



PHIRE – Public Health Innovation and Research in Europe

Innovations Report

Poland

December 2011

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This report is the result of PHIRE Work package 4 which is coordinated by Karolinska Institutet, Sweden.

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This publication arises from the project 'PHIRE - Public Health Innovation and Research in Europe', Agreement Number 2009 12 14, which has received funding from the European Union, in the framework of the Health Programme.

PHIRE is implemented from 1 September 2010 until 28 February 2013.

PHIRE is coordinated by the European Public Health Association (EUPHA).

Associated partners are: EHESP, School of Public Health (FR); Faculty of Public Health (FPH, UK); Institute of Hygiene (LIH, LT); Karolinska Institutet (SE); Ministry of Health, the Elderly and Community Care (MHEC, MT); NIVEL – Institute for health services research (NL); Slovak Public Health Association (SAVEZ, SK).

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1. PHIRE Work package 4 - Defining tracer fields and evidence

To assess the outputs, diffusion, and impact of projects in the first European Union's Public Health Programme (PHP), PHIRE work package 4 (WP 4) has identified eight innovations ('tracer projects') that were initiated within the first PHP (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. Additionally, the projects should have been completed at least three years before the start of PHIRE. The selection of the innovations and gathering of information was done in close collaboration with seven of the 18 EUPHA Section leads.

To assess the uptake of the results and to determine national and regional impact on public health actions from the innovations across the 30 European Economic Area (EEA) countries, a web based questionnaire was distributed to informants from each country. The country informants (CIs) were chosen in very different ways, e.g. through membership lists from EUPHA sections. WP 4 will present an integrated report comparing uptake of the innovations in different fields, including Thematic Uptake reports and Country reports.

Table 1: Selected innovations from the first EU Public Health Programme, by EUPHA Section

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

2. The eight innovation projects

Below, a summary of each of the eight innovations is provided, including information whether the project was also implemented in Poland, based on information from the Section lead/contact person for each project.

All projects continued after the first phase. However, this report covers only the results from the first project financed by the EU's Public Health Programme between 2003-2005.

2.1. VENICE - Vaccine European New Integrated Collaboration Effort

General objectives of VENICE

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

Summary listed in the final report

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 European Union Member States and two European Economic Area 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.

VENICE had collaborators/partners/expertise from 29 countries in the project, including Poland (Table 2).

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

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.

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

The process to identify the country informants

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 persons to contact;
- Searches of the PubMed database using the following search terms: vaccination AND the name of the specific country (e.g. Poland);
- If the CI could not answer, he/she was asked to recommend one or two other possible CIs that could be contacted (snowball method). The process of identifying CIs and get them to respond to the survey required a great deal of work for the Section lead.

Answers to the questionnaire regarding VENICE were obtained from ten countries, including Poland (Table 2).

Table 2. VENICE - Summary of countries involved, regarding different aspects

EEA-countries	Project collaborators/ partners/expertise	Results were disseminated according to the VENICE final report	Respondent to the PHIRE web-based questionnaire
Austria	x	x	x
Belgium	x	x	
Bulgaria	x	x	
Cyprus	x	x	
Czech Republic	x	x	x
Denmark	x	x	x
Estonia	x	x	
Finland	x	x	
France	x	x	
Germany	x	x	x
Greece	x	x	x
Hungary	x	x	
Ireland	x	x	x
Italy	x	x	x
Latvia	x	x	
Lithuania	x	x	
Luxembourg	x	x	
Malta	x	x	x
Netherlands	x	x	
Poland	x	x	x
Portugal	x	x	
Romania	x	x	
Slovakia	x	x	
Slovenia	x	x	
Spain	x	x	
Sweden	x	x	x
United Kingdom	x	x	

Iceland	x	x
Norway	x	x
Switzerland		

2.2. CHOB - Children, Obesity and Associated Avoidable Chronic Diseases

General objectives of CHOB

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

Summary listed in the final report

The aim of the project is 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.

The 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 in the project as collaborators/-partners/expertise. However, Poland was not represented in the project (Table 3).

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 ways of dissemination were used: brochures, peer-reviewed articles, poster and oral presentation at international conferences, international meetings, seminars, lectures, national conferences, seminars, lectures, through training, websites, mass media (e.g. television, radio, newspapers), by 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.

The process to identify the country informants for PHIRE WP 4

The EUPHA Section on Food and Nutrition lead used the following strategies to identify, include and contact CIs for CHOB: 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 project:

Phase one (February – March 2011):

Members of the Food and Nutrition Section mailing list have been contacted with personalized emails

Members of the section who replied to the original personalized email who didn't agree in taking part in the project were asked to provide additional contacts in their country. This "snowball method" has been successful in some cases, especially when it was the originally contacted member of the section himself who provided the initial information of PHIRE, 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 no members were subscribed to the Food and Nutrition Section, the two following approaches were used: (i) personal contacts with experts of the field (which were not part of the Section list) and (ii) personalized email to experts identified through PubMed & Google were used. (4 of 18 country informants have been identified thanks to these 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 for PHIRE WP 4

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

- Poor response rate and necessity of using repeated emails and reminders;
- Some contacted expert have expressed an interest in being involved in further publications or an economical remuneration;
- In a large number of cases, country experts have asked us to look at the questions of the survey before agreeing in taking part in PHIRE. This approach has led to various drop-outs in an early phase of the data collection, but not in a later phase;
- Quality of the answers: in a few cases, members of the Food and Nutrition Section have answered the questions without providing additional justification and examples. However, the quality of the answers is in general good, in some cases also very detailed and exhaustive. We will take into account these differences in describing the results for the final report;
- The snowball 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).

Answers to the questionnaire regarding CHOB were obtained from 19 countries. However, no CI from Poland responded to the web-based questionnaire (Table 3).

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

EEA-countries	Project collaborators/ partners/expertise	Results were disseminated according to the CHOB final report	Respondent to the PHIRE web-based questionnaire
Austria	x	x	x
Belgium	x	x	x
Bulgaria			x
Cyprus			x
Czech Republic	x	x	
Denmark	x	x	
Estonia	x	x	
Finland	x	x	x
France	x	x	x
Germany	x	x	
Greece	x	x	x
Hungary	x	x	
Ireland	x	x	x
Italy	x	x	x
Latvia			x
Lithuania			x
Luxembourg			
Malta			x
Netherlands	x	x	x
Poland			
Portugal	x	x	x
Romania			x
Slovakia			x
Slovenia	x	x	x
Spain	x	x	
Sweden	x	x	
United Kingdom	x	x	x
Iceland	x	x	
Norway	x	x	
Switzerland			x

2.3. EURO-URHIS I - European system of urban health indicators

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 listed in the final report

The study proceeded 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 invaluable information about local health indicator availability, definitions and sources. The local respondents were painstaking, conscientious and hard-working. An amazing 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.

