevance of the topic was commented by 15 of the CIs:

"Because the information were mainly restricted to a scientific context and it varies with the region. Diabetes is a progressively increasing heavy burden for the affected individuals and for the society. A system for data collection on the epidemiology of diabetes is already in place in the country. It was cited as an example of our country's performance in diabetes epidemiology and care in national and international meetings and congresses. It was cited and used in documents of the Ministry of Health and National Health Institute."

"Diabetes is a chronic condition which has a growing impact on the people suffering from this condition, on their families, on the health care system, and, overall, on the society."

"It helped the discussion of data collection for diabetes care in our country. As well the clinical field as the government were involved and interested."

"European core indicators in diabetes mellitus might reflect the quality of diabetes care."

"DM is ongoing burden in our country, according to the last available data 300 000 people officially suffer from DM. It is estimated that the next 300 000 have not been diagnosed yet because they are not aware of burden and symptoms of DM. Unfortunately, our country was not involved in the EUDID nor EUCID projects. However there is developed health data collection system in our country including data of DM."

"Having been reporting on local, regional and national diabetes outcomes in our country since 1995, EUCID allowed us to compare diabetes outcomes internationally across Europe and was the logical next step. EUCID defined core diabetes indicators for diabetes across Europe. The project in our country was one such example of activities proving the EUCID whose main aim was to promote secondary promotion of prevention of diabetes."

"Our country was not selected for the pilot research."

"In our country we have high quality datasets on the management of diabetes. However, we lack European comparisons which would add value considerably."

"It was again demonstrated that EU wide a huge variation exists in the way data are collected. Differences are 1) definition of the indicator, taking into account the nominator and the denominator frequency and way of collecting and registering. In theory we have defined the indicators in the previous studies EUDIP (HMP 2000-2002), the next step should be that all members states should discuss these indicators (up to a certain extend) and implement them at least some key indicators. In EUCID we wanted to evaluate what had happened after this first project and had to conclude that at a national level a work was still needed this has been discussed at different levels and hopefully over the next years a national diabetes plan may lead to improved registration of reliable indicators."

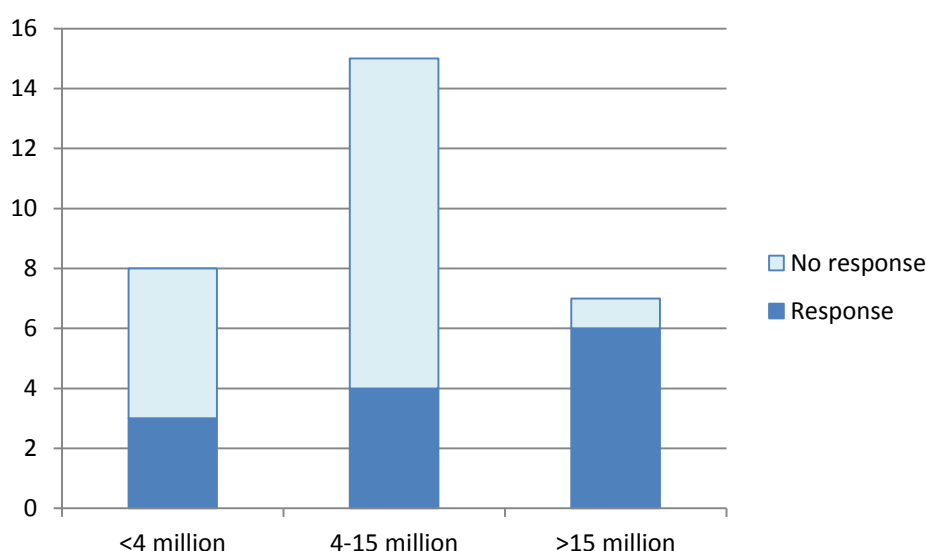
"We are responsible for surveillance of the same indicators. In our country, some indicators cannot be provided due to the lack of data (blindness) despite the fact that it is an important outcome. Some indicators can be provided and demonstrate the potential for improving health care. Cross-country comparisons are relevant as they provide information about where our country stands."

"Diabetes is becoming an important public health problem in our country in terms of prevalence, incidence, and distribution of determinants in the population and is already a significant burden for the healthcare system."

"A standardised approach to collecting diabetes health indicators is very advantageous."

