
Interim Evaluation of the Public Health Programme 2003- 2008

Inception report

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CHAPTER 1 Introduction

Health problems vary around the world but are often grouped into four categories: communicable diseases, non-communicable diseases, trauma, and mental disorders¹. Public health interventions aim to improve the health of the population as measured by health status indicators and as influenced by social, economic and physical health determinants. These determinants include income, housing, personal health choices, human biology (including human genetics), nutrition, and health services (including health promotion and disease prevention interventions). Public health practitioners recognize the wide range of factors that influence the health status of a population, and how these interact in complex ways. This has the benefit of directing public health practice towards the underlying causes of ill health and so reducing the burden on health care services. But it brings with it the complication that the connections linking policy inputs to health outcomes may be complex and extended, and will involve considerable time lags. Furthermore, while public practitioners are keenly aware of the importance of the ‘traditional’ aims of disease prevention, communicable disease control, and health protection, there has also been a growing emphasis on supporting a positive condition of wellbeing².

Under these circumstances, decision-makers in public health require evidence and evaluations both to demonstrate their past accomplishments and improve their future decisions³. Such evaluations must be sensitive to the complexities created by multi-agency interventions and should accommodate the various perspectives and knowledge bases of the multiple players involved in delivering, for example, improved health status, risk factor reduction, appropriate methods for continuous surveillance, and improved services and protection^{1,4}. The aim of integrating health benefits systematically into wider

¹ Holland WW (2004). Health technology assessment and public health: a commentary. *International Journal of Technology Assessment in Health Care*, 20 (1): 77-80.

² See: Ministry of Health. Prescriptions for a healthier Norway: a broad policy for public health Report No. 16 to the Storting (2002-2003); High Committee on Public Health: Health in France 1994-1998; European Public Health Association (2005) 10 Statements on the Future of Public Health in Europe Report 2004-1

³ Pencheon, D. Guest, C. Melzer, D. Muir Gray, J.A. (2001) *Oxford Handbook of Public Health Practice* Oxford: OUP; Part 2.

⁴ Rootman, I. Goodstadt, M. Hyndman, B McQueen, D., Potvin, L. Springett, J and Ziglio, E (2001) *Evaluation in health promotion. Principles and perspectives* WHO Regional Publications European Series, No. 92.

policy-making remains central but elusive⁵. Finally, not only is public health concerned with disease prevention, health promotion, and multi-agency intervention, but it is also increasingly concerned with reducing health inequalities (e.g. access to health care).

In contributing to public health, the European Commission (EC) is therefore a part of a complex public health system involving many actors, whose actions it can complement and (modestly) influence. These actors include academia and scientific institutions (dealing with public health, the sociology of health, the analysis of health determinants), surveillance organizations, decision-makers within governmental public health infrastructures and healthcare delivery systems, community organization and associations, employers, the general public and the media.^{6,7} In pursuit of public health objectives, the EC engages with these actors through a variety of activities including research commissioning, inter-institution collaboration, lawmaking, and networking. Currently, activities they seek to influence include immunization, access to healthcare, health promotion, chronic disease control, risk management, pharmaceuticals monitoring and environmental control.

The competence for Health is shared between the European Union (EU) and Member States. These were defined in the 1992 Treaty of Maastricht and enhanced by the Treaty of Amsterdam in 1998. However, a concern with the health and wellbeing of European citizens is implicit in policies, which have been in place since the European community's inception. Member states have responsibility for financing, organizing, managing and running health services and developing national health policies. Under the European Union Treaty, the EU is responsible for:

- Ensuring that the combined effect of EU policies and actions provides a high level of health protection. This includes other key areas of Community activity, such as internal market, social affairs, research and development, agriculture, trade policy, environment, etc.⁸
- Assisting Member States to coordinate their action and collaborate on health.
- Taking joint action with member states on 'threats to health' especially where these have a cross-border dimension.
- Standard setting and regulating in specific areas such as pharmaceuticals, medical devices, blood products and organs for transplantation.

In 1993, the EC presented a Communication on the Framework for Action in the Field of Public Health as an initial strategy document to develop work on public health, consisting of eight programmes (health promotion, cancer, drug dependence, AIDS and other communicable diseases,

⁵ Press backgrounder EURO 03/2000: Copenhagen, 4 July 2000: Rethinking health – The Verona Initiative Grows

⁶ IOM (2002) *The Future of the Public's Health in the 21st Century*: The National Academies Press.

⁷ IOM (2002) *The Future of the Public's Health in the 21st Century*: The National Academies Press.

⁸ Commission of the European Communities (2000). Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the health strategy of the European Community. COM (2000) 285 final. Brussels.

health monitoring, rare diseases, accidents and injuries, and pollution-related diseases)⁹. In 2002, the European Parliament and the Council adopted a new Community action plan for public health that runs from 2003-2008. The Public Health Programme aims to ‘address the EU citizens’ concern about health risks and provide coherent and coordinated assistance to the Member States for a high level of health protection throughout the EU’¹⁰. The Programme focuses on three objectives or themes:

- Improving health information and knowledge
- Rapid response to health threats
- Health promotion through addressing health determinants

In delivering these policies, the main outputs include:

- Legislation
- Funded programmes
- Contributions to the public health infrastructure
- Coordinated action with member states

However, in addition to these more formal outputs, DG SANCO is also involved in a range of other efforts to coordinate and influence. Activities such as networking, coordinating health activities, sharing experiences, educating and disseminating relevant information and knowledge, are all used to improve population health¹¹. Particular attention is paid to links with other Community programmes and actions (these include environment, transport, employment, statistics, social inclusion, free movement of people, and care for the elderly). In addition, EU specialized agencies provide supporting functions such as the European Centre for Disease Prevention and Control, the European Environment Agency, and the European Monitoring Centre for Drugs and Drug Addiction. In the areas of communicable diseases, lifestyles, diet and physical activity, and health service systems and policy, the Commission regularly works with an established network of organizations. Effective co-operation of the Member States and key international organisations (including the World Health Organisation and the Organisation for Economic Co-operation and Development) are also considered crucial to delivering the overall aim and general objectives of the Public Health Programme.

⁹ A description of the previous programmes can be found on: http://europa.eu.int/comm/health/ph_overview/previous_programme/previous_programme_en.htm

¹⁰ DECISION No 1786/2002/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008). Official Journal of the European Communities, 2002.

¹¹ Braun A. (2005) Healthcare: Key Technologies for Europe. Synthesis paper for the European Commission.

Clearly, the social, political and public health environment of the Programme is changing and any evaluation of its relevance and effectiveness is influenced by this context. There are at least six dimensions to this changing environment.

First, the research and evidence base for public health policy is more important than ever. As Els Borst-Eilers, former minister of Health for the Netherlands put it “the most important thing is to put into practice knowledge we already possess. This concerns knowledge about health determinants, the causes of ill health and ways of avoiding it. This body of knowledge is growing all the time, but we are doing little with it.”¹² Developing a relevant evidence base and ensuring that this knowledge is mobilized for the benefit of policy-makers will be a continuing challenge. Secondly, effective partnership working to deliver public health benefits through concerted action is likely to become increasingly important. Thirdly, the enlargement of the EU will bring new opportunities and threats relating to, for example, the regulation of pharmaceuticals, the movement of health professionals and other workers, and the trading in legal but potentially hazardous products (especially alcohol and tobacco). Finally the re-emergence of traditional diseases and the emergence of new diseases may outstrip the capacity of current surveillance and disease control systems and for this reason we have seen an extension of European activity in relation to such cross-border threats as influenza pandemics, new variant Creutzfeldt Jacob Disease, HIV, TB and bio-terrorism.

With this inception report RAND Europe supports DG Health and Consumer Protection of the European Commission in describing the evaluation methodology for an evidence-based interim evaluation of the first three years of the Public Health Programme 2003-2008. We will assess the effectiveness of the PH Programme in relation to its objectives expressed in the Programme Decision (1786/2002/EC) and we will identify the lessons this provides for future action.

The Commission is responsible for the interim evaluation, but our contribution strictly follows the evaluation requirements specified in the contract (SANCO C1/FS (op) D(2005) 310880, 14 December 2005) in presenting the intervention logical framework and the evaluation criteria and indicators to be used to answer each of the evaluation questions.

1.1 Objectives

RAND Europe’s contribution specifically supports the following components of the interim evaluation:

1. To assess the impact achieved on health in the European Union
2. To assess the efficiency of resource use
3. To assess how consistently and how well the programme complements other relevant Community programmes, actions and initiatives

In this respect, we focus especially on the following criteria (and summative questions) on the basis of which the Programme will be examined:

¹² Kirch, W. ed. Public Health in Europe: 10 years EUPHA. Springer Verlag: 62.

- **Relevance:** To what extent are the policy's objectives pertinent in relation to the evolving needs and priorities in the policy field (or of the target population)?
- **Effectiveness and sustainability:** To what extent have the policy's impacts contributed to meeting near-term and long-term policy objectives?
- **Efficiency:** How economically have the various inputs been converted into outputs (and outcomes)?
- **Consistency:** To what extent are consistency and complementarity ensured between policy actions and other policies and activities?
- **Acceptability:** To what extent do the policy's intended or unintended impacts concur with the interests of stakeholders?

The evaluation is intended to not only support summative learning about the Programme to date but also to provide formative insights for delivering the remaining years of the Programme and preparing for the 2007-2013 Programme as outlined in the proposal 'Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions' published in 2005.¹³ This rearticulates the EU's Health and Consumer policies in three core objectives:

1. Protect citizens from risks and threats, which are beyond the control of individuals and that cannot be effectively tackled by individual Members States alone (e.g. health threats, unsafe products, unfair commercial practices).
2. Increase the ability of citizens to take better decisions about their health and consumer interests.
3. Mainstream health and consumer policy objectives across all Community policies in order to put health and consumer issues at the centre of policy-making.

More specifically for health it foresees the following 'strands of action':

- Enhanced surveillance and control of health threats
- Deliver response to health threats (new strand)
- Promote health by tackling determinants
- Prevent disease and injury (new strand)
- Achieve synergies between national health systems (new strand)
- Generate and disseminate more and better health information to citizens, health experts and policy-makers

¹³ Commission of the European Communities (2005) *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions* Proposal for a Decision of the European Parliament and of the Council Com (2005) 115 final.

Our evaluation will therefore not only assess the impacts of the existing Programme (as described in Article 12 of the Programme Decision¹⁴, the Public Health Programme 2003-2008 should be externally evaluated with regard to the implementation and achievements) but will also explicitly consider the implications of the evidence and analysis for the following forward-looking, formative, clusters of questions that drill down into the meaning of sustainability:

- A) How successful is the current Programme in **protecting citizens from risks and threats** through enhanced surveillance, control and response to health threats, which are beyond the control of individuals and cannot be effectively tackled by individual Member States alone? What are the reasons for this success or lack of success? What implications does this have for future action?
- B) What does the evaluation of the current Programme tell us about the capacity of the Commission to **increase the ability of citizens to take better decisions about their health**? What implications does this have for future action?
- C) How effectively are health policy objectives **mainstreamed across all Community policies**? What does this tell us about achieving this more effectively in the future? What implications does this have for future action?
- D) How successful has the current Programme been in **tackling health determinants**? What are the barriers and facilitators to successful delivery? What implications does this have for future action?
- E) How successful has the current Programme been in **preventing disease and injury**? What are the barriers and facilitators to successful delivery? What implications does this have for future action?
- F) How successful has the current Programme been in **achieving synergies between national health systems**? What are the barriers and facilitators to successfully achieving this? What implications does this have for future action?
- G) How successful has the current Programme been in **generating and disseminating more and better health information** to citizens, health experts and policy-makers? What are the barriers and facilitators to successful dissemination? What implications does this have for future action?

1.2 Approach

Our approach to the interim evaluation of the Public Health Programme involves four steps:

¹⁴ Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008). Official Journal of the European Communities, 2002.

1. Examining the logical framework of the Programme (including strand and project level).
2. Setting the evaluation criteria and evaluation questions.
3. Collecting evidence on the impacts, management procedures and quality of the Programme implementation process
4. Using the evidence and the conceptual framework to formulate and validate conclusions and recommendations

In the following chapters we will elaborate on each of these steps.

CHAPTER 2 Evaluation Framework

2.1 Introduction

As the evaluation of policies is a multi-dimensional task that involves different levels (society, programme, project and activities) and stages (e.g. input-process-output), it calls for a framework that sheds light on both the overall design and structure of the programme and the different activities undertaken in its component parts. The heart of such an evaluation framework is a logic model. Logic models are widely used in evaluation to understand input-process-output relationships.

Figure 1 provides an overview of the different stages and levels in the development and implementation of a policy or programme. The boxes identify the potential focal points of the evaluation and the possible measures of success (i.e. evaluation criteria). Each measure has a distinct information demand. Assessment of effectiveness, for instance, involves a comparison of the outcomes and the initial aims of the Programme (i.e. design phase). For the establishment of an evaluation framework, this requires delineation of (proxy) indicators measuring outputs and outcomes. With the help of the framework presented below, evaluation criteria are defined (see further section 2.4) on the basis of which the Public Health Programme will be evaluated. These criteria can be quantitative or qualitative.

Success is the crucial measure of the evaluation. However, measurement of success depends upon the viewpoint taken. Different stakeholders may have different viewpoints¹⁵. First, there may be

¹⁵ This concerns an issue of subjectivity and we will address this in the following manner:

- 1) For 'design' – type evidence (e.g. priorities, choice of modalities) it is appropriate to gather the views of a (suitably) representative sample of stakeholders and prepare a statistical summary of the results. This approach is particularly relevant to the different criteria for measuring "success".
- 2) For data relating to efficiency, the appropriate reflection of the 'different perspectives' consideration is to take account of the incidence of costs and benefits and any external costs or savings. This is likely to be particularly important for the trans-European aspects.
- 3) For evidence relating to outcomes or impacts, this perspective shows up in the need to take account of the equity of Programme impacts. This means considering whether the net effect of the Programme – in combination with other activities – is to make access to health information, risk management activities, etc. more equitable. Statistical general public health information can be used to provide measures of equality of health care access and outcomes (using e.g. Gini indices).

differences in opinion as to how the Programme should perform with respect to a single criterion: for example implementation (these opinions are defined by different interests). Second, stakeholders may focus on different criteria for success. With respect to these different criteria, the study will examine the extent to which the effects match the goals, needs and interests; the relevance of the policy objectives; and the quality and efficiency of the process.

Figure 1 also distinguishes different levels related to programme development and implementation: from the wide socio-economic context to the specific policy-making context. In evaluating the impact of the Public Health Programme, the activities at a lower level will have to be logically correlated to goals or desires at a higher level. Conversely, in order to understand the impact at higher levels, knowledge of activities at lower levels is required to attribute *success* to Programme activities. Furthermore, it is important to distinguish *external factors* from (programme related) *input factors*. *External factors* (defined as contextual conditions and developments in Figure 1) affect the functioning of the Programme, but lie outside the span of control of the Programme; examples include economic development or population ageing. Changes in external factors may lead to effects that cannot be attributed to programme activities. On the other hand, predictable external factors (e.g. population trends) should be considered in programme development and implementation. The *input factors* related to the Programme lead to *outputs*, which a wide range of stakeholders and society as a whole may take up; leading in turn to the *outcomes and broader impacts* of the Programme.