The responses to the questionnaires 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.

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.

EURO-URHIS I had collaborators/partners/expertise from 30 countries in the project, including Poland (Table 4). 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.

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

The process to identify the country informants for PHIRE WP 4

The Country Informants (CI) were collated by accumulating contacts from previous research projects including European Urban Health Indicator System (EURO-URHIS) 1 and EURO-URHIS 2, and combining those with a list from the European Public Health Association (EUPHA).

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. This questionnaire would then be distributed by email after the contact provided consent.

The contacts were included if their profession was in public/urban health and had an interest in the Tracer Project.

Problems encountered during data collection for PHIRE WP 4

The researcher had difficulties recruiting sufficient contacts from each of the thirty countries specified. Based at the University of Manchester, the researcher had frequent contact with colleagues from the Netherlands, Sweden, UK, Italy, etc. However, contacts with universities from smaller countries like Iceland, Estonia, Malta and Cyprus have traditionally always been limited for the University of Manchester.

Following the procedure, the researcher conducted follow up phone calls to CIs from countries where responses had been low. The difficulty was that few researchers at the University of Manchester are multilingual and have to rely on the CI's ability to speak English.

The researcher found that some CIs referred to more senior colleagues to answer the evaluation questions on EURO-URHIS 1. This obviously increases the response time for evaluation as the researcher had to establish contact with a new higher positioned CI and begin the procedure anew.

The researcher noted that some of the contact information was incorrect (telephone numbers, email addresses). Consequently, the researcher was forced to search for the contact on the internet or identify another CI.

Some of the CIs stated that they could not take part in the evaluation of EURO-URHIS 1 as they contributed to the project initially and as such would provide biased answers.

Answers to the questionnaire regarding EURO-URHIS I were obtained from 13 countries, including Poland. (Table 4).

Table 4. EURO-URHIS I - Summary of countries involved, regarding different aspects

EEA-countries	Project collaborators/ partners/expertise	Results were disseminated according to the EURO-URHIS I final report	Respondent to the PHIRE web-based questionnaire
Austria	x	x	x
Belgium	x	x	
Bulgaria	x	x	
Cyprus	x	x	
Czech Republic	x	x	
Denmark	x	x	
Estonia	x	x	
Finland	x	x	
France	x	x	
Germany	x	x	
Greece	x	x	
Hungary	x	x	
Ireland	x	x	
Italy	x	x	x
Latvia	x	x	
Lithuania	x	x	x
Luxembourg	x	x	
Malta	x	x	
Netherlands	x	x	x
Poland	x	x	x
Portugal	x	x	x
Romania	x	x	x
Slovakia	x	x	x
Slovenia	x	x	x
Spain	x	x	x
Sweden	x	x	x
United Kingdom	x	x	x
Iceland	x	x	
Norway	x	x	
Switzerland		x	x
Turkey	x	x	
Macedonia		x	

2.4. HA - Healthy Ageing

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 listed in the final report

The intention of Healthy Ageing 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 for a duration of 36 months with the start at 1 August 2004. 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.

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

Healthy Ageing had collaborators/partners/expertise from 11 countries in the project. However, Poland was not represented in the project (Table 5).

The process to identify the country informants for PHIRE WP 4

Several methods for contacting informants were used. Three steps can be distinguished in approaching the potential country informants:

Step 1: Purpose-built sampling

In step one purpose-built sampling was applied and informants personally known to the lead of the EUPHA Section on Public Mental Health were contacted. The contact persons were leading persons in the field of public mental health.

Step 2: Purpose-built sampling and snowballing

To increase the number of informants, snowballing (i. e. the persons 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 purpose-built 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.

Answers to the questionnaire regarding Healthy Ageing were obtained from nine countries. However, no CI from Poland answered the web-based questionnaire (Table 5).

Table 5. Healthy Ageing - Summary of countries involved, regarding different aspects

EEA-countries	Project collaborators/ partners/expertise	Results were disseminated according to the HA final report	Respondent to the PHIRE web-based questionnaire
Austria	x		
Belgium	x		x
Bulgaria			
Cyprus			
Czech Republic	x		
Denmark			
Estonia			
Finland	x		
France			
Germany			
Greece			x
Hungary			x
Ireland			
Italy	x		x
Latvia			x
Lithuania			
Luxembourg			
Malta			x
Netherlands	x		x
Poland			
Portugal	x		x
Romania			

Slovakia	
Slovenia	
Spain	x
Sweden	x
United Kingdom	x
Iceland	
Norway	x
Switzerland	x

2.5. EAAD - European Alliance Against Depression

General objectives of EAAD

The main focus of the EAAD project was to initiate community-based intervention programs using the 4-level approach on a regional and national level in 17 European countries. The 4-level approach includes:

1. Co-operation with general practitioners (GPs) and paediatricians. GPs and paediatricians are invited to educational workshops on how to recognize and treat depression and explore suicidal tendency in the primary care setting.
2. Public Awareness Campaign. The public is addressed by large-scaled public awareness campaigns with the aim to improve knowledge about adequate treatments and to reduce the stigmatization of the topic "depression" and the affected individuals.
3. Offers for high risk groups and self-help activities. "Emergency Cards" are handed out to high risk groups providing direct access to professional help in a suicidal crisis.
4. Training sessions for multipliers. Educational workshops are provided to various target groups playing an important role in disseminating knowledge about depressive disorders (e.g. health care professionals, priests, counsellors, police). Particular emphasis is put e.g. on special offers for parents, youth workers and teachers.

Summary listed in the final report

EAAD was implemented from 2004 to 2008. The adaptation of the 4-level approach in various countries throughout Europe began in 2004 with the formation of 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 e.V. was founded (homepage: 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.

According to the final report, results were disseminated by means of reports, brochures, peer-reviewed articles, poster or oral presentations at national and international conferences, seminars, through lectures, websites, training, international networks, mass media, and by co-operation with other researchers and with other organisations. Results were disseminated to the following key targets: government, health authorities, health care providers, professional organisations, local and regional authorities, universities, other research organisations, non-governmental organisations, the general population, and the target population addressed in the project.