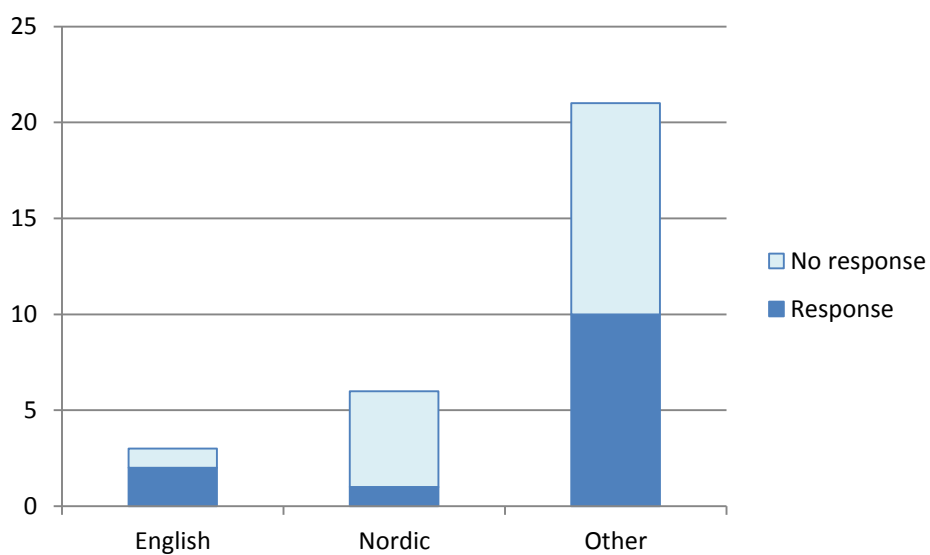
### 10. Responders to the EUCID web survey by category of country

When categorizing the countries according to number of inhabitants (see page 10), most countries that responded to the EUCID web survey were in the group with more than 15 million inhabitants. About one third of the countries in the two groups with up to 15 million inhabitants responded and almost all of the countries with more than 15 million inhabitants responded (Figure 71).



**Figure 71.** Number of participating countries with regard to number of inhabitants in the countries (representing 38%, 27%, and 86 %, respectively, of the counties in each group)

Based on the categorization regarding the knowledge of English language within the general population, the distribution shows that Other countries were in majority. Two thirds in the English speaking group, and half of the countries in the “Other” group, but few in the Nordic group responded (Figure 72).



**Figure 72.** Number of participating countries with regard to three language areas (representing 67%, 17%, and 48%, respectively, of the countries in each area)

**Table 9. EUCID - Summary of number of countries and CIs involved, regarding different aspect**

EEA-countries	Project collaborators/partners/expertise in these countries*	EUCID results were disseminated in these countries**	Invited CIs	Invited CIs in the EUPHA database	Responding CIs	Number of invited countries	Responding countries	Invited CIs involved in EUCID
Austria	1		1			1		
Austria			1			1		
Belgium	1		1			1		
Bulgaria								
Cyprus	1		1			1		
Czech Rep.			1	1	1	1	1	
Denmark	1		1			1		
Estonia								
Finland	1							
France	1		1		1	1	1	1
France			1					
Germany	1		1			1		
Greece	1		1			1		
Hungary			1	1		1		
Ireland	1		1		1	1	1	1
Ireland			1					
Italy	1		1	1	1	1	1	
Italy			1	1	1			
Italy			1		1			1
Latvia								
Lithuania			1		1	1	1	
Luxembourg	1		1		1	1	1	1
Luxembourg			1					
Luxembourg			1					
Malta								
Netherlands	1		1	1	1	1	1	1
Netherlands			1	1				
Netherlands			1					
Netherlands			1					
Poland			1			1		
Portugal	1		1	1	1	1	1	
Portugal			1		1			
Portugal			1					
Romania	1		1	1	1	1	1	1
Romania			1	1				

Table 9 continues on next page!

<b>Cont. Table 9 EUCID</b>	Project collaborators/ partners/expertise in these countries	EUCID results were disseminated in these countries*	Invited CIs	Invited CIs in the EUPHA database	Responding CIs	No. of invited Countries	Responding countries	Invited CIs involved in EUCID
EEA- countries								
Romania			1		1			
Slovakia			1	1	1	1	1	
Slovenia			1	1	1	1	1	
Spain	1		1	1	1	1	1	
Spain			1	1				
Spain			1					
Spain			1					
Spain			1					
Sweden	1		1			1		
Sweden			1					
Sweden			1					
UK	1		1	1	1	1	1	
UK			1		1			1
UK			1		1			1
UK			1					
Iceland								
Norway								
Switzerland			1	1		1		
<b>Sum</b>	<b>17</b>	<b>-</b>	<b>46</b>	<b>15</b>	<b>19</b>	<b>24</b>	<b>13</b>	<b>8</b>

\* Also from Turkey

\*\* Information not provided in the final report of the EUCID.