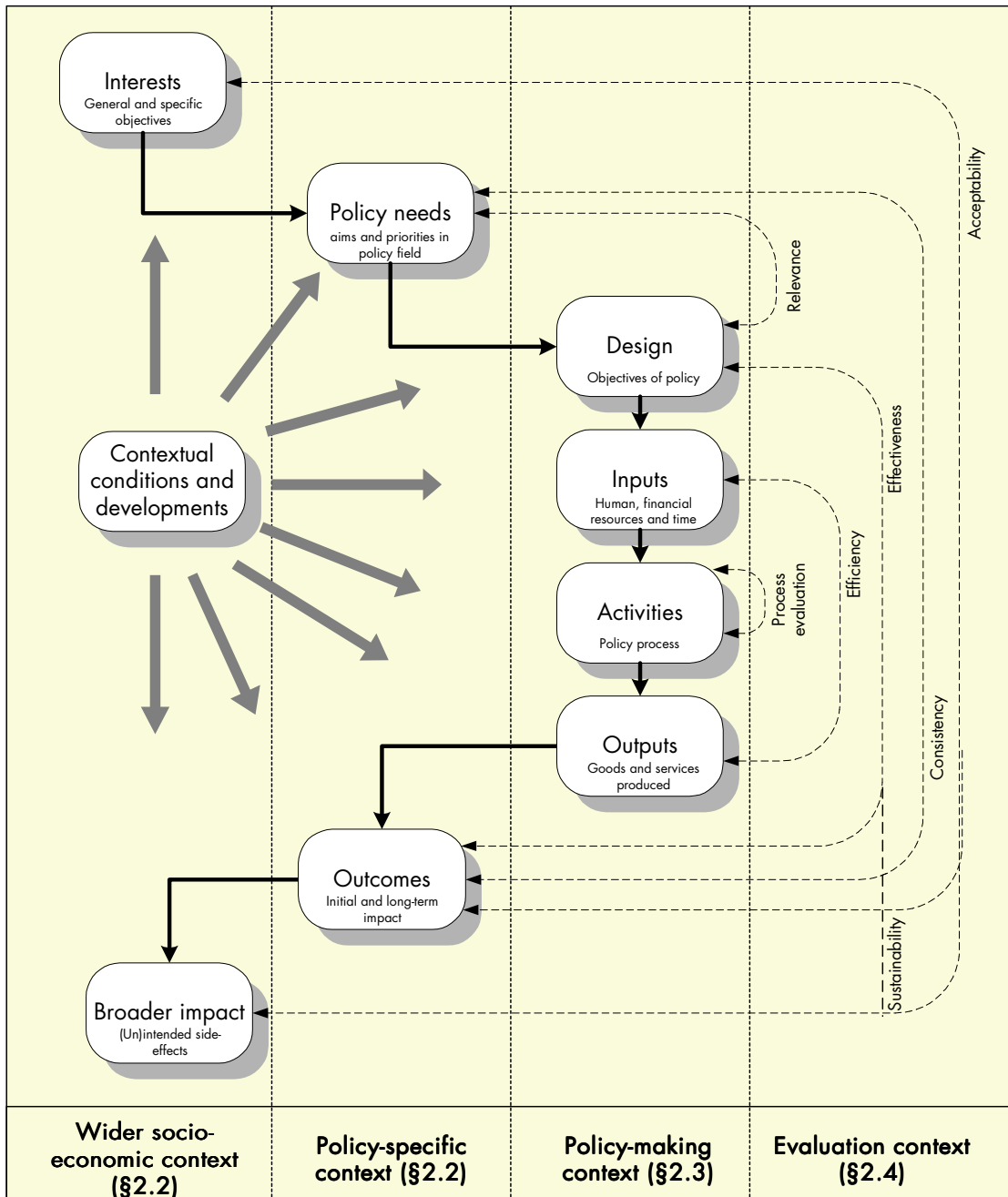


Figure 1. Different elements in policy evaluation

The model starts from the *wider socio-economic context* within which specific problems attract the attention of different stakeholders (European Parliament, citizens, governments, interest groups, other relevant DGs (e.g. DG Employment, DG Research, DG INFSO, DG Agriculture and Rural

Development, DG Enterprise, DG Environment), academia, public health practitioners etc). These stakeholders operate at different levels and in different activities (e.g. wider legislative and networking activities), and they influence each other.

The next level is the *policy-specific context* – the realm of the organisation that is responsible for the policy or programme to be evaluated (in this case DG SANCO). This level focuses on the formulated goals and the available means. Activities include e.g. networking, co-ordinating health activities, sharing experiences, educating and disseminating relevant information and knowledge, links with other Community programmes and actions as well as effective co-operation of the Member States and key international organisations as further described in Chapter 1 and the sections below.

The third level is the most concrete. The organisation implements a specific policy or programme in the *policy-making context*. Here, specific policies or programmes are *designed* – concrete objectives are formulated, financial, human and other resource *inputs* are allocated, and these are used in *activities* that lead to *outputs* (goods and services produced, e.g. legislation, funded programmes, contributions to the public health infrastructure and coordinated action with member states). Here, this encompasses design of the Public Health Programme, selection of themes, choice of instruments (e.g. financing) and allocation of budgets to the different themes. Outputs of the process include information systems, publications, enhanced knowledge bases, enhanced skills, and awareness among the general public or public health practitioners.

The policy-making level must be connected back to the policy-specific context: it is one thing for a specific activity to generate outputs, but it is more important to identify whether these outputs actually lead to desired changes in the form of *outcomes* (such as improved health status, risk factor reduction and methods for continuous surveillance) and possibly even *broader impacts* beyond the remit or direct control of the policy-making authority: other stakeholders may be tempted to change their activities as a result of policies.

This is where the *evaluation context* becomes important: relationships within each level and among the levels/stages can be evaluated. For each single activity one can evaluate whether the process is undertaken in a responsive way, whether management leads to efficient use of resources, and whether the process is timely and yields expected and desired levels of quality. Where activities are performed in a ‘correct way’ the next question is whether the balance of output(s) to inputs is optimal – in other words, whether the intervention is *efficient*. Although efficiency is important (resources should not be squandered), it is subordinate to the issue of whether the policies were *effective and sustainable*: whether the outcomes are those that were envisaged in the design of the policy, and whether the effects (not necessarily the activities) will continue to produce the needed benefits in the future, after the specific intervention has come to an end. The next level of analysis is the link between the policies undertaken and the actual goals and needs of the policy organisation under scrutiny: a very effective and efficient policy may nevertheless be disconnected from these goals. This is the question of whether policies are *relevant* to the stakeholders and whether the outcomes of the policies are *consistent* with the overarching goals. Finally, at the highest level, the question is whether the outcomes and broader impacts of the policy are *acceptable* not only to the organisation itself, but to the context in which the organisation operates. In the present case, this not only means that the concept of public health should be broadly accepted, but also that the specific interventions are seen

as valuable and appropriate by the stakeholders. This is not a separate criterion, since the programme operates with limited resources in an environment rich in risks and other activities; acceptance and consequent engagement (cooperation, participation, uptake) are essential to the production of sustained benefit.

The sections that follow describe the different contexts of the policy evaluation of the Public Health Programme to provide an understanding of the effects the Programme intends to produce. Section 2.4 links the logic model to measurable indicators and identifies risk factors that may influence the evaluation process.

2.2 Wider socio-economic context and policy-specific context

Prior to the evaluation of the Programme, it is important to understand the wider socio-economic decision-making process of the Public Health Programme, including the Public Health Programme Decision (2002). There are several reasons to identify public health as a key issue across the European Union:

- The EU has an obligation to ensure that “A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities” (Article 152 of the Treaty). Health is also mentioned in Articles 153 (Consumer policy), Article 175 (Health and environment), 137 (Workers safety), Article 3 (Health protection), and Article 95 (3) (Health, safety, environmental and consumer protection).
- European countries face common trends affecting public health such as aging populations, re-emerging and new infectious diseases and growing concerns over food safety¹⁶. Taking these developments into account requires an integrative approach to maintaining and improving public health. This means that links with all other relevant programmes related to public health are of importance, such as (health) research (DG Research) and eHealth (DG Information Society)¹⁷, DG Employment, DG Agriculture and Rural Development, DG Enterprise).
- Total health care spending has grown faster than GDP in the majority of the EU Member States during the last 20 years. The management of health care services is clearly the responsibility of the Member States. The EC's role is to complement their efforts, to add value to their actions and to deal with issues that Member States cannot deal with on their own¹⁸.

¹⁶ European Communities (1997). Innovative research and appropriate health care for the citizens of Europe. Proceedings of the invitational conference on the occasion of the Netherlands' EU Presidency. Edited by Evered D, Kroes R, Klases EC. Luxembourg: Office for Official Publications of the European Communities.

¹⁷ Van der Kreeft, P (2003). Notes of the EU Public Health Programme 2003-2008: Information day.

¹⁸ Commission of the European Communities (2000). Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the health strategy of the European Community. COM (2000) 285 final.

- With respect to national autonomy and the subsidiarity principle, there are both community and transnational aspects related to public health. For example, biomedical science and technology development are international issues, and the multinational industry functions in every country. The programme therefore depends on effective cooperation with the Member States and their full commitment to implement EU actions in the field. In return, the programme supports and complements Member State actions and measures at EU level.

Each Member State has a healthcare system that has evolved over time in ways that reflect social and cultural preferences. These characteristics make alignment of policies complex and sensitive. With regard to research and development (as promoted within this programme), the key phrase is “European added value” because there are many areas in which European collaboration can add value. We use the concept of ‘European added value’ to identify one of a number of circumstances. The first is through *cost saving*. This arises, for example, through avoiding the duplication of provision. The second is through *synergy*. This arises where two or more providers are able to collaborate to provide added value, for example, by focusing different skills or research disciplines on a shared problem. The third is through *scale*. This arises where by combining resources a better quality of service can be provided as with combining two or more databases, or providing a sufficient patient base for medical research into rare disorder. The fourth is through *addressing problems*, which are poorly addressed through the existing architecture of service provision. For example, a new pandemic emerging outside the EU but moving towards it. Finally, it is relevant to note that in addition to these technical efficiencies, *improving allocative efficiency* by directing services towards those who need them most can add value.

Therefore the relation with regional/national initiatives in the field of public health and other international programmes of the WHO, OECD and the Council of Europe are of main importance. The Commission and the WHO cooperate in several fields, for example collection and use of information and data for health monitoring and determinant purposes; strengthening communicable disease surveillance; and strengthening and maintaining health risk reduction policies. Cooperation with the OECD includes performance indicators of health care institutions to assess and compare quality strategies; mobility of health professionals; and support for systems of health accounts in areas not covered by the EU Statistical programme. The Commission and the Council of Europe have agreed to further develop their co-operation with regard to e.g. equity in health; health information; the impact of information technologies on health care; and quality and safety of organs and substances of human origin, blood and blood derivatives. Synergy and complementarity with the activities performed by these organisations will be pursued.

These issues are illustrative for the public health practice. As described by Gunning-Schepers in 1997⁴, public health practice is concerned with using the available sources in society to improve the health of populations, through the organised efforts of society and through health policy measures. The Public Health Programme can be seen as one of these measures, of which the European

Commission is the driving force on the basis of the Decision on the programme of Community action in the field of public health adopted by the European Council and Parliament in 2002¹⁹.

2.3 Policy-making context - Public Health Programme

The public health programme underpins the development of the Community's health strategy. The European Commission (DG Health and Consumer Protection (SANCO)) executes the Programme with the following general objectives:

- To improve information and knowledge for the development of public health;
- To enhance the capability of responding rapidly and in a coordinated fashion to threats to health;
- To promote health and prevent disease through addressing health determinants across all policies and activities²⁰.

These objectives reflect the three main themes of the Programme: Health Information, Health Threats and Health Determinants. The outcomes of the Programme should contribute to general public health objectives as stated in the Public Health Programme decision 1786/2002/EC²¹.

On the basis of this information we suggest the following layers of the logical framework (Table 1).

¹⁹ Deloitte (2004). European Commission – Health and Consumer Protection DG. Final Evaluation of eight Community Action Programmes on Public Health. Available at:

http://europe.eu.int/comm/health/ph_programme/documents/evaluation/frep_evaluation_en.pdf

²⁰ European Commission (2005). Health & Consumer Protection Directorate-General. Directorate C – Public Health and Risk Assessment. Programme Committee for Public Health. Call for Proposals 2005. Evaluation report.

²¹ Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008). Official Journal of the European Communities, 2002.

Table 1. Programme structure to examine the logic of separation into threads

Layer 0: Public health policy objectives		
<ul style="list-style-type: none"> ▪ Protecting citizens from risks and threats through enhanced surveillance, control and response to health threats which are beyond the control of individuals and cannot be effectively tackled by individual Member States alone ▪ Improving capacity to increase the ability of citizens to take better decisions about their health ▪ Effective mainstreaming of health policy objectives across all Community policies ▪ Effective tackling of health determinants and of prevention of disease and injury ▪ Improving synergies between national health systems ▪ Generating and disseminating improved health information to citizens, health experts and policy-makers 		
Layer 1: Public Health Programme (general objectives)		
To improve health information and knowledge for the development of public health by:	To enhance the capability of responding rapidly and in a coordinated fashion to threats to health by:	To promote health and prevent disease through action on health determinants across all Community policies and activities by:
Layer 2: Specific objectives/themes (actions and support measures)		
1. Health information	2. Health threats	3. Health determinants
1.1. Health monitoring system 1.2. Early warning 1.3. Data sharing 1.4. Analysis and consultation mechanisms 1.5. Impact of health policy developments 1.6. Health technologies information exchange 1.7. Good practice 1.8. Joint Internet information	2.1. Communicable disease: surveillance 2.2. Communicable disease: network operations 2.3. Non-communicable disease: prevention, information exchange, response 2.4. Emergencies (incl. Terror) 2.5. Vaccination & immunisation 2.6. Substances of human origin: safety 2.7. Substances of human origin: vigilance 2.8. Environmental threats (radiation, noise) 2.9. Antibiotic resistance	3.1. Lifestyle 3.2. Socio-economic determinants (inequalities) 3.3. Environmental determinants 3.4. Genetics 3.5. Evaluating health promotion 3.6. Capacity building
Layer 3: Operational objectives		
Projects, tenders, reports, communications and legislation	Projects, tenders, reports, communications and legislation	Projects, tenders, reports, communications and legislation

The target group levels are diverse, e.g. citizens and patients, professional audiences, authorities²².

The Programme Decision (2002) describes the actions and support measures with regard to the three themes (sections 2.3.1 - 2.3.3).