EAAD had collaborators/partners/expertise from 14 countries in the project. However, Poland was not represented in the project (Table 6).

The process to identify the country informants for PHIRE WP 4

We used several methods for contacting EAAD informants. Three steps can be distinguished in approaching the potential country informants:

Step 1: Purpose-built sampling

In step one purpose-built sampling was applied and informants personally known to the lead of the EUPHA Section on Public Mental Health were contacted. The contact persons were leading persons in the field of public mental health.

Step 2: Purpose-built sampling and snowballing

To increase the number of informants, snowballing (i.e., the persons 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 purpose-built 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.

Answers to the questionnaire regarding EAAD were obtained from 13 countries. However no CI from Poland has answered the web-based questionnaire (Table 6).

Table 6. EAAD - Summary of countries involved, regarding different aspects

EEA-countries	Project collaborators/ partners/expertise	Results were disseminated according to the EAAD final report	Respondent to the PHIRE web-based questionnaire
Austria	x		
Belgium	x		
Bulgaria			
Cyprus			
Czech Republic			x

Denmark		x
Estonia	x	
Finland	x	
France	x	
Germany	x	x
Greece		
Hungary	x	x
Ireland	x	
Italy	x	x
Latvia		x
Lithuania		
Luxembourg		
Malta		
Netherlands		x
Poland		
Portugal	x	x
Romania		x
Slovakia		
Slovenia	x	x
Spain	x	x
Sweden		x
United Kingdom	x	
Iceland		
Norway	x	x
Switzerland		

2.6. ENHIS - Implementing Environmental and Health Information Systems in Europe

General objectives of ENHIS

The aim of ENHIS is 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 project supports decision-makers, informs citizens and professionals, and facilitates the exchange of information, data, knowledge and good examples.

The objectives of ENHIS:

1. Enable Member States and the European Commission to focus policy actions on priority areas most relevant to health;
2. Enable tracking progress in environment and health, and the effectiveness of respective policies across Europe;
3. Provide Member States with appropriate environment and health information to make international comparisons and support their on-going national policies;

4. Increase effectiveness of the use of the existing information;
5. Enhance national and international capacities for effective processing, exchange and use of environmental health information.

The one-year project aimed at the establishment of solid methodological and organizational basis for implementation of the system in all countries covered by the EU 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 European Commission's Environment and Health Strategy, and in particular on children, environment and health.

Summary listed in the final report

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 in the project, including Poland (Table 7). 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 EAA countries, also in Poland (Table 7). 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 web. 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. 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 focused on the information needs of policy makers.

The process to identify the country informants for PHIRE WP 4

The original participants were contacted as well as WHO contact officers in the European countries in as far as these were known to the Section lead. They were contacted by email.

Answers to the questionnaire regarding ENHIS were obtained from ten EEA countries. However, no CI from Poland answered the web-based questionnaire (Table 7). In addition, one person from Russia responded.

Table 7. ENHIS - Summary of countries involved, regarding different aspects

EEA-countries	Project collaborators/ partners/expertise	Results were disseminated according to the ENHIS final report*	Respondent to the PHIRE web-based questionnaire
Austria	x	x	x
Belgium		x	x
Bulgaria		x	x
Cyprus		x	
Czech Republic	x	x	
Denmark		x	
Estonia		x	
Finland	x	x	
France	x	x	x
Germany	x	x	x
Greece		x	
Hungary	x	x	
Ireland		x	
Italy		x	
Latvia		x	
Lithuania		x	x
Luxembourg		x	
Malta		x	
Netherlands	x	x	
Poland	x	x	
Portugal		x	
Romania	x	x	x
Slovakia		x	
Slovenia		x	
Spain	x	x	x
Sweden		x	x
United Kingdom	x	x	x
Iceland			
Norway			
Switzerland			
Russia			x

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

2.7. CSAP - Child Safety Action Plans, Phase I

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. Objectives of CSAP are:

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.
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.
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 listed in the final report

After 30 months several countries are close to having a government endorsed CSAP (Austria, Czech Republic, 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, Spain). In Germany, the federal government participated to some degree, but 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 in the project, including Poland (Table 8). 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, also in Poland (Table 8). 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.

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 EUPHA Injury Section members. A few country informants contacted the CI for clarifications or to decline to respond.

Twenty-seven countries were invited to participate in the CSAP questionnaire and answers were obtained from 18 countries, including Poland (Table 8).

Table 8. CSAP - Summary of countries involved, regarding different aspects

EEA-countries	Project collaborators/ partners/expertise	Results were disseminated according to the CSAP final report	Respondent to the PHIRE web-based questionnaire
Austria	x	x	x
Belgium	x	x	
Bulgaria			
Cyprus	x		
Czech Republic	x	x	x
Denmark	x	x	x
Estonia		x	x
Finland	x		
France	x	x	
Germany	x	x	x
Greece	x	x	x
Hungary	x	x	x
Ireland	x		x
Italy	x	x	x
Latvia	x		x
Lithuania	x		x

Luxembourg	x	x	
Malta	x		
Netherlands	x	x	
Poland	x	x	x
Portugal	x	x	x
Romania			
Slovakia	x		
Slovenia	x		
Spain	x	x	x
Sweden		x	x
United Kingdom	x	x	x
Iceland	x		x
Norway	x	x	x
Switzerland			

2.8. EUCID - European Core Indicators in Diabetes Mellitus

General objectives of EUCID

The aim of 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:

1. The first objective was to show the feasibility of the data collection.
2. The second objective was to create a stable platform for the data collection.
3. 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 listed in the final report

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 years) from 11 in Spain to 60 per 100,000 in Finland; standardized prevalence of overweight (25-74 years) 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 years), 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 micro-albuminuria 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; micro-albuminuria, 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, standards of measurement is an issue that should be addressed in the future. EUCID had collaborators/partners/expertise from 18 countries in the project. However, Poland was not represented in the project (Table 9).

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. The final report did not provide information on the number of countries to which results were disseminated.

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.

The process to identify the country informants for PHIRE WP 4

The process of identification of CIs for evaluation of EUCID has been done in several steps:

1. invitation to become a CI for EUCID was sent to all members of the EUPHA Section on Chronic Diseases;
2. partners of EUCID were identified and sent an invitation to evaluate the project;
3. diabetes organisations from the countries which had not responded in the first and second steps were identified and invited to cooperate;
4. possible CIs in the diabetes field were identified based on abstracts presented at the EUPHA conferences (both oral and poster) and were published in the European Journal of Public Health.
5. finally, personal contacts were used in countries which had not replied in earlier steps.