## Summary of results for the eight innovative public health projects

### 1. Invited and responding CIs

As described in the introduction of each innovative project, the way of inclusion and invitation to the CIs to participate in the web survey differed somewhat between the eight projects. The process to identify and to invite CIs and to find new ones when the CIs did not respond also varied somewhat between the Section leads. To support this, the WP4 coordinators arranged telephone conferences, had contacts via e-mail and telephone and sometimes supplemented with suggestions of possible CIs.

Thus, the numbers and the proportions presented in Table 10 must be interpreted with caution since the method for identification of CIs differed between the projects. Generally, the experience was that this way to collect rather specific and complex information from experts and researchers around Europe was by some CIs experienced as difficult. The instrument (the web survey) was extensive and although the CIs were experts in their field they sometimes had to search for the requested information from different sources. The type of information asked for here is not the types usually documented – nevertheless, of importance in order to get an understanding of impact of projects. We also realise that even though the invited CIs most likely had great interest in the topic of the project, the time to spend to respond to the web survey competed with the time to complete their ordinary work duties.

The goal was that for each of the eight projects, CIs from at least 20 of the 30 EEA countries (e.g., 67%) should have answered the web survey. This goal was only reached for CHOB (67%) followed by CSAP and URHIS I with 60% and 50%, respectively, of the countries represented (Table 10).

The main way to identify the CIs was through both old and new membership lists of the EUPHA Sections. Thereafter, other ways could be used, such as using own networks, based in the Section leads own expertise in the area. For four of the projects, the majority of the CIs were not in the EUPHA database.

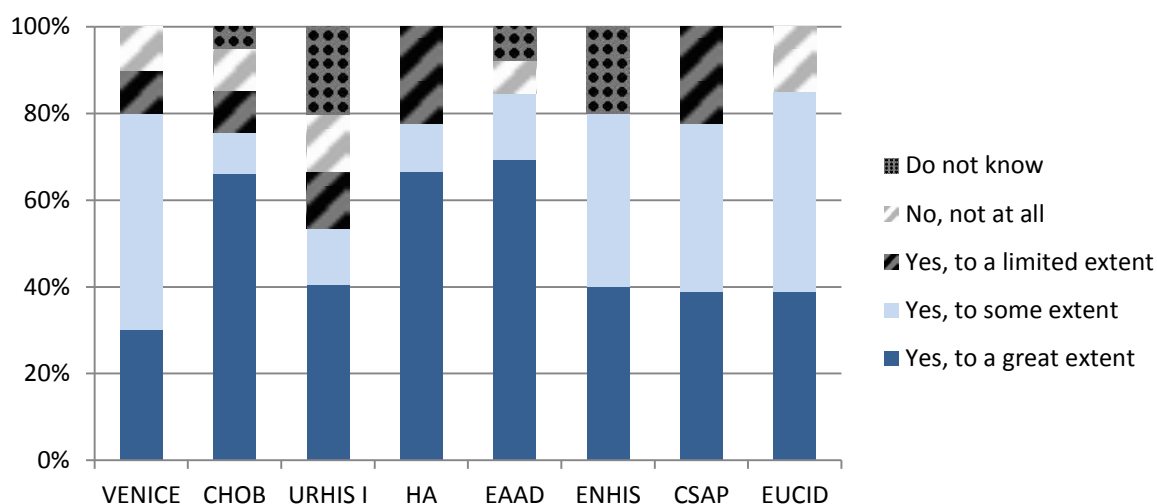
**Table 10. Summary of invited CIs, respondents and membership in EUPHA Sections**

Projects	No. invited CI	% of the invited CIs that responded	% of invited CIs in the EUPHA database	No. invited countries	No. responding countries	% of the 30 EES countries that responded
VENICE	23	56.5	52.1	18	10	33.3
CHOB	27	77.8	66.6	23	20	66.7
URHIS I	47	40.4	85.1	20	15	50.0
HA	40	22.5	85.1	30	9	30.0
EAAD	47	29.8	31.9	30	13	43.3
ENHIS	28	35.7	31.9	22	10	33.3
CSAP	40	45.0	25.0	28	18	60.0
EUCID	46	41.3	32.6	24	13	43.3