2.3.1 **Actions and support measures of Theme 1: Health Information**

The specific objectives of Theme 1 are to improve health information and knowledge for the development of public health by:

- 1.1. Developing and operating a sustainable health monitoring system to establish comparable quantitative and qualitative indicators at Community level on the basis of existing work and of accomplished results, and to collect, analyse and disseminate comparable and compatible age- and gender-specific information on human health at Community level concerning health status, health policies and health determinants, including demography, geography and socio-economic situations, personal and biological factors, health behaviours such as substance abuse, nutrition, physical activity, sexual behaviour, and living, working and environmental conditions, paying special attention to inequalities in health.
- 1.2. Developing an information system for the early warning, detection and surveillance of health threats, both on communicable diseases, including with regard to the danger of cross-border spread of diseases (including resistant pathogens), and on non-communicable diseases.
- 1.3. Improving the system for the transfer and sharing of information and health data including public access.
- 1.4. Developing and using mechanisms for analysis, advice, reporting, information and consultation with Member States and stakeholders on health issues relevant at Community level.
- 1.5. Improving analysis and knowledge of the impact of health policy developments and of other Community policies and activities, such as the internal market as it affects health systems, in contributing to a high level of human health protection, including developing criteria and methodologies for assessing policies for their impact on health and developing other links between public health and other policies.
- 1.6. Reviewing, analysing, and supporting the exchange of experiences on, health technologies, including new information technologies.
- 1.7. Supporting the exchange of information and experiences on good practice.
- 1.8. Developing and operating a joint action with the plans drawn up under e-Europe to improve availability to the general public on the Internet of information on health matters, and considering the possibilities for establishing a system of recognisable Community seals of approval for Internet sites.

The existing data and the information provided by the system should be easily accessible to the Community, relevant users in Member States and, as appropriate, international organisations.

²² Van der Kreeft, P (2003). Notes of the EU Public Health Programme 2003-2008: Information day.

The statistical element of the system will be developed, in collaboration with Member States, using as necessary the Community Statistical Programme to promote synergy and avoid duplication. Developing links with relevant Community programmes and actions and with national and regional activities is a key element of the Public Health Programme.

These actions and support measures are translated into the following Action lines for Health information in the work plans for 2003, 2004 and 2005²³:

- Developing and co-ordinating the health information and knowledge system (2003 – 2005)
- Operating the health information and knowledge system (2004, 2005)
- Developing mechanisms for the reporting and analysis of health issues and producing public health reports (2003 – 2005)
- Developing strategies and mechanisms for preventing, exchanging information on and responding to non-communicable disease threats, including gender specific health threats and rare diseases (2005)
- EHealth (2004, 2005)
- Supporting the exchange of information and experiences on good practice (2003, 2005)
- Health Impact Assessment (2003 – 2005)
- Co-operation between Member States (2005)
- Ageing and health (2003)
- Improving access to and the transfer of data at EU level (EU public health portal) and other publishing platforms (2003)
- Operating the health monitoring system (2003)
- Health in applicant countries (2004)

2.3.2 **Actions and support measures of Theme 2: Health Threats**

The specific objectives for Theme 2 are to enhance the capability of responding rapidly and in a coordinated fashion to threats to health by:

- 2.1. Enhancing the capacity to tackle communicable diseases by supporting the further implementation of Decision No 2119/98/EC on the Community network on the epidemiological surveillance and control of communicable diseases.
- 2.2. Supporting the network's operation, in the Member States and the countries participating on the basis of Article 10 of this decision, in particular in relation to common investigations, training, continuous assessment, quality assurance and, where appropriate, in relation to its contribution to the actions described in points 1.2 and 1.3.

²³ European Commission. Community action in the field of public health (2003 to 2008). Work plans 2003-2005.

- 2.3. Developing strategies and mechanisms for preventing, exchanging information on and responding to non-communicable disease threats, including gender-specific health threats and rare diseases.
- 2.4. Exchanging information concerning strategies in order to counter health threats from physical, chemical or biological sources in emergency situations, including those relating to terrorist acts, and developing or using, when appropriate, Community approaches and mechanisms.
- 2.5. Exchanging information on vaccination and immunisation strategies.
- 2.6. Enhancing the safety and quality of organs and substances of human origin, including blood, blood components and blood precursors by developing high standards of quality and safety for the collection, processing, storage and distribution and use of these substances.
- 2.7. Implementing vigilance networks for human products, such as blood, blood components and blood precursors.
- 2.8. Promoting strategies and measures concerning the protection of human health from possible adverse effects from environmental agents such as ionising and non-ionising radiation and noise.
- 2.9. Developing strategies for reducing antibiotic resistance.

These actions and support measures are translated into the following Action lines for Health threats in the work plans for 2003, 2004 and 2005²⁴:

- Surveillance (2003 – 2005)
- Exchanging information on vaccination and immunisation strategies (2004, 2005)
- Health security and preparedness (2003 – 2005)
- Safety of blood, tissues, cells and organs (2003 – 2005)
- Antimicrobial resistance (2003 – 2005)
- Capacity building (2004, 2005)
- Early warning and response (2003)
- Rare diseases (2003)
- Supporting the networking of laboratories (2003 – 2005)

2.3.3 Actions and support measures of Theme 3: Health Determinants

The specific objectives of Theme 3 are to promote health and prevent disease through action on health determinants across all Community policies and activities by:

- 3.1. Preparing and implementing strategies and measures, including those related to public awareness, on life-style related health determinants, such as nutrition, physical activity, tobacco,

²⁴ European Commission. Community action in the field of public health (2003 to 2008). Work plans 2003-2005.

alcohol, drugs and other substances and on mental health, including measures to take in all Community policies and age- and gender-specific strategies.

- 3.2. Analysing the situation and developing strategies on social and economic health determinants, in order to identify and combat inequalities in health and to assess the impact of social and economic factors on health.
- 3.3. Analysing the situation and developing strategies on health determinants related to the environment and contributing to the identification and assessment of the health consequences of environmental factors.
- 3.4. Analysing the situation and exchange information on genetic determinants and the use of genetic screening.
- 3.5. Developing methods to evaluate quality and efficiency of health promotion strategies and measures.
- 3.6. Encouraging relevant training activities related to the above measures.

These actions and support measures are translated into the following Action lines for Health determinants in the work plans for 2003, 2004 and 2005²⁵:

- Supporting key Community strategies on addictive substances: Tobacco (2003 – 2005)
- Supporting key Community strategies on addictive substances: Alcohol (2003 – 2005)
- Supporting key Community strategies on addictive substances: Drugs (2003 – 2005)
- Integrative approaches on lifestyle and sexual health: Lifestyles (2003 – 2005)
- Integrative approaches on lifestyle and sexual health: Sexual health (2003 – 2005)
- Integrative approaches on lifestyle and sexual health: HIV/AIDS (2003 – 2005)
- Integrative approaches on lifestyle and sexual health: Mental health (2003 – 2005)
- Public health actions to address wider determinants of health: Social Determinants (2004, 2005)
- Public health actions to address wider determinants of health: Environmental (2003 – 2005)
- Disease prevention and prevention of injuries (2003 – 2005)

²⁵ European Commission. Community action in the field of public health (2003 to 2008). Work plans 2003-2005.

2.3.4 Intervention logic

Within the structure presented above, it is appropriate to layout the intervention logic for:

- The *overall institutional framework* i.e. the rationale for the overall structure and the ‘process map’ of Programme decision-making (including responsibilities, follow-up and evaluation of the themes).
- For *each theme*, i.e. the common elements of the various Action lines. The items to assess include:
 - The involved groups (target and delivery), with their powers of action, preferences and ‘skill’ level;
 - The way the various groups relate in taking decisions and actions (incidence of decision-making, actions, costs, benefits);
 - The ‘business case’ or identification of needs and issues relating to the theme itself.
- For each *Action line* (or suitable aggregate to minimise duplication and take account of internal synergies and shared logic), the logic behind the separation of Action lines and the support resources and modalities provided for projects in these lines and the scheduling of activities throughout the Programme.

Draft logical frameworks at Programme level and Theme level are described in the sections below.

2.4 Evaluation context

Each of the logical frameworks includes indicators to measure the achievement of an objective. An indicator reflects either quantitative or qualitative information (data). The following tables, describing drafts of different intervention logical frameworks, provide an overview of:

- The *objectives* of each stage in the evaluation (i.e. Design, Inputs, Activities, Outputs, Outcomes, Broader and sustained impact). The Design stage includes Programme design, Specification of (various levels of) objectives, Design of support modalities and Identification of Action lines);
- The *indicators and data* needed to measure their achievement (please note that Chapter 3 provides further detail on data collection);
- The *evaluation criteria* (see also section 1.1). To some degree, the criteria are crosscutting (across stages). In this sense, we want to collect data and information for relevant aspects of a given evaluation criterion according to different stage-specific evaluation questions, aggregating them to assess the ‘master’ criterion.
- Potential (external) *risk factors*. Risk factors are of importance to an evaluation because they provide insight into the factors that may bias the measurement of indicators.

2.4.1 Use of the logical framework to answer the evaluation questions

The evaluation framework is based on a systematic view of the function of the Programme, described in Figure 1. This leads to a clustering of summative and formative evaluation questions in terms of specific criteria as described in Chapter 1.

The logical framework serves two functions. First, it describes appropriate versions of the evaluation questions applicable to each layer of the evaluation. Second, it links each criterion to the evidence and supporting analysis used to assess performance against that criterion and to contextual or external factors that might affect either the performance or the attribution of performance to programme design and activities.

The following discussion *indicates* how the results from the logical framework will be used to assess performance according to the appropriate evaluation criteria. The link of these assessments to the formative and summative questions will be further described in Chapter 3.

Efficiency

In general, for direct consequences of the Programme, the efficiency criterion is primarily based on technical efficiency, which is roughly the ratio of output(s) to input(s). It is simplest to assess when inputs and outputs can be expressed in a common unit – generally monetary. In this case, data on the budgetary or (preferably) opportunity costs of programme activities are combined with monetised data on the (opportunity) value of outputs produced and cost-benefit differences computed²⁶. Of course, for many Action lines it is inappropriate to monetise all outputs and no sound, relevant and acceptable basis for doing so exists.

In this case, the preferred approach is to use separate measures for inputs and outputs and apply cost-effectiveness analysis. While this may work well at the project level, it is less satisfactory at the Action line or theme levels, which are inherently multicriterion, calling instead for a scorecard approach. For consistency, the same approach should be used when evaluating complementarity, since the opportunity cost of a given public health outcome is measured in terms of an alternative (and presumably disaggregated or less-coordinated) way of delivering the same level of benefit. The criterion also applies to allocative efficiency – the degree to which a reprogramming of activity could make all parties better off. In effect, technical efficiency asks whether the programme carries out its chosen role without waste, while allocative efficiency considers whether a rebalancing of responsibilities might produce a better result. This can only be given objective meaning for areas where a private market coexists, and is thus of limited applicability to this particular evaluation.

Effectiveness

The effectiveness criterion considers whether the programme produced expected results of good quality. Where external factors affected delivery – or the attribution of results to programme activity, the analysis will consider whether those factors were foreseeable, anticipated and well-managed. This

²⁶ If suitable monetary data are available on a range of similar projects or interventions at the international and Member State levels, this may be complemented by non-parametric “Farrell technical efficiency” measures derived from data envelopment analysis.

is assessed in two ways: by examination of the contingency plans, monitoring and information systems and by event studies of one or two suitable ‘challenges’ to the programme.

The attribution evaluation must also consider whether, in the absence of the programme, the results would have come about anyway, with the same quality, speed and utility and/or at greater cost. This is necessarily counterfactual, so relevant evidence must be based on valid comparators (in other programmes, areas and contexts (Member States, international experience) and on judgements elicited through key informant interviews.

2.4.2 Evaluation at the Programme level

Table 2. Draft logical framework at Programme level

Stage	Evaluation criteria	Measurable indicators		Risk factors
		Data/Indicator(s)	Sources	
Design	Relevance Acceptability	Process map Objectives Thread structure	Programme documents External documents Consultation	Legislative process External programmes
Inputs	Efficiency (adequacy, availability)	Quality Quantity Allocation	Budget Financial regulation Work Programmes Staffing plans	Funding delays Personnel interruptions
Activities ²⁷	Efficiency (management, quality, engagement)	Process evaluation: accessibility, responsiveness, timeliness, communications, enforcement, monitoring (administrative procedures, reporting requirements)	Programme documents Changes in work programmes Grant management Survey Interviews	Procedural delay Engagement by externals
Outputs	Efficiency	Cost-benefit ratios Cost-effectiveness Balance of costs (fixed/variable, overhead) Co-financing (mechanisms) Output delivery (cost, quality, timeliness)	Mostly rolled up from thematic level	

²⁷ At this level, activities concern Programme (re) design, WP/Call drafting, engagement strategy, concertation etc.

Stage	Evaluation criteria	Measurable indicators		Risk factors
Outcomes	Effectiveness European Added Value	Rolled up from themes	External documents Consultation	Ability of PH systems to use outputs External shocks to PH
Broader impact	Impact Acceptability Consistency	Improvements in public health indicators Matching or follow-up activities Spillovers into Member States Coherence of integrated strategies Health status inequalities (Gini, Fields indices, benchmarks or spatial econometrics) Member State cooperation (joint policies) and coordination (harmonised policies) Public health concerns in other policy areas (e.g. transport, labour, food, research etc.)	Statistics External documents Interviews Survey Strategy documents Health data (WHO, OECD) Interviews	Awareness Parochialism MS political developments Differences in health system, demographic, health capacity etc. Coordination failures

In general, evaluation according to a specific criterion can be based on several complimentary types of evidence and derived indicators (triangulation). For *relevance*, the underlying issue is the match between the need for programme activities (based on concrete information provided in programme and research documents), the programme objectives and the design details. The indicators used to assess this match are a description of unmet needs (including the need for coordination at the European level), a map relating these needs to the programme objectives, and a process map corresponding to the programme structure. The same evidence used to demonstrate *relevance* can be used to assess *effectiveness*. As with any long-term programme, relevance may be affected by changes in need, changes in the policy environment, and the emergence of complementary or substitute activities at the international, EC or Member State level, so these external factors must be considered when evaluating the relevance of the programme.

The next level is concerned with the availability, quantity and quality of inputs (*efficiency*). The evidence used are the budgets and staffing of the programme. Indicators are suitable summaries of the totals available to the programme as a whole (and its components). Their adequacy can be inferred from the costs of similar interventions elsewhere, the per-project allocations, levels of co-funding and interviews with proposal leaders.

The evaluation of activities (*efficiency* of programme activities) is based on management indicators, a process map of programme-level activities (to identify any points of congestion or coordination) and

statistical data on internal costs and delays. Survey data can be used to provide an evaluation from the perspective of external participants, who will be asked to rate management quality, timeliness and the impact on their own costs and benefits of participation. If available, indicators of average timeliness of outputs and payments will be computed.