In total 15 countries responded: 13 out of 30 EEA countries (43.3% response rate) and two from outside the EEA (Turkey and Croatia) However, no one from Poland responded to the questionnaire. (Table 9).

Table 9. EUCID - Summary of countries involved, regarding different aspects

EEA-countries	Project collaborators/ partners/expertise	Results were disseminated according to the EUCID final report*	Respondent to the PHIRE web-based questionnaire
Austria	x		
Belgium	x		
Bulgaria			
Cyprus	x		
Czech Republic			x
Denmark	x		
Estonia			
Finland	x		
France	x		x
Germany	x		
Greece	x		
Hungary			
Ireland	x		x
Italy	x		x

Latvia		
Lithuania		x
Luxembourg	x	x
Malta		
Netherlands	x	x
Poland		
Portugal	x	x
Romania	x	x
Slovakia		x
Slovenia		x
Spain	x	x
Sweden	x	
United Kingdom	x	x
Iceland		
Norway		
Switzerland		
Turkey	x	x
Croatia		x

* Information not provided in the final report.

3. Results of selected questions from the web-based questionnaire

The aim of the PHIRE web-based questionnaire was to get information regarding the impact, policy changes and lessons learned in the 30 European Economic Area (EEA) countries on account of the eight different tracer projects.

The comprehensive questionnaire (Appendix 1) included the following five sections:

A: General questions regarding the situation in your country before the project

B: How results from the project were disseminated

C: Impact on different stakeholders in your country

D: Factors hindering and/or facilitating impact

E: Activities to promote dissemination of results from the project

The results below are based on questionnaire data for Poland for the following **three tracer projects**:

- VENICE - Vaccine European New Integrated Collaboration
- EURO-URHIS I - European System of Urban Health Indicators
- CSAP - Child Safety Action Plans, Phase I

As mentioned above, there were no country informants from Poland for the other five tracer projects, that is:

- CHOB - Children, Obesity and Associated Avoidable Chronic Diseases
- HA - Healthy Ageing
- EAAD - European Alliance Against Depression
- ENHIS - Implementing Environmental and Health Information System in Europe;
- EUCID - European Core Indicators in Diabetes Mellitus

In Figures 1 - 6, data for these projects is presented and each project has its own pattern.

Figure 1. Channels that were used to disseminate/spread/communicate the results from the tracer projects in Poland. Figures indicate number of tracer projects that have used a specific channel.

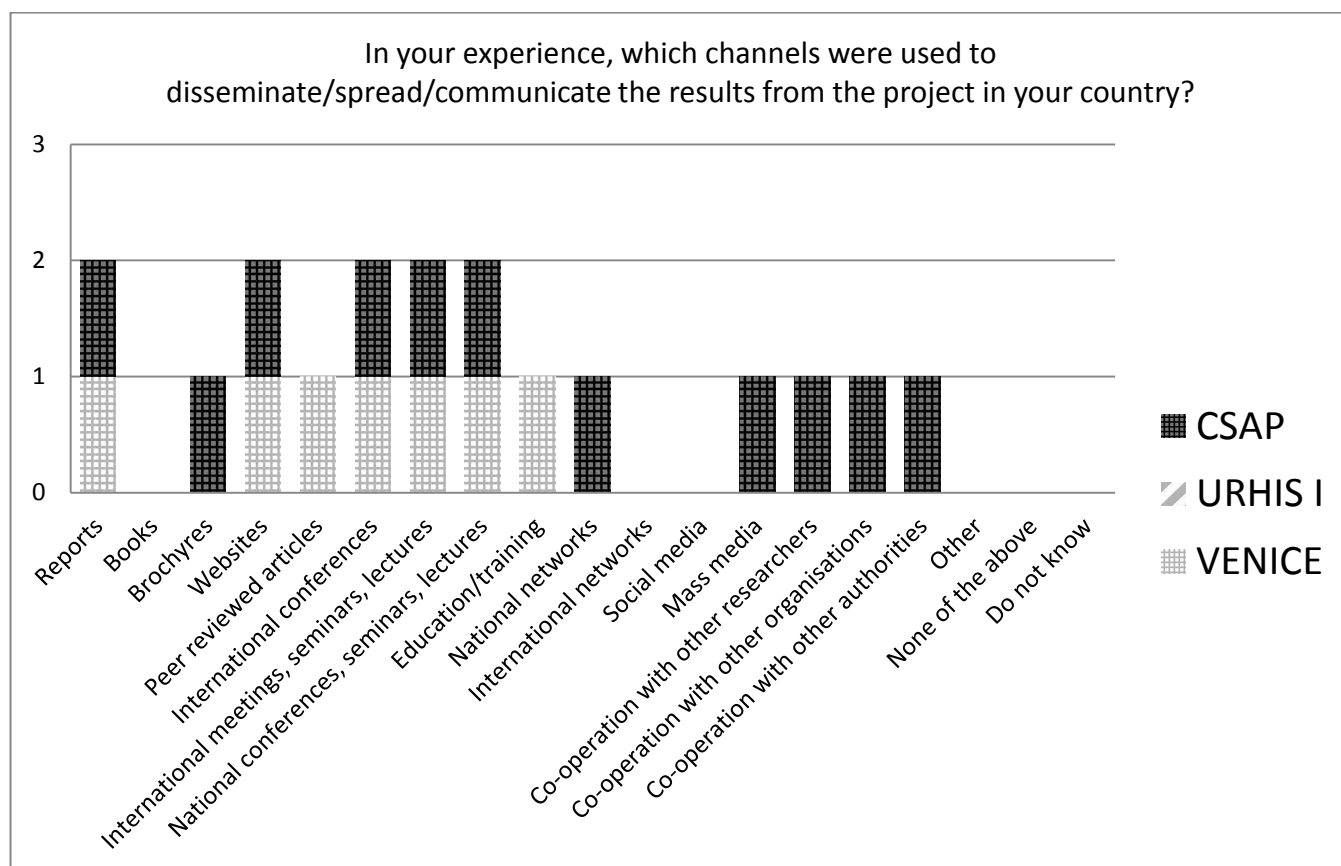


Figure 2. Groups/organisations reached by information about the projects in Poland. Figures indicate number of tracer projects that have reached each group/organisation.