## 2. Relevance of the topic of the innovative project

The results of the views of the CIs about the relevance of the topic of the innovative project in their respective country showed that for more than 60% of the countries EAAD, HA, and CHOB were found to be of relevance to a great extent (Figure 73). For the remaining five projects, between 30% and 40% of the countries stated that the projects had relevance ‘to a great extent’. Merging the two response alternatives of relevance, to a great extent and to some extent, implies that for seven of the projects at least 70% of the countries reported the projects to be of relevance. For URHIS I, 50% of the countries reported relevance to a great or to some extent. As many as 20% of the countries that responded for URHIS I and ENHIS, reported that they did not know about the relevance of the topic of those projects. Regarding HA and CSAP, no country responded that they did not know about the relevance of the topic in their country. Regarding CSAP, this is not surprising since all CIs reported that they had been involved in the innovative project as project leader/coordinator or as a project partner. However, this was not the case among the countries responding for HA.



**Figure 73.** Distribution of the countries’ estimation of relevance of the different innovative public health projects’ topic.

## 3. Signals of impact of the innovative public health projects

The question: ‘How many of the following twelve types of groups/organisations were reached by information about the project’ had the following response options: government, national health authorities, health care providers, professional organisations, local/regional authorities, universities, research organisations, non-governmental organisations (NGOs), general population, target population addressed in the project, mass media, trading and other authorities (see Annex 6). Table 11 shows that for CHOB it, among the countries, was most common to report that 0-1 group/organisation had been reached by information about the project, 57% of the countries did so. For CSAP and EAAD the picture was the opposite, it was most common to report that  $\geq 5$  groups/organisations had been reached by information, with 72% and 46% reporting this, respectively.

**Table 11. Proportion (%) of countries indicating number of groups/organisations that were reached by information about each of the eight innovative public health projects.**

Projects	No. of countries that answered the web survey	0-1 type of organisation	2-4 types of organisations	≥5 types of organisations
VENICE	10	30.8	53.8	15.4
CHOB	20	57.1	33.3	9.5
URHIS I	15	42.1	42.1	15.8
HA	9	11.1	77.8	11.1
EAAD	13	38.5	15.4	46.2
ENHIS	10	20.0	70.0	10.0
CSAP	18	0.0	27.8	72.2
EUCID	13	21.1	42.1	36.8

#### 4. Impact on knowledge/awareness of stakeholders

It was a great difference in the proportions of Country Informants that stated *considerable or high impact* on *knowledge/awareness* of the ten different suggested stakeholders in the eight projects (Figure 74). National health authorities, Government, Professional organisations and Universities were the stakeholders that most often, that is by at least 30% of the countries, were reported that the respective projects had had considerable or high impact on their knowledge/awareness.