At the output level, monetary data on costs will be appropriately discounted, aggregated and allocated (as far as possible) between fixed (overhead) and variable costs (*efficiency*). Adjustment will be made for co-financing and external costs. On the benefit side, a preliminary feasibility study will be made drawing on the cost-effectiveness literature for public health evaluations to see whether sufficient data exist for a meta-level estimate of benefit value. Additionally, comparative programme- and project-level data will be collected relating to similar activities in other public health programmes supporting similar interventions. Inevitably, the benefits will be the hardest element to quantify, so the most likely indicators are cost-effectiveness ratios or cost per unit of output measured in activity terms.

Effectiveness will be assessed on the basis of measures of uptake and utilisation. The specific indicators will vary by project type: for projects resulting in research output, the indicators will include publications, both in aggregate and bibliometrically weighted (for journal ranking and citation weight). Initially, this will be based on Web of Science data. Where relevant, corresponding data on patents can be constructed from e.g. the Derwent Patent Citation Index²⁸. But the scholarly literature is only one vehicle for dissemination and engagement, and the overall effectiveness of programme contributions or knowledge and practice can also be gauged from references in public health programme documents from Member States, other EC directorates-general, European Parliament documents and international organisations. Awareness and utility scores can also be derived from survey data and interviews. For public health information, effectiveness can be scored in terms of the amount of material made available through various channels and (at least for electronic information) the number of ‘hits’ or amounts downloaded. While the limitations of such measures are increasingly well known, there are few feasible alternatives for measuring uptake by the general public. Information on access and utilisation by practitioners may be approached through professional bodies and national health systems and survey information.

European Added Value (*consistency*) refers to a range of ways in which the programme can enhance the effectiveness of existing and new activities at the Member State level. One mechanism is net cost savings through eliminating duplication and realising economies of scale and scope. This can be assessed through time-series analysis of specific cost aggregates. A second mechanism is synergy – for instance, through complementarity of skills or experience. This can be measured indirectly through indicators of the ‘networking²⁹’ among participants – and in particular the European reach of such projects or their follow-on activities. On the information side, scale and scope effects are indicated by database linking or data mining, especially when such data pooling helps overcome small numbers statistical problems. A further route for the attainment of European Added Value is the ability to

²⁸ Database of citations, both to patents and journal literature, appearing in patents from six major patenting authorities, i.e. European Patent Office, Germany, United Kingdom, Japan, United States.

²⁹ E.g. path length and cluster coefficient measures on networks of collaboration or co-authorship among programme stakeholders.

address problems that do not fit well within national public health system ‘stovepipes’ – e.g. identifying the emergence and epidemiology of a new health threat, or dealing with cross-border (e.g. drug) problems. Finally, where resources are scarce relative to need, broadening the front across which provision and need are matched enhances equity and ensures that services are available to those in greatest need. Interviews with stakeholders will also provide information about this issue.

The broader impacts (*acceptability, consistency*) should, ideally, be evaluated on the basis of ‘objective’ public health data. However, these data are collected at high levels of aggregation (relative to the scale of the programme) and will probably be of limited utility, except in specific instances. A further possibility is a (Cochrane) literature review. At the procedural level, programme actions to broker cooperation among external parties or to pilot new forms of activity can be assessed through the existence and continuation of follow-up activities. These can range from the continuation of funding through the ongoing development of new data or concerted action (input from survey). Of course, the evaluation will collect and include benchmark indicators of public health outcomes (incidence and prevalence of public health threats, resulting outcomes in lives and costs, etc.) but these can only be indirectly linked to the programme itself. However, to the extent that specific data are cited in establishing the rationale for and design of the Programme, a closer focus is possible. One example is the provision of consistent European-wide data through the European Monitoring Center for Drugs and Drugs Addiction (EMCDDA) – there is a clear record of the induced data collection and report activities in the Member States and the use of comparative data in the design and execution of drugs policy. Moreover, the Centre’s own data sources provide perhaps the only qualitative benchmark against which broader progress in this area of public health can be gauged. But in this case as in others it is vital to recognise the essentially trans-European nature of the work supported by the Programme. Concretely, different Member States face different problems and the comparative data not only provide pointers to good practice but also to specific conditions favouring or inhibiting a particular approach. Moreover, several Member States are pursuing radically different policies whose relative performance will, over time, lead to better outcomes throughout the EU – but (and this is the crucial point) at the moment the value added through learning exceeds that of adopting what appears at the moment to be ‘best practice.’ In this sense, the urge to aggregate broader impact measures to the highest level should be resisted: it masks both distributional inequalities and the exchange of information.

2.4.3 Evaluation at the Theme level

As each theme is set up in the same way, except for the statement of design objectives, this framework can be applied for each theme. In terms of concrete impacts, we agreed that attributing changes in real public health data to the Programme might be ambitious at this stage, but we suggest developing a (modest) set of performance indicators for the public health system in areas specifically addressed by the Programme. For this purpose we will use different sources, such as the website of DG SANCO, evaluation reports, etc. The indicators are not all health-related and could easily fit into the logical framework. In some cases, attribution (of impacts to Programme activities) would come from direct links (personnel, project involvement), in others it would depend on indirect evidence of parallel developments (e.g. implementation of consistent data definitions, shared technologies tied to projects) or simply because of coincidental correlation (e.g. when causality was not disputed). The methodological stance is that of a study with fixed and time-varying elements, such as:

- Measures of the availability and utilisation of information by public health authorities (data sharing, monitoring systems, etc.) and uptake by national statistical offices (e.g. Eurostat)
- Mirroring of Programme data in local public health systems and use in strategy planning
- Health econometric measures of the incidence, prevalence and dynamics of public health threats (especially communicable diseases)
- Environmental health data
- Indicators of public health system computerisation and electronic data collection, sharing and analysis

Of particular interest is the possibility to collect “event study” data relating to specific threats (such as bird flu, BSE/CJD, drug-related epidemics (the recent ‘bad heroin’ situations), MRSA, resistant Tuberculosis, etc.). Indicators would gauge speed and consistency of response, not necessarily effectiveness, since there are specific risk factors in terms of local demographic/exposure/susceptibility differences and public health delivery systems beyond the reach of the Programme. The ideal event study would have both cross-sectional and a longitudinal dimension. In this sense it would be best to have one recurrent but episodic threat (e.g. influenza) and one emergent threat (e.g. MRSA). The studies would have both narrative and statistical components. The former would identify the *relevance* and perceived *utility* of programme assistance to the participants ‘on the ground’, while the statistical part would attempt to identify the key outcome determinants and quantify the contribution of programme activities (*effectiveness*). In the first case, the study would collect data on the epidemiology of the threat (as to incidence, prevalence and consequences) and model its spread, growth and decay using a simple susceptible/infected/recovered model with a simple (e.g. regional) spatial dimension. The dynamics would be analysed using a cluster analysis, and a spatial econometrics time-series model. The objective would be to differentiate patterns in different regions and at different times. These differences would then be explained in terms of behavioural determinants (e.g. levels of vaccination uptake), exogenous factors (e.g. weather) and programme interventions. One analytic complication is the possibility of endogeneity: not only are the various influences on the outcome correlated with each other, but the course of the epidemic affects the responses adopted. Patterns of international cooperation show this quite clearly, with repeated episodes and threshold levels accompanying step-changes in the degree of effective cooperation. The narrative evidence could be used to develop an appropriate specification and to identify suitable instruments to clear up any endogeneity and specification issues. For the second type of event, the focus is more on specific decisions – both public health responses and international cooperation. In the statistical thread the time-course of the threat and associated decisions (identified from the narrative evidence) can be modelled using a discrete-choice model.

In the following table we provide an overview of the draft logical framework at Theme level.

Table 3. Draft logical framework at Theme level

Stage	Evaluation criteria	Measurable Indicators		Risk factors
		Data/Indicator(s)	Sources	
Design	Relevance Consistency Acceptability	Process map Objectives (per theme) Thread structure Appropriateness of support modalities to the target audiences	Programme documents External documents Consultation	Legislative process External programmes
Inputs	Efficiency (adequacy, availability)	Quality Quantity Allocation	Budget Financial regulation Work Programmes Staffing plans	Funding delays Personnel interruptions
Activities ³⁰	Efficiency (management, quality, engagement)	Management criteria as in Programme level Contact lists Information Day attendance Proposal levels, success rates, distribution Proposal quality distribution (scores or above/below line)	Programme documents Changes in work programmes Change management Survey Interviews	Procedural delay Engagement by externals
Outputs	Efficiency	Output delivery (cost, quality, timeliness (of deliverables, cost claims, payments, workshops)	Mostly rolled up from thematic level	
Outcomes	Effectiveness	Realisations Level of satisfaction Follow-up or complementary initiatives (others generated directly from Action lines)	External publications Consultation	Ability of public health systems to use outputs External shocks to public health
Broader impact	Impact	Availability Timeliness Sharing of public health information Response level, speed, consistency to threats Existence, resourcing of contingency plans Improvements in public health indicators Matching or follow-up activities Impacts on member states and other “determinants” activities	Statistics External documents Interviews	Awareness Parochialism Member states' political developments

³⁰ At this level activities focus on specific call texts, initial expert consultation, information days, tendering process, bid evaluation, selection and negotiation, ex post debriefing and guidance, project management, concertation, exploitation and dissemination.

CHAPTER 3 **Evaluation questions and data collection**

3.1 **Introduction**

In Section 1.1, we described the criteria that will be used to assess the Public Health Programme for the years 2003-2005. These criteria are specified in the evaluation requirements of the Terms of Reference, contract (SANCO C1/FS (op) D(2005) 310880, 14 December 2005). The evaluation criteria relates to the nature of the change allowing to considering progress of the Public Health Programme. Evaluation questions determine the area of judgment for which an answer is required.

3.2 **Evaluation questions**

In June 2003, former WHO Director General, Dr. Gro Brundtland argued: “Perhaps the most important lesson of all from recent experience in public health is that improving people’s lives remains the bottom line...Despite the months of work they take, negotiating treaties and targets is the easy bit. Putting them into practice is the hard part... Agreeing what constitutes the right to health is an important step, but making sure that right is protected or realized is the step that really makes the difference”³¹. This interim evaluation seeks to evaluate the ‘hard part’ by asking what impact the public health programme has had on the lives of citizens of Europe. We do not believe that this can be done with precision but we would agree with the assertion “Far better an approximate answer to the right question...than an exact answer to the wrong question”³².

In addressing this question, we are confronted by the problem of leverage. The Commission’s Public Health Programme has been estimated to cost less than eight pence per European citizen³³. Its impact therefore depends upon the decisions and actions of many others. Attributing any specific outcome to the Programme is imprecise and we need consider evidence other than changes in health status (the intended longer-term impact). This problem is compounded by the recognition that the relationship between short-term outcomes and longer-term impacts may not follow the anticipated path. One

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http://www.soros.org/initiatives/health/focus/phw/articles_publications/publications/brochure_20050901/brochure_20050819.pdf

³² Tukey JW (1962) ‘The Future of Data Analysis’ *Ann Math Stat*, 33

³³ Price, C. (2004) ‘EU Public Health Strategy’ *ph.com The newsletter of the Faculty of Public Health* Sept 2004 www.fph.org

preferred solution to this complexity is to introduce a quasi-experimental model allowing researchers to investigate a ‘real life’ counterfactual. This would provide a basis for establishing what would have happened in the absence of the Programme. Clearly, this is not possible in this case; there is no observable counterfactual state. Under these circumstances, we prefer to identify the implicit causal relationships linking the Programme inputs to the longer-term outputs and to evaluate these claims against a body of evidence (including subjective assessments) and alternative explanations. This has been recommended in other cases where complete comparators are unavailable – especially in sustainability analysis or situations where selection and incentive effects limit the coverage of RCTs. The issue is further addressed in the unpacking of our evaluation questions below. The likely deviation from the intended outcomes identified through this work would be our ‘nonexperimental impact estimation’.

However, we anticipate significant limitations to data availability. This is partly due to the fact that Programme is still running, and that its results need to be disseminated and implemented for some years to produce measurable broader (health) impacts³⁴. This is less likely to be a problem when analyzing cost-minimization, which will be estimated by assessing how far the Programme has minimised duplication of effort, encouraged sharing of available data, and supported core skills. It becomes more problematic when considering cost effectiveness and even more challenging when considering cost-benefit analysis where there may not be sufficient periods of data available, measures may not be consistent over time, and data collection may be incompletely built into programme plans. Under such circumstances (and we anticipate that these circumstances will be common) we will need to depend upon expert opinion, case histories, and a triangulation of evidence (as identified below).

The terms of reference and the foregoing analysis raise the following formative and summative evaluation questions. The latter are categorised by evaluation criterion. Each is followed by a brief description of the relevant evidence, indicators and analysis to be used in answering it.

Formative questions:

- A. How successful is the current Programme in enhancing the effectiveness of surveillance, control and response to health risks and threats that cannot effectively be tackled by Member States alone? What are the reasons for success or lack of success and what implications do they have for future activities?

This question ultimately focuses on the European Added Value of the programme. Indicators include response speed and effectiveness of public health surveillance measures (based on the coverage and communications links of early warning systems and event studies of the time from first warning to various levels of response). This would be measured by country and based on measures contained in specific reviews of such responses (e.g. the data in the reviews of responses to SARS). This in turn depends on capturing economies of scale

³⁴ Hanney S, Gonzalez-Block M, Buxton M, Kogan M (2003). The utilisation of health research in policy-making: concepts, examples and methods of assessment. *Health Research Policy and Systems*,1 (2).

and economies of scope, facilitating harmonisation and information exchange, and supporting standardisation and appropriate localisation.

- B. How successful have programme interventions been in encouraging citizens to take better decisions about their health and what implications does this have for future action?

This moves the focus beyond the direct impacts of the programme to the leverage of the Programme. In other words, to the extent that information supplied via the Programme is useful to and used by citizens, the direct results can be sustained over time and used to leverage progress in other issues. It can be assessed globally by evidence on healthy behaviours and more narrowly by access to and use of information provided or disseminated by the Programme. This is based on two concrete sets of data: behavioural data covering areas of programme activity (e.g. diet exercise, smoking, drug use) and reviews of the effectiveness of public health information programmes.

- C. How effectively are health policy considerations incorporated across Community policies? What does this tell us about achieving this more effectively in the future? What implications does this have for future action?

The incorporation of public health considerations into other Community policies is evaluated through document review (to demonstrate the consideration of health matters) and interviews to assess their effectiveness. Specific search terms will be drawn from Programme documents. This information is qualitative and lack numerical measures.

- D. How successful has the current Programme been in tackling health determinants? What are the barriers and facilitators to successful delivery? What implications does this have for future action?

The evidence for this question stems from available public health data on determinants and the incidence and prevalence, as well as mortality/morbidity data of health problems to which they are linked. The first level of assessment is simply whether problems are getting worse or better and can be based on quantitative and data peer-reviewed analysis (e.g. of smoking, obesity, hygiene). The second level is the degree to which Programme activities have influenced or aligned with these changes. The high level of aggregation of these data do not permit an econometric analysis, but an analysis of the literature relating to some key determinants will determine whether the programme's structure is broadly aligned with unmet needs and will draw out lessons for future priorities.

- E. How successful has the current Programme been in helping the public health system reduce the incidence of disease and injury? What are the barriers and facilitators to successful delivery? What implications does this have for future action?