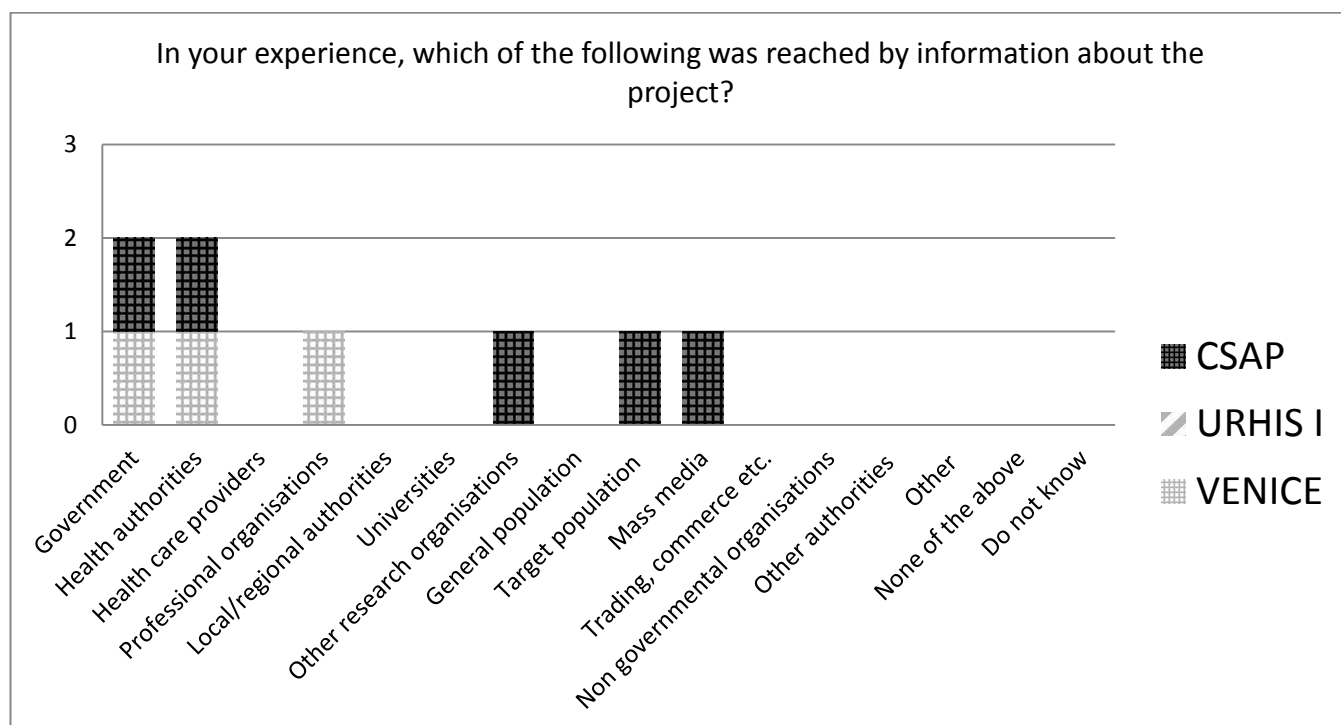


Figure 3. Level of impact of the tracer projects on government on: knowledge/awareness, policy/reforms, project initiated and regulation/law changes. Figures indicate the following response options: 1= no impact; 2= limited impact; 3= considerable impact; 4= high impact; 5= not relevant and 6= do not know.

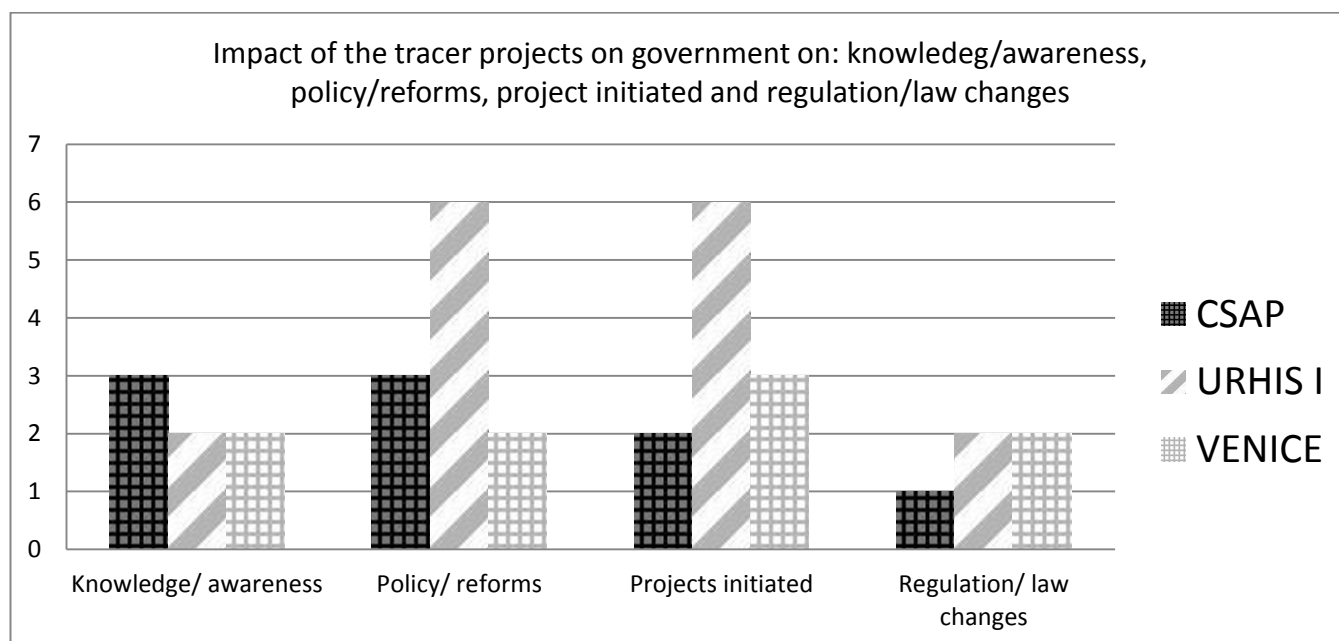


Figure 4. Factors that hindered impact of the tracer project in Poland. Figures indicate number of tracer projects that indicated each factor.