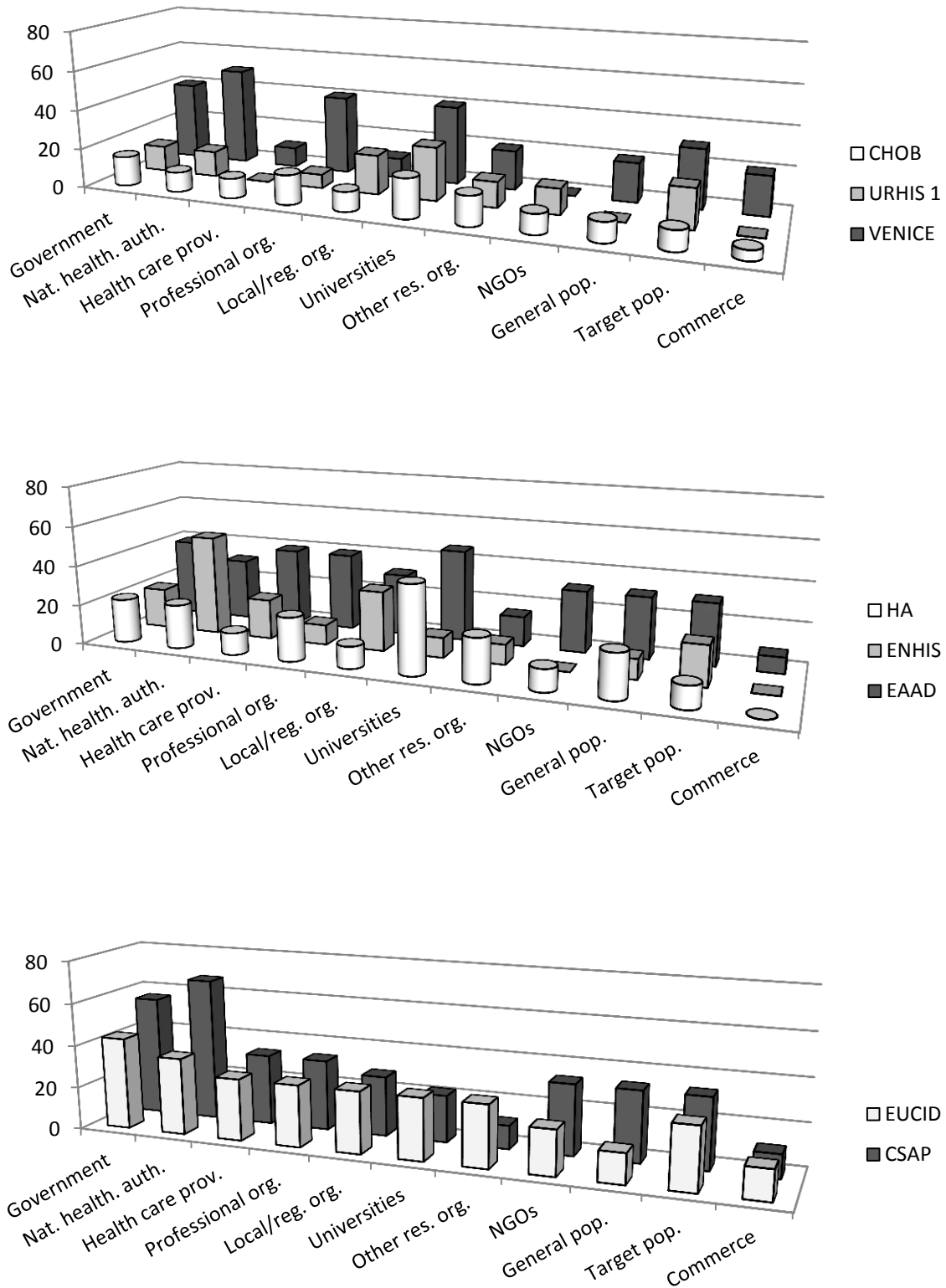
For EAAD, more than 30% of the countries stated considerable or high impact on knowledge/awareness of all of the suggested stakeholders, except for ‘Other research organisations’, where 15% of the countries reported impact. The highest proportion of impact on knowledge/awareness from EAAD was stated for Universities, where 46% of the countries reported impact (Figure 74).

The impact from CSAP on knowledge/awareness was also noteworthy; 67% of the countries stated impact on the National health organisations and 56% stated impact on the Government. Additionally, more than 30% of the countries indicated impact on knowledge/awareness from CSAP on the following five stakeholders: National health providers, Professional organisations, NGOs, General population and the Target population.

From both VENICE and EUCID, 30% or more of the countries indicated considerable or high impact on knowledge/awareness of Government, National health authorities, Professional organisations and Universities. For the remaining six stakeholders, the reporting of impact was less pronounced, and more so for VENICE compare to EUCID.

Regarding ENHIS, the countries indicated impact on National health authorities (50%) and on Local/regional authorities (30%). According to 44% of the countries, the HA project had had impact on Universities. To a lower proportion this was also the case for CHOB (20%) and URHIS (27%).

The results regarding impact might be an underestimation, as it is difficult to have knowledge on impact among organisations/stakeholders that you have little or no contact with or knowledge of.



**Figure 74.** Distribution of countries from the eight innovative public health projects that indicated considerable or high impact on knowledge/awareness of stakeholders, presented in three different, comparable figures.

## 5. Involvement in the original project and reported impact

If the CI had been involved in the original project as project leader/coordinator or as a project partner this was associated with the responses regarding impact on government (Table 12). Among CIs involved in the project, 49% responded considerable or high impact of the project on Knowledge/awareness of the Government compared to 17% reporting such impact on government among those not involved in the project. Among those not involved in the project, a higher proportion responded that they did not know about the impact (29%), compared to 7% among those who had been involved.