The public health system as a whole aims to reduce the incidence of disease and injury. This includes concrete data (incidence/prevalence) on diseases. The question is whether the Programme helps them do this in an efficient, effective and equitable way. To address this question, the overall baseline data must be complemented by specific indicators of

interaction with targeted public health initiatives, taking into account any differences in the extent to which specific health threats are tackled as public health threats.

- F. How successful has the current Programme been in achieving synergies between national health systems? What are the barriers and facilitators to successfully achieving this? What implications does this have for future action?

This combines two aspects – the function of the Programme as a “marriage broker” or facilitator for linkages among national health systems and the way the Programme acts synergistically with those systems. The first is measured by indicators of Programme-sponsored Concertation activities and joint actions that follow Programme initiatives, and the second by participation of national public health practitioners and officials in ‘bilateral’ Programme activities and the extent to which these are continued in an individual Member State context.

- G. How successful has the current Programme been in generating and disseminating more and better health information to citizens, health experts and policy-makers? What are the barriers and facilitators to successful dissemination? What implications does this have for future action?

This will be evaluated by looking at the quality, availability and uptake of such information (the impact measure) and backing up to see whether the content and dissemination channels originated in the Programme. This is already part of the *ex post* evaluation. To give it a suitably *ex ante* character, the evaluation should also have an implicit time-series dimension. If the content is being used but did not originate with the programme, it is good for effectiveness but bad for efficiency and relevance. If the content started with the programme but is now provided from other sources, it is good for relevance and efficiency and for effectiveness and sustainability, but the key issue is whether the availability and use of such information is equitably spread (across population groups and countries). Finally, if the bulk of the information continues to originate with and be disseminated by the programme, it is good for relevance and possibly effectiveness, but not so good for sustainability unless soft evidence suggests a strong European Added Value component that makes a common source and platform valuable.

Evaluation questions:

Relevance

1. To what extent does the current Programme address the stakeholder and citizen needs and confirm the rationale for European intervention in public health?

As mentioned in Chapter 2, the indicators are a summary of unmet needs, a correspondence between these and Programme objectives and a process map for the identification and modification of these lists and relationships. Information will be provided by means of desk research, interviews and portfolio analysis.

2. How can a model identifying the mechanisms for arriving at Programme policy be designed and used, identifying how the programme objectives address the needs of stakeholders?

This is evaluated based on a combination of document review and interviews. The indicators are qualitative in nature and measure the perceived openness and responsiveness of consultation, engagement and feedback processes at the Programme level.

Effectiveness and sustainability

3. To what extent are the objectives set in the Programme Decision and annual work plans achieved?

These are assessed on a combination of effectiveness, impact, acceptability and consistency. Desk research, a survey of all funded projects and portfolio analysis will provide information to answer this question.

4. To what extent do results achieved through financial support meet the objectives set in the Programme Decision and annual work plans?

This is a sub-question of question 3, focusing on financial support and also on whether the meeting of the objectives can be attributed directly to this financial support. It is evaluated by restricting attention to financial support measures and incorporates the associated input and efficiency assessments. Desk research and a survey of selected projects will provide information to answer this question.

5. To what extent are the results likely to be sustainable?

This raises the central issue of sustainability: what is to be sustained? The literature clearly indicates that some results (while good at the time) should not be sustained. In this case, many of the European added value activities should migrate to Member States or international organisations. The activities stimulating behavioural change should move on once the change has been attained, so the evaluation should look carefully at the information systems that they use to keep track of whether the message is getting through and identifying groups or areas where effort needs to be refocused. A further point is that the evidence for sustainability needs to consider plausibility and institutional evidence rather than the specific results of specific projects. Information from the interviews and survey, as well as from desk research will be used to answer the question of sustainability.

6. To what extent are the results of projects likely to be adequately disseminated?

This combines two dimensions. The first distinguishes content to be disseminated from channels for dissemination – both are important and each depends on the other. The second is the difference between the dissemination (and uptake) of results to date and the prospects for further dissemination into the future. In indicator terms, this means considering (for current dissemination) the spread of and references to project outputs and the further activities of project personnel. Information to answer this question mainly results from the survey and bibliometrics³⁵.

³⁵ Use of published data to evaluate the knowledge produced by research activities (e.g. number of publications, their quality and impact, patent applications)

7. To what extent does the Programme complement national policies?

See question 8.

8. To what extent has the Programme developed synergies with international organisations?

For evaluation purposes, we will consider evidence of synergies in various forms. These are spelled out here for synergy with international organisations but apply equally to Member States (question 7) and other EC activities (question 11):

- a. *Co-working* – joint projects, joint planning, co-funding, collaboration in the generation and dissemination of information, etc.
- b. *Complementarity* – this means that the Programme and the international organisations do different things, but that taken together they cover the landscape. This complementarity can be seen and assessed in terms of activities, groups addressed or issues tackled. The evidence is ‘scored’ in terms of duplication, gaps and ‘cross-purposes.’
- c. *References* – this is the weakest form of evidence, and considers the degree to which the programme and the international agencies are aware of each other’s interventions. The evidence consists largely of interview questions and documentary cross-references, with some stronger evidence from scholarly co-citation and/or co-authorship or co-sponsorship of conferences.

For this purpose, we will conduct desk research, a survey and interviews.

Efficiency

9. What is the efficiency of the proposal and tender processes?
10. What is the efficiency of Commission selection and management processes?

These questions consider awareness among the potentially interested community, time-scales for proposal and decision, resources required inside the Programme. The areas involved include drafting, informing, evaluation, debriefing, negotiation and possibly contract management outside the programme. The evidence base is derived from management data and interview data on the key factors in deciding whether to bid, the resources required in putting the bid together (including consortium formation and the extent to which it involves new connections).

Consistency and complementarity

11. How consistent and complementary are the actions implemented under the current Programme with other Community policies and activities?

Desk research, interviews, and statistical analysis will provide information to answer this question.

Acceptability

12. To what extent do stakeholders accept public health policy in general and the Programme as implemented?

This is based on ‘stated preference’ types of evidence. It should reflect a clear delineation of stakeholders along the lines indicated in Chapter 1. The ‘functional’ stakeholders (actors in the public health system) clearly accept public health policy in general, but evidence on the acceptance of public health by those involved in “national health systems” should be presented. These can be surveyed as to (1) general views and awareness of the Programme, ranking of the programmes objectives, appropriateness of the programme’s support and action modalities and (2) direct suitability and utility. The other important stakeholder group is the general public. They are likely to have a wide range of views relating to the different threads of the Programme. As these views are routinely gathered using fairly well-funded (and well-developed) tools, it seems appropriate to undertake an evaluation (using Cochrane reviews as the starting point – see www.cochrane.org).

In addition, the terms of reference also refer to additional concepts, which can be related to the following issue:

Monitoring

13. How well does the current monitoring system of the Programme function?

This should be evaluated along several dimensions. The first is procedural – how does the monitoring system function and how aware are stakeholders? The second is summative – how are the results used, and what changes have they produced? It is necessary to separate the latter two because any monitoring system operates in two ways – it has an incentive function of heightening awareness of performance and thus aligning activities and encouraging effort and development. It also has a corrective function of identifying situations where things have gone wrong and triggering corrections. Information to answer this question will result from desk research, interviews and survey data.

The sections that follow provide an overview of the necessary information sources to answer each of these evaluation questions and how the data will be collected. We would like to stress that the questions will be answered considering internal Commission constraints (e.g. Financial Regulations, Commission ‘vademecum’ of grant management).

3.3 **Data collection methods**

In the following table we provide an overview of linking different methods for data collection to the evaluation questions stated above.

Table 4. Linking evaluation questions to methods of data collection

Evaluation question	Desk research	Survey	Interviews	Portfolio analysis	Statistics
1. To what extent does the current Programme address the stakeholder and citizen needs and confirms the rationale for European intervention in public health?	X		X	X	
2. How can a model identifying the mechanisms for arriving at Programme policy be designed and used, identifying how the programme objectives address the needs of stakeholders?	X		X		
3. To what extent are the objectives set in the Programme Decision and annual work plans achieved?	X	X		X	
4. To what extent do results achieved through financial support meet the objectives set in the Programme Decision and annual work plans?	X	X			
5. To what extent are the results likely to be sustainable?	X	X	X		
6. To what extent are the results of projects likely to be adequately disseminated?	X	X			X
7. To what extent does the Programme complement national policies?	X	X	X		
8. To what extent has the Programme synergies with international organisations?	X	X	X		
9. What is the efficiency of the proposal and tender processes?	X		X		X ³⁶
10. What is the efficiency of Commission selection and	X		X		X ³⁷

³⁶ Determining transaction costs

³⁷ *ibid.*

management processes?					
11. How consistent and complementary are the actions implemented under the current Programme with other Community policies and activities?	X		X		X
12. To what extent do stakeholders accept public health policy in general and the Programme as implemented?	X		X		
13. How well does the current monitoring system of the Programme function?	X	X	X		

Data collection will take place at the various levels of intervention of the stakeholder as described in Chapter 2. It is important to notice that the level of understanding of the different stakeholders is different, depending on their position in the process. In the former evaluation by Deloitte this has also been stressed³⁸.

In the interim evaluation of the Public Health Programme (2003-2008), the main inputs for data collection will be through desk research, a survey and interviews with key stakeholders. Portfolio analysis (i.e. an analysis of projects at an aggregate level) and statistical analysis (e.g. number of publications, patents and networks resulting from the projects, transaction costs) play a limited role in the interim evaluation.

3.3.1 Desk research

We will use several documents and sources to direct our interim evaluation (addressing evaluation questions 1-11 and 13). More specifically we will look in detail at:

- Programme statements with regard to addressing the stakeholder and citizen needs
- Annual Work Programmes
- Calls for Proposal
- Calls for Tender
- Proposal documentations
- Programme Decision
- Literature on sustainability
- Commission guidelines on dissemination

³⁸ Deloitte (2004). European Commission – Health and Consumer Protection DG. Final Evaluation of eight Community Action Programmes on Public Health. Available at: http://europa.eu.int/comm/health/ph_programme/evaluation_en.htm

- EC and national public health policies
- Public health policy documents of international organisations
- Guidelines on monitoring
- Project database

3.3.2 Survey of all projects funded

The survey is partly based on the survey questions used in the former evaluation by Deloitte and our study to measure the impact of health research in the Netherlands. The survey will be sent to all projects (both resulting from Call for Tender and Call for Proposal) funded within the Programme., which amounts to at least 200 surveys to be distributed. It will provide information on objectives and the themes (Action lines) to which it corresponds, resources used for executing the project, main realisations and results of the projects, and on the use and dissemination of the results. The survey will address evaluation questions 3-8 and 13 and is outlined in Appendix 1. Our aim is to receive a minimum response of 50 completed surveys that will feed into the evaluation (which amounts to a response rate of 25%). To increase the number of returns we suggest to send a mandate letter, issued by the EC, to the project leaders being surveyed. We will also follow up on project leaders by email or telephone in order to reach the amount of 50 responses. We will pilot the survey prior to sending it to all project leaders.

3.3.3 Interviews

Often, interviews allow for deeper interrogation of specific topics of interest. With the interviews we will address evaluation questions 1-2, 5, 7-13. The interview protocol is partly based on the interview questions used in the former evaluation by Deloitte (Appendix 2 describes the general interview protocol that will be utilised for each group). The interview protocol will be piloted to make sure it makes sense to the intended recipient (a read-through with at least to persons).

We will perform interviews with different stakeholders consisting of a *representative sample* of:

- Proposal leaders of rejected proposals (should be able to assess the Commission's proposal and tender processes)
- Project leaders of granted projects (should be in a good position to assess understanding of the Public Health Programme, should provide information on projects' results)
- Commission officials, independent experts, Committee members (including members of the Evaluation Committee, staff members of DG SANCO C1-C4; DG Research, DG Employment, DG INFSO, DG Environment, DG Agriculture) (should be in a good position to assess programme coherence, project selection process, project monitoring, programme results and impacts at EU level)
- National Health Authorities (should be in a good position to assess broader impact and EU added value)
- Representatives of international organisations such as the WHO and OECD (should be in a good position to assess complementarity)

- Interest groups such as High Level Committee for Health, Association of Schools for Public Health in the European Region, European Public Health Association, Public Health Agencies such as the European Monitoring Centre for Drugs and Drugs Addiction, European Environment Agency and European Centre for Disease Prevention and Control as well as academics (should be able to inform us on the acceptability and uptake of EU activities on a national/local level)

Representative sample

For interviews the important question is what constitutes a representative sample.

With regard to interviewing a *sample of project leaders and proposal leaders of rejected proposals*, we propose to use the following selection criterion: How likely is it that the information and assessment of a project/proposal reliably reflect those of the entire body of projects/proposals to which it belongs?

As a starting point for selecting a representative sample of *project leaders* we developed a matrix that provides an overview of submitted proposals and granted projects for the period 2003-2005 sorted by theme (health information, health threats and health determinants) (Table 5).

Table 5. Overview proposals and projects 2003-2005

Year \ Proposals	Accepted	Reserved	Rejected	Ineligible	Excluded	Total submitted
2003	72	53	274	0	28	427
<i>Health information</i>	32	21	61	0	*	*
<i>Health threats</i>	20	14	32	0	*	*
<i>Health determinants</i>	20	20	147	0	*	*
<i>Crosscutting applications</i>	0	12	34	0	*	*
2004	67	12	139	9	4	231
<i>Health information</i>	26	8	60	0	2	96
<i>Health threats</i>	17	0	23	3	1	44
<i>Health determinants</i>	24	4	56	6	1	91
2005	55	17	161	0	9	242
<i>Health information</i>	18	5	61	0	5	89
<i>Health threats</i>	12	0	18	0	1	31
<i>Health determinants</i>	25	12	82	0	3	122

* Information not available

The 2003 work plan includes crosscutting activities. However, for the consecutive years these were integrated in the three themes Health information, Health threats and Health determinants.

Given the available time for the interim evaluation, we suggest interviewing people from a sample of about 30% of the total number of projects granted in which at least one of each of the Action lines is represented. The different Action lines per Theme are described in the boxes in sections 2.3.1 - 2.3.3. The analysis and selection of a representative sample of granted projects is based on a predefined set of criteria. For 2005 we have selected those projects that have a signed grant agreement. According to the DG Public Health website³⁹ the remaining projects are still in the process of receiving co-financing under condition that the negotiation procedures with the European Commission are successful and that the grant agreement is signed. Therefore we suggest including in our interview sample only those projects that have a signed grant agreement.

The project analysis and selection results in a representative sample of 53 projects: 23 from 2003, 20 from 2004 and 10 from 2005 (see Appendices 3, 4 and 5). In this sample we make sure that the three themes are proportionally represented and that projects of different sizes and with project leaders from different member states are selected. The sample of projects for 2003, 2004 and 2005 has been varied on the following criteria:

- Year
- Theme (health information, health threats, health determinants)
- Action line
- Leader organisation
- Country of origin leader organisation

In reference to the calls for proposals⁴⁰ for the period 2003-2004 the call is, in addition to the 15 Member States of the European Union and the acceding countries, also open to participation by the EFTA-EEA countries (Iceland, Liechtenstein and Norway) within the context of the Agreement on the European Economic Area. The call is also open to the applicant countries, which will participate in the public health programme.