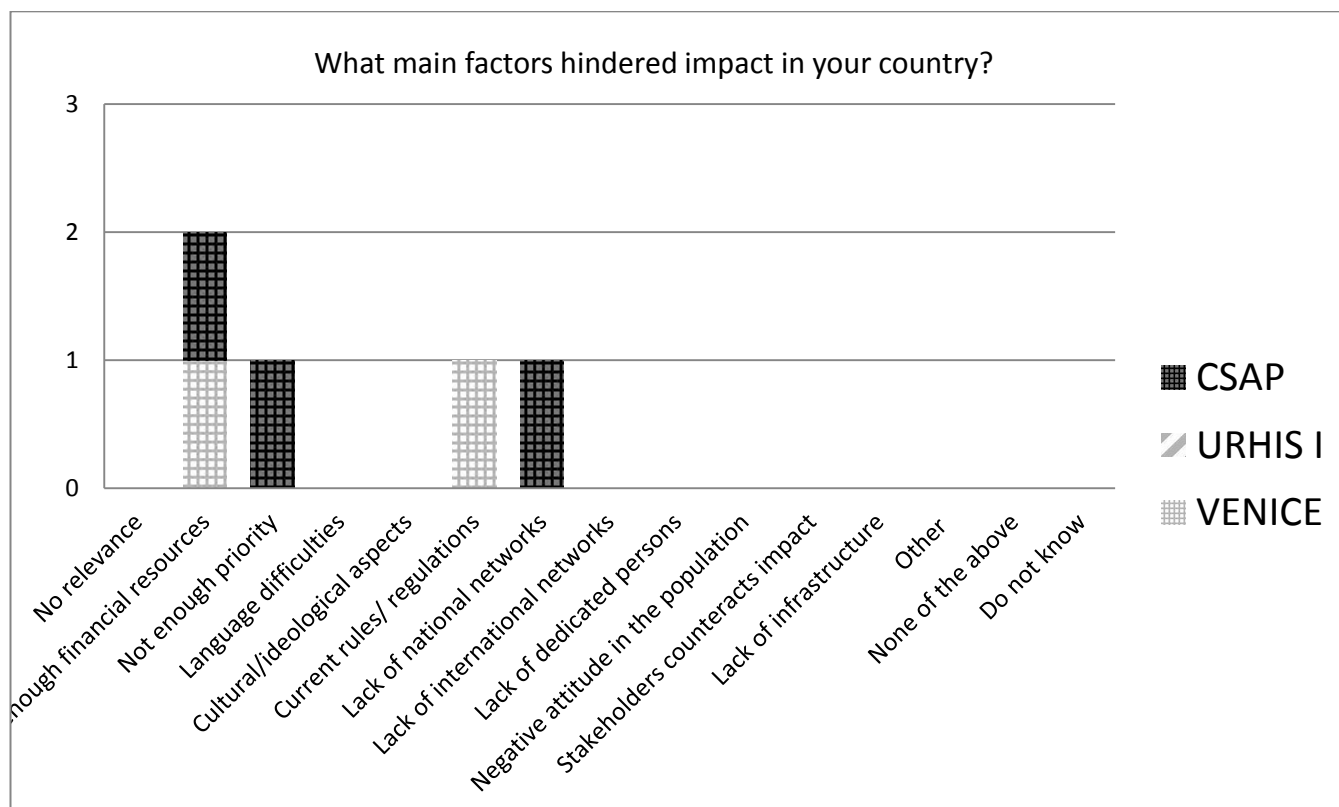


Figure 5. Main factors that facilitated impact of the tracer projects in Poland. Figures indicate number of tracer projects that have indicated each factor.

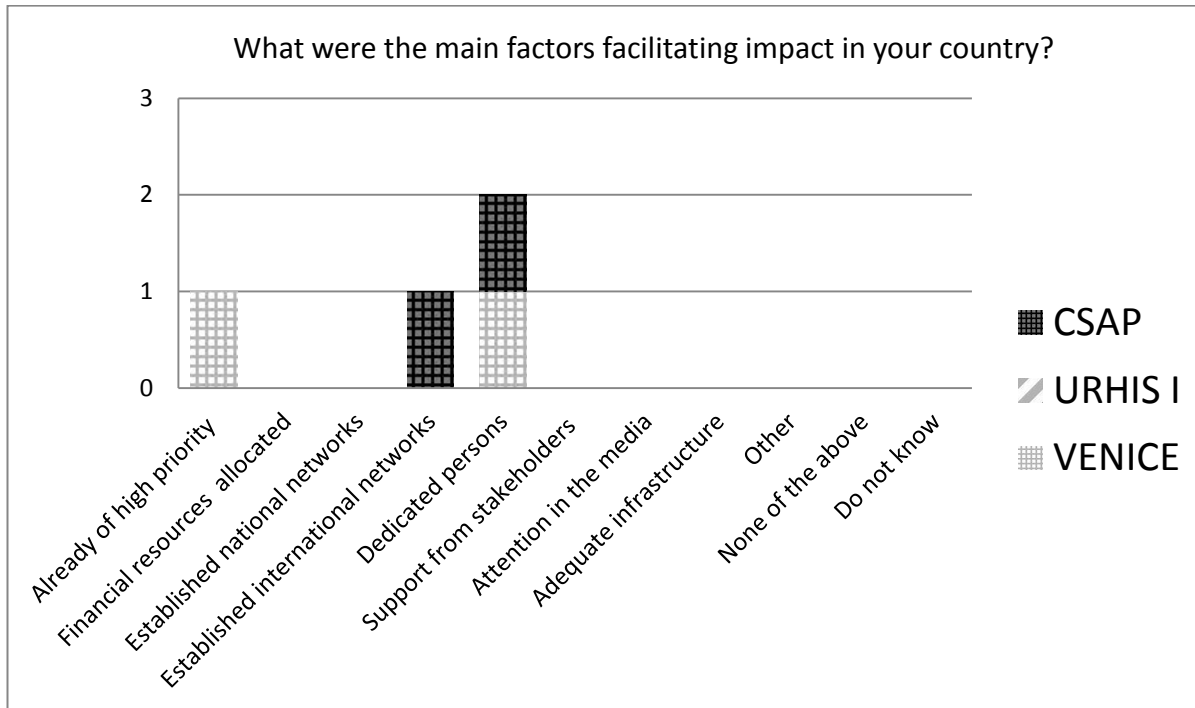
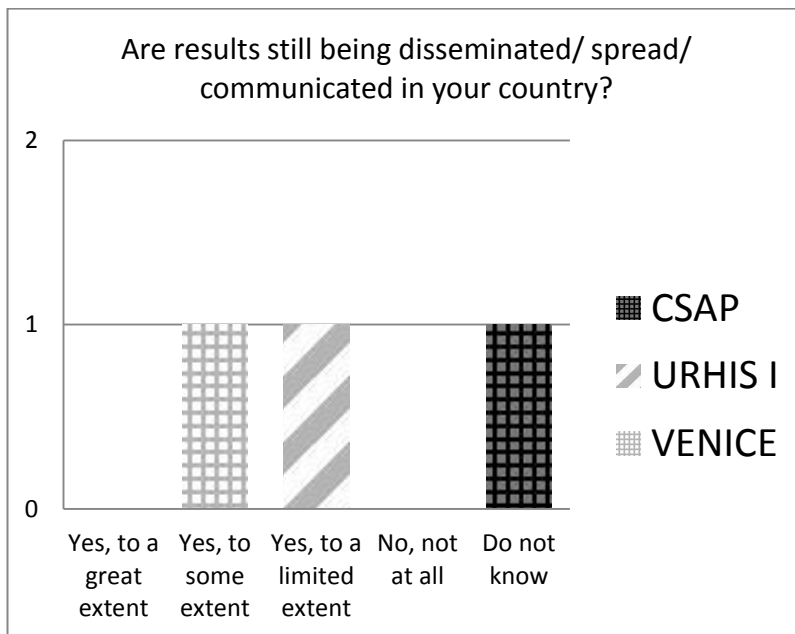