**Table 12. Involvement in the original project and answer to: impact of the project on knowledge/awareness of government.**

Involvement in the original project?	Number of CIs	No impact (%)	Limited impact (%)	Considerable or high impact (%)	Not relevant (%)	Do not know (%)
No	77	24.7	27.3	16.9	2.6	28.6
Yes	45	15.6	28.9	48.9	-	6.7

Similar difference between those involved in the original project or not was found also when reporting impact on knowledge/awareness of national health authorities (Table 13). A higher proportion among those who had been involved reported considerable or high impact on national health authorities (53%) compared to 18% among those not involved.

**Table 13. Involvement in the original project and answer to: impact on knowledge/awareness of national health authorities.**

Involvement in the original project?	Number of CIs	No impact (%)	Limited impact (%)	Considerable or high impact (%)	Not relevant (%)	Do not know (%)
No	77	16.9	32.5	18.2	2.6	29.9
Yes	45	8.9	31.1	53.3	-	6.7

Also regarding impact on health care providers (Table 14) as well as on local/regional authorities (Table 15), a difference in the reporting was seen for those involved in the project or not. However, this difference between the groups was smaller.

**Table 14. Involvement in the original project and answer to: impact on knowledge/awareness of health care providers.**

Involvement in the original project?	Number of CIs	No impact (%)	Limited impact (%)	Considerable or high impact (%)	Not relevant (%)	Do not know (%)
No	77	32.5	22.1	10.4	2.6	32.5
Yes	45	20.0	35.6	31.1	4.4	8.9

**Table 15. Involvement in the original project and answer to: impact on knowledge/awareness of local/regional authorities.**

Involvement in the original project?	Number of CIs	No impact (%)	Limited impact (%)	Considerable or high impact (%)	Not relevant (%)	Do not know (%)
No	77	22.1	31.2	13.0	3.9	29.9
Yes	45	22.2	37.8	28.8	2.2	8.9

Generally, the estimated impact of respective project on policy, reforms, guidelines and routines varied much, from none stating it had had a considerable or high impact to about 50% of the responding countries stating this. Among those who stated such impact, the impact on National health authorities was highest, compared to the impact respectively on Government, Health care providers, and Professional organizations.

In most projects, a very large variety of channels to disseminate project results had been used.

Another finding is that we, through the comprehensive web survey, identified some more methods/ways that results had been disseminated from the innovative public health projects than initially had been mentioned in the innovation projects' own final reports.

## Discussion and conclusions

As in all projects attempting to collect information on impact of intervention projects, we encountered several types of difficulties in doing so. Some of them are mentioned here.

### *Collecting data*

Within the WP4 we initially spent quite some time on discussing what type of information we needed to fulfil the aims of the WP – that is, what we meant by uptake and impact of public health interventions and on different ways to actually measure that. We developed a model of the different aspects of impact these types of projects can have, at different structural levels, and through various ways in society.

There are several limitations and problems regarding these types of data collection and the area clearly needs development of theories and methods – as well as of concepts. EUPHA and other public health organisations could consider how to increase awareness and competence of such issues. It is possible that the web survey was too extensive in terms of information asked for. However, limiting the items in the questionnaire would mean excluding some ways of disseminating knowledge or some types of stakeholders. We wanted to be very inclusive in this first study of this type, something which proved productive as we in this way e.g. identified other ways of dissemination than mentioned in the specific project reports. In several cases, depending on the position of the CI, the questionnaire implied having to contact other people. In a few cases also more than one person was involved in answering the survey. As in all surveys, participants might have interpreted the questions differently. The risk for this is larger when the respondents come from very different countries and also answer questions posed in a foreign language, which was the case for the absolute majority of the responders.

Most the EUPHA Sections are relatively young organizations and have yet not established a wide coverage across European countries. For PHIRE, therefore about half of CIs were invited from outside EUPHA Sections. The limited time available to Sections leads for the PHIRE work, as well as the methods used to identify, invite, and motivate CIs to provide data, mean that the results regarding the possible impact of the innovative public health projects probably were underestimated. On the other hand, a few CIs had previously been directly involved in the chosen innovative project and, therefore, probably had greater information about impacts – however, not necessarily meaning that they overestimated the impact.

A weakness is that we do not know to what extent we identified and gained responses from the ‘right’ country informant, which is why we sometimes used more than one CI. A further weakness of EU projects may be in gaining CIs in smaller countries. Nevertheless, our analysis of this factor in three groups by size of country did not show strong systematic differences.