- Number of associated partners
- Geographic scope of project (Europe, European Union, acceding countries, applicant countries, EFTA and EEA countries)
- Project status (completed or ongoing)
- Starting date, duration (in months) and end date
- Percentage accepted contribution (Accepted contribution from the Commission / Total cost)

³⁹ http://europa.eu.int/comm/health/ph_projects/project_en.htm

⁴⁰ Call for proposals 2003 – Programme of Community Action in the Field of Public Health (2003-2008), 2003/C 62/04
Call for proposals 2004 - Programme of Community Action in the Field of Public Health (2003-2008), 2004/C 52/06

The financial provisions in the calls for proposals for the period 2003-2005 describe that the financial contributions under the call could be envisaged for a maximum financing of up to 80% of eligible costs where a project has significant European added value, involves the acceding states and applicant countries in a substantial manner, as well as having regard to the cross-cutting themes set out in the work plan. In our selection of projects we have taken this into account.

With regard to project leaders of the *rejected proposals*, we propose to select 1 proposal per theme per year, which totals to 10 projects for the years 2003-2005 (see Appendix 6). For this purpose the following criteria have been applied:

- Year
- Theme (health information, health threats, health determinants, crosscutting applications (only for 2003))
- Action line
- Leader organisation
- Country of origin leader organisation

In reference to the calls for proposals for the period 2003-2005 the call is, in addition to the Member States of the European Union and the acceding countries, also open to participation by the EFTA-EEA countries (Iceland, Liechtenstein and Norway) within the context of the Agreement on the European Economic Area. The call is also open to the applicant countries, which will participate in the public health programme.

- Number of associated partners
- Geographic scope of project (Europe, European Union, acceding countries, applicant countries, EFTA and EEA countries)
- Total budget
- Reason for rejection (this information was only available for the rejected proposals in 2003).

With regard to interviewing a representative *sample of other relevant stakeholders*, we suggest to use the selection criterion: How likely is it that an interviewee's opinions and observations reliably reflect those of the entire population to which he or she belongs? What this means for each of the indicated stakeholder group is further described below.

Sample of interviewees

Due to time and budget constraints, we are limited to interviewing a sample of all potential stakeholders.

Selected project leaders and proposal leaders

The interviews, which can be either face-to-face or telephone interviews with selected project leaders and proposal leaders (of non-granted proposals) should focus on assessing understanding of the Public Health Programme and will address objectives and expected impacts of the projects, position

of project in the Public Health Programme (Theme), possible missing information on resources/realisations. In interviewing project leaders we will also ask for the (dissemination of) results of the projects, perceived impacts of the project, administrative management and communications with DG SANCO, added value and sustainability of the project and adequacy with public health needs; clearly the interviews will build on the information gathered in the survey. The project leaders of the 43 selected studies will be contacted as well as 10 proposal leaders of proposals that were not granted. We aim to interview a minimum of 35 project/proposal leaders (assuming that a response rate of approximately 70% is feasible).

Selected Commission officials

There are two types of commission officials that we would like to interview: selection committee members, as well as staff members of DG SANCO C1-C4, DG Research, DG Employment, DG INFSO, DG Environment, and DG Agriculture (complementary areas). The selection committee members should be in a good position to assess programme coherence and the project selection process. DG SANCO officials will be mainly queried about project monitoring, programme results and impacts at the EU level. The officials from the other directorates general will mainly be interviewed on the overlap that this programme has with their own programmes and the extent to which communication and coordination takes place. We suggest that a representative sample of these officials would encompass at least 5 selection committee members, 5 DG SANCO officials and 5 officials from each of the other DG's mentioned (i.e. 1 person per DG).

Selected National Health Authorities

Only health authorities from a range of EU countries can address the questions to what extent the programme overlaps with national programmes and activities and what are the broader impacts and added value of EU intervention. With the help of contacts from the High Level Committee on Health, the Members of the Programme Committee or the Network of Competent Authorities (for Health Information) as provided by the European Commission, we will select a minimum of 15 national health authorities that represent member states, acceding countries, applicant countries, EFTA, and EEA countries for interviewing.

Representatives of international organisations

Representatives of the organisations WHO, OECD and the EU Health Policy Forum should be in a good position to assess the complementarity of the programme with their own activities, as well as possibly national activities they might know of (Questions 7 and 8). We will select a minimum of 5 persons for an interview.

Representatives of interest groups and of academics

Representatives of the interest groups such as the High Level Committee for Health, Association of Schools for Public Health in the European Region, European Public Health Association, Public Health Agencies such as the European Monitoring Centre for Drugs and Drug Addiction, European Environment Agency and European Centre for Disease Prevention and Control and well-known academics in the field of public health (e.g. Martin McKee, Ulrich Laaser), should be in a good position to assess whether the current Programme addresses the stakeholder and citizen needs

(Question 1). We select 1 person to interview per interest group/academic world with a minimum of 5 persons.

3.3.4 **Confidentiality**

We acknowledge that in research concerning a dependency relationship between two stakeholders (as projects are dependent upon funding of DG SANCO), it is preferable to keep answers confidential, as attribution could lead to biased answers. Therefore, all written surveys will have the following text:

"All your answers will be treated with confidentiality: no attribution will be made to specific persons. However, your name will be mentioned in a list of contributors to this research".

Face-to-face and telephone interviews will also be introduced with this phrase.

One obvious exception to the attribution of answers is the case in which we ask specific project-related information from project leaders. However, given our experience with comparable projects, we do not expect that this will hinder the project leaders from answering.

3.4 **Using the evidence and the conceptual framework**

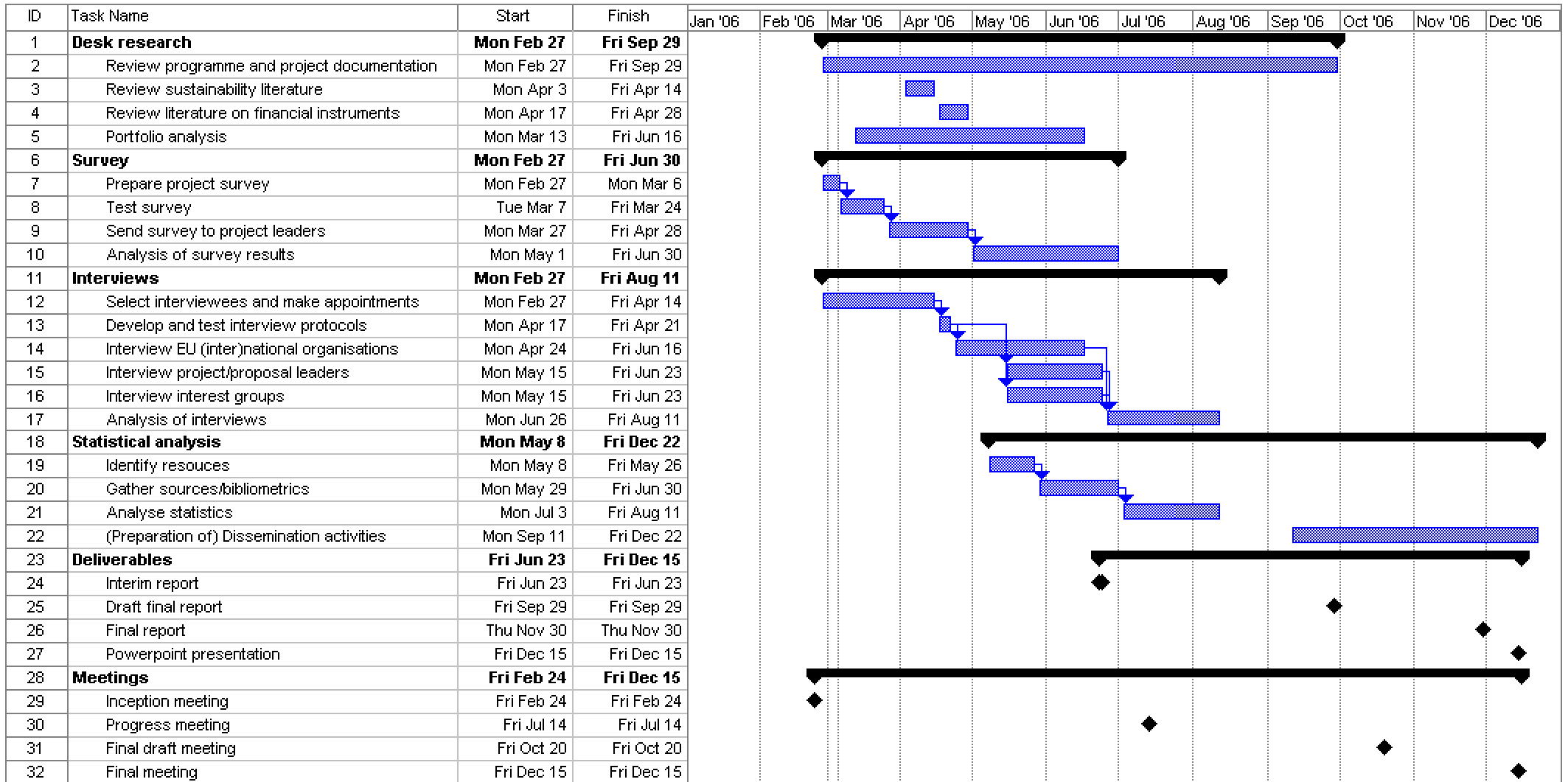
Based on the evaluation methodology and the methods selected we can come to (preliminary) conclusions and recommendations. We will provide a systematic answer to the evaluation questions as presented in this Chapter. The conclusions will be evidence-based and the recommendations will contribute to future and optimal functioning of the Public Health Programme.

CHAPTER 4 Detailed planning

In the proposal we mentioned that in Task 1 (Month 3-6) we would collect data and provide a first answer to 8 of the 13 questions asked in section 2.3 of the Terms of Reference⁴¹. The focus of Task 1 is on data collection and undertaking preliminary analysis. Thereafter, we would conduct Task 2, which should focus on providing answers to the remaining 5 questions, *which in part depend on the results of Task 1*, and revisits the previous questions as needed, focusing on analysis and drawing conclusions. In Task 3 (Month 10-12) formal delivery of the final report and proceeding to other dissemination activities regarding the evaluation were seen as the main activities.

After developing the evaluation methodology, we believe that Task 1 and Task 2 may be subdivided based on the preparation time that is required for the method selected. E.g. developing questionnaires and identifying interviewees could be seen as Task 1 (preparatory phase), whereas the actual interviews and sending out the questionnaire could be seen as Task 2. In the table below we provide a detailed time schedule for the different activities of the interim evaluation taking into account the original planning as stated in the proposal.

⁴¹ Task Specification (Terms of Reference). SANCO Framework Contract on Evaluation, Impact Assessment and Related Services. Annex A of Request for Services in the context of the framework contract on Evaluation, Impact Assessment and Related Services, 2005.



APPENDICES

Appendix 1: Survey of all funded projects

In this appendix we provide the general outline of the web-based survey that will be sent to all projects funded within the Public Health Programme 2003-2008 (PHP)⁴². The web-based lay-out differs from the lay-out that is presented below. The survey consists of questions related to:

A) General information about projects funded within the PHP

B) The PHP and your project

1. Satisfaction with PHP
2. Programme management
3. Project follow-up by the commission
4. Importance of PHP
5. Contribution to PHP objectives
6. Dissemination of research findings
7. Capacity building and sustainability
8. Use of research findings in public health policy
9. Application of research findings in health practice
10. Broader impact on public health/health care sector

⁴² All projects funded until 15-02-06 are included in the sample.

PART A. GENERAL INFORMATION

Please correct and/or update the provided information where necessary.

Title of the project

Workplan addressed

[2003, 2004, 2005]

Theme addressed

Starting date

(Expected) end date

Project leader

Number of associated partners

Number of collaborative partners

Survey completed by:

Name/ title	
Organisation/ Department	
Country	
Telephone/Fax number	
E-mail address	
Date	[generated by server upon survey submission]

PART B. THE PUBLIC HEALTH PROGRAMME AND YOUR PROJECT

1. SATISFACTION WITH PHP

Please rate the following general items:

- Application procedures [very bad, bad, neutral, positive, excellent]+[specify]
- Proposal evaluation procedures [very bad, bad, neutral, positive, excellent]+[specify]
- Overall project administration [very bad, bad, neutral, positive, excellent]+[specify]
- Information on project submission requirements (e.g. call for tender, call for proposal) provided by DG SANCO? [very bad, bad, neutral, positive, excellent]+[specify]
- Relative attractiveness over other schemes [very bad, bad, neutral, positive, excellent]+[specify what attracted you (e.g. alignment of topics, possibility of European-scale impact, career promotion)]
- Relative attractiveness over national programmes [very bad, bad, neutral, positive, excellent]+[specify]
- Strategic orientation of the programme [very bad, bad, neutral, positive, excellent]+[specify]
- The chance to work with numerous European partners [very bad, bad, neutral, positive, excellent]+[specify]
- Project payment arrangements [very bad, bad, neutral, positive, excellent]+[specify]

2. PROGRAMME MANAGEMENT

2a. How would you rate the content of annual workplans?

[very unclear, unclear, neutral, clear, very clear]+[specify]

2b. Which of the elements of the programme were unclear, discouraging or difficult to cope with in the design of the project?

[open question]

3. PROJECT FOLLOW-UP BY THE COMMISSION

3a. How would you rate your interaction with the project officers?

[very bad, bad, neutral, positive, excellent]+[specify in terms of frequency, responsiveness, project officer's expertise]

3b. How would you rate the monitoring and evaluation activities by the PHP?

[very bad, bad, neutral, positive, excellent]+[specify in terms of monitoring frequency, project officer's expertise, issues addressed]

3c. Do you agree that the following should be undertaken for improving monitoring and evaluation of projects?

- Frequency [More often, less often, no change]+[specify]
- More self-assessment procedures at project level [Yes, No]
- More in-depth interim evaluations at project level [Yes, No]
- Increase of external evaluations [Yes, No]

3d. How should monitoring activities take place (e.g. phone, meetings, visits)?

[open question]

4. IMPORTANCE OF PHP

4a. Did the PHP enhance the impact of the project? [Not at all, A little, Moderately, Considerably, Extensively]+[specify]

4b. What would you have changed without the PHP?

- Would not have undertaken the project [yes/no] +[specify]
- Would have done exactly the same project [yes/no] +[specify]
- Funding source [more external funds, more internal funds, no search, n/a] +[specify]
- Scale [smaller, larger, no change, n/a] +[specify]
- Number of partners [smaller, larger, no change, n/a] +[specify]
- Types of partners [more national, more international, no change, n/a] +[specify]
- Time scale [shorter, longer, no change, n/a] +[specify]

- Objectives [Less ambitious, more ambitious, no change, n/a] +[specify]
- Expected benefits [lower expectations, higher expectations, no change, n/a] +[specify]

4c. Does the PHP facilitate networks of PH stakeholders? [Not at all, A little, Moderately, Considerably, Extensively]+[specify]

5. CONTRIBUTION TO PHP

5a. Is your project a follow-up activity of a former PHP or another EU-funded activity? [Yes, No]+[specify how this project followed former activities].