Figure 6. Ongoing dissemination/spreading/communication of the results from the tracer projects in Poland. Figures indicate number of tracer projects that have indicated a specific response option.



Appendix 1. PHIRE web-based questionnaire




Welcome to the PHIRE-survey! EUCID

This survey is a part of the EU-funded project "Public Health Innovation and Research in Europe" which aims at assessing the impact and changes resulting from the first EU Public Health Programme (2003-2005).

You can save your answers at any time and continue later by clicking "Save answers". If you need to revise your answers, just rewrite and save again. Be sure to press "Save answers" before you close down the web survey. To re-enter the survey later, just click on the link in the e-mail you received.


When you have finished the survey, please press "Submit", which is found at the bottom of the last page. If you need to revise answers already submitted, just click on the link in the e-mail, rewrite and press "Submit" again. The web survey will be open between **the 26th of April to the 24th of May, 2011.**

Mandatory questions are marked with a red dot . If you haven't answered the mandatory questions, you will be notified and redirected to those questions when pressing "Submit".

If you have any questions about the project, please contact Dr Iveta Nagyova, e-mail: iveta.nagyova@upjs.sk.

If you have questions of technical nature, please contact Margaretha Voss, e-mail: margaretha.voss@ki.se or phone +46 8 5248 3222.

Thank you for your participation!

 = Mandatory question

This survey concerns the project for which we are seeking your help: **EUCID - European core indicators in diabetes mellitus, 2005109**. The survey is aimed at assessing the impact and policy changes and lessons learned in your country on account of the project.

The survey includes five sections:

Contact information: **9 questions**

A: General questions regarding the situation in your country before the project: **4 questions**

B: How results from the project were disseminated: **4 questions**

C: Impact on different stakeholders in your country: **30 questions**

D: Factors hindering and/or facilitating impact: **4 questions**

E: Activities to promote dissemination of results from the project: **4 questions**

Contact information:

 **Title:**

 **Name:**

 **Current occupation:**

 **E-mail:**

 **Phone:**

 **Address:**

 **Institution:**

 **Country:**

 **Have you personally been involved in this project: "EUCID - European core indicators in diabetes mellitus"?**

- ☐ No
- ☐ Yes, as project leader/coordinator
- ☐ Yes, as a project partner

☐ Yes, please describe:

Section A: General questions regarding the situation in your country before the project started in 2006.

 **1. Did the topic of the project "EUCID - European core indicators in diabetes mellitus" have relevance in your country?**

- ☐ Yes, to a great extent
- ☐ Yes, to some extent
- ☐ Yes, to a limited extent
- ☐ No, not at all
- ☐ Do not know

 **Please describe why or why not:**

 **2. To what extent had this public health matter already been addressed in your country?**

- ☐ To a great extent

- ☐ To some extent
- ☐ To a limited extent
- ☐ Not at all
- ☐ Do not know

 **Please describe what had been done prior to the start of the project:**

Section B: How results from the project were disseminated

 **3. In your experience, which channels were used to disseminate/spread/communicate the results from the project in your country (choose one or more options):**

- ☐ Reports
- ☐ Books
- ☐ Brochures
- ☐ Websites
- ☐ Peer-reviewed articles
- ☐ Poster/oral presentations at international conferences
- ☐ International meetings/seminars/lectures
- ☐ National conferences/seminars/lectures
- ☐ Education/training
- ☐ National networks
- ☐ International networks
- ☐ Social media (e.g. Blogs, Facebook, Twitter, Youtube etc.)
- ☐ Mass media (e.g. Television, radio, newspapers)
- ☐ Co-operation with other researchers
- ☐ Co-operation with other organisations

- ☐ Co-operation with other authorities
- ☐ Other (please specify)
- ☐ Other (please specify)
- ☐ Other (please specify)
- ☐ None of the above
- ☐ Do not know

 **Please describe in more detail:**

 **4. In your experience, which of the following was reached by information about the project? (choose one or more options)**

- ☐ Government
- ☐ Health authorities
- ☐ Health care providers
- ☐ Professional organisations
- ☐ Local/regional authorities
- ☐ Universities
- ☐ Other research organisations
- ☐ General population
- ☐ Target population addressed in the project
- ☐ Mass media
- ☐ Trading, commerce, producers and retailers (of foods, drugs etc.)
- ☐ Non governmental organisations (please specify)

- ☐ Other authorities (please specify)
- ☐ Other (please specify)
- ☐ None of the above
- ☐ Do not know

 **Please describe in more detail:**

Section C: Impact on different stakeholders in your country

5a-m. Assessment of impact on different stakeholders

You will now get several questions about the impact (i.e. effects, influence, uptake) of the project in your country. The stakeholders you will be asked to assess impact on are: 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.

Please, select one of the following levels for each and every stakeholder:

No impact
 Limited impact
 Considerable impact
 High impact
 Not relevant
 Do not know

Different countries have different systems regarding the organisation of health authorities etc., if you need to please describe more about your country in the space for comments.