The different ways to include CIs impacted the response rates. Telephoning the CIs before getting the web survey seemed to lead to more responses. On the other hand, sending the survey to colleagues you had had much contact with before did not seem to have the same positive effect. In this project we did not investigate/obtain information about those who refused to respond or dropped out. Nevertheless, some invited CIs stated that this was not their area of expertise or interest. Others stated lack of time was the main reason for not participating.

Maybe more than one CI should have been included for the very large countries, e.g. in Germany, UK or France, as the dissemination might differ much between regions – regions that in themselves are larger than many of the smaller included countries. Then, the CIs could report on the geographical region of these large countries, if they do not work in the same region.

In future project it also might be of interest to evaluate to what extent research had added to the impact of the projects and how the projects had impacted research.

An interesting outcome is that PHIRE itself has increased the impact of the EU's innovative projects. It has improved the awareness among a wider range of people, not only among the CIs and Section leads. Those who participated in the data collection also learned of different ways to disseminate results.

The very rich material generated by the open comments made by some CIs could also be used as bases for revision of the web-based questionnaire.

### *European development*

This project has been much about networking, making contacts, informing, discussing results and impact

A suggestion is that, in the future, EU Health Programme projects should collect baseline data (“before”) on what the project aims to impact upon (i.e. “after”). This would much enhance the possibility of evaluating the impact of the project (“before – after”). The EU would generate knowledge beyond support and finance, in areas often lacking scientific knowledge. It is especially important, as many projects have a very short duration, to learn what types of impact on organizational and behavioural they actually reach.

In the future we need more knowledge, not only on what to intervene for or against, but also on the effects for the different intervention methods as well as on how to implement the chosen most effective intervention method, in different groups or societies. Especially this last aspect, effective methods for implementation, warrants more knowledge – to design intervention projects so that they can generate such knowledge would lead to greater possibilities for optimal use of public health funds and for better public health in Europe.

### *Methodological considerations*

In order to be sure to achieve the proposed target of six innovation (“tracer”) projects, we initially included eight projects, in case we failed to achieve the data collection for some projects. Our goal, if such a ‘drop out’ occurred, was also to learn from what had not worked out in those ‘drop-out projects’. However, we actually had no such drop outs. We have data from all eight projects and from all seven Section leads. Based on this, one could conclude that the methods used in WP4 for choosing the eight projects, and for data collection (e.g. the survey instruments), were adequate and successful.

However, some weaknesses of the methods used need to be acknowledged.

1. The country informants had different levels of knowledge about the project. This may have biased the responses when, for example in URHIS and EAAD, the project impacts were likely to be local rather than national.
2. The limited data availability from some countries

3. There were no baseline data from which to measure the impacts
4. All the eight innovative projects studied have continued in one way or another, which means that it might have been difficult for the CIs to distinguish effects of the studied projects from the effects of the continued project.
5. It took more time, in terms of work hours and in terms of duration over the months, to get answers from the country informants to the survey and to get answers to the questionnaire from the Section leads, and for the WP4 coordination, than initially anticipated.
6. The eight innovation projects differed in nature in several ways – e.g. Regarding focusing on developing policy or developing tools, which means that the same type of impacts from them could not be expected.
7. Include questions about how research had added to the impact of the projects and how the projects had impacted research.

Moreover, we have used an organization – EUPHA - that initially is not set up to conduct these types of evaluations. However, EUPHA, with its strong focus on public health research, policy, practice, as well as training, with members in all EES countries, proved a promising organization for this kind of work. EUPHA can draw from the genuine and inter-disciplinary competence in all public health areas.

The PHIRE WP4 drew on the interest and deep knowledge, within their research areas, of the EUPHA Section leads. They brought contacts with the members in their Section, and with other networks. Their close cooperation was a prerequisite and absolutely invaluable for WP4.

### *Conclusion*

Our contribution to PHIRE achieved the goals. Through EUPHA Sections, we were able to engage public health research experts in describing the impact of EU innovation projects at country level. We were able to identify some – although not necessarily large – impacts for these projects. The Country Informants also reported on facilitating and inhibiting factors for the public health innovations.

These results can be of use for European Union policy. They show the potential benefit of coordination between countries, and the value of investment by the EU in cooperative projects through the Health Programme. They also show the need to improve evaluation instruments and methodologies, and to incorporate measures of impact in the funded projects themselves.