5b. Rate the extent to which your project helped achieve the objectives set in the Programme Decision and annual work plans? [Not at all, A little, Moderately, Considerably, Extensively]+[specify]

5c. To what extent does the programme overlap with other activities of national and/or international organisations that you know of? [Not at all, A little, Moderately, Considerably, Extensively]+[specify whether this is desirable]

5d. To what extent is the programme complementary to other activities of national and/or international organisations that you know of? [Not at all, A little, Moderately, Considerably, Extensively]+[specify]

6. DISSEMINATION OF RESEARCH FINDINGS

6a. Please indicate which of the following publications were generated by your project (peer-reviewed journal article, book (incl. PhD thesis), other media used (e.g. newspaper articles, DVD, TV, radio)). Please specify below.

Type	Publication
Article, Book, Other	

(list grows as respondents fill in)

6b. Please state how many presentations have been made to the following types of audiences (target groups). What is the potential size of each target group? What percentage did you reach?

Audience	Level	Number of presentations	Potential size of target group	What percentage did you reach?	Comments
Primarily academic audiences	European				
	National				
	Regional/Local				
Primarily health practitioner audiences	European				
	National				
	Regional/Local				
Primarily policy-oriented audiences	European				
	National				
	Regional/Local				
Primarily service user (e.g. patient, citizens, industry) audiences	European				
	National				
	Regional/Local				
Other (please specify)	European				
	National				
	Regional/Local				

6c. Which factors strongly (positively or negatively) influence the outcome of your project? (E.g. specific audience, timing, staffing, budget, the research findings being taken up by key stakeholders etc).

[open question]

6d. Did the target groups of your project express an opinion on its quality / usefulness / interest following dissemination? How was the opinion taken into account?

[open question]

7. CAPACITY BUILDING AND SUSTAINABILITY

7a. Has participation in this project led to formal or practical qualifications (e.g. PhD, degree, qualification) for any members of the project team or target group? [Yes, No]+[specify]

Degree/qualification	Specific target group	Number of people

(list grows as respondents fill in)

7b. Have the project findings, methodology or theoretical developments generated follow-up activities? [Yes, No]+[specify]

Title of follow-on projects	Lead organisation	Importance of your project	Size of grant (€)
		[Considerable, moderate, small]	

7c. Is the sustainability of the project and of its results guaranteed once the financing support of the PHP will be stopped? [Yes, No, Don't know]+[specify how this will be guaranteed (e.g. financing, use of project output, further development of content)].

8. USE OF RESEARCH FINDINGS IN PUBLIC HEALTH POLICY

8a. Have the activities of your project influenced policy as described below or are these influences expected?

- Changes in decisions by the Ministry of Health [yes, no, expected]+[specify]
- Citing of the findings by advisory councils [yes, no, expected]+[specify]
- Citing of the findings in guidelines from a national or local professional group [yes, no, expected]+[specify]
- Inclusion of the findings in a contract or in a document from an audit, an inspectorial or an evaluative body [yes, no, expected]+[specify]
- The establishment of a working group to examine the implications or implementation of the findings [yes, no, expected]+[specify]

9. APPLICATION OF RESEARCH FINDINGS IN PUBLIC HEALTH PRACTICE

9a. Have the activities of your project led to changes in public health practice as described below or are these influences expected?

- Application of policies [yes, no, expected]+[specify]
- In the behaviour of public health practitioners & managers [yes, no, expected]+[specify]
- In the involvement of users (patients, citizens) [yes, no, expected]+[specify].

10. BROADER IMPACT ON PUBLIC HEALTH / THE HEALTH SECTOR

10a. Have the activities undertaken led to broader impact as described below or are these influences expected?

- Improved health status [yes, no, expected]+[specify]
- Risk factor reduction [yes, no, expected]+[specify]
- Improved services and protection [yes, no, expected]+[specify]
- Appropriate methods for continuing surveillance [yes, no, expected]+[specify]

11. **Would you mind if we contact you for a follow-up interview? [yes, no]**

PART D. COMMENTS

If you wish to make any further comments about your project or this survey please use the space provided below.

Thank you very much for your assistance!

Appendix 2: Stakeholder interview protocol

In this appendix we will provide an overview of the questions for the selected interview (face-to-face/telephone) with key stakeholders (as described in Chapter 3). The interview will last approximately 45 minutes.

The interview will address:

- Awareness of the Public Health Programme 2003-2008 (PHP) (interview questions 1-2)
- Relevance and acceptability of the PHP (interview questions 3-4)
- Consistency and complementarity of the PHP (interview questions 5-6)
- Effectiveness and sustainability of the PHP (interview questions 7-8)
- Efficiency of the PHP (interview questions 9-10)
- Other comments/remarks (interview question 11)

Per interview question we indicate for which stakeholder group these questions are relevant:

- PL: project leaders of granted projects
- RP: proposal leaders of rejected proposals
- DI: directly involved officials of DG SANCO and committee members
- EC: officials of other DGs
- NH: National Health Authorities
- IO: International organisations
- IG: Interest groups

INTERVIEW QUESTIONS

(The first question is to determine the interviewee's knowledge of the programme and his/her ability to answer the subsequent questions). We indicate between [brackets] to which stakeholder group these questions refer.

1. Knowledge of the PHP [all]

- Do you know the general objectives and themes that this programme addresses?
- Are you aware of specific projects [PL: except for your own] that were started through this programme?
- To which degree do the effects of the PHP meet health challenges? [RP, PL, NH, IG: as seen from the perspective of your Member State; DI, EC, IO, IG: as seen from a EU or international level perspective]

2. Interviewee's role in the Public Health Programme 2003-2008 (PHP) [DI, EC, NH, IG, IO]

- To what extent do you have any influence on the PHP?

3. Stakeholders targeted [all]

- Does the PHP address the relevant target groups in your Member State? Are there audiences that should be targeted but are not? [RP, PL, NH, IG]
- Do you think that the groups targeted by the projects within the programme(s) have indeed benefited from them? To what extent?
- Did the target groups of the programme(s) express an opinion on its quality / usefulness / interest? How was this measured?

4. Rationale and focus of PHP [all except DI]

- To what extent does your organisation/stakeholders accept the role of government in public health policy? Are there limits to this role?
- Is there a rationale for European intervention in public health? Does this answer differ for different stakeholder groups?
- To what extent does your organisation/stakeholders accept the current Programme?
- Does the current Programme address stakeholder and citizen needs?

- Are there themes that, in your opinion, need to be added or removed? If so, why?

5. Synergies between national/international policies and activities and the programme [all]

- Did the PHP influence the design and/or implementation of (public health) programmes? [DI: in general; PL, RP, NH: in your Member State; EC, IO, IG: of your organisation]
- Do national health authorities or international organisations actively use or promote the PHP outcomes?
- Can you also mention areas and activities (specific examples) where the policies of different levels (regional, national, European, international) may concur?
- Do you have suggestions for removing (potential) barriers or promoting facilitators to improve synergies?

6. Overlap between the PHP and other EC programmes/activities [DI, EC]

- To what extent does the PHP interact with other EC activities?

7. Success of the programme [all]

- Which are the most important outcomes of your project? Does this contribute to the overall objectives of the PHP? [PL]
- Do the annual work plans support the Programme's objectives? [PL, DI]
- Which are the most important outcomes of the PHP?
- Did the programme/project meet the needs of specific stakeholders? Which?
- Are you aware of indicators that have been collected to measure success? Are those indicators available?
- Have the results of one or more projects directly been used in your Member State/organisation? If yes, how and to what extent? [EC, NH, IO, IG]

8. Long-term effects [all]

- Are there long-term effects (anticipated)? Are these already visible?
- Are projects expected to continue to function and to produce results beyond support of the PHP?

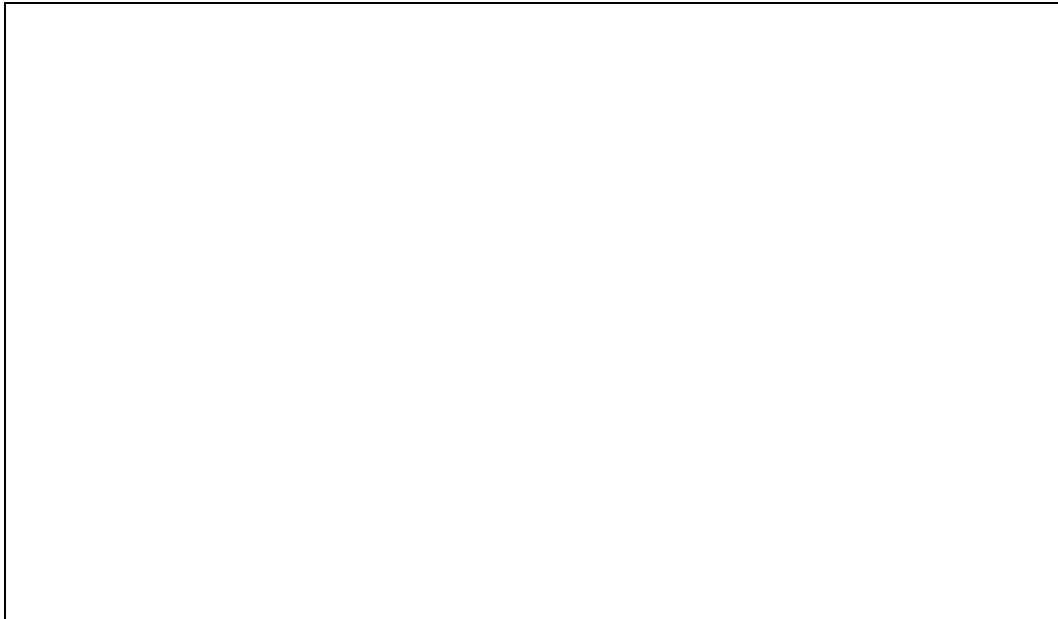
9. Procedure for the call for applications [RP, PL, DI]

- To what extent could dedicated calls for tender for specified and prescribed projects improve the achievement of the Programme objectives? In other words: would you prefer calls for tender above calls for proposal?
- Are there improvements to be made to the call procedure?

10. Expertise of the management staff [RP, PL, DI]

- To what extent was the staffing of the Programme management sufficient for the selection, monitoring and evaluation of the projects?
- How would you assess the management and reporting procedures of the PHP?

11. Comments or remarks [all]



Appendix 3: Selected projects for interviews 2003

	Project Title	Proposal number	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	End date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution
1	ENHIS - Implementing Environmental and Health Information System in Europe	791311	Health information	Developing and co-ordinating the health information system	WHO (World Health Organization), Regional Office for Europe	Denmark	12	EU	Completed	1/7/2004	30/06/2005	12	1118286	390614	0.35
2	Unified Central and Eastern European surveillance/monitoring system for healthcare quality and efficiency indicators CEEQNET (Central and Eastern Europe Quality Network)	791257	Health information	Operating the health information system	Institute of Health Information and Statistics	Slovak Republic	4	Central and Eastern Europe	Ongoing	1/5/2004	31/07/2006	26	636500	500000	0.79
3	AgeingNutrition - Comparative analysis of existing data on nutrition and lifestyle of the ageing population in Europe, especially in the "new" Baltic, Central and Eastern regions of the Community	790880	Health information	Developing mechanisms for the reporting and analysis of health issues and producing public health reports	Rheinische Friedrich-Wilhelms-Universität Bonn	Germany	13	"New" Baltic, Central and Eastern regions of the Community	Ongoing	1/5/2004	30/04/2006	24	300000	240000	0.80

Project Title	Proposal number	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	End date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution
4 EUPREVCON - EU Evidence-based Consensus Conference on Prevention of Cardiovascular Diseases	791244	Health information	Developing strategies and mechanisms for preventing, exchanging information and responding to non-communicable disease threats, including gender specific health threats and rare diseases	DoHC (Department of Health and Children)	Ireland	2	EU and accession countries	Completed	1/12/2003	28/02/2005	15	282939	226351	0.80
5 eHID - Electronic Medical Records for Health Indicator Data	791043	Health information	eHealth	University of Nottingham	United Kingdom	8	EU	Ongoing	1/7/2004	30/06/2007	36	492363	295418	0.60
6 The effectiveness of Health Impact Assessment	791307	Health information	Health Impact Assessment	WHO (World Health Organization), Regional Office for Europe	Denmark	16	EU and accession countries	Ongoing	15/08/2004	15/08/2007	36	1241667	745000	0.60
7 Ben RHM II - Benchmarking Regional Health Management (Phase 2)	790874	Health information	Co-operation between Member States	Ministry of Health, Social Affairs, Women and Family	Germany	7	Europe	Ongoing	1/6/2004	31/05/2007	36	1066027	639616	0.60
8 EpiNorth – A framework for communicable disease surveillance, communication and training in Northern Europe, 2004-2006	791202	Health threats	Surveillance	Norwegian Institute Of Public Health	Norway	6	Northern Europe and parts of Russia	Ongoing	1/1/2004	31/12/2006	36	572393	343436	0.60
9 GSCT - Development of Generic Scenarios alerting system and training modules relating to the release of Chemicals by Terrorists	790951	Health threats	Health security and preparedness	Health Protection Agency	United Kingdom	3	EU	Ongoing	1/11/2003	30/04/2007	42	1041659	832732	0.80

Project Title	Proposal number	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	End date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution
10 European Quality System For Tissue Banking	790978	Health threats	Safety of blood, tissues and cells	Hospital Clinic I Provincial De Barcelona	Spain	15	EU	Ongoing	15/05/2004	15/05/2007	36	929768	548563	0.59
11 ESAC - European Surveillance of Antimicrobial Consumption	790835	Health threats	Antimicrobial resistance	Universiteit Antwerpen	Belgium	27	Europe	Ongoing	1/2/2004	31/1/2007	36	2201516	880606	0.40
12 EU-IBIS - Invasive Bacterial Infections Surveillance in the European Union	790917	Health threats	Surveillance	Health Protection agency – Communicable Disease Surveillance Centre	United Kingdom	38	EU	Ongoing	2/10/2003	30/09/2006	36	1179588	665877	0.56
13 ENYPAT Framework Project 2003	790842	Health determinants	Supporting key Community strategies on addictive substances: Tobacco	KTL (National Public Health Institute)	Finland	18	EU and accession countries	Completed	1/1/2004	31/12/2004	12	2395256	1387021	0.58
14 EUROCARE - Alcohol Policy Network in the Context of a Larger Europe: Bridging the Gap	790823	Health determinants	Supporting key Community strategies on addictive substances: Alcohol	Alliance House Foundation	United Kingdom	0	EU, applicant countries, EEA countries and Switzerland	Ongoing	1/12/2003	30/11/2006	36	1479934	1139550	0.77
15 ENDIPP - European Network on Drugs and Infections Prevention in Prison	791120	Health determinants	Supporting key Community strategies on addictive substances: Drugs	Wissenschaftliches Institut der Ärzte Deutschlands geme-e.V.	Germany	1	EU member states and applicant countries	Ongoing	1/12/2003	30/11/2006	36	3158704	1895223	0.60