5a. Impact on government

	Select level of impact:	Examples are welcome:
Knowledge/ awareness	<input type="text"/>	<input type="text"/>
Policy/ reforms	<input type="text"/>	<input type="text"/>
Projects initiated	<input type="text"/>	<input type="text"/>
Regulation/ law changes	<input type="text"/>	<input type="text"/>

Other (please specify)	<input type="text"/>	<input type="text"/>
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 **Please describe in more detail:**

 **5b. Impact on national health authorities**

	Select level of impact:	Examples are welcome:
Knowledge/ awareness	<input type="text"/>	<input type="text"/>
Policy/ guidelines	<input type="text"/>	<input type="text"/>
Projects initiated	<input type="text"/>	<input type="text"/>
Regulation changes	<input type="text"/>	<input type="text"/>
Data collection/ surveillance	<input type="text"/>	<input type="text"/>
Increased funding/ resource allocation	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>

 **Please describe in more detail:**

5c. Impact on health care providers

	Select level of impact:	Examples are welcome:
Knowledge/ awareness	<input type="text"/>	<input type="text"/>
Policy/ routines	<input type="text"/>	<input type="text"/>
Increased funding/ resource allocation	<input type="text"/>	<input type="text"/>
Projects initiated	<input type="text"/>	<input type="text"/>
Research initiated	<input type="text"/>	<input type="text"/>
Organisation/ management	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>

 Please describe in more detail:

5d. Impact on professional organisations

	Select level of impact:	Examples are welcome:
Knowledge/ awareness	<input type="text"/>	<input type="text"/>
Policy	<input type="text"/>	<input type="text"/>
Projects initiated	<input type="text"/>	<input type="text"/>
Exchange of best practice information	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>

 Please describe in more detail:

5e. Impact on local/regional authorities

	Select level of impact:	Examples are welcome:
Knowledge/ awareness	<input type="text"/>	<input type="text"/>
Increased research funding	<input type="text"/>	<input type="text"/>
Projects initiated	<input type="text"/>	<input type="text"/>
Data collection	<input type="text"/>	<input type="text"/>

Other (please specify)	<input type="text"/>	<input type="text"/>
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 **Please describe in more detail:**

 **5f. Impact on universities**

	Select level of impact:	Examples are welcome:
Knowledge/ awareness	<input type="text"/>	<input type="text"/>
Increased research funding	<input type="text"/>	<input type="text"/>
Projects initiated	<input type="text"/>	<input type="text"/>
Education policy	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>

 **Please describe in more detail:**

 **5g. Impact on other research organisations**

	Select level of impact:	Examples are welcome:
Knowledge/ awareness	<input type="text"/>	<input type="text"/>
Increased research funding	<input type="text"/>	<input type="text"/>
Projects initiated	<input type="text"/>	<input type="text"/>
Education policy	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>

 **Please describe in more detail:**

 **5h. Impact on non governmental organisations (please specify what organisation below)**

	Select level of impact:	Examples are welcome:
Knowledge/ awareness	<input type="text"/>	<input type="text"/>
Projects initiated	<input type="text"/>	<input type="text"/>
Increased funding/ resource allocation	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>

 **Please describe in more detail:**

 **5i. Impact on general population**

	Select level of impact:	Examples are welcome:
Knowledge/ awareness	<input type="text"/>	<input type="text"/>
Behaviour	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>

 **Please describe in more detail:**

 **5j. Impact on target population addressed in the project**

	Select level of impact:	Examples are welcome:
Knowledge/ awareness	<input type="text"/>	<input type="text"/>
Behaviour	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>

 **Please describe in more detail:**

 **5k. Impact on mass media**

	Select level of impact:	Examples are welcome:
Amount of coverage of the topic	<input type="text"/>	<input type="text"/>
Change in type of content	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>

 **Please describe in more detail:**

 **5l. Impact on trading, commerce, producers and retailers (of foods, drugs etc.)**

	Select level of impact:	Examples are welcome:
Knowledge/ awareness	<input type="text"/>	<input type="text"/>

Policy	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>

 **Please describe in more detail:**

 **5m. Impact on other authorities (please specify authorities below)**

	Select level of impact:	Examples are welcome:
Policy	<input type="text"/>	<input type="text"/>
Projects/ reforms	<input type="text"/>	<input type="text"/>
Increased research funding	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>

 **Please describe in more detail:**

 **6. Could you indicate potential health benefits in the population resulting from the project?**

 **7. If there were any negative outcomes from the project, please specify:**

 **8. In your opinion, is it likely that any of the impacts described in question 5a-m could have occurred without the project?**

 **9. Other comments about impact :**

Section D: Factors hindering and/or facilitating impact

In the following questions we are interested in what factors that hindered or facilitated impact in different organisations and among the population in your country.

10. What main factors hindered impact in your country? (Choose one or more options)

- ☐ The project had no relevance to this country
- ☐ Not enough financial resources allocated
- ☐ The issue does not have high enough priority
- ☐ Language difficulties
- ☐ Cultural or ideological aspects
- ☐ Current rules/ regulations
- ☐ Lack of national networks
- ☐ Lack of international networks
- ☐ Lack of enthusiastic/ dedicated persons
- ☐ Negative attitude in the population
- ☐ Stakeholders counteracts impact (e.g. political organisations, corporation, business, lobby organisations)
- ☐ Lack of infrastructure (please specify, e.g. internet)
- ☐ Other (please specify)
- ☐ None of the above (please give comments)
- ☐ Do not know

 Please give examples or comments regarding hindering factors:

 **11. What were the main factors facilitating impact in your country? (Choose one or more options)**

- ☐ The topic of the project was already of high priority in the country
- ☐ Sufficient financial resources were allocated
- ☐ Established national networks
- ☐ Established international networks
- ☐ Dedicated persons
- ☐ Support from stakeholders (e.g. political organisations, corporations, business, lobby organisations)
- ☐ Attention in the media
- ☐ Adequate infrastructure (please specify, e.g. internet)
- ☐ Other (please specify)
- ☐ None of the above (please give comments)
- ☐ Do not know

 **Please give examples or comments regarding facilitating factors:**

Section E: Activities to promote dissemination of results from the project

Here you will be asked questions about activities to promote knowledge and understanding of the results in different organisations and among the population.

 **12. Are results still being disseminated/ spread/ communicated in your country?**

- ☐ Yes, to a great extent
- ☐ Yes, to some extent
- ☐ Yes, to a limited extent
- ☐ No, not at all
- ☐ Do not know

 **Please describe in more detail:**

 **13. Other comments about activities to promote dissemination of results from the project**

Section F: Comments

 **14. Please add any further comments regarding the project and its impact in your country!**