	Project Title	Proposal number	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	End date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution
16	The way forward: a European partnership to promote the sexual and reproductive health and rights of youth	790910	Health determinants	Integrative approaches on lifestyle and sexual health: Sexual Health	IPPF-EN (International Planned Parenthood Federation European Network)	Belgium	2	Europe	Ongoing	1/5/2004	30/04/2007	36	1124125	674475	0.60
17	European Centre AIDS & Mobility A&M	790846	Health determinants	Integrative approaches on lifestyle and sexual health: HIV / AIDS	NIGZ (Netherlands Institute for Health Promotion and Disease Prevention)	The Netherlands	16	EU and applicant countries	Ongoing	1/1/2004	31/12/2006	36	2048934	1559334	0.76
18	Implementation of mental health promotion and prevention policies and strategies in EU Member States and applicant countries	791068	Health determinants	Integrative approaches on lifestyle and sexual health: Mental Health	FIOSH (Federal Institute for Occupational Safety and Health)	Germany	7	EU member states and applicant countries	Ongoing	1/7/2004	30/06/2006	24	1499424	895118	0.60
19	ENHPS – European Network on Health Promoting Schools	791312	Health determinants	Cross-cutting theme	WHO Regional Office for Europe	Denmark	0	EU	Completed	1/12/2003	30/11/2004	12	489002	293401	0.60
20	Coordination and Administration of the European Injury Prevention Network	791171	Health determinants	Disease prevention and prevention of injuries	National and Kapodistrian University of Athens	Greece	10	EU	Ongoing	1/4/2004	31/03/2006	24	782089	469253	0.60
21	EMPH - European Master of Public Health	790993	Health determinants	Capacity building	ASPHER (Association of Schools of Public Health in the European Region)	France	11	EU	Completed	1/3/2004	31/12/2005	20	144380	86628	0.60

	Project Title	Proposal number	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	End date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution
22	EUROTHINE - Tackling Health Inequalities In Europe: an integrated approach	790909	Health information	Cross-cutting theme	EMC (Erasmus MC) - The Universitair Medisch Centrum Rotterdam (University Medical Center Rotterdam)	Netherlands	45	Europe	Ongoing	1/9/2004	30/08/2007	36	1056727	634036	0.60
23	HEM - Closing the Gap - Reducing Premature Mortality. Baseline for Monitoring Health Evolution Following Enlargement	791083	Health information	Cross-cutting theme	COI (Centrum Onkologii)	Poland	0	EU and applicant countries	Ongoing	1/12/2004	30/11/2007	36	974300	584580	0.60

Appendix 4: Selected projects for interviews 2004

	Project Title	Proposal number	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	End date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution
1	EHIP - European Health Information Platform	790685	Health information	Developing and co-ordinating the health information system	European Broadcasting Union	Belgium	5	EU	Ongoing	1/2/2005	30/04/2006	15	Developing and co-ordinating the health information and knowledge system	1871147	0.35
2	HAEMACARE - Cancer Registry based Project on Haematologic Malignancies	790573	Health information	Operating the health information system	Instituto Nazionale Per Lo Studio E La Cura Dei Tumori	Italy	6	Europe	Ongoing	1/11/2005	31/10/2008	36	Operating the health information and knowledge system	596652	0.79
3	PIA - PHR Policy Impact Assessment Of Public Health Reporting	790768	Health information	Developing mechanisms for the reporting and analysis of health issues and producing public health reports	Landesinstitut Für Den Öffentlichen Gesundheitsdienst Nordrhein-Westfalen	Germany	8	EU	Ongoing	1/9/2005	31/08/2008	36	Developing mechanisms for reporting and analysis of health issues and producing	789607	0.80

Project Title	Proposal number	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	End date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution	
												public health reports			
4	RDTF - Scientific Secretariat Of The Rare Disease Task Force	790837	Health information	Developing strategies and mechanisms for preventing, exchanging information and responding to non-communicable disease threats, including gender specific health threats and rare diseases	Institut National De La Santé Et De La Recherche Médicale	France	1	EU	Ongoing	1/6/2005	31/05/2008	36	Improving access to and the transfer of data at EU level	560549	0.80
5	WHO/European eHealth consumer trends survey	790622	Health information	eHealth	Universitetssykehuset Nord-Norge HF, Norwegian Centre for Telemedicine	Norway	6	Europe	Ongoing	1/6/2005	31/05/2008	36	eHealth	733713	0.60
6	HIA-NMAC - Health Impact Assessment In New Member States And Pre-Accession Countries	790725	Health information	Health Impact Assessment	Syddansk Universitet (SDU)	Denmark	10	New Member States And Pre-Accession Countries	Ongoing	1/8/2005	31/07/2007	24	Health Impact Assessment	1056860	0.60
7	International Conference "Challenges Of Delivering Health In The Enlarged Europe - Experience And Perspectives From Member States And Accession Countries"	790864	Health information	Co-operation between Member States	Faculty Of Public Health, Medical University, Sofia	Bulgaria	8	EU	Ongoing	15/07/2005	15/11/2006	16	Co-operation between Member States	150784	0.60

	Project Title	Proposal number	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	End date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution
8	ESSTI - European Surveillance Of Sexually Transmitted Infections	790599	Health threats	Surveillance	Health Protection Agency	Greece	32	EU, EFTA, Bulgaria, Romania, Turkey	Ongoing	1/1/2006	31/12/2008	36	Surveillance	2255995	0.60
9	Development Of An Improved Diagnostic Capability In The Eu With The Collaboration Of Russian Scientists	790708	Health threats	Health and security preparedness	Robert Koch-Institut	Germany	1	EU	Ongoing	1/1/2006	31/12/2008	36	Health security and preparedness	872852	0.80
10	EU-Q-Blood-SOP - Development of a pan-European standard operating procedure (SOP) methodology reflecting European best practice	790659	Health threats	Safety of blood, tissues and cells	DRK Blutspendedienst Baden-Württemberg-Hessen	Germany	15	Europe	Ongoing	1/10/2005	30/04/2007	18	Safety of blood, tissues and organs	495028	0.59
11	ETHREAT - European Training For Health Professionals On Rapid Response To Health Threats	790740	Health threats	Capacity building	National And Kapodistrian University Of Athens	Greece	6	Europe	Ongoing	1/5/2005	30/04/2008	36	Capacity building	444809	0.40
12	European Coordinated Action For The Reduction Of Smoking Prevalence And Tobacco Related Harm.	790614	Health determinants	Supporting key Community strategies on addictive substances: Tobacco	Réseau Européen Pour La Prévention Du Tabagisme "European Network For Smoking Prevention"	Belgium	60	Europe	Completed	1/3/2005	28/02/2006	12	Tobacco: Smoking prevention and cessation	4153716	0.69
13	ELSA - ENFORCEMENT OF NATIONAL LAWS AND SELF-REGULATION ON ADVERTISING AND MARKETING OF ALCOHOL	790581	Health determinants	Supporting key Community strategies on addictive substances: Alcohol	Stichting Alcoholpreventie	Netherlands	22	25 Member States and applicant countries and Norway	Ongoing	14/06/2005	14/06/2007	25	Alcohol	727407	0.58

	Project Title	Proposal number	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	End date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution
14	Democracy, cities and drugs	790783	Health determinants	Supporting key Community strategies on addictive substances: Drugs	FESU - Forum Européen pour la Sécurité Urbaine	France	7	Europe	Ongoing	1/2/2005	31/01/2008	36	Drugs	1740531	0.77
15	TAMPEP7 - European Network for Transnational AIDS/STI Prevention among Migrant Prostitutes	790665	Health determinants	Integrative approaches on lifestyle and sexual health: Sexual Health	TAMPEP International Foundation	Netherlands	22	EU, accession countries and 2 associated countries	Ongoing	1/1/2005	31/12/2006	24	Sexual and reproductive health	992960	0.60
16	ICAAASE - Innovative Care Against Social Exclusion	790811	Health determinants	Public health actions to address wider determinants of health: Social Determinants	OMEGA - Verein für Opfer Von Gewalt und Menschenrechtsverletzungen	Austria	4	EU and applicant countries	Ongoing	14/06/2005	14/12/2007	30	Socio-economic determinants of health	675747	0.60
17	EURO HEAT - Improving Public Health responses to extreme weather/heat-waves	790648	Health determinants	Public health action to address wider determinants of health: Environmental	World Health Organization, Regional Office For Europe	Denmark	5	Europe	Ongoing	1/4/2005	31/03/2007	24	Environmental health determinants	1322082	0.76
18	DRAGON FLY - Development Of Structures For Dissemination of Good Practice in the Field Of Workplace Health Promotion in The Acceding And The Applicant Countries	790606	Health determinants	Public health action to address wider determinants of health: Several of the above	The Nofer Institute of Occupational Medicine	Poland	5	Acceding and applicant countries	Completed	3/4/2005	21/10/2006	18	Health determinants	286525	0.60

	Project Title	Proposal number	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	End date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution
19	European Cancer Network	790832	Health determinants	Disease prevention and prevention of injuries	IARC – International Agency for Research on Cancer - World Health Organization	France	3	Europe	Ongoing	1/6/2005	30/09/2007	28	Disease prevention	803321	0.60
20	BALTIC HEALTHTRAIN - Baltic Sea Public Health Training Network	790755	Health determinants	Capacity building	University Of Tartu	Estonia	7	Baltic Sea region	Ongoing	1/7/2005	31/05/2007	24	Training in public health	341231	0.60

Appendix 5: Selected projects for interviews 2005

	Project Title	Proposal number	Theme	Acton line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution
1	E-Health 2006 High Level Conference	790545	Health information	eHealth	Fundación Progreso y Salud	Spain	0	EU and EFTA countries	Ongoing	2006	12	849030	300000	0.35
2	Quality Labelling of Medical Web Content using Multilingual Information Extraction	790604	Health information	eHealth	National Centre for Scientific Research "Demokritos"	Greece	6	EU	Ongoing	2006	36	1472315	774064	0.53
3	Scientific Platform of the Working Party 'Lifestyle and other Health Determinants'	790631	Health information	Operating the health information system and knowledge system	Technische Universität Dresden	Germany	3	EU	Ongoing	2006	28	1553602	932152	0.60

	Project Title	Proposal number	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope project	Project status	Starting date	Duration (months)	Total cost (Euro)	Accepted contribution Commission (Euro)	Percentage accepted contribution
4	Feasibility of a European Health Examination Survey	790742	Health information	Developing strategies	National Public Health Institute	Finland	4	EU	Ongoing	2006	24	909709	775767	0.85
5	Building Capacity for Improving Health across Europe	790534	Health determinants	Capacity building	Health Promotion State Agency	Latvia	11	New EU member states and applicant countries	Ongoing	2006	18	257797	154678	0.60
6	European Alliance Against Depression II	790537	Health determinants	Mental Health	Ludwig-Maximilians-Universität München	Germany	18	Europe	Ongoing	2006	30	1842051	1050000	0.57
7	Organisation of a conference on the prevention of type 2-diabetes during the Austrian presidency	790568	Health determinants	Disease prevention and prevention of injuries	Austrian Institute of Health	Austria	1	EU	Ongoing	2006	13	267585	160550	0.60
8	Health in the World of Work – Prolonging Healthy Working Years	790580	Health determinants	Social determinants	Finnish Institute of Occupational Health	Finland	25	Europe	Ongoing	2006	20	274865	148718	0.60
9	Tackling Health Inequalities: Governing for Health	790607	Health determinants	Public health actions to address the wider determinants of health	UK Public Health Assoc/Royal College of Physicians	United Kingdom	8	EU	Ongoing	2006	12	1104185	500000	0.45
10	Peer Education project for young drivers to prevent alcohol and drugs in connection with road use – Drive Clean!	790660	Health determinants	Supporting community key actions on additional substances	MISTEL/Sozialpädagogisches Institut Berlin Forschung GmbH	Germany	13	Europe	Ongoing	2006	36	2517504	675000	0.27

Appendix 6: Selected proposals for interviews 2003-2005

	Proposal Title	Proposal number	Year	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope proposal	Total budget (Euro)
1	Promote Health and Prevent the Illnesses acting on the Determining Factors in all Politics and Activities	790848	2003	Health information	Operating the health information system	Fundacio Gresol - Project Home	Spain	5	EU and acceding countries	942369
2	Save Antibiotics for Europe - SAFE	790997	2003	Health threats	Antimicrobial resistance	University Medical Centre Utrecht - Eijkman Winkler Institute	Netherlands	16	Europe	991361
3	Determinants of physical activity, sedentary behaviour and nutritional practices in European children and youth	790827	2003	Health determinants	Nutrition and physical activity	Loughborough University	United Kingdom	12	Europe	193290

	Proposal Title	Proposal number	Year	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope proposal	Total budget (Euro)
4	The development of practice relevant methods and procedures for the integration of health provision in Europe in accordance with needs and quality considerations (INTEGRAEUROHEALTH)	790987	2003	Cross cutting theme	-	Thuringian Ministry of Social Affairs, the Family and Health	Germany	13	Europe	259417
5	Trans European Environmental, Educational and Health Network	790746	2004	Health information	Improving acces to and the transfer of data at EU level	National And Kapodistrian University of Athens	Greece	13	EU and acceding countries	1120646
6	Safety of Blood and Blood Components. Quality Management Systems Implementation in Blood Transfusion Services	790646	2004	Health threats	Safety of blood, tissues, cells and organs	World Health Organisation	Denmark	14	EU, applicant countries, EFTA-EETA	502886
7	Therapeutic Community Phoenix - Development of Best Practice For Rehabilitation of Drug Dependent Individuals in Bulgaria	790578	2004	Health determinants	-	Institute for Ecology of Cognition	Bulgaria	1	Bulgaria	4389560
8	Pragmatic approach to health behaviour in monitoring in Europe	790591	2005	Health information	Developing and co-ordinating the health information system Developing mechanisms for the reporting and analysis of health issues and producing public health reports	Kaunas University of Medicine	Lithuania	21	Europe	568222
9	Surveillance of Antimicrobial Resisantace and its Dynamic Relationship to Antimicrobial Use by Time Series Analysis: a Pilot European Network	790658	2005	Health threats	Antimicrobial resistance	Centre Hospitalier Universitaire de Besançon	France	18	EU	1713223

	Proposal Title	Proposal number	Year	Theme	Action line	Leader organisation	Country of origin	# of partners	Geographic scope proposal	Total budget (Euro)
10	Planning effective prevention of obesity: from the understanding of determinants to intervention evaluation	790748	2005	Health determinants	Public health actions to address wider determinants of health: Social Determinants	European Medical Association	Belgium	9	Europe	696827

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